VAN NATTA'S
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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 precedental value.

JULY-SEPTEMBER 1995

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CITE AS

47 Van Natta ____ (1995)

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 94-04361
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order which affirmed an Order on Reconsideration's aggravation date for claimant's left carpal tunnel condition. The insurer cross-requests review of that portion of the ALJ's order which awarded temporary partial disability benefits for the period October 10, 1990 through January 20, 1993. On review, the issues are aggravation date and temporary disability benefits. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation Date

On April 17, 1989, claimant first saw Dr. Wayson for complaints of bilateral numbness and tingling in her hands with arm pain primarily on the right. (Ex. 1). By stipulated agreement approved September 26, 1989, the insurer accepted claimant's right carpal tunnel syndrome (CTS).

On March 19, 1991, claimant filed a separate occupational disease claim for left CTS, listing the date of injury as March 15, 1991. (Ex. 9). On February 12, 1993, the insurer accepted the left CTS as a disabling claim. The acceptance was preceded by a January 7, 1993 Order on Review finding the left CTS compensable. Arlene J. Koitzsch, 45 Van Natta 13 (1993).

On October 29, 1993, claimant's left CTS claim was closed by Determination Order (DO) that awarded temporary total disability from January 21, 1993 through August 10, 1993. Determining that the date of injury of this left wrist claim was October 27, 1989, the DO stated that claimant had five years from that date within which to file an aggravation claim. An Order on Reconsideration increased claimant's permanent disability award, but affirmed the DO in all other respects.

Claimant requested a hearing, seeking modification of the "aggravation date" contained in the DO. The Referee concluded that, because claimant first sought treatment for her bilateral CTS on April 17, 1989, even though she did not file a left CTS claim until March 1991, the correct date from which to calculate aggravation rights was April 17, 1989. The Referee relied on the reasoning expressed in Donald G. Stacy, 45 Van Natta 2360 (1993), aff'd Stacy v. Corrections Division, 131 Or App 610 (1994).

Claimant has requested Board review, contending that the Referee incorrectly relied on Stacy in affirming the aggravation date stated on the DO and Order on Reconsideration. We agree.

ORS 656.273(4)[1] provides:

"(a) The claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268."

"(b) If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury."

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[1] Although the Legislature amended parts of ORS 656.273, this subsection was not amended. See Senate Bill 369 (SB 369), 68th Leg., Reg. Sess. (June 7, 1995).

In Stacy, we determined the "date of injury" for an initial occupational disease claim for purposes of determining aggravation rights for a nondisabling injury. See ORS 656.273(4)(b). Specifically, in Stacy, we disavowed our holding in Robert E. Wolford, 45 Van Natta 435 (1993), which had held that in the case of an occupational disease claim, the "date of injury" for purposes of determining a claimant's aggravation rights is the date that the insurer accepts the occupational disease claim. Relying on Papen v. Willamina Lumber Company, 123 Or App 249 (1993), we held that, for the purposes of determining aggravation rights for nondisabling claims, the "date of injury" in occupational disease claims is either the date of disability or the date when medical treatment is first sought.

Here, claimant's claim was originally accepted as disabling. (Ex. 19). Thus, ORS 656.273(4)(b) does not apply, and the date of injury, as discussed in Stacy, supra, is not determinative. Rather, to determine the date by which an aggravation claim must be filed, we look to the date that claimant's claim was first closed. See ORS 656.273(4)(a). In this case, that date was October 29, 1993. (Ex. 24). Accordingly, claimant must file a claim for aggravation within five years of that date, or before October 29, 1998. The Order on Reconsideration and Determination Order shall be modified accordingly.

Temporary Disability

The disputed temporary disability benefits relate to claimant's left CTS. Claimant contends, and the ALJ found, that claimant was entitled to temporary partial disability benefits between October 10, 1990[2] and January 20, 1993. Claimant argued that Dr. Johnson, treating physician, found claimant partially disabled beginning October 12, 1990, due to her left hand, as well as her right. The ALJ agreed, basing his conclusion on an October 12, 1990 chart note in which Dr. Johnson notes numbness of both hands, right greater than left, and states "[claimant] cannot return to previous duties." (Ex. 4-1).

A claimant's substantive entitlement to temporary disability accrues upon closure and is based on proof of disability due to the compensable claim during the time the claim was open. See SAIF v. Taylor, 126 Or App 658 (1994). Here, the insurer contends that one cannot conclude from Dr. Johnson's chart note that claimant was disabled in October 1990 from her left wrist condition. We agree.

On January 1, 1991, Dr. Nathan examined claimant at the insurer's request. (Ex. 5). The history Dr. Nathan obtained concerning claimant's hand symptoms is informative concerning claimant's left wrist condition in October 1990. Claimant related a history of beginning work at a nursing home in September 1990, working two days and becoming symptomatic in the right wrist. (Ex. 5-1, 5-3). Claimant stated that she then sought treatment on September 28, 1990 from Dr. Johnson, who first diagnosed right wrist tendinitis. (See Ex. 4-1).

On October 12, 1990, claimant returned to Dr. Johnson. He noted numbness of both hands, diagnosed CTS, and stated that claimant could not return to her previous duties (as a nurses aide in the nursing home). (Ex. 4-1, 5-1). However, Dr. Johnson did not indicate whether his diagnosis of CTS was for one hand or both, or that claimant was disabled due to her left CTS.

On July 8, 1991, claimant returned to Dr. Nathan. At that time, Dr. Nathan did not consider claimant to be disabled by her left CTS. (Ex. 12-5). On July 19, 1991, Dr. Johnson concurred that claimant's CTS is "not a reason for disability." (Ex. 13).

In a February 12, 1993 supplemental medical report, Dr. Johnson stated that, as of January 21, 1993, claimant was not released to work. (Ex. 18). The report indicates the date of the injury as March 15, 1991, which is the date of injury for claimant's left CTS. (See Ex. 19). This report from Dr. Johnson is the first in the record from claimant's treating physician that specifically takes claimant off work because of her left CTS. Based on this medical report, the October 1993 DO awarded temporary total disability beginning January 21, 1993.

Because we find no persuasive evidence in this record that claimant was disabled due to her left CTS prior to January 21, 1993, we reverse the ALJ's award of temporary partial disability from October 10, 1990 through January 20, 1993.

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[2] Dr. Johnson's chart note is dated October 12, 1990. The ALJ apparently misread the date as October 10, 1990.

ORDER

The ALJ's order dated July 15, 1994 is reversed in part and affirmed in part. Claimant's 5-year aggravation rights for her left carpal tunnel syndrome claim shall begin to run from October 29, 1993. The ALJ's award of temporary partial disability benefits for the period October 10, 1990 through January 20, 1993 is reversed. The ALJ's "out-of-compensation" attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

July 3, 1995 Cite as 47 Van Natta 1295 (1995)

In the Matter of the Compensation of
DAVID J. ROWE, Claimant
WCB Case No. 94-08059
ORDER ON REVIEW
Schneider, Hooten, et al, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that reduced claimant's scheduled permanent disability awards for loss of use or function of his hands from 20 percent (30 degrees) for the left hand, and 21 percent (31.5 degrees) for the right hand, as granted by an Order on Reconsideration, to zero. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Matter

The ALJ considered "post-reconsideration order" testimony of the medical arbiter concerning the causation of claimant's impairment. Claimant contends that ORS 656.268(7) prohibits the medical arbiter's testimony. We agree.

Amended ORS 656.268(7)(g)[1] provides that, after reconsideration, "no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure." This language has been interpreted as prohibiting the admission of medical evidence of a worker's impairment that was developed after the medical arbiter's report. See Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993).

Subsequent to the ALJ's order, in Daniel Bourgo, 46 Van Natta 2505 (1994), we held that "supplemental" or "clarifying" medical arbiter reports constituted "subsequent medical evidence" of the worker's impairment and, therefore, were prohibited from being admissible under ORS 656.268(7).[2] In addition, we have recently held that ORS 656.268(7) prohibits not only post-arbiter medical evidence of impairment, but also medical evidence concerning the causation of impairment. David B. Weirich, 47 Van Natta 478 (1995).

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[1] ORS 656.268(7) was amended by the 1995 legislature. SB 369, 68th Leg., Reg. Sess., § 30 (June 7, 1995). Amended ORS 656.268(7)(g) provides that: "[a]fter reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the department, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure." The only change is that the statute now prohibits subsequent medical evidence after the date of the Order on Reconsideration rather than after the date of the medical arbiter's report. Here, the medical arbiter's testimony was taken after the date of the Order on Reconsideration. We need not decide whether the amended statute is retroactively applicable because, under either version of the statute, this evidence is inadmissible.

[2] In Bourgo, we noted two limited exceptions to the rule that "post-medical arbiter" reports were inadmissible. Specifically, we noted that "supplemental" arbiter reports were admissible where a supplemental arbiter report was requested by the department or where the arbiter indicated that the initial report was incomplete. Neither of these two exceptions is applicable in this case.

We find no distinction between the medical arbiter's testimony in this case and the "supplemental" or "clarifying" medical arbiter reports discussed in Bourgo. Accordingly, we conclude that the medical arbiter's testimony constitutes "subsequent medical evidence" of the worker's impairment which is prohibited by ORS 656.268(7). Therefore, we conclude that the medical arbiter's testimony is not admissible.

The insurer argues that claimant failed to object to Dr. Peterson's testimony at hearing, and may not now raise his objection on Board review. In light of the express statutory prohibition, we conclude that an express objection is not required. ORS 656.268(7) allows no discretion to the department, the Board, or the courts to admit post-medical arbiter evidence. Rather, the statute explicitly prohibits the admission of "post-medical arbiter" evidence. Accordingly, notwithstanding claimant's failure to timely object, we conclude that Dr. Peterson's testimony is prohibited by ORS 656.268(7).

We distinguish the present case from Arlene J. Koitzsch, 46 Van Natta 1563, on recon 46 Van Natta 2265, on recon 46 Van Natta 2347 (1994). In Koitzsch, at a hearing from an Order on Reconsideration regarding the extent of a claimant's permanent disability, the insurer did not raise a timely objection to an apparently out-of-state physician's status as an attending physician under former ORS 656.005(12)(b)(A). We interpreted the insurer's failure to object as a concession that the doctor was an attending physician. In light of such a concession, we reasoned that the physician's opinion could be considered in rating the extent of the claimant's permanent disability.

Here, by contrast, claimant has not conceded that the "post-medical arbiter" testimony was actually "pre-arbiter," and, in any case, the record does not support a conclusion that the testimony was given prior to the medical arbiter report. Moreover, even assuming that such a concession was made, "post-arbiter report" medical evidence pertaining to impairment is explicitly prohibited by ORS 656.268(7). Thus, we are expressly prohibited from considering the "post-arbiter report" regardless of a party's failure to object.

Our holding in Gary C. Fischer, 46 Van Natta 60, on recon 46 Van Natta 221 (1994), is consistent with this rationale. In Fischer, we found that a medical report from the claimant's attending physician was not relevant because it did not address the claimant's condition on the date of the reconsideration order as required by ORS 656.283(7). On reconsideration, the claimant argued that neither party had objected to the report on relevance grounds. We rejected that argument, concluding that the relevance of the medical report was an inquiry which was necessary for us in performing our statutory duty to weigh the medical evidence and determine the extent of the claimant's permanent disability.

We find Fischer analogous to the present case. Here, in spite of the lack of objection, determining the admissibility of the medical evidence under ORS 656.268(7) is a necessary function if we are to weigh the medical evidence and determine the extent of claimant's permanent disability. Moreover, because the statute explicitly prohibits "post-arbiter" report evidence, ORS 656.268(7) requires us to determine whether medical evidence is admissible under the statute.

Extent of Scheduled Permanent Disability

We apply the disability standards in effect on the date of the Determination Order or Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C). OAR 436-35-003(2). Claimant's claim was closed by Determination Order dated September 23, 1993. Accordingly, those standards contained in WCD Admin. Orders 6-1992 and 17-1992 apply to claimant's claim.

As an initial matter, we note that because the insurer requested a hearing on the extent of disability, the burden of proof rests with the insurer. Roberto Rodriguez, 46 Van Natta 1722, on recon 46 Van Natta 2230, on recon 46 Van Natta 2530 (1994).

The medical evidence concerning the extent of claimant's scheduled permanent impairment comes from Dr. Brett, claimant's attending physician, and Dr. Peterson, the medical arbiter.

In his closing examination, Dr. Brett found that claimant had full wrist range of motion and no objective neurologic deficit with preserved strength and sensation. Dr. Brett declared claimant medically stationary and released him to all activities without restrictions. (Ex. 8).

Dr. Peterson saw claimant for a medical arbiter examination. Dr. Peterson noted that two days prior to the examination, claimant was placed in handcuffs for thirty minutes while attempting to pay an outstanding ticket. Claimant reported to Dr: Peterson that the handcuff incident had caused acute swelling of his wrists. (Ex. 14-3). Dr. Peterson found reduced range of motion of the right thumb, loss of sensation of each hand and chronic conditions which limited repetitive use of both hands.

We generally defer to the treating physician's opinion absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to defer to Dr. Brett's opinion concerning claimant's impairment. In addition, Dr. Brett performed claimant's carpal tunnel release surgery and is in the best position to render an opinion concerning claimant's condition and impairment. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Finally, we note that two days prior to Dr. Peterson's medical arbiter examination, claimant was placed in handcuffs for half an hour, which caused acute swelling of claimant's wrists.

Considering all of the circumstances, we find Dr. Brett's impairment findings more persuasive than those of Dr. Peterson. In reaching our decision, we acknowledge that the medical arbiter's findings were made closer in time to the date of the Order on Reconsideration. See ORS 656.283(7). Nevertheless, for the reasons given above, we are more persuaded by Dr. Brett's opinion which supports a conclusion that claimant has not suffered permanent impairment due to the compensable injury. See ORS 656.214(2); OAR 436-35-010(2). Accordingly, we conclude that the insurer has met its burden of proof and we affirm the ALJ's order reducing claimant's scheduled award to zero.

ORDER

The ALJ's order dated November 14, 1994 is affirmed.

July 3, 1995 Cite as 47 Van Natta 1297 (1995)

In the Matter of the Compensation of
MILAN F. SHUBERT, Claimant
WCB Case No. 94-08858
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) found that the Hearings Division had jurisdiction over claimant's request for hearing; and (2) increased claimant's unscheduled permanent disability from 17 percent (54.4 degrees), as awarded by an Order on Reconsideration, to 22 percent (70.4 degrees). In addition, SAIF moves to strike claimant's "Statement of the Case" as set forth in his "Cross-Petition for Review." Claimant cross-requests review of that portion of the ALJ's order that declined to find that the Director's temporary rule was invalid. On review, the issues are motion to strike, jurisdiction, validity of a temporary rule and extent of unscheduled permanent disability. We deny the motion to strike and affirm the ALJ's order.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, SAIF moves to strike the "Statement of the Case" portion of claimant's cross-petition. Claimant's statement concerns a petition for review filed with the Court of Appeals regarding the validity of the temporary rule at issue in this case. Claimant's statement is informational, but we do not consider it as evidence and we would not consider evidence that is not in this record. Moreover, even if we were to consider the statement, it would have no effect on our resolution of this matter. Although we have discretion to strike claimant's "Statement of the Case," we do not find it appropriate to do so in this case. See Scott Petty, 46 Van Natta 1051 (1994) (Board has discretion to allow a brief that was not timely submitted, where an extension was granted). Because the disputed portion of claimant' brief does not affect the resolution of this matter, SAIF's motion is denied.

Jurisdiction

We adopt the conclusions and reasoning as set forth in the ALJ's order with the following supplementation.

SAIF contends that the Hearings Division lacks jurisdiction on the basis that the extent of claimant's permanent disability was previously litigated before ALJ Barber in WCB Case No. 89-22007 and subsequently reviewed by the Board on appeal. However, as the ALJ correctly found, our Order on Review, concerning the appeal of ALJ Barber's order, was not a final order. Milan F. Shubert, 46 Van Natta 760 (1994). Rather, we vacated ALJ Barber's order and remanded the claim to the Director for promulgation of a temporary rule. The Director promulgated a temporary rule and issued a new Order on Reconsideration. Claimant requested a hearing on the Order on Reconsideration under former ORS 656.268(6)(b) (renumbered ORS 656.268(6)(f) by SB 369, 68th Leg., Reg. Sess., § 30 (June 7, 1995)). Accordingly, the Hearings Division has jurisdiction over claimant's request for hearing. Former ORS 656.268(6)(b); ORS 656.283(1).

Validity of Temporary Rule

We adopt the conclusions and reasoning as set forth in the ALJ's order with the following supplementation.

We agree with the ALJ that the Hearings Division and the Board lack the authority to declare the temporary rule invalid. See Eileen N. Ferguson, 44 Van Natta 1811 (1992) aff'd Ferguson v. U.S. Epperson Underwriting, 127 Or App 478 (1994). Assuming *arguendo* that we had such authority, we would not find the rule invalid. ORS 656.726(3)(f) authorizes the Director to promulgate "standards" for the evaluation of permanent disability. ORS 656.726(3)(f)(C) gives the Director the authority to promulgate temporary rules when it is found that the "standards" do not address a worker's disability.

Here, pursuant to our remand order, the Director found that claimant's left shoulder Bristow repair and malleolar screw removal surgery was not addressed by the "standards." Our order did not determine whether or not claimant had ratable impairment as a result of the surgery, but merely determined that the surgical procedure was not addressed by the Director's "standards." In this regard, our review of a worker's permanent disability is limited to the application of the Director's "standards. ORS 656.295(5).

As a result of our order, the Director promulgated a temporary rule (OAR 436-35-500 E38-6617) which addressed the surgery. Applying the temporary rule, the Director found that claimant was not entitled to an impairment value for the surgical procedure. This action was within the Director's authority pursuant to ORS 656.726(3)(f)(C).

The promulgation of a temporary rule does not automatically result in a worker receiving an impairment value. Not all impairment necessarily results in a worker receiving an impairment value under the "standards." For example, 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." See OAR 436-35-330(1) (a worker not entitled to an impairment rating for the shoulder joint where he retains 150 degrees of forward elevation). This particularly is true where, as here, Dr. Brenneke provides no explanation for his conclusion that the surgical procedure resulted in 10 percent impairment where such a procedure was designed to improve the function of claimant's shoulder. (Exs. E, 8, 9). Under these circumstances, the Director's action was not inconsistent with the statutory authority granted the Director by ORS 656.726.

Extent of Unscheduled Permanent Disability

We adopt the conclusions and reasoning as set forth in the ALJ's order with the following supplementation.

The ALJ found that claimant was released to medium work with restrictions and therefore gave claimant an adaptability value of 4. SAIF contends that claimant was released to medium work, so the adaptability value should be 3. We agree with the ALJ.

In Harold J. Lawrence, 46 Van Natta 2356 (1994), the claimant was released to medium work, with restrictions on repetitive overhead work. We held that the restrictions would preclude frequent performance of climbing and lifting. Therefore, we reasoned that the claimant qualified as a restricted worker under OAR 436-35-270(3)(e) and his residual functional capacity was medium/light.

Here, Dr. Brenneke released claimant to medium work with restrictions on prolonged overhead use of his arms. We find no meaningful distinction between this case and Lawrence. Consequently, we agree that claimant's residual functional capacity is medium/light and he is therefore entitled to an adaptability value of 4.

Inasmuch as we have not disallowed or reduced the compensation awarded by the ALJ, claimant is entitled to an assessed attorney fee under ORS 656.382(2). 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 concerning SAIF's request for review is $750, to be paid by SAIF. 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. We further note that claimant is not entitled to an attorney fee for services devoted to his unsuccessful cross-request for review.

ORDER

The ALJ's order dated November 2, 1994 is affirmed. For services on review, claimant's counsel is awarded a reasonable attorney fee of $750, payable by the SAIF Corporation.

July 5, 1995 Cite as 47 Van Natta 1299 (1995)

In the Matter of the Compensation of
CATHALINE L. FIELDING, Claimant
WCB Case No. 93-13587
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's aggravation claim for right greater trochanter bursitis. On review, the issue is aggravation. We remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with two exceptions. We do not adopt the last sentence in the fifth full paragraph on page 3 ("Claimant was not then able to carry out her regular work duties") and we do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

SAIF contends that the ALJ improperly addressed a claim for related acute bursitis of the right greater trochanter. According to SAIF, claimant never claimed bursitis as a new injury and SAIF never accepted or denied that condition at any time. SAIF contends that adjudicating compensability of that condition was beyond the scope of the ALJ's review.

An ALJ's scope of review is limited to the issues raised by the parties. See Saedeh K. Bashi, 46 Van Natta 2253 (1994). As a general rule, an issue listed in a request for hearing is sufficiently "raised" to allow the Board to address the issue on review. See Liberty Northwest Ins. Corp. v. Alonso, 105 Or App 458 (1991) (case remanded to Board to address issue raised in prehearing pleadings); see also Murray L. Johnson, 45 Van Natta 470 (1993) (following Alonso).

Here, claimant's request for hearing indicated "aggravation" and referred to a denial dated November 16, 1993. SAIF's November 16, 1993 denial referred to claimant's accepted claim for a lumbar strain and denied her request to reopen the claim because her "condition" had not worsened since the last award or arrangement of compensation. (Ex. 43). At hearing, claimant identified the issues as the "compensability of the June 1993 aggravation, and penalties and fees regarding an unreasonable denial." (Tr. 2).

SAIF's aggravation denial pertained to claimant's "condition." Moreover, neither claimant's prehearing pleadings nor the statement of issues at hearing focused exclusively on an aggravation claim for a low back condition. Under such circumstances, we find that claimant's right greater trochanter bursitis could be encompassed within claimant's denied aggravation claim. Nevertheless, such a conclusion does not end our inquiry. We must determine whether the record regarding the bursitis issue is completely and sufficiently developed.

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

In Murray L. Johnson, supra, the ALJ held that the claimant's condition was compensable as an occupational disease. On review, the carrier argued that an occupational disease claim had not been raised by either party. We found that the compensability theories advanced at hearing pertained to the claimant's current condition as related to his compensable 1987 low back claim. No compensability theory expressly presented at hearing was premised on a "new" claim (either "new injury" or "occupational disease"). In addition, we found the medical evidence submitted by the parties did not address an "occupational disease" theory. We concluded that the record regarding the "occupational disease" theory was incompletely and insufficiently developed and we found a compelling reason to remand.

In the present case, the ALJ noted that the medical experts relied upon by SAIF had not addressed the development of right trochanter bursitis, but had limited their inquiry to claimant's degenerative disc disease and the propriety of back surgery. The ALJ found a "total absence of an attention to the development of acute bursitis involving the right trochanter." (O & O at 7).

On July 12, 1993, Dr. Golden diagnosed claimant with chronic lumbosacral spine strain and right greater trochanteric bursitis. (Ex. 31). However, Dr. Golden's August 4, 1993 request to reopen the claim referred only to an "injured disk at L5-S1 with fissuring of the anulus, but no distinct herniation." (Ex. 36). Thus, the specific request to reopen the claim made no reference to claimant's bursitis. Moreover, we agree with the ALJ that the medical experts did not focus on claimant's right trochanter bursitis condition.

Under these circumstances, we find that the record regarding the right trochanter bursitis condition is incompletely and insufficiently developed. See Murray L. Johnson, supra. Since the ALJ proceeded to address the compensability of the bursitis condition, and because this condition could be encompassed within SAIF's appealed denial, we find a compelling reason to remand this matter to the ALJ for further evidence concerning the right trochanter bursitis condition.[1]

Accordingly, the ALJ's order dated September 20, 1994 is vacated. This matter is remanded to ALJ McWilliams with instructions to take additional evidence from both parties pertaining to the right trochanter bursitis condition. Such evidence may be taken in any manner that the ALJ determines achieves substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] After the ALJ's order, the legislature enacted Senate Bill 369. SB 369, 68th Leg., Reg. Sess., § 66 (June 7, 1995). ORS 656.273(3), as amended, provides, inter alia, that a "claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or worker's representative." SB 369, 68th Leg., Reg. Sess., § 31(3) (June 7, 1995). See also ORS 656.262(7)(a), as amended (referring to "new medical condition claims"). SB 369, 68th Leg., Reg. Sess., § 28(7)(a) (June 7, 1995). In light of our conclusion to remand this case, we need not decide whether the amendments in ORS 656.273 apply retroactively in this case.

In the Matter of the Compensation of
GEORGE E. FREYER, Claimant
WCB Case Nos. 94-08380 & 94-08379
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Moscato, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Bethlamy's order that: (1) declined to award temporary partial disability benefits from July 10, 1993 through March 24, 1994; and (2) declined to assess penalties or attorney fees for the self-insured employer's allegedly unreasonable claims processing. On review, the issues are temporary disability and penalties and attorney fees. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on July 10, 1993. The July 10, 1993 claim was closed by Notice of Closure dated August 31, 1994, which awarded 24 percent unscheduled permanent disability, but awarded no temporary disability benefits. Prior to the closure notice, claimant had requested a hearing, contending that he was entitled to temporary partial disability (TPD).

The ALJ found that claimant was not entitled to procedural TPD from July 10, 1993 to March 24, 1994. In reaching this conclusion, the ALJ found that claimant had failed to establish that the employer reduced his hours because of the compensable injury.

On review, claimant argues that he is entitled to procedural temporary disability benefits for the above period because he was released to modified work during that time and because he contends that the employer reduced his hours as a result of his injury. Specifically, claimant contends that the employer either withdrew modified work by reducing his hours of work or improperly "terminated" temporary partial disability.

Under ORS 656.268(4)(e) and (5), the Hearings Division lacks original jurisdiction to address challenges regarding an injured worker's substantive entitlement to temporary disability. However, an ALJ has original jurisdiction over disputes concerning an injured worker's procedural entitlement to temporary disability because that issue is ripe for adjudication prior to claim closure. See Galvin C. Yoakum, 44 Van Natta 2403, 2404, on recon 44 Van Natta 2492 (1992).

In Yoakum, we established three criteria for distinguishing whether a dispute concerns procedural entitlement to temporary disability benefits: (1) the hearing request must be filed before the claim is closed; (2) the request must raise issues regarding the carrier's "pre-closure" conduct; and (3) the claimant must not be seeking a greater temporary disability award than that granted by the Notice of Closure or Determination Order. See James C. Schultz, 47 Van Natta 295 (1995); Michael J. Drake, 45 Van Natta 1117 (1993).

Claimant's hearing request was filed on July 13, 1994, prior to the August 31, 1994 Notice of Closure and arguably raises issues regarding the carrier's "pre-closure" conduct. However, claimant concedes that he seeks a greater award of temporary disability than was awarded by the Notice of Closure. Under the circumstances, we lack jurisdiction to address claimant's entitlement to temporary disability. Michael J. Drake, supra; Galvin C. Yoakum, supra.

Moreover, because claimant seeks a temporary disability award when the Notice of Closure awarded none, we conclude that claimant is actually seeking a substantive change in the Notice of Closure award. See Monte W. Kentta, 46 Van Natta 1460 (1994). Claimant's argument that he was partially disabled from July 10, 1993 should be raised through a direct appeal of the Notice of Closure.

In reaching this conclusion, we disagree with claimant's contention that the employer is being allowed to avoid responsibility for processing the claim. To the contrary, consistent with Yoakum, Drake and their progeny, we are merely assuring that decisions involving a claimant's entitlement to temporary disability (and the carrier's responsibility for such benefits) are uniformly and consistently decided. When, as here, claimant is seeking benefits in an amount greater than that granted by the Notice of Closure, we adhere to our previous conclusion that the appropriate method for resolution of that dispute is by means of appealing that administrative closure. Through that procedure, claimant will likewise ultimately be able to raise the issue of penalties for the employer's allegedly unreasonable conduct in processing the claim.

ORDER

The ALJ's order dated November 16, 1994 is vacated in part and affirmed in part. That portion of the ALJ's order which addressed claimant's entitlement to temporary partial disability from July 10, 1993 through March 24, 1994 is vacated. The remainder of the ALJ's order is affirmed.

July 5, 1995 Cite as 47 Van Natta 1302 (1995)

In the Matter of the Compensation of
ALAN L. HUSSEY, Claimant
WCB Case No. 94-00729
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld the SAIF Corporation's denial of his injury claim for exposure to airborne/bloodborne pathogens; and (2) upheld SAIF's denial of his claim for a right hand injury. 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 is employed as a security guard for the employer. On November 30, 1993, he was working at a concert. During the latter portion of the concert, patrons pushed down a plywood retaining wall which separated the crowd from the musicians. While trying to restrain the crowd in order for the wall to be repaired, claimant cut his right hand on the wall.

After sustaining the cut to his hand, claimant was escorting some patrons off the stage. While performing this job duty, claimant escorted a patron who was bleeding from a wound on the side of the head. This blood dripped onto claimant's injured hand. Later in the concert, another patron attempted to leave by a prohibited exit. While claimant was informing the patron that he could not leave through the exit, the patron vomited on claimant. The vomit struck claimant on the face and chest and was watery in consistency.

On December 1, 1993, claimant signed an 801 form claiming exposure to bodily fluids. On December 6, 1993, claimant saw Dr. Sanford, who noted that claimant had a scab on his right hand. Additionally, Dr. Sanford reported that claimant was concerned about exposure to hepatitis B and HIV as a result of his exposure to body fluids. Tests for hepatitis B and HIV were negative. As a result of claimant's concern over exposure to body fluids, Dr. Sanford recommended that claimant receive a gamma globulin shot. Claimant did not miss any time from work.

SAIF subsequently denied claimant's claim for exposure to bodily fluids and his claim for a right hand injury. Claimant requested a hearing. The ALJ concluded that claimant had not established a compensable disease or injury as a result of his work exposure to airborne or bloodborne pathogens. Based on the following reasoning, we disagree.

A "compensable injury" is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment, requiring medical services or resulting in disability or death. Such an injury must be established by medical evidence supported by objective findings. ORS 656.005(7)(a).

In concluding that claimant had not established a compensable injury, the ALJ relied on our decision in Daniel L. Hakes, 45 Van Natta 2351 (1993), aff'd mem 131 Or App 363 (1994). In Hakes, the claimant, an air ambulance pilot, got blood on his hands while unloading a trauma patient. The claimant sought treatment for a variety of complaints, which his physician reported were unrelated to his blood exposure. The claimant was concerned about exposure to HIV because of abrasions on his hands. There was no indication that the claimant in Hakes suffered the abrasions while performing his work duties.

We reversed the ALJ's order in Hakes which had set aside the employer's denial of the claimant's claim for blood exposure. We reasoned that, although the claimant was exposed to blood, there was no evidence that claimant had been injured by his work exposure or had a disease.

We find Hakes distinguishable. Here, claimant did not merely get blood on his hand during the course of his work activities. Rather, claimant cut his hand while performing his work duties and, as a result of those job duties, claimant's open wound was exposed to another person's bodily fluids. Thus, unlike in Hakes, claimant had more than just the presence of blood on his skin; he had an open wound sustained while performing his job duties. Moreover, again while claimant was performing his job duties, this open wound then came into contact with the body fluids of another person. Finally, this exposure resulted in claimant's need for medical services in the form of blood testing, as well as a gamma globulin shot. In other words, a material (if not the sole) cause of claimant's need for medical treatment was his exposure to blood in conjunction with a cut suffered while performing his work activities.

We likewise find this case distinguishable from Brown v. SAIF, 79 Or App 205, rev den 301 Or 666 (1986). In Brown, the claimant was concerned about his health because of his exposure to asbestos at work. The court held that he did not establish that he had a disease or was injured. Unlike in Brown, claimant in this case did sustain an injury when he cut his hand and was subsequently exposed to bodily fluids. This injury required medical treatment (gamma globulin shot) and necessitated diagnostic testing (tests for HIV and hepatitis B). Accordingly, Brown is distinguishable.

We find this case factually similar to Kelly Barfuss, 44 Van Natta 239 (1992). In that case, the claimant sustained a "needle stick" injury while performing her work activity as a dental assistant. The "needle stick" injury required medical services because the claimant's physician ordered laboratory testing. The claimant discussed her concerns with her doctor and he recommended that claimant repeat HIV testing in 3 months and again in 6 months. Based on this evidence, we affirmed the ALJ's order setting aside the carrier's denial of the claimant's "needle stick" injury.

Here, as in Barfuss, claimant sustained an injury (a wound) during the course of employment which, in conjunction with his work exposure to bodily fluids, necessitated medical services. As a result of the injury, claimant was entitled to know how badly he was hurt and whether any treatment was appropriate. See Finch v. Stayton Canning Co., 93 Or App 168 (1988); Kelly Barfuss, supra. Accordingly, we conclude that claimant has established compensable claims.[1]

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. Amended ORS 656.386(1). 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 at hearing and on review is $3,200, 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 attorney's statement of services on review), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

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[1] Inasmuch as claimant's need for medical treatment was attributable to his exposure to bodily fluids in combination with his work-related cut, we conclude that both injuries/exposures are materially related to his treatment and, as such, are compensable.

ORDER

The ALJ's order dated November 25, 1994 is reversed. The SAIF Corporation's denials are set aside and the claims are remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,200, payable by SAIF.

July 5, 1995 Cite as 47 Van Natta 1304 (1995)

In the Matter of the Compensation of
ANTONIO J. LOPEZ, Claimant
WCB Case Nos. 93-09752 & 93-09162
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Hartford Insurance Company (Hartford) requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its denial of claimant's aggravation claim for his current left leg and buttock (herniated L4-5 disc) condition; and (2) upheld Fireman's Fund Insurance Company (Fireman's) denial of claimant's aggravation claim for the same condition. Fireman's cross-requests review of that portion of the ALJ's order that awarded claimant a $2,800 attorney fee under former ORS 656.386(1) for prevailing over Fireman's compensability denial. On review, the issues are responsibility and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The ALJ found that claimant's current disc condition is compensable, which the parties do not challenge on review. The ALJ further found that Hartford, the carrier on the risk at the time of claimant's 1992 industrial low back injury, rather than Fireman's (the carrier responsible for a 1986 compensable back injury), is responsible for the subsequent L4-5 disc herniation condition under the rule of Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984).

The ALJ determined that by virtue of Hartford's acceptance of claimant's lumbosacral sprain in 1992, claimant sustained a "new compensable injury" under 656.308(1).[1] The ALJ found, however, that claimant's disc herniation subsequent to the December 1992 industrial injury was a new condition "separate" from the disc herniation claimant experienced in 1986. The ALJ also found that the disc herniation following the December 1992 injury was a separate condition from the lumbosacral sprain that was accepted by Hartford. Having determined that the later disc herniation was not the "same condition" as the 1986 disc herniation or the 1992 accepted lumbosacral sprain, the ALJ concluded that ORS 656.308(1) was not applicable to this responsibility dispute. See Smurfit Newsprint v. DeRosset, 118 Or App 368, 371, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).

Finding ORS 656.308(1) inapplicable, the ALJ turned to the "last injury rule" and the rebuttable presumption adopted by the Court of Appeals in Kearns. Applying Kearns, the ALJ found that Hartford failed to rebut the presumption that it was responsible for claimant's condition because the medical evidence established that claimant's 1992 industrial injury independently contributed to a pathological worsening of the low back condition, resulting in the second L4-5 disc herniation.

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[1] Subsequent to the ALJ's order, Senate Bill 369 (SB 369) was enacted. SB 369, 68th Leg., Reg. Sess. (June 7, 1995). The bill amends ORS 656.308(1) and ORS 656.005(7)(a)(B). Sections 1 & 37. Here, we need not resolve the applicability of these amendments because, under either version of the statutes, the result would be the same.

On review, Hartford argues that: (1) there is no basis for the ALJ's finding that claimant's current disc problem is not the same condition as the condition accepted by Fireman's; (2) the Court of Appeals' decision in Dietz v. Ramuda, 130 Or App 397 (1994), is applicable; (3) SAIF v. Drews, 318 Or 1 (1993), is also applicable; and (4) the medical evidence does not establish that the 1992 industrial injury was the major contributing cause of claimant's recurrent disc herniation and need for surgery. We address these arguments in reverse order.

Contrary to Hartford's contention, the medical evidence supports the conclusion that the 1992 injury was the major contributing cause of claimant's current condition and need for treatment. As the ALJ noted, four doctors rendered opinions on causation, Drs. Waller, Winkler, Watson and Dineen. Drs. Watson and Dineen, the insurer-arranged examiners, opined in September 1993 that claimant's present situation related to the original injury of 1986. (Exs. 138, 148). At that time, both Drs. Waller and Winkler concurred with that assessment. (Exs. 146, 149). However, at the time of these opinions, the doctors did not have the benefit of the myelogram and CT scan (done in December 1993) that showed a recurrent disc herniation on the left at L4-5. (Exs. 154, 155).

Of the four doctors, only Dr. Waller, claimant's treating neurosurgeon (who performed the 1989 surgery) reviewed the December 1993 radiographic studies. He then revised his earlier opinion and concluded that claimant's 1992 industrial injury was the major cause of the new disc herniation. (Ex. 159-6). He explained that the abnormalities shown in the December 1993 studies were more impressive than the prior MRI scan had indicated, and either the prior test was less sensitive or claimant's condition had evolved. He concluded: "Nonetheless, at this time, I think that the history of the fall in 1992 followed by back and leg pain is indeed best characterized as a new injury causing a recurrent disc herniation." (Ex. 158).

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Here, Dr. Waller is claimant's treating neurosurgeon and also the only examining physician to review the December 1993 myelogram and CT scan and diagnose the disc herniation. Because Drs. Winkler, Watson and Dineen were not aware of the full extent of claimant's current low back condition, we find their opinions were based on incomplete information. We therefore give those opinions little weight. Rather, we are persuaded by Dr. Waller's revised opinion that the December 1992 industrial injury is the major contributing cause of claimant's current disability and need for treatment.[2]

Given our finding that the December 1992 injury is the major contributing cause of claimant's condition, we conclude the ALJ properly assigned responsibility for claimant's current condition to Hartford. Indeed, we find Hartford is responsible regardless of the analysis adopted or the burden of proof assigned. See, e.g., Eva R. Billings, 45 Van Natta 2142 (1993) (when actual causation is proved with respect to a specific employer, the last injurious exposure rule is not applicable). For example, Hartford contends that the analysis of Drews is applicable.[3] However, even under that analysis, Hartford remains responsible for claimant's condition because the December 1992 work incident is the major factor in claimant's current need for treatment. The same would be true if we applied the rule of

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[2] In his report dated August 2, 1994, Dr. Waller noted that he was revising his opinion "based on new information, the new information of the myelogram and CT scan." (Ex. 158-1). In his later deposition, he clarified his use of the term "material cause" in that August 1994 report. He explained that, in his opinion, the December 1992 injury was the major cause (meaning more than 50 percent) of the worsening of claimant's condition. (Ex. 159-6).

[3] Although the parties developed the evidence and argued the case under the principles of Drews, the ALJ concluded that the Drews analysis was not applicable to the facts of this case. We agree. In Drews, the issue was whether the claimant's second work injury was a "new compensable injury" under ORS 656.005(7)(a) so as to shift responsibility *forward* to the carrier on the risk at the time under former ORS 656.308(1). Here, on the other hand, Hartford has already accepted claimant's 1992 low back strain. Therefore, the issue here is whether responsibility for further medical services and disability relating to the new disc herniation should shift *back* to Fireman's (who accepted the 1986 disc herniation) or remain with Hartford, as the insurer on the risk at the time of the last compensable injury to that same body part. See Kearns, supra.

Dietz. The medical evidence establishes that the December 1992 injury is both the precipitating and the primary cause of claimant's current condition.[4]

Finally, given our determination that the 1992 injury is the major contributing cause, we need not address whether claimant's current disc herniation is the "same condition" as the condition accepted by Fireman's or a separate injury to the same body part. Indeed, if we assume it is the same condition and if ORS 656.308(1) applies, Hartford remains responsible for "all further compensable medical services and disability involving the same condition" because claimant sustained a "new compensable injury involving the same condition" in December 1992. See Bonni J. Mead, 46 Van Natta 1185 (1994).

Conversely, if we assume that claimant's December 1992 injury involved the same body part (low back), but not the same condition (lumbosacral strain) as that for which he now seeks compensation (disc herniation), then the Kearns analysis applies. See Raymond H. Timmel, 47 Van Natta 31 (1995) (where the claimant has several accepted claims for injuries involving the same body part but not the same condition, Kearns remains valid law, notwithstanding the enactment of former ORS 656.308(1)). Under Kearns, as the ALJ found, Hartford remains responsible because it cannot rebut the presumption. The evidence, in particular Dr. Waller's opinion, shows that the December 1992 injury independently (and primarily) contributed to claimant's current condition.

For the foregoing reasons, we affirm the ALJ's decision assigning responsibility for claimant's recurrent disc herniation to Hartford.

Attorney Fee

The ALJ awarded an attorney fee, payable by Fireman's, for claimant's counsel's services in setting aside Fireman's compensability denial. On review, Fireman's concedes that the assessed fee is proper, but contends that Hartford should be responsible for a portion of that fee.

It has been this Board's longstanding policy to hold a carrier ultimately determined not responsible for a claimant's condition responsible for an attorney fee if the carrier denies the compensability of the claim and the responsible carrier only denies that it is responsible for the claim. Dorothy J. Hayes, 44 Van Natta 792, 793 (1992), aff'd Safeway Stores, Inc. v. Hayes, 119 Or App 319 (1993); see also SAIF v. Bates, 94 Or App 666 (1989) (court upheld assessment of fee under former ORS 656.386(1) against carrier that necessitated a claimant's participation to establish the compensability of the claim). For these reasons, we reject Fireman's attorney fee argument.[5]

Although compensability was not raised on review, it was an issue at hearing and addressed in the ALJ's order. Therefore, because of our de novo review of the ALJ's order, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod 119 Or App 447 (1993). Accordingly, claimant's counsel is entitled to an assessed fee for services rendered on review, payable by Hartford. See International Paper Co. v. Riggs, 114 Or App 203 (1992); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $750. In reaching this decision, 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 services devoted to the ALJ's attorney fee award. See Dotson v. Bohemia, Inc., 80 Or App 233, 236 (1986).

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[4] In Dietz, the Court of Appeals held that a work incident that precipitates a claimant's condition or symptoms is not necessarily always the major contributing cause of that condition. The court noted that former ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause, including the precipitating cause, to establish which is the primary cause.

[5] Amended ORS 656.386(1) now defines a "denied claim" as a claim for compensation which the insurer refuses to pay "on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation." SB 369, § 43. Thus, whether former or amended 656.386(1) applies, claimant is entitled to a fee under this section, payable by Fireman's, for overcoming the denied claim.

ORDER

The ALJ's order dated December 2, 1994 is affirmed. For services on Board review, claimant's attorney is awarded $750, to be paid by Hartford.

July 5, 1995 Cite as 47 Van Natta 1307 (1995)

In the Matter of the Compensation of
LLOYD MONROE, Claimant
WCB Case No. 92-13369
ORDER ON REVIEW
David D. Force, Claimant Attorney
Brian L. Pocock, Defense Attorney
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order which: (1) upheld the SAIF Corporation's denial of claimant's back injury claim; (2) found that claimant's sternal fracture claim was not compensable; (3) declined to award additional interim compensation; and (4) declined to assess penalties or attorney fees for SAIF's allegedly unreasonable claim processing. On review, the issues are course and scope of employment, compensability, interim compensation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a ranch hand, was thrown from his horse on December 24, 1991, while riding with the noncomplying employer, a physician who owned the ranch on which claimant was employed. Although claimant advised the employer immediately after the fall that he was "hurting" and was told that he probably pulled a muscle, claimant continued to perform his customary employment duties the remainder of the day, as well as during the ensuing weeks. Some of this labor involved lifting heavy hay bales and strenuous ranch maintenance. While he did self-medicate with a veterinary medicine, Butazolidin, after his fall, claimant did not seek medical treatment until he briefly moved to Ohio on February 14, 1992, after quitting work without notice the day before.

In Ohio, x-rays revealed compression fractures at L1 and T5. In March 1992, claimant filed a claim for a "back" injury, which SAIF denied on behalf of the noncomplying employer on September 25, 1992. The stated basis for the denial was that claimant's "injury" did not arise out of and in the course of his employment. Claimant was paid interim time loss to the date of the denial.

In the meantime, a bone scan had been conducted on September 22, 1992, which identified a fracture of claimant's sternum. Subsequently, claimant underwent chest surgery for the sternal fracture, as well as a surgical procedure in the upper lumbar and lower thoracic spine.

The ALJ found that claimant's primary purpose in going for the horseback ride was that he enjoyed riding horses. The ALJ thus concluded that claimant was not in the course and scope of his employment when he was thrown from his horse on December 24, 1991, reasoning that claimant was engaged in a recreational activity primarily for his own personal pleasure. See ORS 656.005(7)(b)(B). The ALJ also found that claimant was not in the course and scope of his employment after applying the factors listed in Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, rev den 300 Or 249 (1985). The ALJ also determined that claimant's accident was not compensable under the "bunk house" rule or the "personal comfort" doctrine. See Wallace v. Green Thumb, Inc., 296 Or 79 (1983); Leo Polehn Orchards v. Hernandez, 122 Or App 241 (1993).

The ALJ alternatively found that, even if claimant was in the course of his employment when thrown from his horse, his spinal and sternal fractures were not compensable. The ALJ relied on the medical testimony of an expert radiologist, Dr. Warren. Finally, the ALJ determined that claimant was not entitled to additional interim compensation or penalties or attorney fees for SAIF's allegedly unreasonable claim processing and alleged failure to timely provide discovery.

On review, claimant contends that he was in the course and scope of his employment when thrown from his horse on December 24, 1991, and that his L1 and sternal fractures resulted from that accident. Claimant further asserts that he is entitled to interim compensation from SAIF's first notice of his sternal fracture to the date of the January 6, 1994 hearing, as well as penalties and attorney fees for SAIF's allegedly unreasonable failure to accept or deny the sternal fracture claim, to pay interim compensation and to timely provide discovery.

Course of Employment

We have reservations regarding the ALJ's conclusion that claimant's fall did not arise out of the course and scope of his employment. See Kaiel v. Cultural Homestay Institute, 129 Or App 471 (1995) (worker's personal enjoyment does not preclude finding that activity was within course and scope of employment). Nevertheless, we need not decide whether claimant was in the course of his employment when thrown from his horse, because, even if he was, the medical evidence does not establish that his lumbar and sternal fractures are compensable.

Compensability

Inasmuch as claimant alleges that his sternum and lumbar conditions are a direct result of his accident, rather than an indirect result of an injury, claimant must prove that the December 24, 1991 fall was a material contributing cause of the sternal and lumbar fractures. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 670 (1992).

While we have determined that a material causation standard would apply if claimant were in the course of his employment when thrown from his horse, we, nevertheless, conclude that claimant still failed to sustain his burden of proof. Like the ALJ, we find the expert medical opinion from the radiologist, Dr. Warren, to be most persuasive. Dr. Warren testified, after careful review of the relevant X-rays, bone scans and CT scan, that claimant's T5 fracture occurred prior to December 24, 1991 and that the lumbar and sternal fractures were more recent than December 24, 1991. Based on our de novo review of Dr. Warren's testimony, we agree with the ALJ that Dr. Warren's opinion is well reasoned, thorough and, hence, persuasive. See Somers v. SAIF, 77Or App 259 (1986).

Moreover, we specifically note Dr. Warren's testimony that, based on the CT scan showing soft tissue swelling, as well as on his experience in observing the kind of fracture claimant suffered at L1(one with "crisp" margins), claimant's lumbar fracture was sustained as recently as 10 days prior to February 14, 1992. (Tr. II, pps. 172, 173, 186). Dr. Warren also testified that a combination of the fractures that claimant sustained almost always occurs in a motor vehicle accident and that such a combination would not occur as a result of another mechanism of injury, including a fall from a horse. (Tr. II, pps. 188-193). This testimony is in accordance with the opinion of Dr. Woolpert, who also reviewed the medical records generated in this claim. Dr. Woolpert opined in both his medical report and deposition that a fall from a horse would not likely cause simultaneous fractures at L1 and the sternum. (Exs. 47-6, 56-9).

Finally, we note that claimant performed his usual employment duties for a month and one-half after the December 24, 1991 fall. Some of these labors were quite strenuous. Dr. Warren testified that this would only have been possible if claimant had been "anesthetized." (Tr. II, p. 231). Dr. Woolpert also testified that the fractures that claimant sustained would have been quite painful and would have required more than a "pill or two" to alleviate his discomfort. Dr. Woolpert concluded that claimant's continued performance of work was incompatible with his having sustained severe sternal and lumbar fractures as a result of being thrown from a horse. (Ex. 56-10).

We recognize that a panel of orthopedic consultants, consisting of Drs. Rich and Colletti, concluded that the mechanism of claimant's injury was compatible with his fracture pattern. However,

Drs. Rich and Colletti did not have all the x-ray data available to Drs. Woolpert and Warren. (Ex. 49-4). Moreover, their conclusion was not well-explained. (Ex. 49-5). We find the thorough and well-reasoned opinions of Dr. Woolpert and, especially Dr. Warren, to be far more persuasive.

Even though neither Dr. Woolpert nor Dr. Warren examined claimant, we find that this case involves a question of expert analysis of radiological studies rather than expert observation of claimant's condition. Thus, the lack of an examination of claimant does not detract from the opinions of Drs. Woolpert and Warren. Cf. Allie v. SAIF, 79 Or App 284, 287 (1986) (In cases of expert analysis, rather than expert observation, deference not accorded attending physician, even though he or she had the opportunity to observe claimant's condition).

In summary, we agree with the ALJ that, even if claimant was in the course of his employment when thrown from his horse, he has, nevertheless, failed to sustain his burden of proving that this accident caused his lumbar and sternal fractures. For this reason, we affirm the ALJ's decision finding these conditions not compensable.

Interim Compensation

As previously noted, claimant seeks payment of additional interim compensation beyond the date of SAIF's September 25, 1992 denial. We note, however, that claimant did not raise this issue until he requested reconsideration of the ALJ's original order. Thus, we are inclined to agree with SAIF that the issue was not timely raised and may not be considered on review. Cf. Larry L. Schutte, 45 Van Natta 2085 (1993) (Board will not consider an issue raised for the first time during closing argument); Accord Leslie Thomas, 44 Van Natta 200 (1992).

Moreover, we agree with the ALJ that SAIF's denial of claimant's "injury" as not arising in the course and scope of his employment applies to any conditions, including claimant's sternal fracture, allegedly related to the December 24, 1991 fall. Thus, even if we were to consider the interim compensation issue on review, we would conclude that claimant is not entitled to additional temporary disability.[1]

Penalties and Attorney Fees

Finally, claimant alleges that he is entitled to penalties and attorney fees for SAIF's allegedly unreasonable failure to provide discovery. While failure to comply with discovery requirements, if found unreasonable, constitutes delay or refusal to pay compensation, see OAR 438-07-015(5), we have determined that claimant is not entitled to additional compensation. Thus, it follows that SAIF has not resisted the payment of compensation. See Boehr v. Mid Willamette Valley Food, 109 Or App 292 (1991) (in order for unreasonable resistance to compensation to be found, the claim must have been compensable). Claimant, therefore, is not entitled to penalties or attorney fees as a result of SAIF's alleged discovery violation.

ORDER

The ALJ's order dated July 22, 1994, as amended on September 16, 1994, is affirmed.

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[1] We note that, in correspondence to the Board, claimant's counsel asserted that he raised the issue of claimant's sternal fracture claim during a hearing before ALJ Gruber, which resulted in a continuance of these proceedings. No transcript of the hearing before ALJ Gruber is available. Inasmuch as no party has challenged claimant's counsel's recollection of those proceedings, we accept his representation that SAIF's counsel agreed to either accept the sternal fracture or issue a formal denial. However, the fact that claimant raised the sternal fracture issue does not cause us to conclude that an issue concerning interim compensation was also raised.

In the Matter of the Compensation of
KENNETH L. STEVENSON, Claimant
WCB Case No. 93-08175
ORDER ON REVIEW
Ackerman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) declined to recalculate claimant's wage rate; and (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are rate of temporary disability, penalties and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a truck driver, worked for the employer from March 1990 through February 1993. At the time of hire, claimant was paid at the rate of 13 cents per hub mile (later increased to 14 cents per mile). In addition, claimant received 5 cents per mile "subsistence" reimbursement for out-of-pocket expenses incurred while he was on the road, and, in any year claimant worked a full year from his hire date, a 2 cents per mile bonus, payable annually. Claimant received a bonus in his April 1991 paycheck for the 1990-1991 work year. In March 1992, claimant sustained this compensable work injury. Claimant received a $1,984.64 bonus in his April 1992 paycheck for the 1991-1992 work year. Claimant continued working until he underwent surgery on April 17, 1992, and returned to work on September 21, 1992. Claimant ceased working for the employer in February 1993.

The ALJ found that under the terms of the contract of hire, claimant's wages did not include the 5 cents per mile subsistence reimbursement. Further, finding that claimant did not earn a bonus (impliedly for the 1991-1992 work year) because he left employment before the expiration of a full year of service, the ALJ concluded that the insurer properly excluded the 2 cent per mile bonus in calculating claimant's temporary disability rate. For the reasons discussed below, we agree with claimant that his temporary disability should be recalculated. We therefore modify the ALJ's order.

We adopt and affirm that portion of the ALJ's order that concluded that claimant's wages did not include the 5 cents per mile subsistence reimbursement, with the following comment.

"Wages" are defined as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident[.]" ORS 656.005(29). Claimant testified that the contract at the time of injury provided that he would be paid at the rate of 14 cents per mile, and separately reimbursed 5 cents per mile for travel expenses. The express terms of the employment contract establish that the 5 cents per mile subsistence allowance was not part of claimant's wages. Accordingly, the insurer properly excluded the 5 cents per mile subsistence in calculating claimant's temporary disability rate. See Edward C. Steele, 46 Van Natta 29 (1994).

At the same time, however, we find claimant is entitled to have his temporary disability rate recalculated to include the 2 cents per mile bonus. OAR 436-60-025(5)(f) (WCD Admin. Order 1-1992) provides that bonus pay shall be considered when provided as part of an employment contract.[1] Claimant's unrebutted testimony establishes that his contract of hire included a 2 cents per mile bonus for any year he worked a full year from his hire date. Moreover, the record establishes that claimant received a bonus for the 1991-1992 work year at issue here.

Therefore, the bonus pay claimant earned for the 1991-1992 work year is to be considered in calculating his temporary disability rate. Consequently, the insurer is directed to calculate claimant's temporary disability rate based on a wage of 16 cents per mile (14 cents per hub mile plus 2 cents per mile bonus).

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[1] Except when an end-of-the-year bonus is paid at the employer's discretion, a circumstance not present in this case.

Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's attorney. ORS 656.386(2).

In addition, claimant seeks a penalty and related attorney fee for the insurer's failure to include the subsistence and bonus amounts in calculating claimant's temporary disability rate. Insofar as the insurer failed in include the 2 cents per mile bonus in calculating claimant's temporary disability rate, we agree that penalties and attorney fees are appropriate.

OAR 436-60-025(5)(f) requires an insurer to consider bonus pay in calculating temporary disability. Given the clear requirement of the rule, we conclude that the insurer's failure to include claimant's bonus pay in calculating his temporary disability rate constitutes an unreasonable refusal to pay compensation. ORS 656.262(11).

Accordingly, we assess a 25 percent penalty based on the additional temporary disability due through January 20, 1994, the date of hearing, such penalty to be shared equally by claimant and his attorney. ORS 656.262(11)(a); Wacker Siltronic Corp. v. Satcher, 91 Or App 654 (1988).

ORDER

The ALJ's order dated October 12, 1994 is modified in part and reversed in part. The insurer is directed to calculate claimant's temporary disability as previously set forth in this order. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly by the insurer to claimant's attorney. Claimant is awarded a 25 percent penalty based on the additional temporary compensation created by this order due through January 20, 1994, to be shared equally by claimant and his counsel.

Board Member Hall specially concurring.

I agree with the majority that the bonus pay claimant earned for the 1991-1992 work year should be considered in calculating claimant's temporary disability rate. I write separately to express my opinion concerning the 5 cents per mile reimbursement claimant received for "out-of-pocket" expenses.[1]

In Edward C. Steele, 46 Van Natta 29 (1994), a case factually similar to the instant case, the Board adopted and affirmed an ALJ's order holding that *per diem* mileage reimbursement for out-of-pocket expenses did not constitute part of the claimant's wages. As Member Gunn correctly observed in his dissent in that case, although labeled *per diem*, the money a worker receives to reimburse expenses incurred incidental to performing a job does not lose its identity as part of the claimant's wages paid for services rendered. Wages, as defined in former ORS 656.007(27) (now renumbered ORS 656.007(29)), includes room, board, rent, housing, lodging or similar advantage received from the employer. By definition, therefore, the employer's payment of claimant's related expenses (room, board, etc.), constitutes a form of wages.

Were it not for the precedential effect of the Board's order in Steele, supra, for the very reasons set forth by Member Gunn, I would in part dissent here. Ultimately, however, I am bound by the principal of *stare decisis*. I therefore concur with the majority's holding that the ALJ properly excluded the 5 cents per mile reimbursement claimant received for out-of-pocket expenses as wages for purposes of calculating claimant's temporary disability rate.

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[1] The 5 cents per mile "subsistence" reimbursement was to pay claimant for his expenses while out on the road, including food, showers, motel lodgings, gloves and other personal expenses. Although claimant kept a record of his actual expenses, the amount of reimbursement was not conditioned on actual expenses. Claimant was not required to substantiate his expenses with receipts. Instead, the reimbursement was paid at a fixed amount, 5 cents per mile, regardless of the actual out-of-pocket expenses claimant incurred.

In the Matter of the Compensation of
TAMERA A. FORCIER, Claimant
WCB Case No. 94-10815
ORDER OF ABATEMENT
Burt, Swanson et al, Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our June 8, 1995 order that found claimant, a partner in a business, to be a subject worker at the time of her left hand injury. Relying on the recently amended version of ORS 656.027(10) (formerly ORS 656.027(9)), SAIF asserts that partners are non-subject workers unless personal coverage is purchased. SAIF therefore requests that we abate our prior order and, on reconsideration, uphold its denial.

In order to further consider SAIF's motion, we withdraw our June 8, 1995 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 21 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK E. COOPER, Claimant
WCB Case No. 94-05070
ORDER OF ABATEMENT
Daniel Snyder, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our June 14, 1995 Order on Review. Specifically, the employer requests reconsideration of that portion of our order that found the claim prematurely closed. With its request for reconsideration, the employer argues that the recently enacted changes to the law made by Senate Bill 369 apply to this case and result in a finding that the claim closure was proper.

In order to consider the employer's motion, we withdraw our June 14, 1995 order. Claimant is granted an opportunity to respond by submitting a response within 21 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
GARY E. FRAZIER, Claimant
WCB Case No. 94-06685
ORDER ON REVIEW(REMANDING)
Robert G. Dolton, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Gunn, Turner-Christian and Neidig.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) found that claimant had unreasonably delayed the prosecution of his claim for more than 60 days; and (2) dismissed claimant's hearing request pursuant to OAR 438-06-071. On review, the issue is dismissal. We reverse and remand.

FINDINGS OF FACT

The following procedural history appears from the parties' allegations and claimant's brief on review.

On May 25, 1994, the insurer denied compensability and responsibility of claimant's right hand condition. Claimant requested a hearing on May 31, 1994. A hearing was scheduled for September 1, 1994.

Claimant resides in Prineville. The insurer scheduled claimant for an insurer-arranged medical examination (IME) with Dr. Radecki in Portland on July 27, 1994. On July 27, 1994, claimant's attorney wrote to the insurer, confirming a telephone conversation that day. Claimant's attorney notified the insurer that claimant would not attend the examination with Dr. Radecki. Claimant's attorney said that claimant would cooperate in an examination with any other doctor.

In the same letter, claimant's attorney also noted that claimant was "deathly afraid" of flying. If the insurer planned to select a Portland doctor to perform the IME, claimant's attorney requested that the insurer send the family mileage and lodging reimbursement in advance. Finally, claimant's attorney stated that claimant's wife would need to be notified at least two weeks in advance so that she could get time off work to drive her husband to Portland.

On August 12, 1994, the insurer moved for an order requiring claimant to attend a rescheduled medical examination and postponing his case until he did so, or in the alternative, an order of dismissal. The insurer argued that claimant did not have a valid excuse not to attend the exam.

Claimant did not object to postponement, but he did object to dismissal. Claimant explained to the ALJ why he would not voluntarily attend an IME with Dr. Radecki. An affidavit in support of claimant's counsel's objection to Dr. Radecki was provided, as well as the results of a survey of the medical community concerning Dr. Radecki's opinions regarding carpal tunnel syndrome. Claimant said that he would attend an examination with any other doctor and he requested a physician located in the Bend/Prineville geographic area. The ALJ granted the motion for postponement on August 29, 1994.

On September 7, 1994, the insurer sent claimant a letter notifying him that it had scheduled an examination with Dr. Radecki in Portland on September 19, 1994. Claimant did not attend the examination.

On September 27, 1994, the insurer renewed its motion to dismiss claimant's request for hearing based on ORS 656.325 and OAR 438-06-071. The insurer asserted that after the second exam had been scheduled, claimant's wife had requested advanced mileage and overnight lodging payments. The insurer decided it would be more convenient for claimant to take a bus and it arranged for the purchase of a bus ticket. On September 15, 1994, claimant's wife indicated that claimant did not want to travel alone on a bus and they wanted advanced travel expenses. Claimant's wife indicated she called to make sure the insurer would send the check right away so she would have it in advance. The insurer sent a check for advanced mileage costs on September 15, 1994. The insurer also agreed that a member of claimant's attorney's office staff could accompany claimant to the exam.

In its motion to dismiss, the insurer asserted that it received a call from claimant's attorney's office on September 19, 1994, indicating that claimant had not received the advanced travel payment and, therefore, would not be attending the IME with Dr. Radecki. According to the insurer, Dr. Radecki had a policy of not rescheduling appointments after two "no shows." The insurer stated that it appeared to be impossible to obtain an examination because of claimant's failure or refusal to cooperate.

On October 27, 1994, the ALJ granted the insurer's motion to dismiss, noting that claimant had not responded to the motion. On November 2, 1994, claimant requested reconsideration. Claimant asserted that he had sent a detailed explanation on October 5, 1994. The ALJ agreed to abate the Order of Dismissal. After reviewing both parties' responses, the ALJ adhered to and republished the Order of Dismissal.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had unjustifiably delayed the case twice by failing to attend an IME that the insurer had a right to schedule and that claimant had a duty to attend. The ALJ explained that the first failure had resulted in a postponement and that he had ordered claimant to attend the second examination or risk dismissal. The ALJ concluded that dismissal was appropriate because claimant did not attend the second examination. The ALJ relied on OAR 438-06-071 and ORS 656.325(1).[1]

Claimant argues that the ALJ erred by dismissing his hearing request because he did not "unjustifiably delay" the hearing process. OAR 438-06-071(1) provides:

> "A request for hearing may be dismissed if a ALJ 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." (Emphasis added).

There is no indication that claimant abandoned his request for hearing. Therefore, the issue is whether claimant's conduct resulted in an unjustified delay in the hearing.

Claimant contends that he had legitimate reasons for failing to attend the IME. Despite claimant's apprehension about the examination with Dr. Radecki, he had planned to attend the IME. He failed to appear, however, because he did not have the funds to travel from Prineville to Portland, a distance of 400 miles, round-trip. While recovering from his injury, claimant had been unable to work and did not have an income. Claimant had requested advanced travel expenses and the insurer sent a check for such expenses on September 15, 1994. Claimant asserts that he did not receive the check until the afternoon of the scheduled IME.

We find that claimant's failure to appear because of a lack of funds necessary to travel from Prineville to Portland was justifiable. Claimant first notified the insurer on July 27, 1994 that he would need to be reimbursed in advance for expenses to travel to Portland. According to the insurer's September 27, 1994 motion to dismiss, claimant's wife called the insurer to make sure that it would send the check right away so she would have it in advance.

Furthermore, OAR 436-10-100(4) provides that medical examinations on behalf of the insurer "shall be at places, times, and intervals reasonably convenient to the worker's place of employment or residence." Claimant asked the insurer to schedule an examination with a physician located in the general Bend/Prineville area. Instead, claimant was expected to travel approximately 400 miles, round trip, for an examination. Under the facts of this case, we do not find that the medical examination was "reasonably convenient to the worker's * * * residence" under OAR 436-10-100(4), particularly without the receipt of pretravel expenses. Compare Rami M. Shureh, 42 Van Natta 1727 (1990), aff'd Shureh v. United Postal Service, 107 Or App 276 (1991) (under ORS 656.325 and OAR 436-10-100, scheduling of IME in Seattle was reasonable, where the insurer chose the physician geographically closest to the claimant and all arrangements including travel and accommodations were made as required).

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[1] We note that the ALJ's reliance on ORS 656.325(1) was misplaced. ORS 656.325(1)(a) provides, in part, that if a worker refuses to submit to a medical examination requested by the insurer, "the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place." That statute applies to "any worker entitled to receive compensation." ORS 656.325(1)(a) has no application here because claimant has no compensation to suspend. See Ring v. Paper Distribution Services, 90 Or App 148 (1988); David M. Foote, 45 Van Natta 270 (1993).

Under these circumstances, we conclude that the ALJ erred by concluding that claimant "unjustifiably" delayed the hearing because he did not attend the second examination. OAR 438-06-071(1) does not authorize the ALJ to dismiss claimant's request for hearing unless the delay was unjustified. See Nick Shevchynski, 46 Van Natta 1297 (1994). In light of our conclusion that claimant's failure to appear at the second IME was justifiable, we vacate the ALJ's dismissal and reinstate claimant's hearing request.[2]

ORDER

The ALJ's order dated October 27, 1994, as reconsidered November 15, 1994, is vacated. Claimant's request for hearing is reinstated. This matter is remanded to ALJ Brazeau with instructions to schedule claimant's case for hearing in accordance with the Board's rules.

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[2] We disagree with the dissent's assertion that our holding sends a message that claimants can choose their IME physicians. If a claimant refused to cooperate and had no reasonable justification for failing to appear at an IME, dismissal would be warranted. Here, however, arrangements were made to enable claimant to attend the IME, but they were not fulfilled. Claimant's failure to appear because of a lack of funds necessary to travel was justifiable.

Board Member Neidig dissenting.

The majority concludes that the ALJ erred by dismissing claimant's hearing request because claimant's failure to appear at the second IME was justifiable. Because I believe that decision is wrong and results in bad policy, I respectfully dissent.

The majority focuses narrowly on whether claimant's failure to appear at the second IME was unjustified and it carefully avoids any analysis of claimant's failure to appear at the first IME. Claimant has clearly changed his tactics during this case. His failure to appear at the first IME had nothing to do with the long distance to Portland or transportation problems or lack of money to pay for transportation. Rather, he simply refused to be examined by Dr. Radecki. On July 27, 1994, the date of the first scheduled IME, claimant's attorney wrote to the insurer, confirming a telephone conversation that day. Claimant's attorney notified the insurer that claimant would not attend the appointment with Dr. Radecki and that the attorney's office had a "firm policy of not allowing our clients to attend examinations with Dr. Radecki." Claimant's attorney stated that a "secondary point" was that claimant was afraid of flying and would need mileage and lodging reimbursement. On August 23, 1994, claimant wrote to the ALJ, stating that he would not "voluntarily attend an IME" with Dr. Radecki.

I am not aware of any statutory provision or administrative rule, under the previous law or the new amendments under Senate Bill 369, that would allow a worker to choose which physicians he or she will see for an IME. Furthermore, although the carrier must reimburse the worker for "related services" in connection with the IME, ORS 656.325(1)(b), there is no requirement that the carrier must pay such costs in advance. In my view, the insurer in this case went above the call of duty by arranging airline and bus transportation, advancing mileage expenses and allowing a member of claimant's attorney's office staff to attend the IME with claimant.

When this record is reviewed as a whole, there is no doubt that claimant's conduct "resulted in an unjustified delay in the hearing of more than 60 days." OAR 438-06-071(1). Claimant's arguments about "convenience" are being raised in hindsight. Claimant simply did not want to attend this IME and there is no justification for his refusal to do so. The majority's holding is a bad policy decision because it sends the message that claimants can choose the physicians they see in connection with independent medical examinations.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
CATHY A. INMAN, Claimant
WCB Case No. 94-03040
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) McCullough's order which: (1) upheld the insurer's denial of her claim for bilateral carpal tunnel syndrome; (2) declined to assess a penalty and related attorney fee for the insurer's allegedly unreasonable delay in reclassifying her 1993 injury claim as disabling; and (3) declined to award her counsel an out-of-compensation attorney fee for services culminating in the reclassification of her 1993 claim as disabling. Claimant contends that the ALJ erred in: (1) denying her motion for postponement/continuance of the hearing to obtain depositions of the insurer's medical experts; and (2) denying her motion for dismissal of the hearing without prejudice. She requests that this matter be remanded to the ALJ for consideration of a post-hearing rebuttal report from her attending physician. On review, the issues are postponement/continuance, remand, compensability, penalties and attorney fees. We deny the motion for remand and, on the merits, affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant compensably injured her left wrist on December 2, 1993. Later that same month, the insurer accepted the claim for a nondisabling left wrist strain. By letter dated January 20, 1994, claimant through counsel requested that the Department reclassify her claim as disabling. By letter dated February 14, 1994, the insurer advised claimant that it was reclassifying her claim as disabling.

On March 10, 1994, claimant through counsel filed a hearing request seeking penalties and attorney fees related to the claim reclassification. By Notice of Hearing mailed on March 25, 1994, the parties were notified that a hearing was scheduled for May 24, 1994.

Meanwhile, claimant had sought treatment with Dr. Hoppert for bilateral hand pain and numbness. The doctor diagnosed bilateral carpal tunnel syndrome and, on January 26, 1994, requested authorization for bilateral carpal tunnel release surgery. At the insurer's request, claimant was examined by Dr. Button, who issued a report on March 2, 1994, concluding that the carpal tunnel syndrome was preexisting and had not been materially changed by her work exposure. (Ex. 26). Claimant's counsel received a copy of Dr. Button's report on March 21, 1994. (Ex. 28A). Dr. Breen reviewed Dr. Button's report and, by "check-the-box" response, concurred with the report.[1] (Ex. 28).

By letter dated March 18, 1994, the insurer advised claimant's counsel that it would not authorize the surgery requested by Dr. Hoppert. On March 28, 1994, claimant through counsel filed a supplemental hearing request designating the surgery denial, penalties and attorney fees as additional issues for hearing.

The left wrist injury claim was closed by Notice of Closure on March 29, 1994 with no permanent disability award. By letter dated March 31, 1994, the insurer denied the claim for bilateral carpal tunnel syndrome. On April 8, 1994, claimant's counsel filed a supplemental hearing request designating the March 31, 1993 denial, penalties and attorney fees as additional issues for hearing.

On May 19, 1994, claimant's counsel telephoned the insurer's counsel to advise that he wished to depose Drs. Button, Breen and Corrigan. The insurer's counsel objected to the deposition request. In addition, about a week before the May 24, 1994 hearing, claimant's counsel wrote Dr. Hoppert requesting a rebuttal report on the issue of causation of the bilateral carpal tunnel syndrome. Due to a misunderstanding between Dr. Hoppert and claimant's counsel, Dr. Hoppert did not have the medical records available to complete the rebuttal report before hearing.

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[1] Dr. Corrigan also issued a "check-the-box" report concurring with Dr. Button's report. That report was initially submitted by the insurer as Exhibit 32, but it was withdrawn on the date of hearing and is not in the record. (Tr. 30).

At the May 24, 1994 hearing, claimant through counsel moved for postponement or continuance of the hearing to obtain depositions of Drs. Button, Breen and Corrigan and to obtain Dr. Hoppert's rebuttal report. The insurer's counsel objected. The ALJ denied claimant's motion for postponement or continuance, reasoning that claimant failed to show due diligence in preparing the case for hearing. Thereafter, claimant's counsel moved for dismissal of the hearing request without prejudice, noting that the appeal rights on the March 31, 1994 denial had not yet expired. The insurer's counsel again objected. The ALJ denied the motion for dismissal without prejudice, reasoning that claimant was attempting to circumvent his unfavorable evidentiary ruling.

The hearing was convened and the record closed on May 24, 1994. By letter dated June 1, 1994, claimant's counsel requested the ALJ to reconsider his evidentiary ruling and reopen the record for Dr. Hoppert's May 25, 1994 rebuttal report. The ALJ denied the request.

CONCLUSIONS OF LAW AND OPINION

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

On review, claimant contends that the ALJ's order should be reversed and this matter remanded for admission of Dr. Hoppert's May 25, 1994 report. Claimant also seeks an out-of-compensation attorney fee for her counsel's efforts concerning the reclassification of her claim.

Remand

In support of her remand request, claimant argues that the ALJ erred in denying her motion for postponement/continuance of the hearing and her motion for dismissal of the hearing request without prejudice. We disagree.

Postponement/Continuance

We first address the motion for postponement/continuance. OAR 438-06-081, the postponement rule, provides that hearings "shall not be postponed except by order of [an ALJ] upon a finding of extraordinary circumstances beyond the control of the party...requesting the postponement." Subsection (4) of the same rule provides that "extraordinary circumstances" shall not include "[i]ncomplete case preparation, unless the [ALJ] finds that completion of the record could not be accomplished with due diligence."

The continuance rule, OAR 438-06-091, provides:

> "The parties shall be prepared to present all of their evidence at the scheduled hearing. Continuances are disfavored. The ALJ may continue a hearing for further proceedings:
>
> "(2) Upon a showing of due diligence if necessary to afford a reasonable opportunity to cross-examine on documentary medical...evidence; [or]
>
> "(3) Upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence...."

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 the ALJ's ruling (on the continuance motion) for abuse of discretion. See Georgia-Pacific Corp. v. Kight, 126 Or App 244, 246 (1994). The postponement rule, on the other hand, contains mandatory language ("shall"), and requires that a postponement motion based on incomplete case preparation be denied, unless there is a showing of due diligence by the moving party.

Both the postponement and continuance rules impose an obligation on the moving party to exercise "due diligence" in preparing to present all of its evidence at the scheduled hearing. The ALJ concluded that claimant failed to make a showing of due diligence in attempting either to obtain depositions (cross-examinations) of Drs. Button, Breen and Corrigan or obtain final rebuttal evidence from Dr. Hoppert. We agree.

The record shows that claimant's counsel received Dr. Button's March 2, 1994 report on March 21, 1994. (Ex. 28A). In that report, Dr. Button described claimant's bilateral carpal tunnel syndrome as a preexisting condition which had not been materially changed by work exposure. (Ex. 26). A week or so later, on March 31, 1994, the insurer issued its letter denying the claim for bilateral carpal tunnel syndrome. (Ex. 30A). On April 8, 1994, claimant's counsel designated the denial as an additional issue for the hearing scheduled for May 24, 1994.

Hence, by April 8, 1994, claimant's counsel should reasonably have known that Dr. Button's report would be submitted in defense of the insurer's denial. At that time, claimant's counsel should have known that a deposition (cross-examination) of Dr. Button and a rebuttal report from Dr. Hoppert would need to be obtained prior to the May 24, 1994 hearing. That allowed claimant's counsel a month and a half to prepare claimant's case. Yet, claimant's counsel apparently did nothing to obtain either Dr. Button's deposition or Dr. Hoppert's rebuttal report until the week before the hearing. That six-week delay was significant and unexplained. We conclude there was no showing of due diligence to support a postponement or continuance of the hearing to obtain Dr. Button's deposition or Dr. Hoppert's rebuttal report.

The ALJ also found there was a lack of due diligence in claimant's efforts to obtain depositions of Drs. Breen and Corrigan. Their reports concerning causation, marked as Exhibits 17 and 28, were received by claimant's counsel no later than May 2, 1994, under the insurer's exhibit list dated April 29, 1994.[2] (Tr. 23). Both reports supported the insurer's denial. Hence, claimant's counsel should reasonably have known on May 2, 1994 that depositions of both doctors would need to be obtained prior to hearing. Claimant's counsel also knew that the hearing was scheduled for May 24, 1994, three weeks later. Under those circumstances, claimant's counsel had an obligation to make a deposition request with due haste. Yet, claimant's counsel apparently did nothing until May 19, five days before hearing. Given the circumstances that were known to claimant's counsel, we conclude there was a lack of due diligence to justify a postponement or continuance of the hearing.

Citing ORS 656.310(2), claimant argues that she was not entitled to cross-examine Drs. Button, Breen and Corrigan until their reports were offered into evidence before the Hearings Division. Noting that their reports were offered into evidence under the insurer's April 29, 1994 exhibit list which her counsel received on May 2, 1994, she argues that her request for depositions 17 days later, on May 19, was timely and appropriate. We disagree.

As a threshold matter, we note that ORS 656.310(2) addresses the obligation of any doctor whose medical report is "presented" for compensation as prima facie evidence of matters contained therein, to consent to cross-examination. Arguably, that obligation would arise only after the doctor's report is offered into evidence. However, ORS 656.310(2) does not preclude a party from requesting cross-examination prior to submission of that doctor's report into evidence if the party knows, or reasonably should know, that the doctor's report will be offered into evidence.[3] In this regard, we emphasize that the Board's postponement and continuance rules require the moving party to exercise due diligence in preparing to present all of its evidence at the scheduled hearing. If, for any reason beyond its control, the moving party is prevented from obtaining timely cross-examination (e.g., the doctor refuses to submit to cross-examination), that fact would be considered in ruling on a motion for postponement or continuance.

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[2] Exhibits 17 and 28 are reports dated January 5, 1994 and March 14, 1994, respectively. Copies of those reports were mailed to the insurer and presumably disclosed to claimant's counsel pursuant to the Board's rules. See OAR 438-07-015(2) (requires the insurer to provide to claimant all claim-related medical reports within 15 days after mailing of a hearing request or written demand). Inasmuch as claimant has not alleged any failure by the insurer to timely disclose Exhibits 17 and 28 pursuant to the aforementioned rule, we could assume that claimant's counsel received those exhibits by April 23, 1994, or within 15 days after its April 8, 1994 hearing request concerning the insurer's denial. Nevertheless, because there is no direct evidence that claimant's counsel received the exhibits before May 2, 1994, we have given claimant the benefit of the doubt in finding that May 2 was the date of first receipt.

[3] If we accepted claimant's argument that a party, who is in receipt of adverse reports disclosed by the opposing party, could wait until those reports were formally offered into evidence before requesting cross-examination, we would be encouraging parties to do nothing until reports were submitted into evidence. That would result in precisely the types of delays which the Board sought to avoid by promulgating the postponement and continuance rules in the first place.

Even if we assumed that claimant was not required to request cross-examination prior to receipt of the insurer's exhibit list on May 2, 1994, we would still reject claimant's argument that her 17-day delay was timely and appropriate. As we stated above, claimant knew that the hearing was scheduled for May 24, 1994. Under this known circumstance, she should have requested cross-examination sooner than five days before the hearing. Because she did not do so, we conclude that the ALJ did not err in denying her motions for postponement and continuance of the hearing.

Dismissal Without Prejudice

Claimant also contends that the ALJ erred in denying her motion for dismissal of her hearing request without prejudice. She notes that, as of the date of hearing, there was still additional time left to appeal the insurer's March 31, 1994 denial.

An ALJ has discretion to set the terms and conditions of an order of dismissal as he or she deems proper; we will not disturb the terms and conditions imposed by the ALJ except upon a showing of abuse of discretion. Ronald D. Robinson, 44 Van Natta 2500, 2501 (1992); Julie Mayfield, 42 Van Natta 871 (1990).

In Robinson, we stated that a party that requested a hearing cannot circumvent the Board's postponement or continuance rules by obtaining a dismissal without prejudice and then subsequently filing a new hearing request on the same issues. We concluded that the moving party must provide an explanation for withdrawing the hearing request and having the hearing request dismissed without prejudice. We based our conclusion on the basic tenet that the party filing the hearing request initiates the hearing process and must therefore be prepared to present its case at the scheduled hearing. To hold otherwise, we reasoned, would delay litigation, encourage lack of preparation, and prejudice the opposing party that has prepared for hearing. Id. at 2502.

Claimant argues that this case is distinguishable from Robinson because claimant added the insurer's March 31 denial as an issue to the already scheduled hearing. She argues that, in doing so, she sought to advance issues of judicial economy and efficiency and deprived herself of the fullest opportunity to prepare her case for hearing. Essentially, claimant argues that she is being penalized for considering judicial economy and efficiency. We disagree. Whether an issue is first raised in the original hearing request or subsequently designated as an additional issue for hearing, the party raising the issue must still exercise due diligence in preparing the case for hearing. That requirement cannot be bypassed by withdrawing the hearing request and refiling at a later time. As we have already explained, claimant did not exercise due diligence under the circumstances. We conclude that the ALJ did not abuse his discretion in denying the motion to dismiss without prejudice.

For the aforementioned reasons, we find no good cause or other compelling basis for remanding this case to the ALJ. See Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986). Claimant's motion for remand is denied.

Attorney Fees

Claimant contends that the ALJ erred in declining to award her counsel an out-of-compensation attorney fee under ORS 656.386(2) for services culminating in the reclassification of her claim as disabling. The insurer argues that claimant sought only an assessed (insurer-paid) attorney fee award under ORS 656.386(1).

The attorney fee issue was first raised in claimant's hearing request without any limitation as to statutory authority. At hearing, claimant's counsel agreed with the ALJ's statement that he was seeking an attorney fee under "ORS 656.386." (Tr. 7). As the insurer argues, claimant's counsel asserted at hearing that he was "instrumental in obtaining compensation." (Tr. 6). That language, while suggesting he was seeking only an assessed fee under ORS 656.386(1), given the broad statement of the attorney fee issue at hearing, cannot be interpreted as a waiver of any other basis for attorney fees under ORS 656.386. Accordingly, we find that claimant's counsel properly raised entitlement to an attorney fee award under ORS 656.386(2).

Therefore, the ALJ's order shall be modified to conclude that claimant's counsel is entitled to an attorney fee award payable out of the increased compensation resulting from the claim reclassification. In the event that the increased compensation has already been paid to claimant, claimant's counsel must first seek recovery of the fee directly from claimant. See Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994). In the event that the attorney's efforts to recover the fee are unsuccessful, claimant's attorney may seek recovery of the fee in the manner prescribed in Volk, supra.

ORDER

The ALJ's order dated June 10, 1994 is modified in part and affirmed in part. The order is modified to award claimant's counsel an out-of-compensation attorney fee of 25 percent of the increased compensation resulting from the disabling claim reclassification, not to exceed $1,050, payable directly to claimant's counsel. In the event the increased compensation has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk, supra. The remainder of the order is affirmed.

Board Member Hall dissenting.

While I agree with the majority that claimant did not exercise due diligence in requesting cross-examination of Dr. Button and a rebuttal report from Dr. Hoppert, I disagree with its conclusion that due diligence was not exercised in requesting cross-examinations of Drs. Breen and Corrigan. I also disagree with the ALJ's denial of claimant's motion for dismissal without prejudice. Therefore, I respectfully dissent.

Claimant filed the original hearing request (seeking penalties and attorney fees) on March 10, 1994. However, the compensability issue was not a matter in litigation until April 8, 1994, the date of filing of claimant's supplemental hearing request from the insurer's March 31, 1994 denial. On April 8, 1994, claimant was also in receipt of Dr. Button's report opposing compensability and should have exercised due diligence in requesting cross-examination of Dr. Button and a final rebuttal report from Dr. Hoppert. Yet, claimant did not make her request until five weeks later, about a week before the May 24, 1994 hearing. As I stated above, I am inclined to agree that claimant did not act with due haste in that instance.

However, with regard to claimant's request for cross-examination of Drs. Breen and Corrigan, my conclusion is different. The record shows that claimant first received their reports on May 2, 1994, about three weeks before hearing. Upon receipt of those reports, claimant was bound to exercise due diligence in requesting cross-examination of Drs. Breen and Corrigan. Claimant made her request for cross-examination 17 days later, on May 19, 1994. The question, therefore, is whether claimant exercised due diligence in making her cross-examination request 17 days after receiving Drs. Breen and Corrigan's reports. I believe she did. As a practical matter, given the nature of litigation practice, generally, I do not find that a 17-day delay in requesting cross-examination is unreasonable. Under these circumstances, I would conclude that the ALJ abused his discretion in denying claimant's motion for continuance to obtain cross-examinations of Drs. Breen and Corrigan.

Finally, inasmuch as the 90-day statutory period for appealing the insurer's March 31, 1994 denial had not yet expired when the hearing was convened on May 24, 1994, I would conclude that the ALJ abused his discretion in denying claimant's motion for dismissal without prejudice. For these reasons, I would remand this matter to the ALJ for cross-examinations of Drs. Breen and Corrigan.

In the Matter of the Compensation of
DOUG S. WALLS, Claimant
WCB Case No. C5-00453
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

On February 22, 1995, 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.

On March 30, 1995, in light of the parties' contrary positions regarding their negotiations leading to execution of the CDA, we entered an interim order remanding the matter to the Hearings Division for a fact finding hearing. Douglas S. Walls, 47 Van Natta 485 (1995). Pursuant to the order, on May 12, 1995, Hearings Officer Marshall held a hearing to determine if the proposed CDA was the result of an intentional misrepresentation of material fact.

Prior to the issuance of any order by Hearings Officer Marshall, the legislature enacted Senate Bill 369 amending ORS 656.236. SB 369, 68th Leg., Reg. Sess., § 24 (June 7, 1995). Before the enactment of the new law, only the worker could disapprove the CDA within 30 days of submitting the disposition for approval to the Board. Former ORS 656.236(1)(c). The statute was amended to provide that, along with the worker, the insurer and self-insured employer also may request disapproval by the Board of the CDA. SB 369, § 24(1)(a)(C).

Hearings Officer Marshall asked for the parties' positions regarding the effect of the new law. In response, both claimant and the employer agree that the CDA should be disapproved.

In light of these recent developments, we have proceeded with our reconsideration of the CDA without awaiting issuance of the Hearing Officer's order.[1] As discussed above, the employer requested that the Board disapprove the CDA on the grounds that claimant had intentionally misrepresented material facts. The employer made this request on March 9, 1995, within 30 days of the submission of the CDA for Board approval. In light of the new law and its retroactive application, we grant the employer's timely request for disapproval of the CDA. Accordingly, we disapprove the disposition.

IT IS SO ORDERED.

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[1] In this regard, we note that our interim order remanding the case to the Hearings Officer retained jurisdiction of the matter with the Board.

In the Matter of the Compensation of
MERRITT I. ANDERSON, Claimant
WCB Case No. CV-95002
CRIME VICTIM ORDER OF DISMISSAL (REMANDING)
Mary H. Williams, Assistant Attorney General

Applicant requested Board review of the Department of Justice's February 22, 1995 Second Order on Reconsideration denying his claim for benefits under the Compensation Act for Victims of Crime. Accompanying applicant's request were numerous documents, including an army discharge report, medical records and a letter addressed to applicant. Most of the documents were not considered by the Department. Subsequent correspondence to the Board from applicant also indicated a desire to obtain a statement or testimony at a hearing of the author of the letter, a request to obtain "the psychological profile" of assailant, and a desire to obtain a statement from a former fiancee.

Reasoning that applicant's submission of documents and correspondence could be interpreted as a motion to remand, we asked for the Department's position for remanding applicant's claim for further consideration. The Department responded that, if applicant "has additional information he can provide" to the Department, it "would be willing to reconsider his claim"; however, the Department expressed an unwillingness to investigate on applicant's behalf to obtain additional information.

Based on applicant's submission to the Board of documents that were not considered by the Department, we find that he has additional evidence for the Department's review. Furthermore, applicant's correspondence referred to specific persons or reports which he believed would aid him with his claim. We find this to be further support that applicant can provide to the Department additional evidence and he is not simply generally requesting that the Department conduct further investigation on his behalf.

In light of such circumstances, applicant's request for Board review is dismissed and this matter is remanded to the Department to proceed with its reconsideration. In reaching this conclusion, we emphasize that it is applicant's obligation to present additional evidence supporting his claim to the attention of the Department. Upon its receipt of such evidence, the Department will proceed further with its investigation. If after completing that investigation, the Department continues to deny applicant's claim for benefits, he may request Board review of that future decision. Thereafter, a hearing regarding his appeal could then be scheduled.

IT IS SO ORDERED.

In the Matter of the Compensation of
CINDY K. CHRISTIAN, Claimant
WCB Case No. 94-03958
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Yturri, Rose, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order which: (1) found that claimant's March 15, 1993 low back injury claim was not prematurely closed; (2) reduced claimant's unscheduled permanent disability award from 11 percent (35.2 degrees), as awarded by Order on Reconsideration, to zero; (3) upheld the self-insured employer's denial of claimant's claim for a new low back injury; (4) upheld the employer's denial of claimant's low back aggravation claim; (5) upheld the employer's denial of claimant's current low back condition; and (6) upheld the employer's "de facto" denial of radiculopathy or sciatica. On review, the issues are premature closure, extent of permanent disability, and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

On March 15, 1993, claimant injured her low back while lifting heavy barrels at work. The employer accepted lumbosacral strain. Claimant's claim was closed on November 22, 1993, by Notice of Closure that awarded no permanent disability. An August 8, 1994 Order on Reconsideration awarded 11 percent (35.2 degrees) unscheduled permanent disability.

Claimant experienced continued low back and leg pain following her injury. (Ex. 22). She attempted working on various occasions, but was not able to return to her employment-at-injury for nearly a year. (Ex. 22-3, 4, 5).

Between November 1993 and March 1994, claimant worked at temporary employment, and sought employment that would not require standing during her work. (Ex. 22-5, 6). During that time, she experienced various exacerbations of her back condition. (Exs. 22-5, 6). In March 1994, claimant returned to modified work for the employer.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The ALJ concluded that claimant's claim had properly been closed on November 22, 1993. We agree.

It is claimant's burden to prove that her claim was prematurely closed. 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 November 22, 1993 Notice of Closure[1] 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). "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 issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

Here, on November 3, 1993, Dr. Henson examined claimant for an independent examination. (Ex 52). Dr. Henson opined that claimant was objectively stable, with physical limitations due to her marked obesity. Dr. Dahlin, attending physician, concurred with Dr. Henson's opinion, also noting that claimant was still symptomatic because of her obesity and excessive smoking. (Ex. 22-5, 55). On May 27, 1994, Dr. Dahlin reiterated that claimant's condition had not significantly changed between November 1993 and May 1994. (Ex. 72). Therefore, he did not alter his opinion that claimant was medically stationary in November 1993.

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[1] Amended ORS 656.268(1)(a) and (b) provide certain exceptions which allow a claim to be closed when a worker's condition is not medically stationary. None of those exceptions apply in this case.

Finding no evidence that claimant was not medically stationary in November 1993, we conclude that claimant failed to prove premature claim closure. Accordingly, we affirm the ALJ's opinion concerning claimant's medically stationary date.

Extent of Permanent Disability

On July 16, 1994, claimant was examined by Dr. Gritzka, medical arbiter. He stated that claimant's lumbar flexion did not meet validity criteria according to the A.M.A. guidelines. Therefore, he concluded that claimant's lumbar ranges of motion were probably invalid. (Ex. 77A-5). Nevertheless, Dr. Gritzka also concluded that claimant had limitations in the ability to repetitively use her low back due to her chronic lumbosacral sprain. The record contains no evidence of additional impairment. Accordingly, relying on Dr. Gritzka's opinion, we conclude that claimant has 5 percent impairment due to her compensable injury. Therefore, we proceed to a computation of the extent of permanent disability. Claimant's condition became medically stationary after July 1, 1990, and her claim was closed by Notice of Closure on November 22, 1993. Therefore, the applicable standards are set forth in WCD Admin. Order 6-1992.

The factors for claimant's age and education total 6. (Ex. 77C-3). Claimant's work at injury, cannery worker (DOT 529.686-014), has a strength demand of light. Claimant's RFC is also light, for an adaptability value of 1. Thus, claimant's age and education total, 6, multiplied by the adaptability value of 1, equals 6.

Claimant is entitled to an impairment value of 5 for chronic condition limiting repetitive use. Adding claimant's social/vocational values of 6, with her impairment value of 5, equals a sum of 11. Claimant is entitled to a total of 11 percent unscheduled permanent disability. Accordingly, we reinstate and affirm the Order on Reconsideration award of 11 percent (35.2 degrees) unscheduled permanent disability.

Compensability-New Injury

Claimant contends that she sustained a new low back injury on May 22, 1994. The ALJ concluded that claimant did not have a new injury. We agree.

On March 8, 1994, after returning to work for the employer, claimant presented to emergency with back pain that had begun the previous day. (Ex. 63). On March 10, 1994, claimant was examined by Dr. Henson for the second time. (Ex. 64). Dr. Henson stated that claimant's original lumbar strain should have resolved long ago, and that there had been no worsening since his previous examination in November 1993. He noted marked functional features, along with obesity. Id.

On May 9, 1994, claimant saw Dr. Dahlin with complaints of lumbosacral pain and intermittent numbness of the leg. (Ex. 69). He noted that the symptoms represented a flare-up of the previous symptom complex which is related to degenerative problems and overweight. He further noted that claimant's "soft tissue injury" was resolved. Id. Dr. Dahlin opined that there was no evidence of worsening of claimant's underlying condition for the past several months, except for symptomatic flare-ups. (Ex. 70).

On May 23, 1994, claimant presented at a clinic with discomfort at the left lateral waist area that had begun while at work the previous day. (Ex. 71-1). She was also experiencing fever and vomiting. The nurse practitioner noted that claimant was being followed for a muscle pull, but also suspected that the current symptoms might represent a urinary tract infection. Id. Employee absentee records for May 20, 21, and 24, 1994 indicate that claimant was off work those days due to a kidney infection. (Ex. 82-3, 4, 6). Claimant did not return to her attending physician after the May 22, 1994 exacerbation.

On June 21, 1994, claimant saw Dr. Ball, neurologist, for the first time. Dr. Ball received a history from claimant of an injury that occurred while working for the employer on May 22, 1994. (Ex. 76A-2). Dr. Ball subsequently signed a questionaire indicating that claimant had sustained a new injury on May 22, 1994. (Ex. 80).

On August 17, 1994, Dr. Henson again examined claimant. (Ex. 78). It was his opinion that the work incident on May 22, 1994 was one of claimant's usual flare-ups associated this time with a urinary tract infection. Dr. Henson further opined that claimant's symptoms were not directly related to her compensable injury. (Ex. 78-3).

Where the medical evidence is divided, we rely on those opinions which are well-reasoned and based on accurate and complete histories. Somers v. SAIF, 77 Or App 259 (1986). Here, we are not persuaded by Dr. Ball's opinion that claimant had a new injury on May 22, 1994. Claimant's history following her March 1993 low back sprain is consistent with other periodic, severe exacerbations of back pain, including an "acute flare-up" that occurred in early May 1994, while claimant was performing the same job duties as those on May 22, 1994. These flare-ups are attributed, by Dr. Dahlin, in large part to claimant's obesity. (Exs. 69, 70).

Here, Dr. Henson examined claimant three times after her March 1993 injury, with her attending physician, Dr. Dahlin, concurring with Dr. Henson's opinions. Dr. Ball, however, examined claimant only one time, following the May 22, 1994 work incident, and there is no evidence that Dr. Ball had reviewed any of claimant's previous medical records.

Accordingly, based on Dr. Henson's opinion that claimant had experienced one of her usual flare-ups, associated with a urinary tract infection, we conclude that claimant did not experience a new injury on May 22, 1994.

Compensability-Aggravation/Current Condition

Claimant contends that, if she did not have a new injury on May 22, 1994, she had an aggravation of her March 1993 injury.[2] We disagree.

Here, after considering the medical evidence discussed above, we conclude that claimant has not proved that she experienced an aggravation of her compensable injury in May 1994. The evidence from claimant's treating physician and Dr. Henson, who have both examined claimant several times since her injury, indicates that there has been no worsening of claimant's compensable condition since claimant was medically stationary in November 1993. Rather, the evidence attributes claimant's continuing complaints to her obesity. Furthermore, in light of this evidence, it follows that claimant's compensable injury is not the major contributing cause of her current low back condition. See ORS 656.005(7)(a)(B).

"De facto" Denial[3]

Claimant contends that the insurer issued a "de facto" denial of a claim for radiculopathy or sciatica. Claimant relies on reports from Dr. Dahlin "diagnosing" those conditions as a result of her injury. However, we conclude that Dr. Dahlin has not made a diagnosis of those conditions from which a claim may properly be made. See Safeway Stores, Inc. v. Smith, 117 Or App 224 (1992) (physician's report stating that claimant had "right shoulder, neck and arm pain, as well as shooting pain down the left arm, and prescrib[ing] physical therapy and medication" constituted a claim).

Here, in a May 7, 1993 chart note, Dr. Dahlin stated: "IMPRESSION: 1) Lumbosacral radiculopathy--right; and 2) R/O herniated disc disease." (Ex. 22-1). On July 12, 1993, Dr. Dahlin reported that "[claimant] is at present incapacitated from work because of sciatic nerve injury as related to her occupational injury." (Ex. 36).

However, in response to a note from claimant's attorney, Dr. Dahlin stated that claimant's "diagnosis of lumbar [strain] is appropriate and sciatica and radiculitis in this case implies primarily referred pain or possibly intermittent sciatic irritation on a degenerative basis. There are no objective findings." (Ex. 70). Considering Dr. Dahlin's response, we conclude that there was no claim made of radiculopathy or sciatica that the employer was required to accept or deny. Safeway Stores, Inc. v. Smith, supra.

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[2] We are mindful of the amendments to ORS 656.273. See SB 369, 68th Leg., Reg. Sess., §31 (June 7, 1995). However, in light of our conclusion that claimant did not experience an aggravation of her accepted condition, we need not apply those amendments.

[3] We are mindful of the amendments to ORS 656.262(6)(d). See SB 369, §28. However, in light of our conclusion concerning the treating physician's diagnoses, we need not apply that amendment.

ORDER

The ALJ's order dated September 26, 1994 is reversed in part and affirmed in part. That portion of the order which reversed the Order on Reconsideration permanent disability award is reversed. The Order on Reconsideration award of 11 percent (35.2 degrees) unscheduled permanent disability is reinstated and affirmed. Claimant's attorney is awarded an approved attorney fee equal to 25 percent of the compensation created by this order, payable directly to claimant's attorney, not to exceed $3,800. The remainder of the ALJ's order is affirmed.

July 11, 1995 Cite as 47 Van Natta 1326 (1995)

In the Matter of the Compensation of
KEVIN D. COX, Claimant
WCB Case No. 93-12345
ORDER ON REMAND
Estell & Associates, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Cox, 133 Or App 666 (1995). The court has reversed our prior order, which determined that claimant was a subject worker at the time of his injury. Reasoning that, under ORS 656.027(9)[1], only bona fide corporate officers and directors with a substantial ownership interest in the employer are excepted from subject worker status, the court has remanded for reconsideration.

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, a millworker, worked for the employer performing the same job at the same premises since about 1987. On July 22, 1993, claimant sustained a severe left hand injury while changing knives on the planer. The employer paid claimant at an hourly rate, with small cost of living raises, during the whole of his employment.

In 1989, the employer incorporated and changed its name. This action was taken to avoid high workers' compensation insurance rates. (Tr. 10). At the time the corporation was formed, the employer gave claimant a "bonus" of $425 or $450, from which it deducted $200 as consideration for stock. Claimant made no further financial contribution to the corporation and was not informed of the percentage "ownership" he held in the corporation. (Tr. 7). Claimant has never received any distribution of corporate earnings.

In March 1990, Rodney Lucas, president of the corporation, applied for workers' compensation insurance. The application named a president, secretary, and seven vice-presidents, including claimant, as directors. Each executive officer/director was listed as having a 10 percent interest in the business. (Ex. A1-A3). Prior to claimant's injury, the employer elected to cover three officers/directors as subject employees. This election did not include claimant. (Exs. A-1, A-4, A-11, A-18, A-19, A-20).

Since the 1989 incorporation, claimant attended four or five corporate board meetings. No corporate business was transacted at these meetings. Only the president had authority to provide raises

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[1] Subsequent to the court's decision, the Legislature enacted Senate Bill 369 which amended ORS 656.027(9). The statute was renumbered to ORS 656.027(10) and reinstated language that had been deleted by a 1990 amendment. The statute now provides that "corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officers [subject to certain limitations not relevant here] are nonsubject workers." (Emphasis added to indicate reinstated language). We need not address the applicability of the new law to this case. Because we find that claimant was not a bona fide corporate officer with a substantial ownership interest, under either version the result is the same.

and to hire and fire employees, including claimant. Claimant had no authority over mill operations or hiring or firing at any time during his employment. At the time of the January 11, 1994 hearing, claimant had not attended any corporate board meetings for the prior two years.

As stated by the court, only bona fide corporate officers and directors are excepted from subject worker status. See Carson v. State Indus. Acc. Comm., 152 Or 455, 459-60 (1936). "Sham" officers and directors are not. Id. Thus, the question is whether claimant, at the time of injury, was an officer of the corporation within the meaning of the Workers' Compensation Act. An officer of a corporation should have at the least some financial interest in the company and have a voice in its management. Carson, supra.

Here, claimant was hired as a millwright paid on an hourly basis by the predecessor employer several years before the corporation was formed. Claimant continued to work as a millwright on the same hourly basis after the employer became a corporation and was working as a millwright at the time he was injured.

Claimant was named as an officer and director of the corporation after receiving a "bonus" from the employer, part of which he was required to remit for the purchase of an unknown number of shares of stock of an unknown value. Although designated as a director and listed as owning a 10 percent[2] interest in the corporation, the record establishes that such authority and ownership was entirely illusory. Claimant exercised no control over the business. He had no voice in hiring, firing, mill operations or policy decisions. His sole work was as an employee millwright.

Consequently, we conclude that claimant was not a bona fide officer or director of the corporation. Thus, claimant is a subject worker and his left hand claim is compensable.[3]

In a case in which a claimant finally prevails in respect to any claim or award for compensation after remand from the Supreme Court, Court of Appeals or Board, the ALJ, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. Amended ORS 656.388(1). Here, claimant has finally prevailed after remand from the court. Since claimant has previously been awarded attorney fees for services at hearing and on Board review, we shall not disturb those awards. However, claimant is also entitled to a reasonable attorney fee for services before the Court of Appeals.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services before the court is $2,000, to be paid 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration of our August 5, 1994 order, the ALJ's order dated January 27, 1994 is affirmed. We republish that portion of our prior order that awarded a $500 attorney fee, payable by SAIF. Finally, for services before the court, claimant's attorney is awarded $2,000, payable by SAIF.

IT IS SO ORDERED.

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[2] The SAIF Corporation contends that, at the time of injury, claimant owned 16.7 percent, or one-sixth, of the corporation. The 16.7 percent was calculated by SAIF to account for a return of 40 percent of the stock to the treasury when four people left the company, which SAIF then allocated among the remaining corporate officers. SAIF's calculation has no relation to the actual allocation, if any, by the corporation. (Tr. 24, 25).

[3] SAIF also argues that claimant, as a corporate officer, failed to elect coverage under ORS 656.039 and for that reason is not a subject worker. Because we have concluded that claimant was not a bona fide corporate officer or director of the corporation, and is a subject worker, there is no need for claimant to have qualified as a subject worker by election of coverage. Moreover, had claimant been a bona fide corporate officer and not a subject worker, an election of coverage is required to be made by the employer, not by claimant. See Quadel Industries v. Luckman, 95 Or App 612 (1989) (An officer of a corporation not a subject worker is not in a position to elect coverage for himself under ORS 656.039(4); that is the choice and responsibility of the employer pursuant to ORS 656.039(1)).

In the Matter of the Compensation of
JAMES R. DRYDEN, Claimant
WCB Case No. 94-07770
ORDER ON REVIEW
Sara L. Gabin, Claimant Attorney
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Gunn and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order which affirmed the award of 11 percent (35.2 degrees) unscheduled permanent disability for injury to claimant's back and 6 percent (11.52 degrees) scheduled permanent disability for loss of use or function of the right arm granted by an Order on Reconsideration. On review, the issues are extent of scheduled and unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

The ALJ rejected claimant's argument that he was entitled to a 5 percent award of scheduled permanent disability for a chronic left arm condition, reasoning that neither the medical evidence from claimant's attending physician, Dr. Lisook, nor the report of a physical capacities evaluation (PCE) with which Dr. Lisook concurred, established that claimant had loss of function of the left arm.

On review, claimant contends that the ALJ erred, citing comments in the PCE that repetitive or forceful use of the hands/arms would exacerbate claimant's compensable upper extremity conditions and that claimant should minimize highly repetitive or forceful activities. (Ex. 28-1). Claimant asserts that this evidence, along with his testimony, establishes that he is unable to engage in repetitive use of his left arm. Thus, claimant argues that he is entitled to an award of scheduled permanent disability for the left arm. We disagree.

A worker may be entitled to scheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a scheduled body part due to a chronic and permanent medical condition. OAR 436-35-010(6). This rule requires a medical opinion of claimant's attending physician, or one with which the attending physician has concurred, from which it can be found that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition. Weckesser v. Jet Delivery Systems, 132 Or App 325, 328 (1995). There must be medical evidence of at least a partial loss of ability to repetitively use the body part. See Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

Here, we find no persuasive medical evidence of a partial loss of claimant's ability to repetitively use his left arm. Dr. Lisook, claimant's attending physician, agreed with the PCE in which it was stated that repetitive use of the upper extremities would exacerbate his bilateral arm conditions. (Ex. 28-1). However, this statement does not establish a partial loss of ability to repetitively use the left arm. See David A. Kamp, 46 Van Natta 389, 390 (1994) (limitations imposed to avoid reinjury insufficient to establish a chronic condition)

Furthermore, although a physical capacities evaluator recommended that claimant minimize highly repetitive activities, that recommendation also does not establish that claimant is unable to repetitively use the left arm. See Rae Holzapfel, 45 Van Natta 1748, 1749 (1993) (recommendation that the claimant avoid repetitive strenuous work with her hands in order to prevent an increase in symptoms insufficient to establish a permanent and chronic impairment of the wrists).

Finally, claimant points to his own lay testimony as evidence of chronic condition impairment; however, such lay testimony alone is insufficient to establish impairment under the standards. William K. Nesvold, 43 Van Natta 2767 (1991). Accordingly, claimant is not entitled to a scheduled permanent disability award for his left arm.

Unscheduled Permanent Disability

A March 2, 1994 Determination order awarded claimant 11 percent unscheduled permanent disability, an award based entirely on permanent impairment, inasmuch as claimant's adaptability value was determined to be zero. This award was affirmed by a June 8, 1994 Order on Reconsideration.

At hearing, the parties stipulated to a value of 1 for claimant's age, a value of zero for formal education and a value of 1 for skills. The DOT code on which the skills value stipulation was based was 802.281-010 which describes claimant's job at injury as "sheet-metal worker." (Ex. A; Tr. 5).

The ALJ found that claimant was not entitled to an impairment value greater than 11, as calculated in the Determination Order. The ALJ also concluded that claimant's base functional capacity was medium and residual functional capacity was also medium. Therefore, applying the matrix in OAR 436-35-310(6), the ALJ determined that claimant's adaptability value was zero. Inasmuch as the product of the age and education values (2) times the adaptability value (0) was zero, the ALJ found that the Determination Order correctly awarded unscheduled permanent disability based solely on permanent impairment.

On review, claimant contends that he is entitled to an adaptability value of 4, based on a comparison of a base functional capacity of heavy to a residual functional capacity of light. While we agree that claimant is entitled to an adaptability value, our calculation differs from claimant's.

No party contests the ALJ's application of the disability rating standards in WCD Admin. Order 6-1992, as amended by WCD Admin. Order 93-056. Under these rules, the adaptability value is based on a comparison of the highest prior strength demands of the worker's jobs during the ten years preceding the time of determination with the worker's maximum residual functional capacity at the time of determination. Former OAR 436-35-310(1) (WCD Admin. Order No. 93-052) (Temp.). In the ten years preceding the time of determination, claimant's most physically demanding job was his job at injury. Therefore, we compare the strength demands of that job with claimant's residual functional capacity to determine his adaptability value.

The ALJ determined the strength demands of claimant's at-injury job to be "medium," based on the DOT code for "sheet metal worker." Claimant asserts that his at-injury strength should have been classified as "heavy." The "heavy" DOT code to which she refers us is "metal fabricator" (DOT 619.361-014). Although we tend to agree with claimant that this is a more appropriate DOT classification for claimant's at-injury employment than sheet metal worker, claimant stipulated that his skills value should be based on the DOT classification for sheet metal worker. Thus, we find it inconsistent for claimant to agree that the DOT classification for sheet metal worker was correct for the purposes of the skills value, but not for purposes of determining the adaptability factor. Accordingly, we conclude that the ALJ correctly determined claimant's base functional capacity as "medium" based on the DOT classification for "sheet metal worker."

However, we disagree with the ALJ's determination that claimant's residual functional capacity was "medium." Although Dr. Lisook agreed with the PCE's assessment that claimant can presently perform medium employment, the PCE evaluator noted that claimant had restrictions on bending, kneeling, crawling, reaching and climbing that limited claimant to less than frequent performance of these functions. (Ex. 28-2). Therefore, we find that claimant qualifies for medium employment with "restrictions" under OAR 436-35-310(l). This places claimant in the medium/light category. Applying the matrix in OAR 436-35-310(6), claimant's adaptability value is 2.

When the adaptability value (2) is multiplied by the sum of age and education (2), the product is 4. When the product is added to the impairment value of 11, claimant's unscheduled permanent disability is 15 percent. The ALJ's order is modified accordingly.

ORDER

The ALJ's order dated October 31, 1994 is modified. In addition to claimant's prior unscheduled permanent disability awards totalling 11 percent (35.2 degrees), claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability, giving him a total unscheduled award of 15 percent (48 degrees). Claimant's counsel is awarded an approved attorney fee of 25 percent of the increased compensation created by this order not to exceed $3,800, payable directly by the SAIF Corporation to claimant's attorney.

In the Matter of the Compensation of
PENNY S. ORCUTT, Claimant
WCB Case No. 94-04996
ORDER ON RECONSIDERATION (REMANDING)
Bischoff & Strooband, Claimant Attorneys
Roberts, et al, Defense Attorneys

Claimant requests reconsideration of our June 19, 1995 Order on Review which remanded this matter to Administrative Law Judge (ALJ) Mongrain for further proceedings. Specifically, claimant contends that we erred in finding that the insurer exercised due diligence in trying to obtain claimant's past medical history. After considering claimant's motion and memorandum in support, we issue the following order.

To begin, claimant asserts that the insurer came into possession of her past medical records subsequent to the hearing and therefore could have submitted those records into evidence. However, claimant's assertion concerns matters that are outside of the record and we decline to consider it.

Claimant further contends that the insurer did not exercise due diligence in trying to obtain her past medical records. We disagree. It is uncontested that claimant did not provide detailed information of her past medical history until questioned by the insurer's counsel at the hearing under an offer of proof. While claimant was under no obligation to provide such information prior to the hearing, the insurer does have the right to cross-examine claimant concerning such information. For the reasons previously expressed in our prior order, we consider it an abuse of discretion for the ALJ to have prevented the insurer from exercising this right. When, as here, the insurer finally receives that information on cross-examination, a continuance is warranted because the sole source of that disclosed information was unattainable until hearing. In other words, lacking a medical history, either directly from claimant or indirectly through her prior statements or medical history, we disagree with claimant's assertion that the insurer lacked due diligence to justify a continuance of the hearing.

Finally, claimant contends that the medical evidence establishes that her prior carpal tunnel condition is not relevant to her current condition. While the evidence in the record may arguably support claimant's contention, it is beyond dispute that none of the medical experts were afforded access to her prior medical records. Consequently, in the absence of a medical history involving treatment for the same body part as that claimed, it cannot be reasonably concluded that the recently disclosed medical history would lack relevance regarding the compensability of claimant's current condition. For these reasons, we continue to adhere to our prior decision.

Accordingly, we withdraw our June 19, 1995 order. On reconsideration, as supplemented herein, we adhere to and republish our June 19, 1995 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
ALVENA M. PETERSON, Claimant
WCB Case No. 94-09432
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Safeco Legal, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that affirmed an Order on Reconsideration which awarded her 10 percent (32 degrees) unscheduled permanent partial disability for a right shoulder condition and did not award any scheduled permanent partial disability for loss of use or function of the elbow. On review, the issues are extent of scheduled and unscheduled 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

Unscheduled Disability

The Order on Reconsideration awarded claimant 10 percent total unscheduled impairment for loss of right shoulder motion due to her accepted condition. The insurer does not challenge this award on review.

Based on Theresa L. Petkovich, 46 Van Natta 1038 (1994), the ALJ affirmed that part of the Order on Reconsideration that gave a neutral value of zero to the age, education and adaptability values under the applicable standards because claimant returned to her regular work. Claimant concedes that Petkovich controlled the ALJ's decision, but argues that we should overrule that opinion, invalidate OAR 436-35-280, and find that her adaptability factor should be 1 based on England v. Thunderbird, 315 Or 633 (1993).

We have recently affirmed the rule of Petkovich (which was based on our decision in Michelle Cadigan, 46 Van Natta 307 (1994)) in Flor Irajpanach, 47 Van Natta 189 (1995), and Michael D. Walker, 46 Van Natta 1914 (1994). We decline to increase claimant's adaptability factor to 1 in this case.

Scheduled Disability

The ALJ declined to award claimant 5 percent scheduled impairment for a chronic condition in the right arm.

Unlike the ALJ, we find claimant is entitled to a scheduled award for a chronic condition in the right arm based on the impairment findings of the medical arbiters.[1] In Foster v. SAIF, 259 Or 86 (1971), the Supreme Court held that if an injury to an unscheduled portion of the body results in disability to both unscheduled and scheduled portions, a claimant is entitled to separate disability awards. Although the pain does not arise out of an injury to that body part per se, we have allowed a separate award for loss of function to a scheduled member. See Pamela A. Perry, 42 Van Natta 1640 on recon 42 Van Natta 1775 (1990); John C. Holland, 42 Van Natta 800, on recon 42 Van Natta 897 (1990).

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[1] Since the medical arbiters were appointed on reconsideration from the Determination Order, we rely on the impairment findings of the arbiters in the absence of other persuasive medical evidence establishing a different level of impairment. OAR 436-35-007(9). Claimant refers us to the report of Dr. Sedgewick, her attending physician's partner, who indicated (without explanation) that claimant had chronic shoulder and elbow disability. We have previously held, however, that impairment findings from a physician other than the attending physician may be used only if those findings are ratified by the attending physician. OAR 436-35-007(8); Stephen K. Rule, 47 Van Natta 83 (1995). Since we find in the record no letter of concurrence or ratification from Dr. Kaesche (the attending physician), we do not rely on Dr. Sedgewick's report.

In Foster, the Court held that the claimant was entitled to an unscheduled award of permanent disability for the shoulder as well as a scheduled award for the arm, where he sustained a shoulder injury with referred pain into the arm. The Court noted that, although the claimant's arm suffered no permanent injury, the loss of use resulted from the shoulder injury. This case presents the same circumstances. The medical arbiters found that, although claimant's right medial epicondylitis resulted in no permanent impairment, claimant has a chronic condition ("limitations related to chronic and repetitive use of her right arm") resulting from her shoulder inflammation. Based on Foster, we find that claimant is entitled to an award of 5 percent scheduled permanent partial disability for this chronic condition in her right arm under OAR 436-35-010(6), even though her epicondylitis had resolved.

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 (5 percent scheduled permanent disability) created by this order. Amended ORS 656.386(2).

ORDER

The ALJ's order dated December 6, 1994 is reversed in part and affirmed in part. That part of the order that affirmed the Order on Reconsideration on scheduled permanent partial disability is reversed. Claimant is awarded 5 percent (9.6 degrees) scheduled permanent disability for a chronic condition of her right arm. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the ALJ's order is affirmed.

July 11, 1995 Cite as 47 Van Natta 1332 (1995)

In the Matter of the Compensation of
JORDICE C. SAVAGE, Claimant
WCB Case No. 93-14180
ORDER OF ABATEMENT
Michael B. Dye, Claimant Attorney
Bostwick, et al, Defense Attorneys

The insurer requests abatement and reconsideration of our June 16, 1995 Order on Review which affirmed the Administrative Law Judge's conclusion that claimant had established a compensable aggravation. Specifically, the insurer contends that Senate Bill 369 compels a different result. See amended ORS 656.262(10).

In order to consider this matter, we withdraw our June 16, 1995 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 21 days from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD M. SOMERS, Claimant
WCB Case Nos. 93-04649 & 93-11034
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order which: (1) upheld the SAIF Corporation's partial denial of his medical services claim for current heart treatment; and (2) upheld SAIF's denial of his occupational disease claim for coronary artery disease (CAD). On review, the issue is compensability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's conclusions and opinion with the following modification and supplementation.

September 17, 1993 Denial

The ALJ concluded that SAIF's September 17, 1993 denial did not purport to deny compensability of claimant's accepted 1982 claim for a myocardial infarction (MI). On review, claimant contends that SAIF's September 1993 denial was overbroad. We agree.

SAIF's September 1993 denial stated, in relevant part:

> "You filed a claim for a cardiac condition which occurred on or about January 14, 1993 while you were self-employed.
>
> "We have reviewed the information in your file and find that your work is not the major contributing cause of your condition diagnosed as coronary atherosclerosis with prior myocardial infarction. Therefore, we must deny your claim." (Ex. 67, emphasis supplied).

The "prior myocardial infarction" refers to the 1982 MI claim which SAIF had accepted. Because that accepted condition was included within the scope of the denial, we conclude that the denial was overbroad. In this regard, we decline to rely on SAIF's closing argument at hearing in narrowly construing the denial. SAIF is bound by the express language of its denial. See Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993) (employers are bound by the express language of their denials). Because the denial purported to deny compensability of the accepted 1982 MI claim, and there is no contention that the MI claim was not compensable, we conclude that the denial was impermissibly overbroad. Accordingly, we set aside the September 17, 1993 denial to the extent it denied the "prior myocardial infarction."[1]

Claimant's counsel is entitled to an assessed attorney fee for prevailing over a portion of the September 17, 1993 denial. See amended ORS 656.386(1). 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 counsel's services rendered at hearing and on review in prevailing over the denial of "prior myocardial infarction" is $1,700, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record and claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[1] At hearing, claimant conceded that the coronary artery disease (CAD), or coronary atherosclerosis, is not compensable. (Tr. 3). Therefore, that portion of the September 17, 1993 denial is upheld.

April 7, 1993 Partial Denial

The ALJ upheld SAIF's April 7, 1993 partial denial of claimant's current heart condition and resultant need for treatment, concluding that the accepted 1982 MI was not the major contributing cause of his current need for treatment.[2] The ALJ also concluded, however, that the 1982 MI continued to be a material contributing cause of the current heart condition. We disagree with this latter conclusion.[3]

"Material contributing cause" means something more than a minimal cause; it need not be the sole or primary cause, but only the precipitating factor. Summit v. Weyerhaeuser Co., 25 Or App 851, 856 (1976).

The ALJ reasoned that, because claimant sustained permanent heart tissue damage from the 1982 MI, the MI remains a material cause of his current condition and need for treatment. We conclude, however, that a preponderance of the medical evidence supports no more than a minimal connection between the 1982 MI and the current need for treatment. Medical opinions were issued by cardiologists, Drs. McAnulty, DeMots, Toren and Falk. All four physicians agreed that claimant's hospitalization in January 1993 was for the progression of CAD (resulting in a partial occlusion of an artery) and that the 1982 MI did not contribute to the progression of CAD. They attributed the progression of CAD to risk factors such as smoking, hypertension and elevated cholesterol level. (Exs. 65, 66, 70, 72).

To support a material relationship, claimant relies on statements by Dr. McAnulty, treating cardiologist, and Dr. DeMots, examining cardiologist. Dr. McAnulty was asked whether claimant will continue to need treatment as a result of the 1982 MI; he responded:

> "While this is somewhat difficult to answer, in one respect the answer is yes--any decisions about further treatment will be effected by the fact that he had the myocardial infarction on June 26, 1982. If nothing ever happens to [claimant] again, at this instant he does not need specific treatment for the myocardial infarction, but that is unlikely to be true and again the infarction of 1982 will have to be considered as any treatment is undertaken. I have only some reluctance in presenting the information in this fashion because in a sense that is true with anybody who has ever had any medical problem and whenever a physician takes care of a patient, a decision about the next problem always has to be put in the context of previous problems. Still if there had to be a one word answer to the question it would be 'yes.'" (Ex. 73).

When specifically asked whether the January 1993 hospitalization was related to the 1982 MI, Dr. McAnulty answered:

> "[T]he angiogram [and angioplasty] would have been performed anyways given [claimant's] symptoms, but since he already had some damage, the need to consider an approach to prevent further damage was slightly heightened by the 1982 event. The answer is that there was some relationship between the angiogram [and angioplasty] and the infarction although the angiogram [and angioplasty] would have been done anyways." (Ex. 73).

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[2] The "current" need for treatment in dispute refers primarily to the hospitalization claimant underwent in January 1993 for his heart condition, and subsequent follow-up treatment. (Exs. 52-56A).

[3] Since briefing in this case was completed, the legislature has significantly amended the Workers' Compensation Law. Senate Bill 369, 68th Leg., Reg. Sess. (June 7, 1995). As amended, ORS 656.245(1) provides that, for "combined" conditions (i.e., conditions resulting from the combination of an otherwise compensable injury with a preexisting disease, see amended ORS 656.005(7)(a)(B)), the carrier shall cause to be provided only those medical services directed to medical conditions caused in major part by the compensable injury. Id. at §§ 1, 25. Under Section 66(1) of SB 369, amended ORS 656.005(7) and 656.245 apply retroactively to all claims existing on or after the effective date of the Act (June 7, 1995), regardless of the date of injury or date of claim presentation. However, we need not decide whether the amendments to ORS 656.005(7)(a)(B) and 656.245(1) apply to this case because we conclude that claimant's current heart condition claim would not satisfy either the material or major contributing cause standard.

We conclude that Dr. McAnulty's statements are insufficient to prove that the 1982 MI materially contributed to claimant's need for the January 1993 hospitalization. Basically, he acknowledged there was "slightly heightened" concern for claimant's heart condition because of his prior MI, but he felt that the 1993 hospitalization would have occurred even without the MI. In other words, while the 1982 MI was a significant event in claimant's prior medical history, it did not alter the course of claimant's treatment in 1993.

Dr. DeMots also discussed the significance of the 1982 MI as a consideration in future treatment. He explained that the MI is important to future treatment because it indicates the presence of progressive CAD and the risk of future MI's. He added that, as a result of the 1982 MI which totally blocked the artery, there was irreversible heart tissue damage, and blood was being pumped through collateral blood vessels which had not been damaged. Dr. DeMots agreed that the collateral vessels would need monitoring, but only for the progression of CAD. He opined that claimant's need for treatment was due to the progression of CAD and not due to the sequela of the 1982 MI. He explained that, although there was dead heart tissue resulting from the 1982 MI, that dead tissue had nothing to do with the current need for treatment. In fact, Dr. DeMots stated that the 1993 hospitalization was directed to a different area of the heart than was affected by the 1982 MI. (Ex. 75, pp. 30-36).

Based on the aforementioned medical opinions, we conclude that claimant has not carried his burden of proving that his current need for treatment was materially caused by the accepted 1982 MI. Accordingly, we uphold SAIF's April 7, 1993 denial.

ORDER

The ALJ's order dated June 10, 1994 is modified in part and affirmed in part. SAIF's September 17, 1993 denial is set aside to the extent it denied claimant's "prior myocardial infarction." Claimant's counsel is awarded an assessed fee of $1,700 for services at hearing and on review, payable by SAIF. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
LORI ANN WAGES, Claimant
WCB Case No. 93-04948
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Gunn, Turner-Christian, and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order which upheld the self-insured employer's denial of her occupational disease claim for a psychological 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

Claimant, a bank teller, filed a claim for an "occupational disease caused by stress" resulting from events and conditions at work. (Ex. 7). Claimant, who is obese, alleged she was subjected to mean-spirited remarks and ridicule regarding her physical appearance, including humiliating pictures circulated within the workplace. (Ex. 8).

Specifically, the stressors to which claimant alleged she was subjected included an incident in which her supervisor and another employee jointly put on claimant's bank sweatshirt, laughed about its size, and had a third employee take a photograph of them. The supervisor then displayed the photograph to other employees and later showed the photograph to claimant and suggested that it should provide incentive for her to lose weight.

Other sources of stress allegedly included jokes and derogatory remarks regarding claimant's obesity, a performance evaluation which claimant interpreted to be critical even though claimant's performance was considered satisfactory and the review resulted in a raise, and the denial of her request for vacation to participate in a "Richard Simmons cruise" designed for obese individuals. Finally, claimant alleged that her supervisor ignored and discriminated against her regarding the manner in which she oversaw and directed claimant's work.

Claimant initially sought treatment with Dr. Christensen, a family physician who referred claimant to a psychologist, Dr. Schumann, for work-related anxiety after claimant experienced a panic attack in a restaurant. The incident in the restaurant occurred after claimant's supervisor had shown claimant the sweatshirt photograph. Dr. Schuman diagnosed an adjustment disorder caused by harassment and ridicule from her supervisor and the photograph incident. (Ex. 13-2). Claimant has also been evaluated by examining psychiatrists Drs. Klein and Turco, who also testified by deposition.

The ALJ found that claimant failed to sustain her burden of proving that her occupational disease claim for a mental disorder (adjustment disorder) was compensable under former ORS 656.802.[1] In reaching this conclusion, the ALJ determined that the photograph incident was real, stressful, and a condition not generally inherent in the workplace. Thus, the ALJ considered it an employment condition for the purposes of determining if work caused claimant's mental disorder.

The ALJ further found that only a portion of the employment conditions involving jokes and remarks about obesity and claimant's denied vacation request existed in a real and objective sense. While acknowledging that claimant's performance evaluation was real and stressful, the ALJ concluded that it was not the critical evaluation that claimant thought it to be. The ALJ also noted that reasonable performance evaluations under former ORS 656.802(3)(b) could not be considered employment related causes of mental disorders. Finally, the ALJ found that claimant's perception of being ignored and harassed had not been shown to have existed in a real and objective sense.[2]

The ALJ concluded that claimant experienced some employment-related stressors that were real and others that were not. ORS 656.802(3)(a).[3] The ALJ also determined that claimant was exposed to some employment stressors that were excluded from consideration under former ORS 656.803(3)(b) and others that were not.

Finding that he was incapable of weighing those contributory causes of claimant's mental disorder that were excluded under the statute against those that were not, and finding that no psychological or medical expert had done so, the ALJ concluded that he could not determine whether cognizable stressors under former ORS 656.802(3) constituted the major contributing cause of claimant's adjustment disorder. Accordingly, the ALJ upheld the employer's denial of claimant's psychological claim.

On review, claimant contends that there was sufficient medical evidence in the record to support a finding that her mental disorder claim is compensable. We agree.

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[1] On June 7, 1995, Senate Bill 369 amended ORS 656.802. We need not determine whether the amendments to ORS 656.802 apply retroactively to this claim since their application would not change the result.

[2] The ALJ also found that claimant suffered from an adjustment disorder which constituted a diagnosis generally recognized in the medical or psychological community. ORS 656.802(3)(c). The ALJ also determined that there was clear and convincing evidence that claimant's adjustment disorder arose out of and in the course of her employment and that employment-related stress was the major contributing cause of that disease, which required medical services and disability. Since the employer argues that the ALJ's order was "correct" and should be affirmed, we conclude that there is no dispute regarding these findings. Even assuming there was a dispute regarding these findings, we would agree with the ALJ's findings based on our de novo review of the record.

[3] This section was not amended by Senate Bill 369.

To establish the compensability of a stress-related mental condition, claimant must prove that employment conditions were the major contributing cause of her disease. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment. Furthermore, there must be a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the medical disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d). Claimant has the burden of proof. ORS 656.266.

Medical evidence that does not factor out excluded from non-excluded employment conditions under ORS 656.802(3) cannot satisfy a claimant's burden of proving a compensable mental disorder. Robert Jarvil, 47 Van Natta 221 (1995); See also Merry J. Morgans, 47 Van Natta 147 (1995) (medical opinions based on factors cognizable under ORS 656.802(3)(b) found persuasive); Cf. Gary W. Helzer, 47 Van Natta 143 (1995) (medical evidence failed to satisfy the claimant's burden of proof because it did not exclude from consideration noncognizable elements of ORS 656.802(3)(b)).

Dr. Schumann, claimant's treating psychologist, opined that claimant was exhibiting many of the classic symptoms of an adjustment disorder. (Ex. 13-1). She concluded that claimant's mental state was caused by stress at work consisting of low level harassment and ridicule from her supervisor and the "ultimate insensitivity if not cruelty" of the photograph incident. We accept the ALJ's finding that the photograph incident and some of the jokes and remarks about claimant's obesity existed in a real and objective sense and were stressful. Given the significance to which Dr. Schumann accorded the photograph incident, we conclude that Dr. Schumann's opinion supports a finding that cognizable stressors under ORS 656.802(3) were the major contributing cause of claimant's mental disorder.

Dr. Klein, a psychiatrist, also examined claimant. She opined that if claimant's history was valid, then Dr. Schumann's diagnosis of an adjustment reaction related to her employment was reasonable. (Ex. 14-10).[4]

Dr. Turco, another examining psychiatrist, did not dispute Dr. Schuman's diagnosis. (Ex. 18-15). Dr. Turco testified that the photograph incident would have had a "significant effect" on claimant. (Ex. 18-31). While Dr. Turco did not explicitly state that the photograph incident was the major contributing cause of claimant's mental disorder, it is well settled that "magic words" are not necessary to establish medical causation. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

When asked what constituted the major contributing cause of claimant's adjustment disorder, Dr. Turco testified that it would have been events at work. (Ex. 18-40). Dr. Turco also confirmed that, if claimant had an adjustment disorder, it would have been produced by circumstances at claimant's place of employment. Id. Although he did not detect evidence of an adjustment disorder when he examined claimant, Dr. Turco stated that it could have resolved prior to his examination. (Ex. 18-14, 47).

We recognize that no medical opinion explicitly weighed excluded stressors (such as claimant's performance evaluation and her allegations of being ignored and harrassed) against non-excluded stressors (such as the photograph incident and jokes and remarks about obesity) as required by ORS 656.802(3) and Robert Jarvil, supra. However, given the emphasis both Dr. Turco and Dr. Schumann placed on the photograph incident (as opposed to the excluded stressors), we are persuaded that it, as well real and objective stress from ridicule regarding claimant's obesity, played the major causative role in producing an adjustment disorder that required medical services and resulted in disability. We, therefore, find that the medical evidence in this case is sufficient to satisfy claimant's burden of proof under ORS 656.802(2)(a). Thus, we reverse the ALJ's decision .

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[4] The ALJ found all witnesses who testified at hearing to be credible. This included both claimant and her supervisor. In areas of conflict the ALJ found claimant to have been more credible in part because of her demeanor. We defer to that demeanor-based credibility finding. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). Given the ALJ's credibility finding, as well as the consistency of claimant's statements to the physicians involved in the claim, we conclude that claimant's history as given to Dr. Klein was valid.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated June 6, 1994 is reversed. The employer's denial is set aside, and the claim is remanded to the employer for processing in accordance with law. Claimant's attorney is awarded $3,000 for services at hearing and on Board review, to be paid by the employer.

Board Member Haynes Dissenting.

The majority concludes that the medical evidence in this case is sufficiently based on cognizable stressors under amended ORS 656.802(3) such that claimant has sustained her burden of proving that her mental disorder claim is compensable. Because I would find the medical evidence in this case to be clearly deficient, I must part company with my colleagues and respectfully dissent.

The majority correctly cites Robert Jarvil, 47 Van Natta 221 (1995); Merry L. Morgans, 47 Van Natta 147 (1995); and Gary W. Helzer, 47 Van Natta 143 (1995). Those cases hold that, to satisfy claimant's burden of proof under ORS 656.802(2)(a), medical evidence must exclude from consideration those employment conditions under ORS 656.802(3) that cannot be considered in the determination of whether claimant has proved a compensable mental disorder. Even though it cites the proper legal authority, the majority misapplies the law in finding this mental disorder claim compensable.

First, there is precious little evidence that employment conditions of any kind are the major contributing cause of claimant's alleged mental disorder. The best evidence the majority can find in this record is from Dr. Turco's deposition. Dr. Turco testified that, if claimant did have an adjustment disorder, work "events' would have been the major contributing cause. However, Dr. Turco does not specify what "events" he was referring to. (Ex. 18-40). This fact is important because claimant does not dispute the ALJ's finding that claimant was subject to both cognizable and noncognizable employment conditions under the statute. Inasmuch as Dr. Turco does not differentiate between those categories of employment conditions, the majority errs in finding that Dr. Turco's opinion supports compensability.

Second, the majority places great weight on Dr. Turco's statement that the photograph incident would have a "significant" effect on claimant's mental disorder, but this comment falls well short of establishing major causation, even under the majority's overly expansive interpretation of McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). The result of this order is that we have now transformed the word "significant" into the equivalent of "major contributing cause." This is a totally unjustified dilution of the statutory standard of proof in mental disorder claims. As for Dr. Schuman's comment regarding causation, it is conclusory and also fails to weigh non-cognizable and cognizable employment conditions, as the ALJ recognized, but the majority does not.

In conclusion, the majority stretches the medical evidence to the breaking point and beyond in order to justify a finding that claimant's perceived ridicule regarding her obesity caused a compensable mental disorder. However, the medical evidence is clearly deficient under the standards this Board recently set in cases such as Jarvil, Morgans and Helzer.

Because the majority erred in applying the relevant cases to the facts of this claim and reaches an obviously improper result, I must dissent from their order.

In the Matter of the Compensation of
RENEE M. WILLSHIRE, Claimant
WCB Case Nos. 94-07436 & 94-00826
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Smith Lumber Company (Smith Lumber), requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of responsibility for claimant's occupational disease claim for right carpal tunnel syndrome; and (2) upheld Liberty's denial of responsibility, on behalf of Ashland Glass & Millwork (Ashland Glass), for the same condition. On review, the issues are responsibility and disclaimer notice. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

On review, the parties do not dispute that claimant has a compensable right carpal tunnel condition.

Scope of Acceptance

Claimant argues that Liberty, on behalf of Smith Lumber, previously accepted her right carpal tunnel condition. She contends that she had been diagnosed with carpal tunnel syndrome before the acceptance and the fact that the less intrusive condition of tenosynovitis was accepted does not preclude a finding that a carpal tunnel condition had been accepted. Liberty, on behalf of Ashland Glass, also asserts that claimant's condition was part of the claim previously accepted by Smith Lumber. We disagree.

A carrier is bound by the express language of the acceptance. SAIF v. Mize, 129 Or App 636 (1994). On April 3, 1990, Liberty, on behalf of Smith Lumber, accepted "[f]lexor tenosynovitis right forearm." (Ex. 7). We agree with the ALJ that the medical evidence establishes that, although tenosynovitis and carpal tunnel syndrome may be interrelated and caused by the same activity, they are separate and distinct conditions. We conclude that Liberty, on behalf of Smith Lumber, did not accept claimant's right carpal tunnel syndrome condition in April 1990.[1] Since there is no accepted right carpal tunnel syndrome claim, we do not apply ORS 656.308(1) to decide this case.

Disclaimer of Responsibility

The ALJ concluded that, because Liberty, on behalf of Smith Lumber, failed to issue a timely disclaimer of responsibility under former ORS 656.308(2), it could not attempt to shift responsibility to another carrier. Liberty, on behalf of Smith Lumber, argues that its untimely disclaimer has no bearing on the responsibility analysis in this case.

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[1] ORS 656.262(6)(d), as amended, provides, inter alia, that a worker who believes a condition has been incorrectly omitted from a notice of acceptance first must communicate in writing to the carrier the worker's objections to the notice. SB 369, 68th Leg., Reg. Sess., § 28(6)(d) (June 7, 1995). ORS 656.262(6)(d), as amended, also provides that the worker may initiate objection to the notice of acceptance at any time.

Here, considering Liberty/Smith Lumber's consistent opposition to the claim that its April 3, 1990 acceptance included a right carpal tunnel condition, we conclude that it would not achieve substantial justice to remand this case for compliance with the aforementioned procedural rules (assuming, without deciding, that the amended version of the statute is applicable).

After the ALJ's order, the legislature enacted Senate Bill 369. ORS 656.308, as amended, no longer requires a carrier to issue a timely "disclaimer" of responsibility. SB 369, 68th Leg., Reg. Sess., §§ 37, 66 (June 7, 1995). If the amendments retroactively apply, it is irrelevant whether Liberty (Smith Lumber) failed to issue a timely disclaimer of responsibility. However, we need not decide whether the new amendments apply to this case. Even if the previous version of ORS 656.308(2) applies and Liberty (Smith Lumber) had issued a timely disclaimer of responsibility, it could not, based on this record, shift responsibility to another carrier. Therefore, the fact that Liberty (Smith Lumber) failed to issue a timely disclaimer of responsibility is of no consequence in this case.

Responsibility

Claimant began working at Smith Lumber in November 1989. Her job duties involved sanding and staining cabinet doors and frames. (Tr. 12). She testified that after about one week she began to experience right hand, wrist and arm symptoms. (Tr. 15). Her symptoms persisted, although the employer changed her job duties so that she did less sanding. On March 15, 1990, claimant was examined by Dr. James, who diagnosed work-related flexor tenosynovitis and felt claimant "probably has a mild carpal tunnel syndrome, possibly associated with this." (Ex. 5). Claimant worked for Smith Lumber for five months until she was laid off. (Tr. 14). On April 3, 1990, Liberty, on behalf of Smith Lumber, accepted "[f]lexor tenosynovitis right forearm." (Ex. 7).

Claimant testified that her symptoms never went away and varied with her activity. She began working part-time for Ashland Glass in 1990 and was employed there for approximately three months. (Tr. 25). Her job duty at Ashland Glass was to wipe stain on wood. (Id.)

In November 1993, claimant sought treatment with Dr. Grant, who diagnosed moderately severe and chronic right carpal tunnel syndrome. (Ex. 12). Dr. Grant recommended a right carpal tunnel decompression.

The ALJ concluded that Liberty, on behalf of Smith Lumber, was responsible for claimant's right carpal tunnel condition. Claimant and Liberty, on behalf of Ashland Glass, agree with the ALJ and argue that claimant's work activities at Smith Lumber actually caused her right carpal tunnel syndrome. On the other hand, Liberty, on behalf of Smith Lumber, contends that responsibility for claimant's right carpal tunnel syndrome should be assigned to Liberty, on behalf of Ashland Glass.

The last injurious exposure rule is applied in situations involving successive employers, where each employment is capable of contributing to the disease and the finder of fact is unable to determine which employment actually caused the condition. On the other hand, where actual causation is established with respect to a specific employer, it is not necessary to rely on judicially created rules of assignment pertaining to successive employments in determining responsibility. See Runft v. SAIF, 303 Or 493, 501-02 (1987); Eva R. Billings, 45 Van Natta 2142 (1993).

Here, because we conclude that the medical evidence establishes that claimant's work activities at Smith Lumber were the major contributing cause of her right carpal tunnel condition, we find that the last injurious exposure rule does not apply. We are persuaded by Dr. Grant's well-reasoned opinion that claimant's work activities at Smith Lumber were the major contributing cause of her right carpal tunnel condition.

Dr. Grant reported that, after her work at Smith Lumber, claimant's carpal tunnel symptoms continued to progress slowly and she attempted to contact Liberty to seek medical treatment. (Ex. 12). He was familiar with the details of claimant's work activities at Smith Lumber and Ashland Glass. (Ex. 38-20, 38-21). He concluded that claimant's work activities at Smith Lumber were the "essential sole cause" of her right carpal tunnel syndrome. (Ex. 36). Dr. Grant felt it was significant that claimant experienced symptoms within two weeks of her work at Smith Lumber. (Ex. 38-22). In contrast, he believed that claimant's work activities at Ashland Glass "were not significant at all to her development of carpal tunnel syndrome." (Ex. 36; see also Ex. 38-19, 38-22). Dr. Grant testified that claimant's work at Ashland Glass did not make any difference to her condition and "she would have ended up the same if she had not even worked at Ashland Glass." (Ex. 38-24).

In contrast, Dr. Jewell found that, given the amount of time interval between claimant's work at Smith Lumber and her current treatment, he could not logically relate the carpal tunnel syndrome back to her work exposure at Smith Lumber. (Ex. 25). He reported that claimant's problems "appeared to resolve" after she saw Dr. James in 1990 and she did not find it necessary to seek subsequent medical care. (Id.). Dr. Jewell believed there were "other factors of causation involved here" which produced the carpal tunnel syndrome and her need for treatment. (Id.)

Dr. Jewell's opinion on causation is based in large part on his impression that claimant's carpal tunnel symptoms had resolved since she did not receive medical treatment again until December 1993. However, claimant testified that her symptoms never went away and varied with her activity. She testified that she attempted to contact Liberty to obtain additional medical care, but did not receive a response until she saw a lawyer. (Tr. 27, 46-47). Claimant thought she had to have Liberty's permission to see a doctor. (Tr. 29). Because we find that Dr. Jewell did not have an accurate history of claimant's right carpal tunnel symptoms, we are not persuaded by his opinion on causation. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

Moreover, in light of Dr. Grant's well-reasoned opinion that explained the progression of claimant's right carpal tunnel condition after her work exposure at Smith Lumber, we are not persuaded by Dr. Jewell's discussion of "other factors of causation." Dr. Grant did not know of any metabolic diseases that claimant suffered from and he felt her problem was related to the repetitive and strenuous use of her hands and arms. (Ex. 38-11 & 38-12). Dr. Grant's opinion is supported by that of Dr. Purtzer, who opined that claimant's work exposure of 1989 was the major contributing cause of her carpal tunnel condition. (Ex. 34). Consequently, we conclude that Liberty, on behalf of Smith Lumber, is responsible for claimant's right carpal tunnel claim.

Alternatively, even if we applied the last injurious exposure rule, we would continue to find Liberty, on behalf of Smith Lumber, responsible for the claim. The last injurious exposure rule provides that when a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994). The dispositive date is the date the claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

Here, claimant sought treatment for pain in her right wrist and forearm in March 1990. Dr. James reported on March 15, 1990 that claimant "probably has a mild carpal tunnel syndrome," possibly associated with her work-related flexor tenosynovitis. (Ex. 5). Dr. James prescribed medication, recommended that claimant wear a splint at night and that she stay on light duty with no electric sanding for at least two weeks. (Id.).

Based on Dr. James' report, we conclude that claimant first sought medical treatment related to her right carpal tunnel syndrome in March 1990. At that time, claimant was employed at Smith Lumber. Therefore, we agree with the ALJ that responsibility is initially assigned to Liberty, on behalf of Smith Lumber. See Timm v. Maley, supra.

In order to shift responsibility to Liberty (Ashland Glass), Liberty (Smith Lumber) must show that a later employment "actually contributed to a worsening of the condition." Oregon Boiler Works v. Lott, 115 Or App 70 (1992). A claimant must suffer more than a mere increase in symptoms. Timm v. Maley, 134 Or App 245 (1995); see Bracke v. Baza'r, supra, 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.").

Liberty, on behalf of Smith Lumber, relies on the opinion of Dr. Jewell to argue that claimant's work activities at Ashland Glass contributed independently to her carpal tunnel condition. Dr. Jewell agreed that it was "medically probable that [claimant's] occupational wiping activities at Ashland Glass during the last half of 1990 and first quarter of 1991 contributed independently to the worsening of her carpal tunnel condition." (Ex. 37).

As previously discussed, Dr. Grant concluded that claimant's work activities at Smith Lumber were the "essential sole cause" of her right carpal tunnel syndrome. (Ex. 36). He believed that claimant's work activities at Ashland Glass "were not significant at all to her development of carpal tunnel syndrome." (Id.; see also Ex. 38-19, 38-22).

In light of Dr. Grant's well-reasoned opinion, we are not persuaded by Dr. Jewell's conclusory opinion that claimant's work activities at Ashland Glass contributed independently to the worsening of her right carpal tunnel condition, particularly since he did not have an accurate history of claimant's carpal tunnel symptoms. We are not persuaded that claimant's work at Ashland Glass actually contributed to a worsening of her right carpal tunnel condition. Consequently, even if the last injurious exposure rule is applied, responsibility would remain with Liberty, on behalf of Smith Lumber.

Although compensability was not raised as an issue on review, it was an issue addressed in the ALJ's order. Therefore, because of our de novo review, claimant's compensation remained at risk. ORS 656.382(2); Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod 119 Or App 447 (1993). Consequently, claimant is entitled to an assessed fee for the services of her attorney on review. ORS 656.382(2).

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 $750, to be paid by Liberty, on behalf of Smith Lumber. 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 November 18, 1994, as reconsidered on December 20, 1994, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $750, to be paid by Liberty, on behalf of Smith Lumber.

In the Matter of the Compensation of
THOMAS J. BARNES, Claimant
WCB Case No. 94-07842
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) affirmed an Order on Reconsideration that awarded 33 percent (105.6 degrees) unscheduled permanent disability for claimant's low back injury; and (2) assessed a penalty pursuant to ORS 656.248(4)(g). In its brief, SAIF contends that the ALJ erred in excluding Exhibit 33 from evidence. On review, the issues are evidence, extent of unscheduled permanent disability and penalty.

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

Evidentiary Ruling

SAIF issued a December 14, 1993 Notice of Closure and claimant requested reconsideration. An arbiter report issued on May 27, 1994, and an Order on Reconsideration issued on June 14, 1994. At hearing, the ALJ excluded Exhibit 33, an August 8, 1994 report by Dr. White, who reviewed claimant's file for SAIF regarding the cause of claimant's lumbar disc injury. The ALJ's ruling was in response to claimant's objection to Exhibit 33 on the basis that it addressed the degree of claimant's impairment by someone other than the attending physician and was generated after the June 14, 1994 Order on Reconsideration.

Citing Frank H. Knott, 46 Van Natta 364 (1994), SAIF contends that the ALJ erred in excluding Exhibit 33 from evidence, on the ground that it addresses the cause of claimant's disc injury as related to the injury of 1988. (Appellant's brief at 5).

Subsequent to the briefing in this case, we issued David B. Weirich, 47 Van Natta 478 (1995), in which we disavowed our opinion in Knott. In Knott, we held that medical evidence concerning the causal relationship between a compensable injury and the permanent impairment necessary to determine the extent of a worker's permanent impairment under ORS 656.214(5) was not excluded by ORS 656.268(7)[1] . Instead, in light of our recent decision in Daniel L. Bourgo, 46 Van Natta 2505 (1994), we concluded in Weirich that, other than certain incomplete arbiter report exceptions (as represented by the arbiter or the Department), ORS 656.268(7) precludes the admission at hearing of post-reconsideration medical evidence, whether it concerns impairment or causation of impairment. The ALJ's evidentiary ruling is, therefore, 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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,300, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated November 2, 1994 is affirmed. Claimant's attorney is awarded $1,300 for services on Board review, to be paid by the SAIF Corporation.

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[1] ORS 656.268(7) was amended by the 1995 legislature. SB 369, 68th Leg., Reg. Sess., § 30 (June 7, 1995). Amended ORS 656.268(7)(g) provides that: "[a]fter reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the department, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure." The only change is that the statute now prohibits subsequent medical evidence after the date of the Order on Reconsideration rather than after the date of the medical arbiter's report. Here, the exhibit in question was generated after the date of the Order on Reconsideration. We need not decide whether the amended statute is retroactively applicable because, under either version of the statute, this evidence is inadmissible.

In the Matter of the Compensation of
BARBARA J. COLLINS, Claimant
WCB Case No. 93-09860
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Claimant cross-requests review of those portions of the order that: (1) upheld the employer's denial of claimant's low back injury claim; (2) upheld the employer's denial of claimant's cervical degenerative disc disease; and (3) upheld the employer's denial of claimant's occupational disease claim for a cervical dorsal syndrome. Claimant also moves to remand the case for admission of additional evidence. On review, the issues are administrative notice, remand and compensability.

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

Claimant works as a waitress. In December 1992, she was struck on the head by a carton of toilet paper. The employer accepted a claim for cervical strain and head contusion. Claimant requested a hearing challenging the employer's denial of a low back condition and cervical degenerative disc disease; claimant also asserted that the employer "de facto" denied claims for bilateral carpal tunnel syndrome and cervical dorsal syndrome.[1]

The hearing was held on March 9, 1994; the record closed July 27, 1994. With regard to the low back condition, claimant asserted at hearing that her low back was injured during the December 1992 industrial injury. On August 5, 1994, the ALJ issued his Opinion and Order, inter alia, upholding the employer's denial of the low back injury claim. The ALJ found claimant's bilateral carpal tunnel syndrome to be compensable but concluded that the cervical conditions were not compensable.

Claimant moved for reconsideration and reopening of the record for receipt of an August 13, 1991 Notice of Closure. In his Order on Reconsideration, the ALJ denied the motion, finding that the document, even if not in claimant's possession, was obtainable. Furthermore, the ALJ found that the document was not relevant since the issues of aggravation and medical services related to the 1991 injury were not litigated.

On review, claimant continues to assert that the case should be remanded for admission of the August 1991 Notice of Closure. We may take administrative notice of such documents. See Shannon K. Hartshorn, 45 Van Natta 1243, 1245 (1993). Thus, we need not consider whether remand is appropriate to admit the Notice of Closure. See Leslie C. Muto, 46 Van Natta 1684 (1994). However, although we take administrative notice of the Notice of Closure, for the following reasons, we give it no probative value.

In determining the compensability of her low back injury claim, the ALJ, finding that claimant had a preexisting low back condition that combined with a December 1992 industrial injury, applied former ORS 656.005(7)(a)(B).[2] Claimant contends that the statute applies only to noncompensable

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[1] Inasmuch as the employer has contested its liability for claimant's bilateral carpal tunnel syndrome and cervical dorsal syndrome conditions throughout this proceeding, it is unnecessary for us to consider the application of amended ORS 656.262(6)(d).

[2] Amended ORS 656.005(7)(a)(B) provides:

"If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the need for treatment of the combined condition." SB 369, § 1.

Since our conclusion would be the same under either version of the statute, we need not decide which version is applicable.

preexisting conditions and, because the 1991 Notice of Closure shows that the "preexisting low back condition" considered by the ALJ was compensable, ORS 656.005(7)(a)(B) is not applicable. Rather, according to claimant, her claim should be treated as a "new injury" under ORS 656.308 or an aggravation under ORS 656.273.

Claimant's contention is without merit. After reviewing the 1991 Notice of Closure, we find no reference to the condition accepted for the claim. Thus, we find no proof based upon this document that claimant's preexisting low back condition considered in this proceeding is the same as that accepted for the 1991 claim. In sum, the 1991 Notice of Closure provides no evidence that the 1991 claim has any relevance to a determination of the compensability of claimant's present need for treatment of her low back condition.

Furthermore, for the reasons expressed by the ALJ, the claim is properly analyzed under ORS 656.005(7)(a)(B) and, in the absence of evidence that the December 1992 event was the major contributing cause of the combined or resultant condition, claimant failed to carry her burden of proof.

Claimant also seeks remand to admit a February 17, 1995 medical report generated by Dr. Ballard on behalf of the employer. Claimant asserts that, because the report states that claimant's low back condition was due to the December 1992 industrial injury, remand should be granted for its admission in order to allow her to "be heard at a hearing on all relevant medical evidence in her claim."

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of the case; and (3) is reasonably likely to affect the outcome. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Although the report was generated after the hearing, it was based on claimant's condition up through the date of the hearing. Thus, the opinion was rendered based on information available at the time of hearing. Consequently, we consider the report, although unavailable, to be "obtainable." Compton v. Weyerhaeuser Co., supra, 301 Or at 648.

Moreover, we find that the report would not affect the outcome with regard to the compensability of the low back condition. Although the report attributes claimant's condition to the December 1992 injury, it also indicates that such a conclusion is premised on the lack of previous back injury. There is no consideration of contribution from claimant's preexisting low back condition. Thus, we find that the report is based on an inaccurate history and entitled to little weight. In view of the limited persuasiveness of the report, it is not likely to change the outcome. Hence, we conclude that there is no compelling reason to remand in order to admit this document.

Finally, we note the employer's objection to the ALJ's statement that the diagnosis of carpal tunnel syndrome was undisputed. Dr. Rosenbaum initially indicated that nerve conduction studies supported a diagnosis of right CTS and provided some evidence of a previous mild left CTS. (Ex. 28). Dr. Rosenbaum also indicated that chartnotes from claimant's treating physicians suggested that claimant may have had CTS in November 1993. (Ex. 33A-2). Dr. Rosenbaum's last report, however, stated that he was unable to diagnose CTS; Dr. Rosenbaum based his opinion on the employer's attorney's description of claimant's hearing testimony, Dr. Rosenbaum's examination and additional medical records. (Ex. 38-1).

Based on Dr. Rosenbaum's final opinion, the diagnosis of CTS was disputed. However, we find that the preponderance of evidence, including the opinions of treating physician Dr. Freeman, the panel of Drs. Baker and Barth, and Dr. Button, establishes such condition. Furthermore, for the reasons stated by the ALJ, we agree that claimant proved compensability of such condition.

Claimant's attorney is entitled to an assessed fee for services on review with regard to the compensability of the CTS condition. ORS 656.382(2). 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 regarding the CTS issue is $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 5, 1994, as reconsidered August 31, 1994, is affirmed. For services on review regarding the compensability of the CTS condition, claimant's attorney is awarded an assessed fee of $750, to be paid by the self-insured employer.

July 12, 1995 Cite as 47 Van Natta 1346 (1995)

In the Matter of the Compensation of
DEBBIE K. CRAFT, Claimant
Own Motion No. 95-0296M
OWN MOTION ORDER ON RECONSIDERATION
Industrial Indemnity, Insurance Carrier

Claimant, pro se, requests reconsideration of our June 23, 1995 Own Motion Order in which we declined to reopen her 1986 injury claim for the payment of temporary disability compensation because she failed to establish she was in the work force at the time of her current disability. With her request for reconsideration, claimant submitted additional information regarding the work force issue.

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

It is undisputed that claimant's compensable condition has worsened requiring surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

The insurer contends that claimant is not in the work force, as room and board and a $20 per week stipend do not constitute earnings from regular gainful employment. In the alternative, the insurer contends that, if claimant's receipt of "earnings" in the form of room and board and a stipend do constitute regular gainful employment, claimant's income remains stable and was unaffected by her recent surgery.

Claimant contends that she qualifies for temporary disability compensation because she continued working until her compensable condition worsened requiring surgery. Claimant has the burden of proof on this issue and must provide evidence, such as pay stubs, a letter from an employer verifying employment, and/or a medical opinion that her compensable condition worsened rendering her unable to work.

Claimant submitted a June 12, 1995 letter from duPont Miller, President and CEO of Berryman House, Inc., in which Mr. Miller stated that claimant is Executive Secretary to Kim E. Berryman, the founder of Berryman House. He further stated that claimant "has held this position since March 9, 1995. As compensation for her services, she receives a weekly stipend of $20.00, and her room and board, which is valued at $300.00 per month."

In a subsequent letter dated June 30, 1995, Mr. Miller stated that "because of her disability, [claimant] has been unable to completely fulfill her responsibilities as Executive Secretary to Kim. E. Berryman. This became effective April 21, 1995." Claimant also submitted an April 21, 1995 certificate from Dr. Ravdel, claimant's treating orthopedic surgeon, in which he opines that claimant is "[u]nable to work until further notice. Under doctor's care."

We have previously found that room and board, without a stipend, constitute "wages." See James L. Emerich, 45 Van Natta 1701 (1993). In this case, claimant earned room and board and a weekly stipend as wages. Therefore, on the record, we conclude that claimant has established that she was working, and continued to work until April 21, 1995, when her physician opined that she was unable to work because of the compensable condition.

Inasmuch as we have found that claimant qualifies for temporary disability compensation because she remained in the work force, we will address the insurer's contention that claimant's income was unaffected by her recent surgery. The insurer submitted a copy of its June 27, 1995 letter to Mr. Miller, in which it alludes to a telephone discussion between the claims examiner and Mr. Miller on June 26, 1995. In that letter, the insurer confirmed that claimant's position as executive secretary provided her with a stipend of $20 per week plus room and board worth $300 per month. The insurer further stated in the letter that, "[y]ou further explained that [claimant] has had no interruption of that compensation because of her injury or her recent surgery." It is presumed that, by this statement, the insurer believes that claimant has missed no work time nor any compensation, and therefore, no compensation is due. However, we are persuaded by Mr. Miller's previously cited June 30, 1995 letter, in which he stated that claimant has been unable to completely fulfill her responsibilities because of her disability. Thus, we find ample evidence that claimant was disabled due to the left knee surgery. In any case, because we have found claimant eligible for temporary disability compensation, the amount of that compensation is a claim processing issue which must be determined by the insurer according to statute. See ORS 656.210.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date she was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

July 12, 1995 Cite as 47 Van Natta 1347 (1995)

In the Matter of the Compensation of
JENNIFER R. HARRISON, Claimant
WCB Case No. 94-04786
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order which: (1) upheld the self-insured employer's denial of claimant's injury claim for a low back condition; and (2) 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 supplementation.

Claimant, a deli clerk, gave the employer about five weeks notice that she would be quitting work at the end of October 1993. Prior to her leaving, on October 27, 1993, claimant experienced low back pain while lifting two 43-pound boxes of pop syrup. The next morning, she also was experiencing a pinched feeling in her right buttock. Claimant worked her remaining scheduled shifts, (through October 28, 1993) without giving the employer notice of her back pain. The following evening, October 29, 1993, she went bowling. While bowling, claimant felt "excruciating" pain in her right buttock radiating into her right leg.

Claimant was examined by Dr. Niles on November 2, 1993. Dr. Niles diagnosed claimant's condition as probable radicular pain in the right lower extremity. Dr. Niles' report referred only to claimant lifting heavy items at work , without reference to claimant's bowling incident. (Ex. 1-2). On April 13, 1994, claimant was examined by Dr. Mason, who diagnosed lumbar nerve root injury. (Ex. 13BB-2). Dr. Mason's history was based on a work injury, with no mention of the bowling incident. Id. Finally, Drs. Reimer and Scheinberg, who performed an insurer-arranged medical examination, diagnosed a herniated L5-S1 disc. Drs. Reimer and Scheinberg opined that claimant's work injury was the major cause of her radiculopathy and L5-S1 disc herniation. (Ex. 15). Their opinions were also made without the knowledge of claimant's bowling activity.

Claimant testified that she told Dr. Niles of the October 29, 1993 bowling incident and that her pain began the next day. (Tr. 39,40). Based on claimant's demeanor, the ALJ found that she was a credible and reliable witness. We defer to that finding. See Bush v. SAIF, 68 Or App 230, 233 (1984). However, noting the absence of the October 29, 1993, "off work" bowling activity in Dr. Niles' history, the ALJ further found that claimant had not presented persuasive evidence of medical causation. On review, claimant relies on her credible testimony to establish that Dr. Niles was aware of her off-work bowling activity.

After considering claimant's contention, we find, as did the ALJ, the absence of claimant's bowling incident in Dr. Niles' medical history significant. Our conclusion is further supported by the similar lack of reference to claimant's bowling activity in the medical histories of Drs. Mason, Reimer and Scheinberg. We base our conclusion on the following reasons.

Claimant must establish that she suffered an accidental injury arising out of and in the course of employment which was a material contributing cause of her disability or need for treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). In light of claimant's work and off work activities, we conclude that expert medical evidence is necessary to establish causation. Uris v. Compensation Department, 247 Or 420, 427 (1967); Barnett v. SAIF, 122 Or App 279, 282 (1993) (when a case involves a medically complex condition, there must be expert medical evidence establishing causation.). Medical opinions based on incomplete or inaccurate information are not afforded persuasive force. See Somers v. SAIF, 77 Or App 259, 263 (1986); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Claimant cites Jerilyn Hendrickson, 46 Van Natta 1888 (1994), and John L. O'Day, 46 Van Natta 1756 (1994), to contend that some inaccuracies in the physicians' medical history are not so significant as to undermine the reliability of their causation opinions. We find each holding to be distinguishable.

In Hendrickson, supra, the carrier argued that the opinion of the claimant's treating physician was unpersuasive because it was based on an inaccurate medical history. Specifically, the carrier noted that the physician had not reported the correct hire date, whether the employer complied with a light duty work release, and the duration of the claimant's light duty work. We rejected the carrier's argument. Reasoning that the physician had a complete history of the claimant's work activity, we were not persuaded by the carrier's challenge to the treating physician's causation opinion. Jerilyn Hendrickson, supra, 46 Van Natta at 1889. We applied similar reasoning in O'Day, supra. There, we found that the claimant's condition was work related, notwithstanding evidence that the claimant had lied in obtaining unemployment benefits. John L. O'Day, supra, 46 Van Natta at 1757.

Claimant's reliance on Hendrickson and O'Day is misplaced. In Hendrickson, while parts of the physician's history were inaccurate, his opinion was, nevertheless, based on an accurate history of the claimant's work activity. In O'Day, the inaccuracy in the record, (claimant lying to the Employment Division), did not bear upon the medical opinion advanced by the claimant's treating physician. Here, the medical opinions were advanced without the knowledge of claimant's "excruciating" pain complaints during claimant's off work bowling activity, which preceded her initial visit for medical treatment. In contrast to both Hendrickson and O'Day, such information bears directly on claimant's history of her complaints, as well as her physical activities prior to seeking medical assistance. Lacking a reference to this off-work event, in the pertinent medical opinions, we are unable to find the medical opinion supporting a compensable causal connection to be persuasive. Somers v. SAIF, supra; Miller v. Granite Construction Co., supra.

In conclusion, in order to find that Dr. Niles had a complete and accurate history, we would have to assume that which is not evident in the medical records; i.e., that Dr. Niles was aware of claimant's pain while bowling a few days before her medical examination and treatment. We are not willing to do so. Accordingly, we find that claimant has not met her burden of proving that her work activity was a material contributing cause of her low back condition. See, e.g., Pamela A. Burt, 46 Van Natta 415 (1994) (Finding a doctor's opinion not sufficient to meet the claimant's burden of proof where there was no indication that the doctor was aware of, and therefore, was precluded from considering, other activities that could have contributed to the claimant's condition).

ORDER

The ALJ's order dated October 20, 1994 is affirmed.

In the Matter of the Compensation of
MARK KRISKA, Claimant
WCB Case No. 93-13746
ORDER ON REVIEW
Lavis, Alvey, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Gunn and Turner-Christian.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order which set aside its denial of claimant's injury claim for multiple body parts. On review, the issue is compensability.

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

Claimant, a mechanic, alleged he sustained multiple injuries as a result of being assaulted by a warehouse manager (Collins). Both claimant's and Collins' versions of what occurred differed considerably.

According to claimant, a secretary (Hargraves) required that he accompany her to Collins' office to confront Collins about an allegedly padded repair bill. Claimant testified that he reluctantly did so because he and Collins were not on good terms and he feared a confrontation with Collins. Claimant further testified that Collins became very angry during their encounter and, before he could leave, Collins struck him multiple times, knocking him to the floor and rendering him unconscious. (Tr. 34).

According to Collins, claimant was a troublemaker with whom he and other employees had numerous problems. During the confrontation directly at issue, Collins and claimant swore at each other, stood up and faced each other chest to chest. Collins then testified that he pointed at claimant, at which time claimant slapped his hand away. Collins further testified that he grabbed claimant in order to defend himself and that eventually both men swung at each other, with claimant missing and Collins striking claimant one time in the face. (Trs. 9, 20). According to Collins, claimant never attempted to back-off during the incident and was not "knocked out." (Trs. 21, 26). Hargraves apparently did not witness the assault itself, but she did not attend the hearing or provide testimony in any other manner.

The ALJ found that claimant's injuries resulting from the incident with Collins were compensable. In reaching this conclusion, the ALJ concluded that claimant was not an "active participant" in an assault or combat not connected to a job assignment and which amounted to a deviation from customary duties. See ORS 656.005(7)(b)(A).

ORS 656.005(7)(b)(A) provides that an "[i]njury 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" is not compensable. A claimant may be an "active participant" if he assumes an active or aggressive role in a fight, and if he has an opportunity to withdraw from the encounter and not participate in the fight, but fails to withdraw. See Irvington Transfer v. Jasenosky, 116 Or App 635, 640 (1992).

In Jasenosky, the claimant was returning to his assigned work area after asking his co-worker why he still wanted to "kick his ass," when his co-worker charged him and assaulted him. The court upheld the Board's findings that the claimant did not have an opportunity to withdraw from the situation and that he did not voluntarily assume an active or aggressive role in the altercation. 116 Or App at 641. Consequently, the court held that the Board did not err in concluding that claimant was not an active participant in the fight and that, accordingly, former ORS 656.005(7)(a) (since renumbered ORS 656.005(7)(b)(A)) did not exclude the claimant's injuries from compensability.

In this case, the parties agree that the only issue is whether claimant was an "active participant" in an assault. There are two considerably different versions of what happened during the confrontation between claimant and Collins. If claimant's version is correct, then we would find that claimant was not an "active participant" in an assault given his testimony that he was suddenly attacked without provocation before he had an opportunity to withdraw. Conversely, if Collins' version was correct, then we would find that claimant actively participated in the assault given Collins' testimony that claimant assumed an aggressive role and did not withdraw from the situation.

The ALJ concluded that, based on his observation of the "body habitus and demeanor" of both men, it was more likely that claimant was not the aggressor. We generally defer to an ALJ's credibility finding based on his or her observation of a witness's demeanor at hearing. See International Paper Co. v. McElroy, 101 Or App 61 (1990); Daniel C. Reddekopp, 43 Van Natta 2391, 2392 (1991). Given this, we find that claimant's version of what happened during the confrontation is more accurate.

The ALJ cited an additional reason for concluding that Collins' version of the incident was inaccurate. The ALJ was persuaded that the medical record was consistent with claimant being struck multiple times rather than one time and also consistent with claimant having lost consciousness either as a result of the blows or the fall to the floor. The ALJ cited the emergency room diagnoses on the date of injury, which listed head trauma with loss of consciousness, abrasions to the lips, facial pain, status post-epistaxes after trauma, neck and upper back strain. (Ex. 2). An abrasion to the neck was also noted.

The insurer argues that the medical record also establishes that claimant embellished his account of the altercation with Collins over time. It cites a portion of the initial emergency room report in which it is reported that claimant denied neck pain, back pain, headache or extremity injury. Claimant was also reported as stating that he was not struck anywhere else apart from the nose and mouth. The insurer contends that claimant's version of events, including having been struck multiple times, is not credible in light of this and other medical reports.

We agree that claimant has embellished or exaggerated his account of the altercation with Collins. Moreover, we are troubled by the history contained in the initial emergency room report, which seems consistent with Collins' testimony that he struck claimant only one time in the face. However, in light of the multiple diagnoses given to claimant's injuries, we are unable to conclude that the medical record is entirely inconsistent with the trauma described by claimant. Moreover, given the ALJ's credibility finding based on his observation of both Collins and claimant, we are persuaded that claimant's version of the events surrounding the incident with Collins is accurate.

Therefore, we agree with the ALJ's finding that claimant was not an active participant in assault or combat. Thus, the ALJ properly set aside the insurer's denial.

Inasmuch as claimant has prevailed over the insurer's request for review, claimant's counsel is entitled to an attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services 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 25, 1994 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
PERRY A. LANG, Claimant
WCB Case No. 94-11757
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall, Turner-Christian and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Howell's order which set aside its denial of claimant's claim for facial injuries. 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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 4, 1995 is affirmed. For services on Board review, claimant is awarded an assessed attorney fee of $1,000, payable by the insurer.

Board Member Haynes dissenting:

I do not believe that every thing that happens at work is compensable, absent a showing of a causal connection between the injury and employment. See Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994). Furthermore, when an injury results from a personal exchange between employees, where the only work connection is the fact that the participants go to work at the same location, I do not find a causal connection between the injury and employment. See Kenneth Hollin, 27 Van Natta 837 (1979).

Here, even though the name calling between claimant and the coworker may have initially been in jest, the coworker soon became offended and asked claimant several times to stop. Given the circumstances surrounding the name calling, and its egregious and personal nature, I do not agree with the majority that claimant's injuries arose out of his employment. Accordingly, I respectfully dissent.

In the Matter of the Compensation of
RICHARD H. LINVILLE, Claimant
WCB Case No. 94-04159
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that awarded claimant's counsel a $1,400 assessed attorney fee for services rendered concerning the employer's "pre-hearing" recision of its denial of claimant's claim for a right foot condition. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

On November 1, 1993, claimant filed an 801 form alleging that he had sustained a work-related injury to his right foot on October 31, 1993. His condition was diagnosed as plantar facsitis and he was released to modified work for approximately two weeks.

On December 30, 1993, the employer denied claimant's claim on the basis that it was not related to his work activities. Thereafter, claimant filed a request for hearing concerning the employer's denial. A hearing was set for June 1, 1994 in Medford, Oregon. Claimant requested a postponement in order to obtain legal counsel. The postponement was granted and the hearing was rescheduled for February 16, 1995.

On May 23, 1994, claimant retained his attorney of record. In mid-July 1994, claimant's counsel spoke with Dr. Corson, a consulting physician, regarding claimant's claim. Following that conversation, claimant's counsel prepared a letter summarizing Dr. Corson's opinion that claimant's right foot condition was work-related. This report was submitted at hearing as Exhibit 8. Thereafter, claimant was examined by Dr. Vessely, M.D., at the request of the employer. In a September 20, 1994 report, Dr. Vessely indicated that claimant's right foot condition was consistent with his described work injury.

During his representation of claimant, claimant's counsel met or spoke with claimant approximately 5 times concerning the claim. Counsel spoke with the employer's claims processor representative and the employer's attorney on numerous occasions regarding claimant's claim. Counsel was not able to estimate the actual amount of time spent talking to claimant, the claims processor's representative or the employer's attorney. On February 13, 1995, claimant's counsel filed a supplemental request for hearing raising the issue of penalties for the employer's allegedly unreasonable failure to accept claimant's claim after September 20, 1994, the date of Dr. Vessely's report. On February 15, 1995, the day before the scheduled hearing, the employer rescinded its denial and agreed to accept claimant's claim.

CONCLUSIONS OF LAW AND OPINION

Based on an "informal policy," the ALJ awarded claimant's counsel $1,400 as a "presumptive" attorney fee for a case of ordinary difficulty. We agree that $1,400 is a reasonable attorney fee award for this case. We reach this conclusion based on the following reasoning.

Attorney fee awards are decided on a case-by-case basis applying the factors set forth in OAR 438-15-010(4). Those factors include: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

Here, claimant's claim was in denied status. (Ex. 7). Although claimant's counsel could not estimate the actual time spent on claimant's case, his unrebutted testimony establishes that he discussed the claim (including the employer's denial and the medical opinions) with his client, as well as the employer's representatives. (Tr. 4, 5, 7). Counsel spoke with Dr. Corson and obtained the first medical report which related claimant's right foot condition to his employment. (Ex. 8). Finally, shortly after counsel filed a supplemental hearing request seeking a penalty for an allegedly unreasonable denial, claimant's claim was accepted by the employer. This acceptance occurred the day prior to the scheduled hearing, some 14 months after the filing of claimant's initial hearing request and some 10 months after claimant had retained counsel.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the ALJ that $1,400 is a reasonable fee for claimant's attorney's services concerning the employer's "pre-hearing" rescission of its denial. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record), the complexity of the compensability issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 22, 1995 is affirmed.

In the Matter of the Compensation of
GARY L. MANLEY, Claimant
WCB Case No. 94-01878
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Nichols' order which: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral shoulder degenerative arthritis; and (2) upheld the employer's denial of claimant's occupational disease claim for a left shoulder rotator cuff tear. The employer cross-requests review of that portion of the ALJ's order which set aside its denial of claimant's bilateral shoulder impingement syndrome. 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.

CONCLUSIONS OF LAW AND OPINION

In October 1983, claimant, a butcher, reported increasing bilateral shoulder complaints, left greater than right. His family physician, Dr. Koester, diagnosed overuse syndrome and tendonitis and eventually referred claimant to an orthopedic surgeon, Dr. Moen, who became claimant's treating physician.

Based on radiological studies, Dr. Moen diagnosed acromioclavicular arthritis in both shoulders. In February 1994, Dr. Moen scheduled claimant for surgery, to consist of debridement of the left rotator cuff to treat a shoulder impingement syndrome. However, on February 2, 1994, the employer had already issued a denial of claimant's bilateral shoulder "overuse syndrome/tendonitis."

On March 3, 1994, Dr. Moen performed arthroscopic surgery of the left shoulder followed by acromioplasty and a distal clavicle excision. Post-surgery, claimant was examined by an orthopedic surgeon, Dr. Fuller, who opined that claimant's bilateral acromioclavicular joint arthritis was the major contributing cause of his bilateral shoulder conditions. Dr. Fuller explained that an osteophyte produced by claimant's degenerative arthritis protruded into the left rotator cuff, causing a rotator cuff tear. Dr. Fuller also opined that claimant's left impingement syndrome was due to a congenital Grade III curvature of the acromion bone that reduced the space between the acromion bone and the rotator cuff. According to Dr. Fuller, claimant's work activities did not "produce" claimant's bilateral impingement syndrome.

Dr. Moen disagreed with Dr. Fuller's conclusions. (Ex. 24). Noting claimant's history that his shoulder symptoms began at work, Dr. Moen opined that claimant's bilateral shoulder conditions were related to his employment. Dr. Moen further explained his disagreement with Dr. Fuller in a subsequent response to an inquiry from claimant's counsel. (Ex. 25).

The ALJ analyzed claimant's bilateral shoulder conditions as occupational disease claims under ORS 656.802. Finding the medical opinion of Dr. Fuller more persuasive than that of the attending physician, Dr. Moen, the ALJ found that claimant's degenerative arthritis condition was not compensable. The ALJ also concluded that there were persuasive reasons not to defer to Dr. Moen's opinion with respect to the compensability of claimant's rotator cuff tear. Finding Dr. Moen's opinion regarding the causation of this condition to be conclusory, the ALJ determined that the left rotator cuff condition was not compensable. Lastly, the ALJ found claimant's bilateral impingement syndrome to be compensable, concluding that claimant's work activities were sufficient to cause this condition.

On review, claimant contends that the ALJ erred in upholding the employer's denial of his bilateral shoulder degenerative arthritis and left rotator cuff tear. We disagree.

We begin with the compensability of claimant's bilateral shoulder arthritis condition. While we generally defer to the opinion of the attending physician when the medical evidence is divided, see Weiland v. SAIF, 64 Or App 810 (1983), we find persuasive reasons not to do so in this case. Although Dr. Moen related claimant's bilateral shoulder symptoms to his employment, we agree with the ALJ that Dr. Moen's conclusion was largely based on a temporal relationship between claimant's work and the onset of symptoms. See Allie v. SAIF, 79 Or App 284, 288 (1986). More importantly, Dr. Moen does not provide any explanation of how claimant's employment caused or worsened the degenerative condition. Inasmuch as it is not well-reasoned or adequately explained, we do not find Dr. Moen's opinion to be persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Because Dr. Fuller concluded that claimant's bilateral degenerative shoulder arthritis condition is unrelated to claimant's work activities, there is no persuasive medical evidence to satisfy claimant's burden of proving medical causation with respect to the degenerative arthritis condition.[1]

We now turn to claimant's torn rotator cuff. Dr. Moen agreed in a concurrence letter to claimant's counsel that claimant's work activities were the major contributing cause of this condition. (Ex. 19-1). This opinion was based on claimant's history of "substantial" overhead work activity. While we do not discount Dr. Moen's opinion merely because it was expressed in the form of a "check-the-box" concurrence, we nevertheless find this opinion unpersuasive because counsel's summary of Dr. Moen's opinion lacks an explanation of how claimant's work activity caused the rotator cuff tear. See Marta I. Gomez, 46 Van Natta 1654 (1994) (the persuasiveness of expert's opinion depends on the persuasiveness of the foundation on which the opinion is based).

Moreover, Dr. Moen's operative report documents the presence of a large osteophyte protruding into the left rotator cuff. (Ex. 14). Dr. Fuller explained that this osteophyte was caused by claimant's non work-related degenerative arthritis. Dr. Fuller opined that it was this osteophyte that caused the rotator cuff tear. (Ex. 22-2). In contrast to Dr. Moen's concurrence letter, the summary provided by the employer's counsel, with which Dr. Fuller concurred, is detailed and provides sufficient reasoning to explain the basis for Dr. Fuller's concurrence. Thus, we find Dr. Fuller's opinion to be persuasive. Marta I. Gomez, supra.

Claimant asserts the rotator cuff tear is compensable because it was caused by the impingement syndrome which the ALJ determined to be compensable. We disagree.

As Dr. Fuller indicated, there are three separate conditions in claimant's shoulders: the degenerative arthritis, left rotator cuff tear and bilateral impingement syndrome. Dr. Fuller clearly ascribed the rotator cuff tear to the osteophyte on the distal end of the clavicle, not to the impingement syndrome resulting from irritation of the rotator cuff by the acromion bone. (Ex. 22-2). Therefore, even if claimant's impingement syndrome is compensable (a finding with which we disagree), the medical evidence does not establish that the rotator cuff tear is a result of that condition.

Finally, we consider the compensability of claimant's impingement syndrome in light of the employer's contention that the ALJ erred in determining that it was compensable. The ALJ concluded that this condition was compensable, finding that Dr. Moen had concluded that claimant's work activities were the major contributing cause of this condition and that Dr. Fuller had agreed that claimant's work activities could cause this condition if they involved work at the shoulder level or above for 50 percent of the time. Although the ALJ found that claimant's job did not require shoulder level work for 50 percent of the time, she did conclude that it did require a "substantial" amount of time using the arms at or above the shoulder level. In light of this, the ALJ concluded that the impingement syndrome was compensable.

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[1] Claimant asserts that Dr. Fuller's opinion is not persuasive because he opined that the arthritic condition is "intrinsic" to claimant. Claimant contends that Dr. Fuller attributes claimant's arthritis condition to "intrinsic" or congenital factors which should not be considered in the major contributing cause calculus because they are predispositions rather than causes of his arthritic condition. See Jerilyn Hendrickson, 46 Van Natta 1888 (1994); Katherine M. Grimes, 46 Van Natta 1861 (1994); Mark Ostermiller, 46 Van Natta 1556 (1994).

However, even if claimant's contention is valid, claimant has the burden of proof. See ORS 656.266. Therefore, even assuming that Dr. Fuller's opinion is not persuasive, claimant still does not satisfy his burden of proof because, for the reasons previously mentioned, Dr. Moen's opinion is not persuasive. Moreover, we do not interpret Dr. Fuller's statement that the arthritis is "intrinsic" to claimant as establishing that claimant was predisposed to developing the condition.

However, we agree with the employer that neither Dr. Moen nor Dr. Fuller specifically stated that claimant's work activities caused claimant's impingement syndrome. In fact, Dr. Fuller stated that claimant's work activities did not cause the condition. (Ex.22). Dr. Moen's reports were limited to expressing his disagreement with Dr. Fuller's opinions. (Exs. 24, 24A, 25). Moreover, even if these reports could be interpreted as an opinion that claimant's work caused his impingement syndrome, there is no explanation how claimant's work duties caused the condition. Somers v. SAIF, supra. Thus, we do not find Dr. Moen's opinion to be persuasive regarding the causation of the impingement syndrome.

Accordingly, we reverse the ALJ's decision on this issue and reinstate that portion of the employer's denial concerning the bilateral impingement syndrome. The ALJ's attorney fee award is also reversed.

ORDER

The ALJ's order dated September 22, 1994 is reversed in part and affirmed in part. That portion which set aside the employer's denial of claimant's impingement syndrome is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

July 12, 1995 Cite as 47 Van Natta 1355 (1995)

In the Matter of the Compensation of
RONALD W. MYERS, Claimant
WCB Case No. 94-11302
ORDER ON RECONSIDERATION
Carney, et al, Claimant Attorneys
John E. Snarskis, Defense Attorney

Claimant requests review of our June 14, 1995 order that: (1) reversed an Administrative Law Judge's (ALJ's) order that awarded claimant 63 percent (94.5 degrees) scheduled permanent disability for loss of use or function of claimant's hands; and (2) reinstated an Order on Reconsideration that had awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of claimant's hands. Contending that we misapplied OAR 436-35-110(6)(d), claimant asks that we affirm the ALJ's order.

We withdraw our June 14, 1995 order for reconsideration. After considering claimant's request and reviewing the record, we conclude that we did not misapply the rule.

OAR 436-35-110(6)(d) provides for a 63 percent impairment value for Raynaud's phenomenon that "occurs on exposure to temperatures below 15 [degrees] Centigrade and is only partially controlled by medication." (Emphasis added). In our prior order, we concluded that claimant had failed to establish his entitlement to a 63 percent impairment value for his compensable bilateral Raynaud's vasospastic syndrome (Raynaud's phenomenon), because there was insufficient evidence that the condition was "only partially controlled by medication."

Claimant first asserts that OAR 436-35-110(6)(d) does not require that he undergo a course of medication for his Raynaud's phenomenon to establish his entitlement to a 63 percent impairment rating. We need not address that argument because, in this case, claimant evidently underwent such a course of medication.[1]

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[1] Member Hall notes the possibility that a physician may, without the benefit of an actual course of medication, determine that medication would not be effective (or only partially effective) in treating a case of Raynaud's phenomenon. Arguably, that scenario could satisfy the medication prong of OAR 436-35-110(6)(d). Because that issue is not on review, however, the Board need not resolve it.

Claimant next asserts that this case is analogous to Ryan F. Johnson, 46 Van Natta 844 (1994). Particularly, he argues that, because the only evidence in Johnson regarding the efficacy of the claimant's Raynaud's phenomenon medication was that based on the claimant's testimony, and because the same evidence is present in this case, he is entitled to a 63 percent impairment rating under OAR 436-35-110(6)(d). We disagree.

Impairment is established by a preponderance of medical evidence based on objective findings. ORS 656.726(3)(f)(B). Lay testimony alone is insufficient to establish impairment under the standards. William K. Nesvold, 43 Van Natta 2767, 2768 (1991); see OAR 436-35-005(5) (impairment defined as decrease in function as measured by a physician). To establish impairment under OAR 436-35-110(6)(d), then, claimant must offer medical evidence based on objective findings showing that his Raynaud's phenomenon is only partially controlled by medication.

Here, the only evidence regarding the efficacy of claimant's medication is his lay testimony. That is insufficient to meet his burden of proof. ORS 656.726(3)(f)(B); William K. Nesvold, supra.

Johnson does not help claimant. In that case, the record included a physician's testimony that the claimant's medication was effective in preventing Raynaud's phenomenon, and that the claimant had told one of his physicians that the medication was not effective. Although some of that evidence was based on the claimant's statements, the record nevertheless contained at least some medical evidence regarding the medication efficacy issue. Here, in contrast, there is no medical evidence regarding that issue. On that ground, we find Johnson distinguishable. For these additional reasons, we reject claimant's arguments under that case.[2]

Accordingly, our June 14, 1995 order is withdrawn. On reconsideration, as supplemented here, we republish our June 14, 1995 order in its entirety. The parties' appeal rights shall run from the date of this order.

IT IS SO ORDERED.

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[2] In Johnson, we did not address the objective findings/lay testimony issue. Because the record in that case appears to have included a physician's objective evaluation of the claimant's subjective complaints, there arguably was sufficient evidence to satisfy the objective findings requirement. Georgia Pacific v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991); see former ORS 656.005(19). Senate Bill 369, 68th Leg., Reg. Sess., § 1 (June 7, 1995) amended ORS 656.005(19)'s definition of "objective findings" to exclude "physical findings or subjective responses to physical examination that are not reproducible, measurable or observable." Because claimant's claim fails under the former version of the Act, we do not address the impact, if any, of that amendment on this case.

In the Matter of the Compensation of
RUFINO RAMERIZ, Claimant
WCB Case No. 93-13486
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Herman's order that affirmed an Order on Reconsideration that reduced to zero claimant's unscheduled permanent disability for a low back injury, whereas a Determination Order awarded 14 percent (44.8 degrees). On review, the issue is extent of unscheduled permanent disability.

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

At hearing and on review, claimant argues that the Department had no authority to reduce his permanent disability award absent a timely cross-request for reconsideration by the SAIF Corporation. As the ALJ concluded, relying on Russell D. Sarbacher, 45 Van Natta 2230 (1993), and Darlene K. Bentley, 45 Van Natta 1719 (1993), we have previously determined that the Department has such authority.

Furthermore, we agree with the ALJ's decisions regarding whether the medical arbiter's "clarification" report and deposition can be considered. (Exs. 27, 30). Specifically, citing Daniel L. Bourgo, 46 Van Natta 2505 (1994), the ALJ found that, because the "clarification" report was requested by the Department in order to complete the medical arbiter's initial report, its findings could be considered. On the other hand, the ALJ found that, because the medical arbiter's deposition was requested by one of the parties, it could not be considered. We have held that, unless a medical arbiter's report is incomplete (as represented by the arbiter or the Department), a medical arbiter's "supplemental" or "clarifying" report is not admissible under ORS 656.268(7). Daniel L. Bourgo, supra; Ryan F. Johnson, 46 Van Natta 844 (1994); Anne M. Younger, 45 Van Natta 68 (1993). Here, as the ALJ found, the medical arbiter's "clarification" report fits within this exception, and the deposition does not.

Finally, we agree with the ALJ that claimant has failed to prove any impairment. In this regard, claimant's treating physician concurred with a medical report that found claimant's range of motion measurements invalid and opined claimant had no objective neurologic or orthopedic deficit. (Exs. 19-3, 19-5, 22). In addition, the medical arbiter recommended against using the range of motion measurements, based on claimant's failure to meet validity criteria. (Exs. 25, 27). See Benjamin G. Santos, 46 Van Natta 1912 (1994) (where issue was the claimant's loss of lumbar flexion and persuasive evidence from the medical arbiter established that the lumbar flexion measurement was invalid, that measurement was properly excluded from calculation of the claimant's impairment).

ORDER

The ALJ's order dated January 11, 1995 is affirmed.

In the Matter of the Compensation of
BOYD K. BELDEN, Claimant
WCB Case No. 94-08868
ORDER ON REVIEW
Schneider & Hooten, Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that upheld the SAIF Corporation's denial of claimant's post-surgical (hardware removal) consequential condition. On review, the issue is compensability.

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

In 1986, claimant was involved in a noncompensable motorcycle accident that fractured his left femur. He underwent surgery which included repair of the femur with a metal plate and screws (hardware). On October 12, 1992, claimant injured his left knee while working for the employer. Dr. Wilson reported on October 21, 1992 that claimant had "medial and lateral scars with some crepitus and grating along the lateral side, presumably over the hardware." (Ex. 1G). Dr. Wilson discussed the possibility of removing the hardware in the future to alleviate some of the lateral joint pain. In June 1993, Dr. Wilson performed surgery to remove the hardware. The ALJ found that SAIF had paid all medical bills submitted on this claim.

Claimant contends that he has a post-surgical (hardware removal) condition that is a compensable consequence of his accepted left knee strain. According to claimant, the record contains a medical diagnosis of damage as a result of surgical incisions and the need for treatment resulting from the incisions.

After the ALJ's order, the legislature enacted Senate Bill 369. ORS 656.262(7)(a), as amended, provides, in part: "Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time." SB 369, 68th Leg., Reg. Sess., § 28(7)(a) (June 7, 1995). ORS

656.262(7)(a), as amended, further provides that the worker must clearly request formal written acceptance of any new medical condition and the carrier shall provide written notice of acceptance or denial within 90 days after receipt of the claim. See also ORS 656.262(6)(d), as amended (providing, inter alia, that a worker who believes a condition has been incorrectly omitted from the acceptance notice first must communicate in writing to the carrier the worker's objections to the notice). SB 369, 68th Leg., Reg. Sess., § 28(6)(d) (June 7, 1995).

We need not decide whether the amendments in ORS 656.262 apply retroactively in this case because the medical evidence does not support claimant's argument that he has a post-surgical (hardware removal) condition that is a compensable consequence of his accepted left knee strain. Moreover, assuming without deciding that such amendments are applicable, since SAIF has consistently objected to claimant's claim, we would conclude that it would not achieve substantial justice to remand this case for compliance with the aforementioned procedural rules.

Six months after surgery, Dr. Wilson reported that claimant had benefited from surgery in that there was less grating and he said that claimant's impairment was essentially unchanged from the preoperative visit. (Ex. 7). Dr. Wilson noted that claimant's "clinical complaints are referable principally to his irritability and achiness in cold weather and feelings of instability in the patellofemoral joint." (Id.) Dr. Wilson reported that claimant had "mild patellofemoral crepitus," although there was no neurovascular impairment.

Contrary to claimant's assertion, the medical reports do not indicate that claimant had any "new condition" that resulted from the surgical incisions of the hardware removal surgery. Moreover, we conclude that there is no evidence of any new medical condition or diagnosis resulting from the hardware removal surgery. After claimant's surgery, Dr. Wilson mentioned achiness in cold weather and mild patellofemoral crepitus, but the medical records indicate that both those conditions were present before claimant's accepted June 1993 hardware removal surgery. Dr. Wilson mentioned crepitus in claimant's knee when he examined him in October 1992. Furthermore, Dr. Fuller reported in February 1993 that claimant had "moderate to severe crepitus in the retropatellar and lateral femoral condylar region." (Ex. 1J). In addition, Dr. Fuller previously reported that claimant had "weather-related aching" which was present prior to the date of the compensable injury. (Id.)

In sum, there is no indication that claimant has a "new condition" resulting from the hardware removal surgery. Compare Janet L. Lundsten, 46 Van Natta 1747 (1994) (the claimant developed postoperative arachnoiditis as a consequence of her L5-S1 surgery). In light of our conclusion, it is not necessary to address whether the amendments to ORS 656.262 apply retroactively to this claim.

ORDER

The ALJ's order dated November 29, 1994 is affirmed.

July 13, 1995 Cite as 47 Van Natta 1358 (1995)

In the Matter of the Compensation of
SHIRRELINE J. BRAY-LODWIG, Claimant
WCB Case No. 93-00544
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that upheld the self-insured employer's denial of claimant's claim for migraine headaches. On review, the issue is compensability.[1]

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[1] Because the employer issued a formal denial of the compensability of the underlying claim, i.e., claimant's headache condition (Ex. 6), we retain jurisdiction to review this dispute even though it involves a claim for medical services. SB 369, 68th Leg., Reg. Sess., § 25 (June 7, 1995).

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

The ALJ found claimant's lay opinion (that her headaches were caused by her 1978 compensable neck injury) was insufficient to overcome Dr. Gambee's medical opinion to the contrary. On review, claimant argues that the "early medical reports" of her treatment following the 1978 injury establish material causation. We disagree.

We must first address the proper causation standard for determining the compensability of claimant's migraine headaches. Claimant argues that she is entitled to treatment for her migraine headaches "as a consequence of" her accepted 1978 neck injury. She does not maintain that the migraines are a compensable consequential condition.[2] Claimant cites former ORS 656.245(1) and Beck v. James River Corp., 124 Or App 484 (1993), rev den 318 Or 478 (1994), to support the contention that she need only establish material causation.

In Beck, the Court of Appeals held that former ORS 656.005(7)(a) did not apply to claims for continued medical treatment of a compensable condition, and therefore the applicable statute was ORS 656.245(1). Moreover, in Joseph R. Klinsky, 47 Van Natta 872 (1995), we recently explained that Beck was limited to the situation where a worker seeks medical services for a condition already accepted. We held that when a claimant seeks treatment for a condition which was not previously accepted, the claimant must establish the compensability of that condition under former ORS 656.005(7)(a).

Here, we find that the condition requiring treatment, migraine headaches, has not been accepted by the employer. Claimant's original claim in 1978 was for a neck strain and right arm pain only.[3] We therefore conclude that claimant must establish the compensability of her migraine headache condition under amended ORS 656.005(7)(a) rather than amended ORS 656.245(1).[4] Klinsky, supra. Accordingly, claimant must establish the compensability of her condition and need for medical services under the "major contributing cause" standard applicable to consequential conditions. However, even if we were to assume that the employer did accept claimant's headaches and amended ORS 656.245(1) was the applicable statute, we find claimant cannot meet even the material cause standard.

Claimant refers us to the medical reports of two doctors she saw in December 1983, Dr. Simpson, D.C., and Dr. Gardner, M.D., to link her current headache condition to the 1978 injury. Dr. Simpson's report accurately indicated that claimant first experienced headaches in early 1982 (three and a half years after her compensable injury) and concluded that claimant's ongoing symptoms (including headaches, neck pain and arm pain) were due to the degenerative process operating in her spine. Dr. Simpson does not specifically relate claimant's headaches to the 1978 industrial injury or the compensable neck condition. Dr. Gardner, on the other hand, diagnosed "tension headaches." However, his opinion is based on an inaccurate history, in that he believed claimant began suffering from headaches the day after her 1978 injury. Medical opinions based on inaccurate information are not afforded persuasive force. See Somers v. SAIF, 77 Or App 259, 263 (1986).

We conclude that these early medical reports are insufficient to establish material causation, let alone major causation. We also find, as did the ALJ, that claimant has not shown that the "tension" headaches first documented in 1983 are the continued migraine headaches that were the basis of her 1992 claim. Accordingly, we agree with the ALJ's decision to uphold the employer's denial.

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[2] When a condition or need for treatment is caused by the industrial accident, a worker must establish that the work injury was a material contributing cause of the condition. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). When the condition or need for treatment is caused by the compensable injury that resulted from the accident, the worker must prove that the compensable injury was the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

[3] We note that the employer's payment of medical bills, even for treatment relating to headaches, does not constitute an acceptance of the migraine headache condition. See ORS 656.262(10); Klinsky, supra.

[4] The amended versions of ORS 656.005(7)(a) and 656.245(1) apply to all claims or causes of action existing or arising after the effective date of the Act, Senate Bill 369 (SB 369), § 66. Because the bill contains an emergency clause, SB 369, § 69, its effective date is June 7, 1995, the day the Governor signed the bill into law. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) ("effective date" of act containing emergency clause is day Governor signs it).

ORDER

The ALJ's order dated November 14, 1994 is affirmed.

In the Matter of the Compensation of
CHARLES D. CHAPPELLE, Claimant
WCB Case No. 94-03355
ORDER ON REVIEW
Susak, Dean & Powell, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order which upheld the insurer's denial of claimant's claim for low back strain. On review, the issue is compensability.

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

Claimant worked for the employer on December 14 and 15, 1993. Claimant allegedly injured his low back while working for the employer. Claimant first sought medical treatment for his alleged injury on January 4, 1994. On January 19, 1994 claimant completed a form 801 identifying the date of injury as December 16, 1993. The insurer denied claimant's compensability claim on March 9, 1994.

The ALJ found that claimant had not proven a compensable injury. We agree. A "compensable injury" is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability. ORS 656.005(7)(a). To establish a compensable injury, claimant must show that: (1) he injured himself in performing his job; and (2) the injury sustained was a material contributing cause of the resultant disability or need for medical services. The first element is a question of legal causation; the second concerns medical causation. Harris v. Farmers' Co-op Creamery, 53 Or App 618 (1981). Claimant carries the burden of proving both legal and medical causation by a preponderance of the evidence. Carter v. Crown Zellerbach Corp., 52 Or App 215 (1981).

On review, claimant contends that the major contributing cause of his low back strain was his work activities for the employer. Additionally, claimant asserts that the ALJ erred in refusing to rely on claimant's testimony. We disagree.

Although the ALJ did not accept claimant's testimony, she made no express credibility findings based upon claimant's demeanor. Although the Board generally defers to the ALJ's determination of credibility when that finding is based on the ALJ's opportunity to observe claimant's demeanor, we are in as good a position as the ALJ to evaluate claimant's credibility based on an objective evaluation of the substance of claimant's testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). After our review of the record, we find material inconsistencies and unexplained discrepancies that cast doubt on claimant's reliability. Here, claimant worked for the employer for two days. Claimant testified that after the second day of work he attempted to call the employer at approximately 7:00 am to report his work-related injury claim. (Tr. 25). Claimant testified that he talked with a "receptionist" who informed him that he was ineligible for workers' compensation because he was a temporary worker and that the employer was out of 801 forms. Id. However, claimant's supervisor testified that, prior to 8:00 am each work day, the phone calls were received by an answering service. (Tr. 51). Additionally, claimant testified that on the afternoon of that same day he spoke with the employer's supervisor, telling him of the work-related injury. (Tr. 24). Yet, claimant's supervisor testified that he was on vacation the day that claimant allegedly talked to him. (Tr. 41). Furthermore, the fact that claimant called the employer four days after the alleged injury, to report that he was available for work, raises doubt as to the whether claimant's alleged work-related injury actually occurred. (Ex. 4-3).

In light of these material inconsistencies we do not find claimant's testimony to be credible. Accordingly, we conclude that claimant has not established legal causation.

Assuming that claimant had established legal causation we find that he has failed to prove medical causation. Claimant relies on the opinion of Dr. Stevens to support compensability. Dr. Stevens' medical reports indicate that claimant did not have any objective evidence of neurological dysfunction and diagnosed his condition as muscular pain/strain. (Ex. 1-2,3). Dr. Stevens testified that claimant's condition was consistent with someone who has had chronic back problems. (Ex. 5-11). In a "check-the-box" letter, Dr. Stevens agreed that the major contributing cause of claimant's low back strain was work activities for the employer. (Ex. 2).

In light of our finding that claimant's testimony was not credible, we are not persuaded that Dr. Stevens' opinion was based on an accurate history of claimant's injury. Accordingly, we conclude that Dr. Stevens' opinion based on claimant's history is entitled to little or no weight. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977). Thus, claimant has failed to prove medical causation.

Because claimant has failed to prove both legal and medical causation by a preponderance of the evidence, we agree with the ALJ that claimant's injury claim is not compensable under either a material or major contributing cause standard.

ORDER

The ALJ's order dated January 11, 1995 is affirmed.

July 13, 1995 Cite as 47 Van Natta 1361 (1995)

In the Matter of the Compensation of
LEE I. FOSTER, Claimant
WCB Case No. 94-09963
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) reduced claimant's unscheduled permanent disability for a low back condition from 8 percent (25.60 degrees), as awarded by an Order on Reconsideration, to zero; and (2) authorized the SAIF Corporation to offset overpaid permanent disability benefits against future permanent disability awarded on this claim. On review, the issues are extent of unscheduled permanent disability and offset.

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

Claimant argues that SAIF is not entitled to recover any money it paid claimant while his claim was being reviewed. Relying on ORS 656.313(2), claimant asserts that the rule against recovery of payments pending appeal includes payments made after a Determination Order. We disagree.

ORS 656.313(2) provides that a carrier cannot recover from a claimant any compensation which was "paid pending the review or appeal."[1] In Kristine M. Cartmell, 44 Van Natta 2323 (1992), we held that ORS 656.313(2) applies only to compensation that is paid pending Board review or court appeal; it does not apply to compensation paid pending a hearing.

Here, claimant stipulated that he received a check from SAIF for the $6,486.75 awarded by the January 1994 Determination Order. Since claimant's compensation was not paid pending Board review or court appeal, ORS 656.313(2) does not preclude the authorization of an offset.. We conclude that the ALJ properly authorized SAIF to offset its overpayment of permanent disability benefits paid pursuant to the January 1994 Determination Order.

ORDER

The ALJ's order dated December 14, 1994 is affirmed.

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[1] After the ALJ's order, the legislature enacted Senate Bill 369. SB 369, 68th Leg., Reg. Sess., Section 66 (June 7, 1995). However, we note that ORS 656.313(2) was not amended.

In the Matter of the Compensation of
MARILYN S. GABBARD, Claimant
WCB Case No. 94-02319
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that affirmed an Order on Reconsideration that awarded her 12 percent (18 degrees) for the left forearm. On review, the issue is extent of scheduled permanent disability.

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

The sole issues in dispute are whether claimant has established a chronic condition impairment and whether loss of sensation in the left hand was properly rated.

Claimant has the burden to prove the extent of disability resulting from her compensable injury. ORS 656.266. To carry her burden of proof, claimant must establish her impairment by medical evidence supported by objective findings. ORS 656.295.

Chronic Condition

A worker is entitled to scheduled chronic condition impairment when a preponderance of the medical evidence establishes that a worker is unable to repetitively use a body part due to a chronic and permanent medical condition. OAR 436-35-010(6). The rule requires medical evidence of at least a partial loss of ability to repetitively use the body part. Donald E. Lowry, 45 Van Natta 1452 (1993).

Here, Dr. Neumann, claimant's treating physician, stated, "[I]f claimant were to do some finite pulling of small objects with her hand, it might be quite difficult." This medical evidence is insufficient to establish even a partial permanent loss of claimant's ability to repetitively use her left hand. Lowry, supra. Moreover, claimant's testimony is insufficient to establish her burden of proof. OAR 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991) (Impairment means a decrease in the function of a body part as measured by a physician).

Loss of Sensation

Claimant contends that she should receive ratings of disability for the loss of sensation in each of the five fingers and the palm. We disagree.

In his closing examination on November 17, 1993, Dr. Neumann indicated that claimant had residual impairment, including decreased sensation, over the ulnar nerve distribution of her left hand. (Ex. 5-2). No other nerve distribution was mentioned.[1]

Dr. Neumann found "less than normal" sensation (7 to 10 mm on two-point discrimination testing) over the ulnar nerve distribution. The ulnar nerve enervates the little finger, the ulnar side of the ring finger and the palm.[2] Loss of sensation in the fingers is rated as a percent of a digit as follows:

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[1] Based on Exhibit 11, a post-reconsideration report from her attending physician, claimant argues that the involvement of the "radial side" of claimant's ring and little fingers indicates that the radial nerve, as well as the ulnar nerve, is impaired. Claimant errs. "Radial side" refers to the side of the finger nearest the thumb and "ulnar side" refers to the side of the finger nearest the little finger. The locator phrase "radial side" does not mean that the radial nerve distribution is impaired. Note: Because the outcome of this case is unaffected by consideration of Exhibit 11, we decline to decide whether this document is admissible under amended ORS 656.283(7), which applies to all cases arising or existing after June 7, 1995, the effective date of the act. SB 369, § 34, § 66.

[2] In addition to the AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed (Rev) (1971), cited by the ALJ, see Frank H. Netter, Musculoskeletal System, Part I, 21 and 51 (1987).

Little finger, less than normal sensation, whole digit is 25. OAR 436-35-110(1). This converts to 1 percent of the hand. OAR 436-35-070(1) and (7). Ring finger, less than normal sensation, ulnar side only, is 10. OAR 436-35-110(1). This converts to 1 percent of the hand. OAR 436-35-070(1) and (6). These values are added together for a total of 2 percent of the hand. OAR 436-35-070(2).

There is no value for "less than normal" loss of palmar sensation. OAR 436-35-110(1)(a) and (c).

The parties do not dispute the value for loss of motor strength, which is 9 percent of the hand/forearm.

The hand/forearm values (2) and (9) are combined for a value of 11 percent. OAR 436-35-007(10). However, where, as here, the insurer makes no argument that claimant's award should be reduced below that found by the ALJ, we decline to adjust the award. Daniel M. Alire, 41 Van Natta 752 (1989).

ORDER

The ALJ's order dated January 3, 1995 is affirmed.

July 13, 1995 Cite as 47 Van Natta 1363 (1995)

In the Matter of the Compensation of
VICTORIA J. HAUGEN, Claimant
WCB Case No. 94-02642
ORDER ON REVIEW
Schneider & Hooten, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) found that claimant had timely requested a hearing concerning the employer's denial of claimant's aggravation claim for a right foot condition; and (2) set aside the employer's acceptance of claimant's consequential right foot ganglion condition as nondisabling. On review, the issues are timeliness of claimant's hearing request and claims processing.

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

The employer contends that the Hearings Division did not have jurisdiction over the aggravation issue. Specifically, the employer argues that claimant's request for hearing was not timely because she did not "check-the-box" concerning the aggravation issue on the Board's request for hearing form. We find the employer's argument unpersuasive.

While claimant did not designate aggravation as an issue in her request for hearing, she did specifically reference the employer's February 7, 1994 denial letter. (Ex. 31A). That letter denies claimant's request for claim reopening on the basis that her condition has not worsened. (Ex. 30). Inasmuch as claimant specifically referenced the employer's aggravation denial in her request for hearing, she timely requested a hearing on the aggravation issue. See Mark A. Newkirk, 46 Van Natta 1227 (1994). Consequently, we agree with the ALJ that the Hearings Division had jurisdiction over claimant's request for hearing concerning the aggravation issue.

The ALJ found that claimant's ganglion condition was disabling. Therefore, the ALJ set aside the employer's notice of acceptance of that condition on the basis that it had classified claimant's condition as nondisabling. We modify.

Claimant's original November 6, 1992 right foot injury was accepted by the employer as disabling. The claim was ultimately closed by the February 5, 1993 Notice of Closure. By letter dated February 7, 1994, the employer denied claimant's claim for aggravation on the basis that her

compensable condition had not worsened. On March 8, 1994, the employer accepted claimant's right foot ganglion condition as part of her 1992 injury claim, but indicated that the condition was nondisabling. This action was consistent with the employer's denial, i.e., that claimant's compensable condition had not worsened and become disabling. Nevertheless, by virtue of the ALJ's finding that claimant had sustained an aggravation, her claim will now be processed as disabling in accordance with ORS 656.273(6) and 656.262. Consequently, it was not necessary for the ALJ to set aside the employer's Notice of Acceptance. We modify the ALJ's order accordingly.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the jurisdiction issue is $1,000, 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 December 16, 1994, as reissued December 20, 1994, is affirmed as modified herein. For services on review, claimant's counsel is awarded a reasonable assessed attorney of $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
DAVID D. PLUEARD, Claimant
WCB Case No. 94-10784
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that declined his request for temporary total disability (TTD) at a higher rate. On review, the issue is temporary disability.

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

We change the findings of fact on page 2, paragraph 5, to reflect that the first time loss payment was due on August 11, 1994, rather than August 11, 1993.

We adopt the ALJ's reasoning and conclusion that claimant's periods of inactivity from work did not constitute "extended gaps" under OAR 436-60-025(5)(a) (WCD Admin. Order 1-1992) for purposes of calculating temporary disability benefits.

Alternatively, claimant argues that the receipt of unemployment benefits should be considered receipt of "anticipated wages" for calculating the rate of time loss. Claimant relies on Wells v. Pete Walker's Auto Body, 86 Or App 739, rev den 304 Or 406 (1987).

Claimant's reliance on Wells v. Pete Walker's Auto Body, supra, is misplaced. In Wells, the claimant received unemployment benefits after his injury and the issue was whether the carrier was allowed to offset the claimant's unemployment benefits against his temporary disability benefits. The court held that unemployment benefits could be treated as post-injury wage earnings and could be offset against temporary disability benefits.

Here, in contrast, claimant wants to characterize unemployment benefits received before his injury as "wages" for purposes of calculating his TTD rate. There is no statutory or administrative basis for including claimant's unemployment benefits in the time loss calculation. ORS 656.210(1) provides,

in part: "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66 -2/3 percent of wages." (Emphasis added). OAR 436-60-025(5) (WCD Admin. Order 1-1992) provides, in part: "The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this section." (Emphasis added). See also OAR 436-60-025(1) ("[t]he rate of compensation shall be based on the wage of the worker at the time of the injury"). The definition of "wages" under ORS 656.005(29)[1] does not include unemployment benefits. Claimant cites no statutory or administrative authority for his argument. We conclude that claimant is not entitled to have his unemployment benefits included in the time loss calculation.

ORDER

The ALJ's order dated December 28, 1994 is affirmed.

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[1] "Wages" are defined as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes the amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips reported, whichever amount is greater. The State Accident Insurance Fund Corporation may establish assumed minimum and maximum wages, in conformity with recognized insurance principles, at which any worker shall be carried upon the payroll of the employer for the purpose of determining the premium of the employer." ORS 656.005(29) (SB 369, 68th Leg., Reg. Sess., § 1(29) (June 7, 1995)).

July 13, 1995 Cite as 47 Van Natta 1365 (1995)

In the Matter of the Compensation of
MARGARET B. SPARKES, Claimant
WCB Case No. 94-08860
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Robert Yanity (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the SAIF Corporation's denial of claimant's facial injury claim. On review, the issue is compensability.

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

Subsequent to the filing of Board briefs, claimant submitted a letter asking us to consider an additional authority, Fou S. Saechao, 47 Van Natta 347 (1995). SAIF responded with additional argument distinguishing that case from the present case, but did not object to claimant's submission.

Any party may provide supplemental authorities to assist the Board in its review of a case, but only if the case was not in existence until after the time of briefing. Betty L. Juneau, 38 Van Natta 553 (1986). We do not, however, consider any supplemental submissions to the extent they contain additional argument. See Debra A. West, 43 Van Natta 2299 (1991). Therefore, we will consider claimant's submission to the extent it advises us of recent developments in the law. However, we do not consider SAIF's response to claimant's submission of supplemental authority.

Claimant contends that her injuries from an assault arose out of her employment because of the increased hazard of her work at night and alone. We disagree.

In Saechao, the claimant, a stock clerk, was shot and killed during an attempted robbery at the convenience store where he was employed. Applying the factors recited in Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571 (1985), we found that the claimant was performing his regular stock clerk duties for pay, as contemplated and directed by the employer, for the employer's benefit, and on the

employer's premises. Reasoning that considering the past history of the store (prior robberies and parking lot squabbles), the risk of robbery, assault, or a shooting was an ordinary risk of employment, we identified the sole remaining issue as whether the claimant was on a personal mission at the time of the incident. Citing Barkley v. Corrections Division, 111 Or App 48 (1992) and finding no evidence suggesting a personal motive for the claimant's death, we concluded that there was a sufficient relationship between the shooting and a risk connected with claimant's employment to conclude that the injury arose out of and in the course of his employment.

Subsequent to our decision in Saechao, in First Interstate Bank v. Clark, 133 Or App 712 (1995), the court stated that the seven-factor Mellis test was not dispositive and was inconsistent with the legal framework of analyzing the unitary work-connection test explained in Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994)[1]. The ALJ relied on the Mellis test in finding the claim not compensable. On review, the parties do not contest the "in the course of employment" factor. We, therefore, must determine under the Norpac Foods analysis whether claimant's injury arose out of employment.

Here, the assailant's motive for the assault was the result of a personal relationship with claimant. The assailant had met claimant earlier that day and had given her a ride to work. Claimant worked alone at night as a baker. She showed the man around the premises and how she did her job. He tried to hug and kiss claimant, but she rebuffed him. The assailant returned later that evening and appeared to ask claimant for directions. Claimant unlocked and exited the premises and walked to the assailant's car. The assailant then grabbed claimant, pulled her into his car, drove off and assaulted her.

Unlike Barkley or Saechao, the assault on claimant was not connected with her employment, but instead resulted from a personal relationship between herself and the assailant. Claimant was not carrying out the business of her employer when she was assaulted. The premises where she worked were locked and not open to the public during her work hours. Her work environment, thus, did not, in itself, expose her to an increased hazard of assault or other violent crimes.[2] Rather, we find that the work environment did not increase the risk of assault and that the assault was not motivated by anything related to work. Therefore, her injury did not arise out of her employment. See Robinson v. Felts, 23 Or App 126 (1975); Pamela E. Fleisher, 44 Van Natta 1258 (1992)(claim not compensable where assault was directed at the claimant personally and the claimant failed to prove that her work environment appreciably increased the risk of attack).

ORDER

The ALJ's order dated November 18, 1994 is affirmed.

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[1] In Norpac Foods, Inc. v. Gilmore, supra, the Court explained that the "in the course of employment" element concerns the time, place, and circumstances of the injury. Id. at 366. The "arise out of employment" element refers to any causal relationship between the injury and employment; that is, the worker must show a causal link between the injury and a risk connected with the job. Id. at 366, 368-69. Moreover, the Court stated that, although an evaluation of both elements is necessary to assess compensability, neither is dispositive. Id. at 366.

[2] Claimant testified that, because her assailant had initially been friendly and had given her a ride to work, she did not see any danger in later opening the locked door and stepping outside to his car to assist him. (Tr. 10, 12).

In the Matter of the Compensation of
FINIS O. ADAMS, Claimant
Own Motion No. 95-0263M
OWN MOTION ORDER
Malagon, et al., Claimant Attorneys
Liberty Northwest, Insurance Carrier

Claimant submitted his request for temporary disability compensation for compensable lumbar spinal stenosis, which required surgery on March 9, 1995. Claimant's aggravation rights expired on August 25, 1983. The insurer opposes reopening of the claim, contending that claimant was not in the work force when his current condition worsened.

Claimant "moves the Board for an appropriate Order directing the carrier to reinstate Claimant to temporary total disability benefits as of March 9, 1995 and assessing appropriate sanctions against the carrier for their failure to act."

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.

Dr. Golden, claimant's treating neurosurgeon, noted in a January 18, 1995 letter that claimant's condition was "clinically worse" on that date. After diagnostic studies revealed severe lumbar spinal stenosis, Dr. Golden recommended surgical decompression and attributed the need for surgery to the compensable injury and its sequela. Claimant underwent surgery on March 9, 1995. Based on this record, we find that claimant's compensable condition had 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. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

The insurer contends that claimant is not in the work force. Claimant contends that he qualifies for temporary disability compensation because he is self-employed, and he remained in the work force until his compensable condition worsened requiring surgery. Claimant has the burden of proof on this issue and must provide evidence, such as tax information or pay stubs verifying employment during the relevant time period, and/or a medical opinion that his compensable condition worsened making work efforts futile.

Claimant submitted 1994 "1099" tax forms, which indicate that claimant was self-employed and received non-employee compensation during 1994. In addition, claimant submitted an undated letter which verified that claimant received "nonemployee compensation" for the 1994 tax year. On this record, we conclude that claimant has established that he remained in the work force until his compensable condition worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning March 9, 1995, the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055. In addition, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

Finally, in his May 16, 1995 letter advising the Board that claimant underwent surgery on March 9, 1995, claimant's attorney requests that the Board assess "appropriate sanctions against the carrier for their failure to act." In its June 1, 1995 recommendation to the Board, the insurer stated that it received claimant's request to reopen his claim on May 18, 1995, presumably by the May 16, 1995 letter from claimant's attorney.

However, the record shows that the insurer first received Dr. Golden's February 7, 1995 written request for surgical authorization on February 17, 1995. We find that Dr. Golden's written request reasonably notified the insurer that claimant's compensable condition had worsened and required surgery. Hence, in accordance with our administrative rules, the insurer is deemed to have received notice of claimant's own motion claim for temporary disability benefits as of February 17, 1995. See OAR 438-12-020(3)(b).

The insurer was required to make a written recommendation to the Board within 90 days of receiving claimant's own motion request. See OAR 438-12-030. The record shows that the insurer did not submit its recommendation to the Board until June 5, 1995, well beyond the 90-day period following claim filing. The insurer has not provided a reasonable explanation for its delay. Therefore, we find that its delay resulted in an unreasonable delay in the payment of compensation. However, inasmuch as there was no compensation due at the time of the insurer's delay, we are not authorized to assess a penalty under former ORS 656.262(10) (now ORS 656.262(11)). See Donald M. Hughes, 43 Van Natta 863 (1991).

Nevertheless, even in the absence of amounts "then due," we are authorized to assess an attorney fee under ORS 656.382(1) for the insurer's unreasonable resistance to compensation. See id. Therefore, we assess the insurer an attorney fee of $500, to be paid to claimant's attorney in addition to the compensation awarded by this order.

IT IS SO ORDERED.

In the Matter of the Complying Status of
PRODUCTION CUTTERS, INC., Employer
WCB Case No. 91-02258
and, In the Matter of the Compensation
JOHN W. BONES, JR., Claimant
WCB Case Nos. 92-09976 & 91-04564
ORDER ON REVIEW
The Law Firm of Michael B. Dye, Claimant Attorneys
Bonnie V. Laux (Saif), Defense Attorney
Robert J. Thorbeck, Attorney

Reviewed by Board Members Neidig and Gunn.

Production Cutters, Inc. (Production Cutters), a noncomplying employer (NCE), and claimant, each request review of those portions of Administrative Law Judge (ALJ) Holtan's order that: (1) upheld the SAIF Corporation's denial, on behalf of R.C. Ogden, Inc. (SAIF/Ogden), of responsibility for claimant's October 1990 injury claim; and (2) set aside Production Cutters' denial of responsibility for the same claim. SAIF, as statutory claim processing agent for Production Cutters, cross-requests review of that portion of the order that awarded claimant's counsel an attorney fee payable by SAIF pursuant to ORS 656.382(2). The Department of Consumer and Business Services (DCBS), submitted a "reply brief," in which it contends that the ALJ erred in failing to determine whether Ogden was claimant's employer at the time of injury and requests remand if the record is insufficiently developed for the Board to make such a determination.[1] On review, the issues are responsibility, remand and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following modifications.

SAIF/Ogden's compensability denial is dated July 9, 1992, not April 1, 1991. (Ex. 43).

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[1] Where, as here, our adjudication includes review of an order of DCBS regarding noncompliance, DCBS is deemed to be a party to the proceeding. Kelsey v. Drushella-Klohk, 128 Or App 53 (1994).

Production Cutters' responsibility disclaimer is dated June 28, 1993, not June 28, 1991. (Ex. 49).

CONCLUSIONS OF LAW AND OPINION

Responsibility

Ogden was incorporated by Raymond C. Ogden for the purpose of engaging in the logging business, including falling and bucking trees. (Ex. A). Raymond C. Ogden has been the president at all times pertinent to this claim. Bryan Ogden, Raymond Ogden's son, was an officer of Ogden. In 1989, Raymond Ogden caused the incorporation of Production Cutters to avoid the payment of workers' compensation premiums. Management authority was designated to the president and vice-president. (Ex. 3, Tr. 30). Bryan Ogden was president. Production Cutters, which contracted solely with Ogden, performed all of Ogden's falling and bucking.

Production Cutters purchased workers' compensation insurance from Liberty Northwest Insurance Corporation effective May 20, 1989. Claimant began working for Production Cutters in late 1989. As a condition of employment, he signed an "Employment Disclosure Form" on November 15, 1989, which stated that he was an officer, director and owner of at least 10 percent of the outstanding stock of Production Cutters; that he would be a non-subject worker for purposes of workers' compensation insurance; and that he voluntarily entered the company with full disclosure and voluntarily waived workers' compensation coverage. Effective December 1, 1989, claimant was elected as the sixth vice president of the corporation and was "issued" 10 shares of stock at $10 a share. No shares or money actually changed hands. (Tr. 72, 73).

On January 1, 1990, Ogden and Production Cutters entered into a contract whereby Production Cutters agreed to fall and buck timber for Ogden. Liberty Northwest cancelled coverage on October 5, 1990, on the basis that Production Cutters had no employees. On October 25, 1990, claimant suffered a serious, compensable injury while thinning trees for Production Cutters at an Ogden site.

The Department of Insurance and Finance (DIF) (now Department of Consumer and Business Services (DCBS)) investigated the injury. DIF determined that Production Cutters was a subject and noncomplying employer and that claimant was a subject worker of Production Cutters when he was injured. On January 31, 1991, DIF entered a Proposed Order of Noncompliance, which Production Cutters appealed. (WCB No. 91-02258).

On April 1, 1991, SAIF, as claims processing agent for the alleged NCE, Production Cutters, accepted the claim and began paying benefits pursuant to ORS 656.054. (Ex. 37A). Production Cutters requested a hearing to object to the claim (WCB No. 91-04564). Production Cutters did not specify the grounds for its objection.

On July 9, 1992, SAIF/Ogden denied compensability on the basis that claimant was not its employee at the time of injury. (Ex. 43). Claimant requested a hearing (WCB No. 92-09976).

On June 28, 1993, Production Cutters' attorney issued a responsibility disclaimer to claimant which stated that the claim was compensable, but that SAIF/Ogden was responsible.

At hearing, all parties agreed that claimant experienced a compensable injury on October 25, 1990, and that the primary issue concerned whether claimant was an employee of Production Cutters or Ogden at the time of injury.

The ALJ concluded that claimant was a subject employee of Production Cutters. The ALJ declined to apply the "right to control" test to determine whether claimant may actually have been an employee of Ogden at the time of the injury.

On review, Production Cutters, claimant and DCBS each contend that the ALJ erred in failing to apply the "right to control" test to determine whether SAIF/Ogden is responsible for claimant's claim. DCBS requests remand if the record is insufficiently developed for the Board to make such a determination.

SAIF/Ogden relies on the contractual relationship between itself and Production Cutters to establish that Production Cutters was a separate legal entity that had the legal right to control its workers, including claimant.

Claimant contends that SAIF/Ogden cannot effectively avoid liability for compensation by attempting to substitute a contractual relationship between itself and Production Cutters for what was, in fact, a direct employment relationship between Ogden and claimant. We agree.

In Woody v. Waibel, 276 Or 189 (1976), the Court held that the fact that either or both of the parties in that case mistakenly considered their relationship to be that of employer-independent contractor does not control in applying the Worker's Compensation Act to establish whether there is an employment relationship. Similarly, here, where an employer is attempting to circumvent the provisions of the compensation act by setting up an admittedly "sham" corporation, we look to the actual facts of the relationship, rather than the legal name and form given it, to determine whether there is an employer-employee relationship. See also, 1B Larson, Workmen's Compensation Law § 46.00 (1993).

A worker is any person who engages to furnish services for a remuneration, subject to the direction and control of an employer. ORS 656.005(28). The test for determining "control" is based not on the actual exercise of control by the employer, but on the traditional right to control test. S-W Floor Cover Shop v. Nat'l Council on Comp. Ins., 318 Or 614, 622 (1994); Castle Homes v. Whaite, 95 Or App 269 (1989). The principal factors in the traditional test of the right to control 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.

Direct Evidence of the Right to, or Exercise of, Control

Claimant contacted Ray Ogden after hearing he was hiring tree fallers and buckers. Ray Ogden hired him, after telling him that joining Production Cutters as a corporate officer and director was a condition of getting the job. (Tr. 39, 78). Ray Ogden informed claimant of where and when to work and was frequently on-site directing the work. (Tr. 81). Bryan Ogden, who ostensibly had management authority for Production Cutters, did not direct the work himself, but relayed messages from Ray Ogden. Moreover, claimant went to the location where he was injured on the direct instruction of Ray Ogden. (Tr. 82). Additionally, when we examine this factor in relation to Production Cutters, we conclude that there is no direct evidence of the right to, or exercise of, control by Bryan Ogden or the other designated manager. Instead, the record shows that Bryan Ogden and the other persons holding the designated management positions performed falling and bucking for Ogden under the direction and control of Ray Ogden, as did all the other "corporate officers" on the Production Cutters payroll. Therefore, we find that all of the evidence indicates that Ray Ogden exercised complete control over claimant's work. Accordingly, this factor weighs in favor of an employment relationship between claimant and Ogden.

Method of Payment

Claimant was issued pay checks from Production Cutters' bank account at an hourly pay rate, which was recited in the contract between Ogden and Production Cutters. (Exs. 1, 8 and 15; Tr. 31). Each payday, Ogden put enough money into Production Cutters' checking account to cover the payroll for that payday. (Tr. 74). Therefore, notwithstanding the fact that claimant was issued paychecks from Production Cutters' account, we find that claimant was actually being paid with funds from Ogden. Hence, the method of payment is a factor weighing in favor of an employment relationship between claimant and Ogden and against an employment relationship between claimant and Production Cutters.

Furnishing of Equipment

The contract between Ogden and Production Cutters specified that Production Cutters would provide all equipment and materials required to do the falling and bucking, except a radio, first-aid equipment and tree-felling signs. (Ex. 8). No evidence was adduced at hearing regarding what equipment was furnished by Production Cutters. However, claimant was paid by a Production Cutters check for the use of his saw from funds placed in Production Cutters' bank account by Ogden in the same manner it provided funds for the payroll. (Ex. 15, Tr. 74). Therefore, notwithstanding the fact that claimant was paid saw rent from Production Cutters' account, we find that claimant was actually being paid with funds from Ogden. Insofar as the evidence indicates that Ogden paid for claimant's saw rent, and absent evidence that any other equipment was provided by Production Cutters, this factor weighs in favor of an employment relationship between claimant and Ogden, and against an employment relationship between claimant and Production Cutters.

Right to Fire

Ray Ogden had the right to fire claimant. (Tr. 39, 90). Bryan Ogden, who was an officer of Ogden as well as Production Cutters, also had the right to fire claimant. (Tr. 42). It is unclear whether Bryan Ogden's authority to fire flowed from his position with Ogden or Production Cutters, so this factor is given little weight in favor of an employment relationship with Production Cutters. More importantly, claimant considered Ray Ogden his "boss," and Ray Ogden had the authority to fire him, as well as any other worker in the event he was dissatisfied with the performance of the job. Accordingly, this factor weighs in favor of an employment relationship between claimant and Ogden, rather than claimant and Production Cutters.

After considering all of the factors of the "right to control" test, we conclude that claimant was an employee solely of Ogden, not Production Cutters.[2] Moreover, for reasons stated by the ALJ, we do not find that claimant was statutorily exempt from workers' compensation coverage. Thus, inasmuch as SAIF provided workers' compensation insurance to Ogden, we hold that SAIF/Ogden is responsible for claimant's injury claim. We consequently set aside SAIF's acceptance as processing agent for Production Cutters. Accordingly, we reverse the attorney fee awarded by the ALJ.

Remand

Because the record was sufficiently developed for us to address the "right to control" issue, we need not remand this matter to the ALJ. Accordingly, the motion to remand is denied.

Attorney Fees

The ALJ awarded a reasonable attorney fee for claimant's services at hearing, to be paid by SAIF as processing agent for the alleged NCE, Production Cutters, pursuant to ORS 656.382(2). On review, SAIF/Production Cutters contends that claimant's attorney is not entitled to a fee because claimant's compensation was not at risk, as only responsibility was denied. We have previously held that, where compensability has been conceded, a claimant can still be entitled to an attorney fee award under ORS 656.382(2) if the record establishes that his compensation was at risk of reduction (his temporary disability rate would be reduced if a carrier's responsibility appeal was successful). See Bonnie A. Stafford, 46 Van Natta 1452, on recon 46 Van Natta 1539 (1994). Here, the record does not establish that claimant's temporary disability rate would be reduced if SAIF/Production Cutters' hearing request was successful. Consequently, we reverse the ALJ's attorney fee award under ORS 656.382(2).[3]

Furthermore, no ORS 656.386(1)[4] fee for counsel's services at hearing or on review is appropriate since responsibility was the sole issue at hearing. See Bonnie A. Stafford, supra. However, since SAIF/Ogden's denial initially contested the compensability of the claim and it was not until the hearing that SAIF/Ogden conceded that claimant's injury arose out of the course and scope of his employment (either Ogden or Production Cutters), claimant is entitled to an attorney fee award for his counsel's services in prompting the rescission of the compensability portion of SAIF/Ogden's denial without a hearing. See ORS 656.386(1); Gates v. Liberty Northwest Insurance Corporation, 131 Or App 164 (1994).

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[2] Because the evidence weighs so heavily in favor of claimant being an employee of Ogden, not Production Cutters, we further conclude that claimant was not under the simultaneous control of both entities in a joint employee arrangement. See Mission Insurance Co. v. Miller, 73 Or App 159 (1985) (a joint employee is subject to the simultaneous control of two employers and performs simultaneous and related services for each).

[3] Claimant asserts that the Director's "NCE" order constitutes an order awarding compensation, which would form the basis of an attorney fee award under ORS 656.382(2) for claimant's defense of Production Cutters' appeal of that order. Yet, the Director's "NCE" order did not "award" compensation. Rather, the order found Production Cutters to be a noncomplying employer and referred the claim to SAIF for processing. In light of such circumstances, an essential prerequisite of ORS 656.382(2) is also not applicable.

[4] ORS 656.386(1) was amended by the 1995 Legislature. SB 369, 68th Leg., Reg. Sess., § 43 (June 7, 1995). We need not address whether the amended statute is retroactively applicable here, because we conclude that, under either version of the statute, a reasonable attorney fee is allowed.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $2,500 is a reasonable fee for claimant's counsel's pre-hearing services in obtaining SAIF/Ogden's concession of the compensability of claimant's injury claim. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Finally, since the record does not establish that claimant's compensation was at risk of reduction on review (in other words, there is no indication that his temporary disability rate would be different under either claim), claimant is not entitled to an attorney fee award under ORS 656.382(2) for his counsel's services on Board review. See Bonnie A. Stafford, supra.

ORDER

The ALJ's order dated January 21, 1994, as reconsidered April 29, 1994, is reversed in part and affirmed in part. The SAIF Corporation's denial, on behalf of R.C. Ogden, Inc., is set aside and the claim is remanded to SAIF for processing according to law. That portion of the order that set aside Production Cutters, Inc.'s disclaimer of responsibility is reversed. SAIF's acceptance, as claim processing agent for Production Cutters, Inc., is set aside. The ALJ's attorney fee award is reversed. For services prior to hearing, claimant's attorney is awarded $2,500, payable by SAIF. The Director's order finding Production Cutters to be a noncomplying employer is reversed. The remainder of the order is affirmed.

July 19, 1995 Cite as 47 Van Natta 1372 (1995)

In the Matter of the Compensation of
LEONA BECKSTEAD, Claimant
WCB Case No. 94-02436
ORDER ON REVIEW
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. With her brief, claimant submits reports regarding two 1993 blood tests. We treat claimant's submission as a motion to remand to the ALJ for the taking of additional evidence. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and compensability.

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

Claimant has included with her brief two 1993 blood test reports, which she contends will show that her thyroid condition was not a contributing factor to her bilateral carpal tunnel syndrome. Since our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand. See Judy A. Britton, supra.

We may remand a case to the ALJ if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). 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).

Here, claimant has offered no reasons why the 1993 blood tests were unobtainable with due diligence at the May, 1994 hearing. Furthermore, we find that the reference to claimant's thyroid condition by Drs. Radecki and Ramirez was in regard to one of several risk factors associated with bilateral carpal tunnel syndrome. (Exs. 5-4; 12-13, 14). As such, additional evidence to rebut this particular risk factor would not reasonably affect the outcome of the case. Therefore, we deny claimant's request for remand.

Turning to the merits, claimant challenges the ALJ's order, which upheld the employer's denial of her occupational disease claim for bilateral carpal tunnel syndrome. The ALJ relied on the opinions of Drs. Radecki and Ramirez. Dr. Radecki, examining physician, performed an insurer arranged medical examination, and opined that claimant's work activities were not the major contributing cause of her bilateral carpal tunnel syndrome. (Ex. 5-3).

Dr. Ramirez, treating physician, agreed with Dr. Radecki's findings that claimant did show signs of bilateral carpal tunnel syndrome and that the problem preexisted her employment. (Exs. 6; 12-6). However, Dr. Ramirez was unable to opine that claimant's work activities were at least 51 percent of the cause for the worsening of claimant's preexisting bilateral carpal tunnel condition. (Ex. 12-15).

On review, claimant contends that the ALJ erred in finding that she did not suffer from a compensable carpal tunnel syndrome. We disagree.

In order to prove the compensability of an occupational disease, claimant must show that "employment conditions were the major contributing cause of the disease or its worsening." ORS 656.802(2). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

Here, based on the medical opinions of Drs. Ramirez and Radecki, we are unable to find that claimant's work activities were the major contributing cause of her bilateral carpal tunnel condition. Accordingly, the employer's denial is upheld.

ORDER

The ALJ's order dated October 25, 1994 is affirmed.

July 19, 1995 Cite as 47 Van Natta 1373 (1995)

In the Matter of the Compensation of
RICHARD J. CARLTON, Claimant
WCB Case Nos. 94-00354, 93-12629, 93-08648 & 93-07890
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys
Marcia L. Barton (Saif), Defense Attorney
Bottini, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Liberty Northwest Insurance Corporation (Liberty) requests review of Administrative Law Judge (ALJ) Spangler's order which: (1) set aside its denial of claimant's aggravation claim for his current low back condition; (2) upheld EBI Companies' denial of claimant's medical services claim for the same condition; (3) upheld Alexis Risk Management's denial of claimant's aggravation claim for the same condition; and (4) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility.

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

Claimant compensably injured his low back in 1982. EBI accepted the claim. In March 1987, claimant sustained a "new" compensable injury to his low back. In September 1987, claimant underwent a myelogram followed by a laminectomy at L5-S1. (Exs. 18B, 19-1). The employer's insurer at this time was Liberty, which eventually accepted the claim. (Ex. 23-1).

In February 1991, claimant compensably reinjured his low back which was diagnosed as a temporary strain. Alexis, the self-insured employer's claims processing agent, accepted claimant's claim as a nondisabling acute low back strain. (Ex. 35B). In April 1993, claimant began treating with Dr. Gallo because of a worsening of his low back condition. SAIF was the insurer for the employer during this time.

All the insurers/claims processors denied compensability and responsibility for claimant's current low back condition. The ALJ found claimant's current low back condition was compensable and determined that Liberty was the responsible insurer.

The ALJ reasoned that Liberty's 1988 acceptance was for claimant's "then current" degenerative disc disease at both the L4-5 and L5-S1 levels, as well as his need for surgery. Liberty contends that it did not accept claimant's degenerative disc disease because its subsequent withdrawn denial of October 5, 1987 did not include claimant's "degenerative disc disease." We disagree.

The scope of acceptance is a factual determination. SAIF v. Tull, 113 Or App 449 (1992). Here, in September 1982, claimant sustained a low back injury. Claimant's condition was diagnosed as "[h]erniated nucleus pulposis with nerve root involvement on the right." (Ex. 4-1). A June 12, 1984 lumbar CT scan revealed "mild degenerative" arthritic change involving the facet joints bilaterally at the lumbosacral level. (Ex. 8-1).

In March 1987 claimant sustained a "new" compensable injury to his low back which Liberty accepted. X-rays of claimant's lumbar spine showed disc space narrowing at L5-S1 with possible degenerative disc disease at that level. (Ex. 11-1). Dr. Schafer, the treating physician, ordered a lumbar CT scan which revealed central herniation of the lumbosacral disc and mild bulge of the L4-5 disc. (Ex. 13-1). Dr. Mundall, referred by Dr. Schafer, diagnosed claimant's condition as lumbosacral strain with probable degenerative disc disease. (Ex. 15-3). Dr. Serbu, examining physician, opined that claimant had a bulging degenerative disc prior to the 1987 injury that resulted in claimant's herniated disc. (Ex. 21A).

Based on the opinions of Drs. Schafer, Mundall and Serbu, we find that Liberty's 1988 acceptance was for claimant's disc herniation, lumbar surgery and degenerative disc disease at the L4-5 and L5-S1 levels.

Responsibility between Liberty and Alexis

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."

To establish a new injury, Liberty must show that claimant's employment activity in February 1991 was the major contributing cause of claimant's disability or need for medical treatment of the "combined condition." ORS 656.308(1); SAIF v. Drews, 318 Or at 9.[1]

The ALJ found that claimant's low back strain, sustained while Alexis was on the risk, was not the "same condition" which was previously accepted by Liberty. Therefore, the ALJ concluded that responsibility did not shift pursuant to pursuant to ORS 656.308(1). We agree.

Liberty contends that if it accepted claimant's degenerative disc disease, then Alexis accepted the "same condition" which Liberty accepted in 1987. Therefore, according to Liberty, ORS 656.308(1) should apply to shift responsibility to Alexis. Liberty relies on the opinion of Dr. Serbu, who treated claimant for his 1987 back surgery and 1991 low back strain, to support its contention.

Dr. Serbu's opinion states that claimant's February 1991 injury aggravated a preexisting condition. (Ex. 39A). We find Dr. Serbu's opinion unpersuasive because it fails to establish that claimant's low back strain in 1991 also included his degenerative disc disease.

The preponderance of the evidence establishes that claimant's 1991 low back strain did not include his degenerative disc disease. We find, as did the ALJ, that in 1988 Liberty accepted claimant's claim for disc herniation, lumbar surgery and degenerative disc disease at the L4-L5 and L5-S1 levels. In 1991 Alexis accepted claimant's claim as a nondisabling "acute low back strain." Claimant did not miss any work due to the low back strain. Furthermore, no medical expert opined that the 1991 strain

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[1] After the ALJ's order, the legislature enacted Senate Bill 369 which amended ORS 656.308(1). SB 369, 68th Leg., Reg. Sess., § 37 (June 7, 1995) . However, we need not decide whether amended ORS 656.308(1) applies retroactively, because the outcome in this case would be the same under either the former or amended versions of ORS 656.308(1). SB 369, 68th Leg., Reg. Sess., § 66 (June 7, 1995).

involved the prior herniations and degenerative disc disease condition accepted by Liberty. Therefore, we find that the 1987 and 1991 claims did not involve the "same condition." Consequently, ORS 656.308(1) does not apply since Liberty and Alexis did not accept the "same condition." Smurfit Newsprint v. DeRosset, 118 Or App 368, 371 (1993). Accordingly, as between Liberty and Alexis, responsibility for claimant's degenerative disc disease at L4-L5 and L5-S1 remained with Liberty.

Responsibility between Liberty and SAIF

Initially, Liberty contends that claimant's current condition was not the "same condition" which it accepted in 1987. Therefore, Liberty argues that the last injurious exposure rule applies to claimant's current claim, and responsibility shifted to SAIF. Liberty relies on the opinion of Dr. Hacker, who opined that claimant's degenerative disease was not the sole cause of his current need for medical treatment. (Ex. 62). Dr. Hacker's opinion fails to adequately distinguish claimant's current condition from his prior low back condition which was accepted by Liberty.

Here, the preponderance of the medical opinion supports a finding that claimant's current condition involves the same body part and condition as Liberty's 1987 accepted claim. Liberty accepted claimant's degenerative disc disease at both the L4-5 and L5-S1 levels, as well as claimant's need for surgery. Drs. Gallo, Woolpert, White, Hunt and Schafer all noted that claimant's current condition involves his degenerative disc disease at the L4-5 and L5-SI vertebrae. (Exs. 37, 46A-5, 47, 48A, 49-5, 51A-2). Therefore, we find that claimant's current condition involves the "same condition" which Liberty accepted in 1987. Consequently, because the 1987 and 1991 claim involve the "same condition," ORS 656.308(1) applies insofar as claimant's current condition "vis-a-vis" Liberty and SAIF. Smurfit Newsprint v. Derosset, supra.

Under ORS 656.308(1), in order for Liberty to shift responsibility to SAIF, Liberty has the burden to prove that the major contributing cause of claimant's current disability or need for treatment was due to his work activities while SAIF was on the risk. Liberty contends that the opinion of Dr. Gallo supports its burden of proof. (Exs. 36, 39). We disagree.

Dr. Gallo opined that claimant's lumbosacral disc degeneration disease was the result of his on-the-job activities as a police officer. (Ex. 36-3). However, Dr. Gallo also opined that claimant's L5-S1 disc degeneration was due to claimant's 1982 injury and discectomy at L5-S1 in 1987, and that claimant's work exposure since 1991 had probably not worsened his back condition. (Ex. 47). We find Dr. Gallo's opinions unpersuasive because of their contradictory nature.

Additionally, the only other physician whose opinion might support a finding that claimant's work from 1991 to 1993 caused his low back to worsen was Dr. Schafer. (Ex. 52A-1). However, Dr. Schafer's later opinion stated that he "does not have a clue" whether claimant's "symptoms and worsening was as a result of his job activities as a police officer." (Ex. 58D-23). Given Dr. Schafer's inconsistent opinions, we find his opinion unpersuasive. Accordingly, Liberty has failed to prove that claimant's "post-1991" work activities, while SAIF was on the risk, were the major contributing cause of claimant's current need for medical treatment. As such, responsibility did not shift from Liberty to SAIF under ORS 656.308(1).

Because compensability was at issue at hearing and the ALJ's order addressed compensability, claimant's compensation remained at risk on de novo review. See Cigna Insurance Companies v. Crawford and Co., 104 Or App 329 (1990). Therefore, claimant's attorney is entitled to an assessed attorney fee for services on review. See ORS 656.382(2). 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 $250, to be paid by Liberty Northwest Insurance Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 23, 1994 is affirmed. For services on review, claimant's counsel is awarded an $250 attorney fee, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
BARBARA S. CLOWNEY, Claimant
WCB Case No. 94-11629
ORDER ON REVIEW
Susak, Dean & Powell, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order which: (1) set aside its denial of claimant's injury claim for a respiratory condition; and (2) assessed a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability and penalties.

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

The ALJ found that claimant, a registered practical nurse, sustained her burden of proving that she sustained a compensable respiratory injury (diagnosed as asthmatic bronchitis secondary to smoke inhalation) when she helped evacuate patients during a fire. Therefore, the ALJ set aside the insurer's denial. Concluding that the insurer's denial was unreasonable, the ALJ also assessed a 25 percent penalty pursuant to ORS 656.262(10).

On review, both the insurer and claimant agree that claimant's exposure to smoke and fumes on June 20, 1994 "combined" with a preexisting respiratory condition to cause disability and a need for treatment. Hence, both parties concur that former ORS 656.005(7)(a)(B) is applicable and requires that claimant prove that the June 20, 1994 smoke and fume exposure is the major contributing cause of her disability or need for treatment.

Effective June 7, 1995, however, Senate Bill 369 amended ORS 656.005(7)(a)(B).[1] We need not decide whether the amendments to that statute are applicable because we would find this claim to be compensable under either former or amended ORS 656.005(7)(a)(B).

We agree that, based on the opinion of claimant's attending physician, Dr. Harris, claimant's June 20, 1994 "injury" combined with a preexisting, underlying reactive airways disease to cause disability or a need for treatment. (Ex. 8A-3). Although none of the three physicians who have expressed an opinion on causation (Drs. Harris, Keppel and Montanaro) explicitly stated that claimant's exposure to smoke and fumes was the major contributing cause of her disability or medical treatment, we note, as did the ALJ, that all three doctors have related claimant's respiratory condition to the June 20, 1994 exposure. (Exs. 8-6, 8A, 9-1, 10). Based on our de novo review, we conclude that the medical evidence is sufficient to establish major causation. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("magic words" unnecessary to establish medical causation).

Accordingly, we conclude that claimant has sustained her burden of proving the compensability under either former or amended ORS 656.005(7)(a)(B). Moreover, inasmuch as the medical evidence unanimously linked claimant's respiratory condition to the June 20, 1994 incident, we agree with the ALJ that the insurer's denial was unreasonable. Thus, we affirm the ALJ with respect to both the compensability and penalty issues.

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 438-15-010(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

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[1] Amended ORS 656.005(7)(a))(B) now 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, and 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."

$1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that claimant is not entitled to an attorney fee for services with respect to the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated January 3, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

July 19, 1995 Cite as 47 Van Natta 1377 (1995)

In the Matter of the Compensation of
DUANE G. HALMRAST, Claimant
WCB Case No. 93-15024
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

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

FINDINGS OF FACT

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

In 1986, claimant filed a claim contending that a psychological condition was related to his 1981 compensable low back injury. Claimant's psychological condition was the subject of an October 1987 Disputed Claim Settlement in which SAIF's denial of the condition was upheld.

There is no objective medical evidence to explain a relationship between claimant's low back injury and his left knee giving out. (Exs. 17, 19, 46-10).

Dr. Kitchel has treated claimant for his low back, but has not treated claimant's left knee condition. (Tr. 46-14).

CONCLUSIONS OF LAW AND OPINION

In 1981, claimant compensably injured his low back and left hip. Following that injury, in approximately 1984, claimant's leg began giving way, causing him to fall on several occasions. Prior to 1984, claimant has had prior injuries caused by falling when his left knee gave way. In July 1988 and January 1989, two prior ALJ's found that there was no material relationship between the falls and claimant's low back injury. Rather, they concluded that the falls that caused a left hand injury, and caused claimant's glasses to break, were the result of claimant's noncompensable psychological condition.

Claimant contends that his left knee injury is a consequence of his 1981 compensable low back and left hip injury. In order to establish the compensability of his current condition, claimant must prove that his 1981 compensable injury is the major contributing cause of the left knee injury. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411, 414 (1992). Further, the injury must be established by medical evidence supported by objective findings. ORS 656.005(7)(a).

The ALJ, relying on Dr. Kitchel's opinion that claimant's low back pain caused the collapse of claimant's knee, and subsequent injury, concluded that claimant had established that his left knee injury is compensable. We disagree.

Claimant has treated with many physicians, but only Dr. Cox and Dr. Kitchel provide opinions concerning the causal relationship of claimant's current left knee condition to his compensable low back injury. However, in 1988, in addressing prior episodes of leg give-way, Dr. Rockey, orthopedic surgeon, stated that there was no objective evidence to explain why the leg gives out due to the back injury. (Ex. 17). Dr. Rockey opined that claimant's efforts to link all his injuries to his back are a reflection of claimant's psychological disorder. Id.

In September 1993, SAIF received billings for treatment by Dr. Cox for a left knee condition. Emergency room records obtained by SAIF indicated that claimant had injured his knee at work. (Ex. 45). In response to SAIF's inquiry, Dr. Cox corrected the history obtained by SAIF, stating that claimant had told Dr. Cox that his knee injury was related to a back strain while lifting bales of alfalfa at home. Thus, Dr. Cox opined that claimant's knee condition was not related to work activities, or to his 1981 injury.

In a November 1993 letter to claimant's attorney, Dr. Kitchel stated that it is not possible to say, with any degree of medical certainty, that claimant's leg-collapsing is caused from his back condition. (Ex. 39). Subsequently, Dr. Kitchel changed his opinion, without explanation, stating that "the injury to [claimant's] left knee is certainly contributed to his current symptoms in his lower back" [sic]. (Ex. 42).

Dr. Kitchel was deposed prior to hearing. (Ex. 46). He agreed with Dr. Rockey that there is no objective evidence to explain why claimant's left leg giving way is related to his back injury. (Ex. 46-10). Dr. Kitchel admitted that he related the knee give-way to the back injury because of claimant's history, rather than by medical findings, and that he had no way of verifying claimant's history. (Ex. 46-6). Furthermore, Dr. Kitchel admitted he had not reviewed claimant's psychiatric studies. Id.

When questioned about his prior statement that it is not possible to say, with any degree of medical certainty, that claimant's leg-collapsing is caused from claimant's back condition, Dr. Kitchel stated that his opinion had not changed. (Ex. 46-14). Finally, Dr. Kitchel opined that, if claimant's history is accurate, it is medically probable that back pain is what caused claimant's leg to give way. However, if the history is not accurate, Dr. Kitchel stated that he would have no basis upon which to say that it was the back that was causing the giving way. (Ex. 46-16).

Generally, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Here, we find persuasive reasons not to rely on Dr. Kitchel's opinion. To begin, Dr. Kitchel admits that there is no objective evidence to explain why claimant's left leg giving way is related to his compensable back injury. Further, Dr. Kitchel relied on an admittedly unverified history from claimant. Finally, Dr. Kitchel did not take into consideration the contribution of claimant's psychological condition, nor did he exam claimant's knee. Accordingly, we do not find Dr. Kitchel's opinion persuasive. Therefore, claimant has not met his burden of proving that his 1981 injury is the major contributing cause of his current left knee condition. ORS 656.005(7)(a)(A).

ORDER

The ALJ's order dated January 4, 1995 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
JACQUELINE J. LOYNES, Claimant
WCB Case No. 94-07361
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian, and Gunn.

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

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated November 28, 1994 is affirmed.

Board Member Gunn dissenting.

This case presents the perfect example of the dichotomy between the legislative policy statements in the Act that require "substantial justice" and a system that processes claims fairly and quickly and discourages litigation. The legal standards set by the courts would work well if every citizen were a lawyer and understood the legal significance of certain documents. These same citizens would also have to forego logical solutions over legal answers.

In the instant case, the claims examiner informed claimant of appeal rights and the right to an attorney. The claims examiner also explained that the claim had been denied because of a lack of medical evidence supporting compensability. Claimant made the fatal error of using the common sense approach that she would supply the employer, within the 60 day appeal period, with the necessary medical evidence regarding the relationship between her condition and her employment. The fatal mistake that claimant made was that she did not realize that she was in a legal process and that those processes often studiously avoid the application of common sense. Claimant supplied the employer with the necessary medical evidence within 60 days of the denial, but she failed to request a hearing, assuming that the employer would accept the claim based on the supplied information.

Given the medical evidence obtained by claimant, this claim probably would have been compensable (assuming a timely hearing request). What claimant lacked at the time she received her denial letter from the employer was a lawyer. A system that utilizes the legislative policies of substantial justice and a non-litigious system should not produce this result.

Given the circumstances, I would find that claimant's actions constituted excusable neglect and that she has established good cause for failing to file a timely hearing request. Because I disagree with the result in this case, I respectfully dissent.

In the Matter of the Compensation of
MICHAEL E. PELCIN, Claimant
WCB Case No. 94-07287
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Neal's order that: (1) concluded that the employer had not "de facto" denied claimant's degenerative right acromioclavicular (A/C) joint disease; (2) did not address the compensability of that condition; (3) declined to assess a penalty for the alleged unreasonable denial of that condition; and (4) reduced claimant's unscheduled permanent disability award from 14 percent (44.8 degrees), as granted by an Order on Reconsideration, to 4 percent (14.8 degrees). The insurer cross-requests review of the ALJ's attorney fee award under ORS 656.382(1). On review, the issues are "de facto" denial and, alternatively, compensability, penalties, unscheduled permanent disability, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

"De Facto" Denial/Compensability/Penalties

We adopt and affirm the ALJ's conclusions regarding these issues, with the following supplementation.

Claimant asserts that, under ORS 656.005(6) and Safeway Stores, Inc., v. Smith, 117 Or App 224 (1992), a "claim" for an injury or condition exists even if the notice of the alleged claim does not, at least, suggest that the injury or condition may be work-related. We have addressed, and rejected, similar arguments in the past, and do so again now. E.g., Hubert R. Graves, 46 Van Natta 1032, 1033 n 1 (1994) (carrier not obligated to accept or deny "claim" until it has information prompting reasonable belief of possible workers' compensation liability); Donna J. Halsey, 39 Van Natta 116, 118 (1987) (before a claim can exist, a worker must assert a right to compensation, or an existing and potentially work-related injury or disease must come to the carrier's attention); see ORS 656.005(6) (a claim is "a written request for compensation from a subject worker * * * or any compensable injury of which the subject employer has notice or knowledge." (emphasis added)).

For the reasons stated in the ALJ's order, we agree that the employer was not apprised of a possible work connection between claimant's right A/C degenerative joint disease until less than 90 days before the hearing. (See Ex. 52). Accordingly, we agree with the ALJ that, at the time of hearing, the employer had not "de facto" denied the degenerative condition. See former ORS 656.262(6) (since amended by Senate Bill 369 (SB 369), 68th Leg., Reg. Sess., § 28 (1995)) (carrier had 90 days to accept or deny claim after it has notice or knowledge of the claim).[1] Consequently, we do not address the compensability and penalty issues relating to the right A/C degenerative joint condition.

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[1] Amended ORS 656.262(6)(d) provides that, if an injured worker believes that a condition has been incorrectly omitted from a notice of acceptance, the worker must first communicate his or her objections to the carrier. The carrier then has 30 days to revise the acceptance or to make other written clarification in response. A worker who fails to comply with these requirements may not allege a "de facto" denial based on the carrier's acceptance. The worker may object to the notice of acceptance at any time. SB 369, § 28.

Because we conclude that no "de facto" denial occurred, we do not address what effect, if any, amended ORS 656.262(6)(d) may have on this case. See also SB 369, § 43 (for purposes of ORS 656.386(1), "denied claim" shall not be presumed or implied from carrier's failure to pay compensation for a previously accepted injury or condition in a timely fashion).

Unscheduled Permanent Disability

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

Claimant asserts that the ALJ erred in concluding that his adaptability factor should be given the value of zero. We disagree.

WCD Admin. Order 93-056 (November 29, 1993) applies to those claims in which a worker is medically stationary on or after July 1, 1990, and the claim is closed on or after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). Here, claimant became medically stationary on April 18, 1994, and her claim was closed on May 23, 1994. (Ex. 51A-1). Therefore, WCD Admin. Order 93-056 governs this claim.

Under these rules, "[t]he factor for adaptability, age and education will be given a neutral value of zero when the worker's wage earning capacity is not affected." OAR 436-35-280(1). A worker's wage earning capacity is not affected when the "worker's residual functional capacity as determined pursuant to OAR 436-35-310(5) is equal to or greater than the worker's base functional capacity as determined pursuant to OAR 436-35-310(4)." OAR 436-35-280(1)(a).

Here, claimant's base and residual functional capacities were for medium strength work. (Ex. 53-4). Consequently, the ALJ did not err in affirming the Order on Reconsideration giving claimant's adaptability factor a value of zero.

Claimant asserts that giving his adaptability factor a value of zero conflicts with England v. Thunderbird, 315 Or 633 (1993), which held that the Director's standards were invalid under former ORS 656.214(5) (since amended by SB 369, § 17 and Or Laws 1990, ch 2, § 7). We rejected a similar argument in Michelle Cadigan, 46 Van Natta 307 (1994). There, we addressed England's applicability under the 1990 version of ORS 656.214(5).[2] Relying on the deletion of language from ORS 656.214(5) in 1990,[3] and the language of ORS 656.726(3)(f)(A),[4] we found that permanent impairment only has to be "modified" by the factors of age, education and adaptability to perform a given job. 46 Van Natta 308.

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[2] The present and 1994 versions of ORS 656.214(5) are identical, with the exception that the present version does not include the sentence, "For the purposes of this subsection, the value of each degree of disability is $100." See SB 369, § 17.

[3] The 1990 version of ORS 656.214(5) provided:

> "In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) and (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f)." (Emphasis added).

Before 1990, ORS 656.214(5) provided that "[e]arning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job." That language was deleted by the 1990 amendments.

[4] ORS 656.726(3)(f)(A) provides that "[t]he criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job." Section 55 of SB 369 amended ORS 656.726(3)(f) by adding a new subsection (D), which provides:

> "Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if:
>
> "(i) The worker returns to regular work at the job held at the time of injury;
>
> "(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or
>
> "(iii) The attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury."

That amendment applied to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. See SB 369, §§ 66(4), 69. Because this claim became medically stationary in 1994, ORS 656.726(3)(f)(D) does not apply to this case.

Consequently, we concluded that, although the adaptability factor may have a value of zero under former OAR 436-35-310(2) (since amended by WCD Admin. Order 93-056), that is a "modification" contemplated by former ORS 656.726(3)(f)(A). Id. In light of the substantial change in the language of ORS 656.214(5), and the lack of contrary legislative history, we concluded that the applicable standards were within the Director's authority pursuant to former ORS 656.726. Id. at 309.

The standards we addressed in Cadigan are similar to those that apply here. Former OAR 436-35-310(2) provided that,

> "[f]or workers who at the time of determination have a physician's release to regular work, or have either returned to or have the RFC [residual functional capacity] for regular work or work requiring greater strength than work performed on the date of injury, the value for factor of adaptability is 0 [zero]."

Similarly, OAR 436-35-280 presently provides that the factor for age, education and adaptability is to be given a neutral value of zero when the worker's wage earning capacity is not affected. In turn, a worker's wage earning capacity is not affected when her residual functional capacity is equal to or greater than her base functional capacity. OAR 436-35-280(1)(a).

Because the standards we addressed in Cadigan are similar to those that apply here, we conclude that the latter standards are within the Director's authority under former ORS 656.726. Accordingly, we reject claimant's argument under England v. Thunderbird, supra.

Attorney Fees under ORS 656.382(1)

The insurer asserts that the ALJ erred in awarding claimant's counsel a $500 attorney fee under ORS 656.382(1),[5] which authorizes an attorney fee if a carrier unreasonably resists the payment of compensation. We agree.

The ALJ's attorney fee award is based on SAIF's failure to forward a written notice of claim acceptance to claimant, even though it had accepted, and paid benefits under, the claim. Even if that conduct was unreasonable, the record does not establish that any compensation was unpaid at the time of SAIF's conduct.[6] Because SAIF cannot unreasonably resist the payment of compensation that has been paid, SAIF v. Condon, 119 Or App 194, rev den 317 Or 162 (1993), no basis exists for an attorney fee award under ORS 656.382(1). See Bruce Hardee, 46 Van Natta 2261 (1994) (in absence of any evidence of unpaid compensation at the time of carrier's allegedly unreasonable conduct, no fee warranted under ORS 656.382(1)). Therefore, we reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated September 22, 1994 is affirmed in part and reversed in part. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

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[5] Section 42b of SB 369 amended ORS 656.382(1) to refer to ALJ's (not referees) and to exclude from the statute's coverage attorney fees pursuant to ORS 656.245, 656.260, 656.327 and 656.340. Those amendments are not germane to the issues in this case.

[6] The ALJ found that "all compensation in regard to the [accepted shoulder condition] ha[ve] been paid." (Opinion and Order at 3). No one contests that finding.

In the Matter of the Compensation of
TREVOR E. SHAW, Claimant
WCB Case No. 94-10424
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order which: (1) denied his motion to reopen the record for the admission of further evidence; (2) modified claimant's temporary disability award as awarded by Order on Reconsideration; and (3) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable termination of temporary disability. On review, the issues are remand, temporary disability and penalties. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant requests remand for admission of a partial transcript of his testimony at a workers' compensation hearing held on October 19, 1993 and admission of an affidavit retracting statements at hearing that were inconsistent with his testimony at the prior hearing. We decline the request.

We may remand a case to the ALJ for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). 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 record does not support a conclusion that the proffered evidence was not available or unobtainable prior to the present hearing. Accordingly, we conclude that remand is not appropriate. Moreover, since the ALJ relied on the medical evidence in determining claimant's entitlement to temporary disability, it is reasonable to assume that claimant's prior testimony would have no effect on the ALJ's decision. Accordingly, we do not find that remand is reasonably likely to affect the outcome of this case.

Because claimant has not established that the additional testimony was unobtainable with due diligence at the hearing, and because such evidence is not reasonably likely to affect the outcome of the case, we deny claimant's motion to remand.

Entitlement to Temporary Disability

The ALJ determined that the insurer could challenge the January 7, 1994 medically stationary date listed in its Notice of Closure. The ALJ then found that claimant's condition was medically stationary on June 7, 1993 and, accordingly, awarded temporary disability to that date. We agree with the ALJ's ultimate conclusion, but for the following reasons.

Claimant contends that the insurer could not request reconsideration of its own Notice of Closure and because the Order on Reconsideration affirmed the medically stationary date provided in the Notice of Closure, the insurer could not challenge the medically stationary date following the Order on Reconsideration. We agree.

Subsequent to the ALJ's order, in Duncan v. Liberty Northwest Ins. Corp., 133 Or App 605 (1995), the court held that former ORS 656.268(5)(b) limits a party's ability to raise issues at hearing when that party failed to request reconsideration of a determination order. The court stated:

> "A party may seek review of the order on reconsideration, but when a party objects at a hearing to a part of the reconsideration order that merely affirms the determination order, the party's true objections are to the determination order and ORS 656.268(5) forecloses the objection if no request for reconsideration was made. Thus, the determination order becomes the instrument that defines the maximum or minimum award when a party fails to raise its objections through a request for reconsideration. However, if the reconsideration order changes the determination order, the propriety of that change can be raised by either party at hearing." Id. at 610-611.[1]

Here, the insurer issued a Notice of Closure on January 17, 1994, which awarded temporary disability benefits from May 3, 1993 through June 6, 1993 and which listed claimant's medically stationary date as January 7, 1994. (Ex. 29). Claimant timely requested reconsideration objecting to, inter alia, the medically stationary and temporary disability dates. (Ex. 30). An Order on Reconsideration issued on August 26, 1994, which affirmed the medically stationary date and awarded additional temporary disability (from June 4, 1993 through June 20, 1993). Both parties requested a hearing challenging the Order on Reconsideration. In particular, the insurer challenged the temporary disability award. Claimant did not challenge the January 7, 1994 medically stationary date.

Because the insurer failed to request reconsideration, it cannot now challenge claimant's medically stationary date.[2] However, the issue of claimant's entitlement to the additional temporary disability awarded by the Order on Reconsideration could be raised by the insurer at the time of hearing. Duncan, supra. Thus, the question is whether claimant is entitled to temporary disability beyond June 6, 1993. We conclude that the answer is no.

Inasmuch as the claim has closed, claimant's substantive entitlement to temporary disability is at issue. Therefore, claimant must show that he was disabled during the pendency of the claim in order to be entitled to temporary disability. See SAIF v. Taylor, 126 Or App 658 (1994). In other words, merely showing that he was medically stationary on January 7, 1994 is not sufficient to establish an entitlement to temporary disability through that date. Claimant also must show that he was disabled due to his compensable low back condition through that date. Id.

Claimant treated with Dr. Sedgewick from May 4, 1993 until May 20, 1993. On May 20, 1993, Dr. Sedgewick recommended continued light duty work, with a follow-up in two weeks for return to regular work. (Exs. 6, 13). Claimant failed to keep his appointment.

On June 3, 1993, claimant sought treatment from Dr. Barnhouse. Dr. Barnhouse authorized time loss for June 4, 1993 in order for claimant to attend a scheduled insurer-arranged medical examination (IME). He released claimant to regular work on June 7, 1993. Dr. Barnhouse also scheduled a closing examination on June 18 following completion of claimant's physical therapy. (Ex. 10). Claimant failed to appear for the IME and for his follow-up appointment with Dr. Barnhouse. (Exs. 15, 23).

Dr. Sedgewick concurred with Dr. Barnhouse's release for regular work. Dr. Sedgewick further reported that the type of injury claimant sustained usually healed without event. (Ex. 18).

On November 1, 1993, the insurer wrote claimant advising him that his claim would be closed if he failed to seek further medical treatment. (Ex. 20). When the insurer failed to receive an appropriate response to its notice, it closed the claim, pursuant to OAR 436-30-035(7), on January 17, 1994 with a January 7, 1994 medically stationary date.

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[1] ORS 656.268 was amended to add Section 8 which provides that "[n]o hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing." SB 369, 68th Leg., Reg. Sess., §30 (June 7, 1995). Since claimant raised all issues in his request for reconsideration, including objecting to the medically stationary date and the temporary disability award, and since the insurer requested a hearing challenging claimant's temporary disability award, that section does not change our result.

[2] We need not decide whether, under ORS 656.268(4)(e), the insurer could request reconsideration of its own Notice of Closure.

On this record, we find no persuasive evidence that claimant was disabled due to his compensable injury from June 7, 1993 through January 7, 1994. Therefore, we conclude that he is not entitled to temporary disability benefits for this period. See SAIF v. Taylor, supra. Consequently, we affirm the ALJ's order that modified the Order on Reconsideration's temporary disability award.

Penalty

Claimant contends that the insurer unreasonably terminated temporary disability on June 6, 1993 in light of the prior ALJ's order which awarded temporary disability through June 20, 1993. We disagree.

On November 4, 1993, ALJ Menashe awarded temporary disability from June 5, 1993 through June 20, 1993. ALJ Menashe reasoned that, under ORS 656.268(3)(c), the insurer could lawfully terminate temporary disability benefits on the latter date. The insurer appealed that prior order. In the interim, the insurer closed the claim by Notice of Closure dated January 17, 1994.

On September 8, 1994, (on review of ALJ Menashe's 1993 order), we found that the insurer had improperly terminated temporary disability benefits after June 4, 1993 and ordered the insurer to pay such benefits from June 5, 1993. However, rather than finding that temporary disability benefits ended as of June 20, 1993 (as found by ALJ Menashe), we concluded that such benefits should continue until properly terminated by law. Trevor E. Shaw, 46 Van Natta 1821 (1994). The insurer appealed our order, but subsequently withdrew its petition for judicial review.

Because ALJ Menashe's November 1993 order awarded temporary disability for periods prior to the date of his order, (i.e., no prospective temporary disability), those "pre-litigation order" benefits were lawfully stayed pending the insurer's appeal. ORS 656.313(1); Eulalio M. Garcia, 47 Van Natta 991 (1995). In addition, since the January 1994 Notice of Closure issued prior to our September 1994 decision, our order, in effect, also did not award "post-litigation order" temporary disability.[3] Thus, no prospective temporary disability accrued for which the insurer was statutorily obligated, under ORS 656.313(1), to pay pending appeal.

Accordingly, since claimant has failed to prove his entitlement to temporary disability due to his compensable condition after June 7, 1993, no compensation exists for the insurer to have unreasonably resisted payment. In addition, we have found that the insurer was entitled to stay the temporary disability benefits awarded by ALJ Menashe. Therefore, neither a penalty nor attorney fees are warranted.

ORDER

The ALJ's order dated December 15, 1994 is modified in part and affirmed in part. The Order on Reconsideration is affirmed insofar as it found claimant's condition medically stationary as of January 7, 1994. The remainder of the order is affirmed.

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[3] We further note that our prior order does not entitle claimant to temporary disability beyond June 6, 1993. Our order directed the insurer to pay temporary disability from June 5, 1993 until such benefits could be properly terminated. Claimant had been released to return to regular work on June 7, 1993, thereby terminating the insurer's obligation to provide further temporary disability benefits. See ORS 656.268(3)(a). In addition, the record contains no verification from the attending physician of an inability to work after June 7, 1993, which would trigger an obligation to pay procedural temporary disability. See SAIF v. Taylor, supra. Thus, procedurally, as well as substantively, claimant's entitlement to temporary disability ended on June 6, 1993.

In the Matter of the Compensation of
MARY J. McKENZIE, Claimant
WCB Case Nos. 93-11096 & 93-10078
ORDER OF ABATEMENT
Gary L. Tyler, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our June 22, 1995 Order on Review. Specifically, the employer requests reconsideration of that portion of our order that found the claim had been prematurely closed.

In order to consider this matter, we withdraw our June 22, 1995 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 shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS R. YON, JR., Claimant
WCB Case Nos. 94-07517 & 94-07397
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant has requested reconsideration of our June 22, 1995 Order on Review. Specifically, claimant contends that we erred in failing to award his counsel an assessed attorney fee pursuant to ORS 656.382(2).

In order to consider this matter, we withdraw our June 22, 1995 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
WALTER L. KEENEY, Claimant
WCB Case No. 94-09191
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Alan Ludwick (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) held that the Hearing Division retained jurisdiction to consider claimant's request for reimbursement for the purchase of custom-made boots; (2) set aside SAIF's "de facto" denial of claimant's "boot" claim; (3) assessed a penalty for allegedly unreasonable claim processing; and (4) awarded a $2,250 carrier-paid a attorney fee under ORS 656.386(1). On review, the issues are jurisdiction, medical services, penalties, and attorney fees. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and briefly summarize the pertinent facts as follows.

Claimant, a 63-year-old former construction worker, sustained a compensable injury to his right foot in 1978, for which he had several corrective surgeries. His initial treating physician, Dr. Woolpert, prescribed modified footwear to enable claimant to walk. Subsequent treating physicians continued the prescription for modified footwear. Over the years, claimant tried various types of footwear and eventually found that a particular brand ("Justin") of western-style boots were most effective, comfortable, and durable. Beginning in 1983, Dr. Woolpert prescribed modified western-style or cowboy boots. (Ex. 3). SAIF consistently paid for the prescribed boots as a compensable medical service.

In April 1994, claimant's current treating physician, Dr. Hayes, prescribed a new pair of custom "Justin" boot, which claimant purchased. (Exs. 37, 38). He then sought reimbursement from SAIF. Instead of reimbursing claimant, the claims examiner sought information from Dr. Hayes. Based on Dr. Hayes response, SAIF declined to pay for claimant's new boots, contending that they are not a reasonable and necessary medical expense. (Ex. 43). However, SAIF does not contest payment for the prescribed modifications to the boots.

The ALJ found that the Hearings Division had jurisdiction over this matter involving the reasonableness and necessity for custom boots. The ALJ further found that these particular cowboy boots are a "prosthetic device" included within the statutory definition of "compensable medical services" under ORS 656.245(1)(c). The ALJ concluded that the preponderance of evidence established that the boots are a reasonable and necessary medical service and, therefore, compensable. We conclude that the Hearings Division does not have jurisdiction over this dispute and vacate the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Former ORS 656.327(1)(a) provided for Director review of medical treatment that is "excessive, inappropriate, ineffectual, or in violation of rules regarding the performance of medical services," if a party or the Director had initiated Director review. However, if there was no "wish" for Director review, jurisdiction remained with the Board. Meyers v. Darigold, Inc., 123 Or App 217, 221-22 (1993).

Similarly under former ORS 656.245(1), we had identified three categories of medical services: curative medical care, compensable palliative care, and palliative care that is not compensable without Director approval. Compensable palliative care was that care identified in former ORS 656.245(1)(b) as compensable without Director approval: (1) when provided to a worker with permanent total disability; (2) when necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition; and (3) to monitor the status of a prosthetic device. Martha V. Slater, 46 Van Natta 1706, 1708 (1994). In Slater, we held that compensable palliative care was not limited to the medical treatment necessary to monitor, prescription medications, but that the category also included the prescription medications themselves necessary to maintain a worker in a medically stationary condition. We reached this conclusion to avoid the absurd result that medical treatment to monitor medications could be automatically compensable, while the medications themselves would not

be compensable. We would apply the same rationale with respect to prosthetic devices. Former ORS 656.245(1)(b) provided that palliative care to "monitor the status of a prosthetic device" was compensable. Applying the rationale in Slater, we would conclude that the prosthetic device itself constitutes compensable palliative treatment.

Here, no one initiated Director review. Instead, claimant filed a request for hearing before the Board's Hearing Division.

The 1995 legislature amended ORS 656.327(1) in Senate Bill 369, section 41, effective June 7, 1995. Amended ORS 656.327(1)(a) now provides:

> "If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties." (emphasis supplied).

The legislature also added ORS 656.245(6), which provides:

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

The question on review is whether the legislature intended the amended provisions to apply to medical service disputes currently pending before the Board. Generally, retroactive application of new laws is disfavored and, in the absence of an indication to the contrary, legislative enactments are not retroactively applied if such application would "impair existing rights, create new obligations or impose additional duties with respect to past transactions." Barrett v. Union Oil Distributors, 60 Or App 483 (1982).

The most important consideration in determining proper application of an enactment, however, is the legislature's intended application. Within constitutional limits, the legislature may impose any special conditions it desires on its enactments. Whipple v. Howser, 291 Or 475 (1981). Furthermore, in determining whether to give retroactive effect to a legislative enactment, it is not our function to make our own policy judgments, but instead to attempt to discern and declare the intent of the legislature. See ORS 173.020; Whipple v. Howser, supra; Lane County v. Heintz Const. Co. et al, 228 Or 152 (1960).

To resolve this question, we must ascertain what the legislature intended when it enacted section 66(1) of Senate Bill 369. ORS 174.020. We begin with the text and context of the statute. ORS 174.020; Porter v. Hill, 314 Or 86, 91 (1992). If those sources do not reveal the legislature's intent, we resort to legislative history and other extrinsic aids. See PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993).

Section 66 of Senate Bill 369 sets forth in subsection 1 the general principle regarding applicability of the amendments:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

Subsections (2) through (13) list specific exceptions to subsection (1), none of which specifically addresses the applicability of ORS 656.245(6) or 656.327.

We conclude that the plain language of the statute is clear and provides, without ambiguity, that the amendments to ORS 656.327, as well as the new provision, ORS 656.245(6), apply to claims currently pending before the Board.

Our next task is to determine what the legislature intended by amending ORS 656.327(1) and adding ORS 656.245(6). Again, we begin with the text and context of those provisions, and resort to extrinsic aids only if those sources are unavailing. ORS 174.020; PGE v. Bureau of Labor and Industries, supra, 317 Or at 611-12; Porter v. Hill, supra, 314 Or at 91.

Amended ORS 656.327(1) provides that if an injured worker, a carrier, or the Director believes that an injured worker's medical services, not subject to ORS 656.260[1], are excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties (Emphasis added). Amended ORS 656.245(6) provides that, if a medical services claim is disapproved for any reason other than the formal denial of compensability of the underlying claim and the disapproval is disputed, the injured worker or carrier "shall request administrative review by the director pursuant to this section, ORS 656.269 or 656.327." (Emphasis added). The mandatory language of those statutes clearly reveals the legislature's intent that ORS 656.327(1) medical services disputes be resolved exclusively by the Director, not the Board or Hearings Division..

This conclusion is supported by amended ORS 656.704(3), which provides that "matters concerning a claim," over which the Board has jurisdiction, do not included matters governed by ORS 656.327. SB 369, Sec. 50. It also finds support in amended ORS 656.283(1), which provides that, "[s]ubject to ORS 656.319[2], any party or the Director may at any time request a hearing on any matter concerning a claim, except for matters for which a procedure for resolving the dispute is provided in another statute, including ORS 656.246, 656.248, 656.260, 656.327 and subsection (2) of this section. SB 369, Sec. 34 (emphasis added). Accordingly, based on the text and context of amended ORS 327(1), as read in conjunction with SB 369's retroactivity provisions, we conclude that the Director now has exclusive jurisdiction over ORS 656.327(1) medical services disputes, including those presently pending before the Board.

Arguably, our inquiry should end here. However, while it is fundamental that the clear unambiguous language of a statute controls, the courts will not apply a statutory provision if an application of the literal meaning would produce an unintended , absurd result or if the literal import of the words is so at variance with the apparent policy of the legislation as a whole as to bring about an unreasonable result. Satterfield v. Satterfield, 292 Or 780 (1982) citing Brown v. Portland School Dist. # 1, 291 Or 77, 83 (1981) and Johnson v. Star Machinery Co., 270 Or 694 (1974); Ida M. Walker, 43 Van Natta 1402 (1991) (interpreting the applicability of the 1990 amendments to worker' compensation law).

Here, the result of a literal reading of the statute is that medical services disputes, such as the one presented in the instant case, will be decided by the Director rather than the Hearings Division and the Board. We do not consider this to be an absurd or unintended result. In fact, the clear language in amended ORS 656.327 and ORS 656.245(6) indicates that this result is exactly how the legislature intended for these type of cases to be resolved. Consequently, we find no basis for departing from a literal reading of Section 66 and conclude that inasmuch neither the Hearings Division nor the Board has jurisdiction over this matter, claimant's request for hearing must be dismissed.

In reaching this conclusion, we are aware that the Director has promulgated rules for the processing of medical disputes. OAR 436-10-046. Under the rules in effect at the time this dispute arose in May 1994, the Director's rules provided that the insurer shall notify the medical provider and all parties of its intent to request Director review within 180 days of its receipt of the first billing for the treatment in question. Former OAR 436-10-046(2) (WCD Admin. Order 13-1992, effective July 1, 1992). The Director's current rules contain the same 180 day time limitation. OAR 436-10-046(5) (WCD Admin. Order 94-064, effective February 1, 1995). Thus, under the present version of the Director's medical services rules, any request for review may well be rejected as untimely. Nevertheless, since the

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[1] ORS 656.260 concerns managed care organizations, which are not at issue here.

[2] ORS 656.319 pertains to timeliness of hearing requests.

legislature has explicitly authorized the Director to address such disputes, the question of whether the Director will dismiss any such request for review rests with him, not with this forum In conclusion, we share the parties' expected frustrations on being required to "change" forums after litigation has already occurred. However, it is not within our purview to ignore a clear legislative mandate, despite a harsh result. See Southwood Homeowners v. City Council of Philomath, 106 Or App 21, 24 (1991).

Finally, because the remaining issues are contingent upon the resolution of the medical services issue, we likewise are without authority to address the accompanying penalty and attorney fee issues. See SB 369, 68th Leg., Reg. Sess., Sec. 42(d)(5) (June 7, 1995).

ORDER

The ALJ's order dated November 28, 1994 is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

Board Member Gunn concurring in part and dissenting in part.

I concur with the majority's conclusion that the clear and unambiguous language of Senate Bill 369 mandates both retroactive application of the law and the transfer of jurisdiction over medical service disputes, such as this one, to the Director.

I write separately to express my view that applying the amendments retroactively in this case will deprive the parties of a remedy and is a fundamentally unfair outcome. I also write separately to call attention to the policy implications of creating a separate and duplicative hearing structure under the Director's purview. Because I believe the parties should have the opportunity to address the retroactivity clause and whether application of the amendments in this case can withstand constitutional scrutiny, I respectfully dissent.

The majority dismisses claimant's request for hearing on the basis that the Hearings Division lacks jurisdiction over this medical services dispute. As the majority explains in its order, the parties' sole recourse is to request review by the Director. In my opinion, the majority summarily applies the amendments in Senate Bill 369 without adequate discussion of the practical implications of dismissing claimant's request for hearing.

While Senate Bill 369 apparently transfers jurisdiction over medical disputes to the Director, its retroactivity provisions appear to have the effect of depriving certain workers and employers of any forum for resolving their disputes. In other words, certain parties are left without a remedy.

I reach this conclusion based on my interpretation of the effect of subsection (6) of Section 66 of Senate Bill 369, which provides:

> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not extend or shorten the procedural time limitations with regard to any action on a claim taken prior to the effective date of this Act." SB 369, 68th Leg., Reg. Sess., § 66(6) (June 7, 1995).

Here, the combined effect of retroactively depriving the Board of jurisdiction over this dispute and prohibiting the modification of procedural time limitations with respect to any action taken on a claim prior to the effective date of the Act is to deprive these parties of any forum for the resolution of their medical service dispute.

At the time this dispute arose in May 1994, claimant sought resolution by requesting a hearing before the Board's Hearings Division. At that time, claimant's action was reasonable and consistent with the law, since Director review of medical disputes was not mandatory. Former ORS 656.327(1); Meyers v. Darigold, Inc., 123 Or App 217 (1993), rev den 320 Or 453 (1994). Thus, relying on the law in effect at the time of their actions, the parties brought their medical service dispute before the Board's Hearings Division in 1994.

Today, however, I believe, consistent with the majority's reasoning, that jurisdiction over medical service disputes lies with the Director. Therefore, the parties should now pursue Director review under ORS 656.327(1) in order to resolve their dispute. However, under the Director's current rules, the time for either party to request Director review has long since expired. OAR 436-10-046(5) (insurer has 180 days from receipt of first billing for treatment to initiate Director review); OAR 436-10-046(4) (worker has 180 days from date of treatment to request Director review) (WCD Admin. Order 94-064, effective February 1, 1995).

While the Director may, in theory, alter its time limitations, it appears that subsection (6) of Section 66 of Senate Bill 369 may prohibit such action by the Director. If Senate Bill 369 prohibits the Director from modifying any procedural time limitations, it appears that any request for Director review by either party will be rejected as untimely. Thus, the parties would be foreclosed from obtaining Director review. If the Board lacks jurisdiction, and the Director cannot assume jurisdiction, then these parties will be left without a remedy, having no forum for resolving their dispute.

This case starkly illustrates the fundamental unfairness of retroactively altering the rights and obligations of those who acted properly in reliance on the law in effect at the time of their actions. I believe this result implicates constitutional issues which warrant supplemental briefing from the parties.

For example, the Oregon Supreme Court has held that Article I, section 10 of the Oregon Constitution, which provides in part that "every man shall have remedy by due course of law for injury done him in his person, property, or reputation," is violated when an injured party is left entirely without a remedy. Neher v. Chartier, 319 Or 417, 424 (1994), citing Hale v. Port of Portland, 308 Or 508, 523 (1989). The remedy does not have to be of the same type or extent; it is enough that the remedy is a substantial one. Id. Here, however, if neither the Board nor the Director can assume jurisdiction over this dispute, the parties will be left entirely without a remedy.[1] See also Carr v. SAIF, 65 Or App 110 (1983), rev dismissed 297 Or 83 (1984) (a claimant cannot be deprived of a constitutionally significant interest without due process; minimal due process requirements are notice, a meaningful opportunity to be heard and an impartial decision maker).

While retroactive legislation may not be per se objectionable, nevertheless, there may be circumstances under which retroactive application of the law may be unconstitutional. For example, I believe the question bears exploring whether there is a rational basis for the legislature's decision to retroactively apply the amendments in Senate Bill 369 in this case, or whether the legislature acted in an arbitrary and irrational way. Cf. e.g., General Motors Corp. v. Romein, 112 S Ct 1105 (1992) (retroactive legislation that furthered a legitimate legislative purpose by rational means did not violate due process). In other words, is there a legitimate legislative purpose, furthered by rational means, that justifies the retroactive application of the amendments resulting in certain parties being deprived of any forum for resolving their disputes?

In short, I believe the parties deserve the opportunity to address whether retroactive application of the amendments in this case violates either party's substantive or procedural due process rights, rights under Article I, section 10 of the Oregon Constitution, the equal privileges clause of Article I, section 20 of the Oregon Constitution, the Equal Protection Clause of the Fourteenth Amendment, or any other rights under the federal or Oregon Constitution.

In my view, applying the retroactivity clause to this case does not serve a legitimate legislative purpose. In fact, it is contrary to the objectives of the Workers' Compensation Law.

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[1] In Hale, supra, 308 Or at 521, the Oregon Supreme Court quoted with approval from Noonan v. City of Portland, 161 Or 213, 250 (1939), that, consistent with Article I, section 10, Oregon Constitution, "'The legislature cannot, however, abolish a remedy and at the same time recognize the existence of a right[.]'" Here, I believe the legislature recognized a worker's continuing right to certain medical services, including prosthetic devices, in amended ORS 656.245(1)(c). SB 369, 68th Leg., Reg. Sess., § 25(1)(c) (June 7, 1995). If the legislature at the same time deprives these parties of a forum for resolving their dispute concerning the compensability of what is arguably a "prosthetic device," then I believe the effect of the retroactivity provision of Senate Bill 369 in this case is to abolish a remedy while at the same time recognizing the existence of a right.

Under ORS 656.012(2)(a), a primary objective of the Workers' Compensation Law is "[t]o provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents." Another objective is "[t]o provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable." ORS 656.012(2)(b). A third objective is "[t]o restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable." ORS 656.012(2)(c).

Application of the statutory amendments to this pending case is inconsistent with the purposes and policies of the workers' compensation law. By dismissing claimant's request for hearing, we are precluding claimant from obtaining "complete medical treatment" pursuant to ORS 656.012(2)(a). Because it appears that the time limits for requesting Director review have expired, the parties will be unable to pursue resolution of their medical services dispute. That is hardly a "fair and just administrative system" for delivery of medical benefits.

Moreover, Senate Bill 369 does not reduce litigation "to the greatest extent practicable." To the contrary, I submit that the amendments to medical services disputes unnecessarily complicate the process and create more litigation. Senate Bill 369 essentially creates two hearings divisions. The function previously provided by the Board's Hearings Division will now be duplicated by the Director. In some situations, both the Hearings Division and the Director will have jurisdiction over different aspects of the same case. That procedure does not provide "sure, prompt and complete medical treatment for injured workers" under ORS 656.012(2)(a). In my view, creation of another forum will actually delay the provision of medical services.

In light of the significant interests at stake in applying the retroactivity clause in this case, I believe we should request supplemental briefing and allow the parties to address the constitutionality of the amendments before we apply them. For the foregoing reasons, I respectfully dissent.

Member Hall concurring in part and dissenting in part.

It is apparent the legislature intended to have those provisions of Senate Bill 369 at issue in this case applied retroactively. It is equally apparent the legislature intended to vest the Director with jurisdiction over medical disputes. To that extent, I concur with the majority. Even when such legislative intent is clear, however, there are occasions (as discussed below) when we must take our analysis a step further. For the following reasons, one procedural and one substantive, I respectfully dissent.

Procedurally, we should not be issuing our decision in this case without the benefit of supplemental briefs and arguments from the parties. This case was litigated, appealed, and briefed before the Board under pre-SB 369 law. The issues surrounding jurisdiction and the consequences of dismissal are of such significance that the parties, the forum, and the public would be better served if we considered points and authorities from the parties before rendering our decision.[1]

As the majority acknowledges:

> "[T]he courts will not apply a statutory provision if an application of the literal meaning would produce an unintended , absurd result or if the literal import of the words is so at variance with the apparent policy of the legislation as a whole as to bring about an unreasonable result. Satterfield v. Satterfield, 292 Or 780 (1982) citing Brown v. Portland School Dist. # 1, 291 Or 77, 83 (1981) and Johnson v. Star Machinery Co., 270 Or 694 (1974); Ida M. Walker, 43 Van Natta 1402 (1991) (interpreting the applicability of the 1990 amendments to worker' compensation law)." (Majority opinion at 1389).

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[1] Member Hall joins Member Gunn in his concerns with constitutional implications which warrant further briefing and analysis.

Unlike the majority, I believe retroactive application of the present amendments would produce an unintended, absurd, and unjust result. I so conclude, because such application, with the resultant dismissal, will leave the parties (both the employer/carrier and claimant) without a forum for resolution of their dispute and this matter will fall through the proverbial cracks. While the legislature intended for medical disputes to be resolved by the Director, we have no basis to conclude that the legislature intended for a claim to be thrown from the system with no forum having jurisdiction to resolve the dispute. As the administrative law currently stands (including the Director's regulatorily prescribed time limits), such will be the unintended, absurd, and unjust result of the majority's decision herein.

The majority also acknowledges:

> "[W]e are aware that the Director has promulgated rules for the processing of medical disputes. OAR 436-10-046. Under the rules in effect at the time this dispute arose in May 1994, the Director's rules provided that the insurer shall notify the medical provider and all parties of its intent to request Director review within 180 days of its receipt of the first billing for the treatment in question. Former OAR 436-10-046(2) (WCD Admin. Order 13-1992, effective July 1, 1992). The Director's current rules contain the same 180 day time limitation. OAR 436-10-046(5) (WCD Admin. Order 94-064, effective February 1, 1995). Thus, under the present version of the Director's medical services rules, any request for review may well be rejected as untimely." (Majority opinion at 1389)."

Consequently, under current law (including the Director's regulations), requests for Director review will be untimely. The majority errs in (at least implicitly) banking on the Director to cure the problem. We should not decide cases based upon speculative future acts. Rather, our analysis must be based on the current state of the law. The majority would have to agree that without the Director changing the current filing time limits, the parties will be without a forum for resolving their dispute.

If we dismiss the case for lack of jurisdiction now, SAIF would be without a remedy, since it is long past the time within which it could request Director review. Likewise, claimant would be without a remedy since it is long past the time within which claimant could request Director review. Former OAR 436-10-046(4) (worker had 90 days from receipt of treatment to request Director review); OAR 436-10-046(4) (worker has 180 days from date of treatment to request Director review). Under such circumstances, retroactive application of Senate Bill 369, which would deprive the Board of jurisdiction over this medical dispute, would produce an unintended, absurd, and unreasonable result in its prejudice to the parties.

Accordingly, I conclude that, notwithstanding Section 66, the legislature, in mandating retroactive application of Senate Bill 369, did not intend to deprive the parties of a forum for resolving their medical dispute. Therefore, I would interpret Section 66 in such a way as to permit the Board to retain jurisdiction over those medical disputes where the time for requesting Director review has expired. Inasmuch as this interpretation avoids an unintended, absurd, and unreasonable result and permits a reasonable and workable law that is not inconsistent with the general policy of the legislature, it becomes our duty to adopt it. See Pacific Power & Light v. Tax Commission, 249 Or 103, 110 (1968).

In the Matter of the Compensation of
RICARDO MORALES, Claimant
WCB Case No. 94-09021
ORDER ON REVIEW
Willner & Heiling, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order which declined to award temporary disability benefits after July 25, 1994. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's employment was terminated for reasons unrelated to his compensable left arm injury. Therefore, relying on Dawes v. Summer, 118 Or App 15 (1993), the ALJ held that claimant was not entitled to temporary disability benefits after the termination. We disagree.

On May 29, 1994, claimant sustained a compensable left wrist injury, which the insurer accepted as a fracture. (Exs. 4, 5). He returned to modified work, light duty with no use of his left hand, on July 18, 1994. (Exs. 8A, 9, 12). On July 26, 1994, claimant was disciplined for a horseplay incident that occurred on July 23, 1994, involving a sharp, box-cutting instrument. Also on July 26, 1994, claimant tendered his resignation. (Exs. 14A, 14C). At that time, claimant was still released to modified work, with limited use of his left hand, and he was not medically stationary. (Exs. 14, 16).

The parties dispute whether claimant was terminated by the employer, or whether he voluntarily resigned. It is not necessary to resolve that dispute in order to determine whether claimant is entitled to temporary disability benefits after he left his employment. The ALJ found, and we agree, that claimant left his employment as a result of the horseplay incident. In other words, we find that claimant left his employment for reasons unrelated to his compensable injury.

First, we note that claimant was not medically stationary at the time of termination, and his claim was still open. Consequently, this claim concerns entitlement to procedural, rather than substantive, temporary disability. Thus, Dawes v. Summer, supra, does not govern this case, since Dawes concerned entitlement to substantive temporary disability benefits. See David P. Becknell, 47 Van Natta 610, 611 n.2 (1995).

Generally, a claimant is entitled to temporary disability compensation if he or she has sustained wage loss as a result of his compensable injury. See RSG Forest Products v. Jensen, 127 Or App 247, 250-51 (1994) (worker is entitled to interim compensation if he has suffered loss of earnings as a result of a work injury).

Here, claimant was released only to modified work at the time he left employment. He was unable to return to his regular work duties. Because his disability was partial, he was entitled, at least theoretically, to temporary partial disability benefits (TPD). ORS 656.212. Accordingly, we reverse the ALJ's decision and direct the insurer to calculate claimant's TPD under the statute.[1]

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[1] Subsequent to the ALJ's decision in this matter, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.212, which now provides that TPD is to be calculated based on the loss reflected in a comparison of claimant's wages at modified employment with his at-injury wages. SB 369, 68th Leg., Reg. Sess., § 16 (June 7, 1995). Assuming that amended ORS 656.212 applies to the present case, the calculation of claimant's TPD rate may result in zero. However, since claimant's entitlement to TPD is the issue before the Board (as opposed to rate), the ALJ's decision should be reversed. See David P. Becknell, supra; Joseph M. Lewis, 47 Van Natta 381, on recon 47 Van Natta 616 (1995). The eventual calculation of claimant's TPD is a claim processing matter, the responsibility for which rests with the insurer.

ORDER

The ALJ's order dated November 15, 1994 is reversed. The insurer is directed to calculate claimant's TPD as previously set forth in this order and to pay claimant TPD at the calculated amount beginning July 26, 1994 and continuing until such benefits may be terminated pursuant to law. Claimant's counsel is awarded 25 percent of the increased temporary disability compensation created by this order, if any, not to exceed $3,800, payable directly to claimant's attorney.

July 24, 1995 Cite as 47 Van Natta 1395 (1995)

In the Matter of the Compensation of
CANDACE A. NESBERG, Claimant
WCB Case No. 94-01886
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Brown's order that affirmed an Order on Reconsideration that awarded 16 percent (51.2 degrees) unscheduled permanent disability for an upper back and neck injury. On review, the issue is unscheduled permanent disability.

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

Claimant worked alone in a small golf course cafe. Her job duties included characteristics of a waitress, bar waitress, cook, short order cook, and bartender. (Ex. 60-4). All of these jobs are listed as requiring light physical demands.

Finding that claimant had been released to regular work, the ALJ concluded that claimant's "adaptability" value was zero. See Michelle Cadigan, 46 Van Natta 307 (1994). However, because the insurer did not seek reduction of the 16 percent unscheduled permanent disability award, the ALJ affirmed the Order on Reconsideration.

Claimant argues that she restocked bottled beer and wine, which is an activity of a bartender helper, according to DOT 312.687-010. Since a bartender helper is a "medium" strength job, claimant reasons that she was not released to her regular work. As such, claimant asserts she would then be entitled to a redetermination of her adaptability factor. We disagree.

Claimant became medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268. Since the Determination Order issued prior to the adoption of WCD admin. Order 93-052 (Temp), the applicable rule is WCD 5-1992. See Cornell D. Garrett, 46 Van Natta 340 (1994), aff'd mem Garrett v. Still Water Corporation, 130 Or App 679 (1994).

Therefore, the applicable standards are set forth in WCD Admin. Order 6-1992. Under the applicable standards, the value for the adaptability factor is zero if, at the time of determination, the worker had a physician's release to regular work or had returned to his or her regular work. Former OAR 436-35-310(2). "Regular work" is defined as "substantially the same job held at the time of injury, or substantially the same job for a different employer." Former OAR 436-35-270(3)(c).

Here, Dr. Kho, neurologist, performed an insurer-arranged medical examination. Recommending a tendon and a scapula injection on a palliative basis. Dr. Kho opined that claimant's condition had stabilized. Dr. Kho also concluded that claimant "should be able to return to regular employment as a waitress." (Ex. 43-5). Subsequently, Dr. Candelaria, claimant's treating physician, agreed with Dr. Kho's overall assessment. (Ex. 46).

Drs. Brown, Case, and Bald performed a medical arbiter examination. (Ex. 57). Noting that claimant reported that she did not feel she could fully perform her waitress duties, the medical arbiters concluded that she has a chronic condition, subject to a 25 pound lifting limitation and light duty restriction.

Contending that her regular work activities extended beyond those of a waitress, claimant argues that she was not released to her regular work. In light of the unlimited nature of Dr. Kho's release (as concurred by Dr. Candelaria), we are inclined to conclude that claimant was released to her regular employment (regardless if that position extended beyond waitress duties). We need not resolve that question because, based on Dr. Kho's findings (as verified by Dr. Candelaria), we would not be persuaded that claimant has suffered permanent impairment as a result of her compensable injury. Thus, in either event, claimant would not be entitled to a permanent disability award in excess of the 16 percent unscheduled award granted by the Order on Reconsideration.

ORDER

The ALJ's order dated September 29, 1994 is affirmed.

Board Member Hall dissenting.

I disagree with the majority's decision which holds that claimant was released to her "regular work," thereby resulting in an adaptability factor of zero. Consequently, I must respectfully dissent.

Former OAR 436-35-310(2), states that the adaptability factor is zero if, at the time of determination, the worker had a physician's release to regular work or had returned to his or her regular work. Former OAR 436-35-310(2). "Regular work" is defined as "substantially the same job held at the time of injury, or substantially the same job for a different employer."

Here, the ALJ determined that claimant's regular job duties included bartender, short order cook, cleaning the kitchen and stocking the bar. The ALJ found that claimant was injured while stocking beer in the employer's cooler. The applicable D.O.T. which describes claimant's work requirement of "stocking beer" is that of "Bartender helper" which is a medium strength job. See D.O.T. 312.687-010. The medical arbiters released claimant for light duty work, due to limitations caused by her on-the-job injury. (Ex. 57-3). Dr. Kho released claimant to employment as a waitress, a light strength job. See D.O.T. 311.477-034.

Based on Dr. Kho's opinion, the majority found that claimant had been released to her "regular work." However, I find it inconsistent to contend that claimant had returned to her "regular work" (i.e., substantially the same job held at the time of injury) when that work included strength requirements in the medium range. The fact that claimant was injured while performing a "medium strength" job exemplifies the point that claimant's "regular work" included more than just light strength duties. Claimant was, in effect, given a "modified work release" because, due to her compensable injury, she was not able to perform the same job duties which she held at the time of injury. Consequently, I find that claimant was not released to her "regular work." As such, claimant's adaptability factor should not have been calculated at zero.

In the Matter of the Compensation of
DALE S. WEITMAN, Claimant
WCB Case Nos. 94-01114, 93-07410 & 93-03162
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Baker's order which: (1) set aside its denial of compensability and responsibility for claimant's "new injury" claim for a low back condition issued on behalf of its insured, Willamina Lumber Co.; and (2) upheld the denial of responsibility for claimant's medical services claim for the same condition issued by Crawford & Co. (Crawford), on behalf of Protective Insurance Co. and its insured, Delta Lines, Inc. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the last two sentences of the 6th full paragraph on page four of the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Claimant has an extensive history of low back injuries and degenerative disc disease. Claimant sustained a compensable low back injury in 1987 for which he received 10 percent unscheduled permanent disability. The insurer responsible for that injury was dismissed from these proceedings.

In August 1982, claimant sustained another compensable low back injury while employed by Delta Lines, for which Crawford is the processing agent. Claimant received a total of 40 percent unscheduled permanent disability for this injury. In June 1991, claimant began working for SAIF's insured, Willamina Lumber Company. On August 3, 1992, claimant experienced low back pain after lifting a 200-pound cant at work. Claimant eventually came under the care of Dr. Nash, a neurosurgeon, who performed surgery at L4-5 and L5-S1 in August 1993.

Claimant filed claims against both SAIF and Crawford. Crawford contested only responsibility, but SAIF denied both compensability and responsibility.

The ALJ found that the August 1992 lifting incident was the major contributing cause of claimant's need for surgery. Thus, the ALJ determined that claimant's current low back condition was compensable and that SAIF was responsible for claimant's current low back condition. In reaching these conclusions, the ALJ found no "compelling reason" not to rely on the opinion of claimant's attending neurosurgeon, Dr. Nash. Dr. Nash concluded that the August 3, 1992 work incident was the major contributing cause of claimant's low back condition requiring surgery a year later. The ALJ noted that claimant was doing "quite well" with his back when he began employment with SAIF's insured in June 1991, and did not have a condition requiring surgery prior to the August 1992 incident.

On review, SAIF raises only the issue of responsibility. All parties agree that former ORS 656.005(7)(a)(B) is applicable in resolving the responsibility dispute. However, since this case was briefed, Senate Bill 369 was enacted, which amends ORS 656.005(7)(a)(B) and ORS 656.308(1).[1] However, we need not determine whether amended ORS 656.005(7)(a)(B) and amended ORS 656.308(1) apply in this case because, for the following reasons, we conclude that SAIF is responsible for claimant's current low back condition under either version of those statutes.

Crawford remains responsible for claimant's future compensable medical services and disability relating to the accepted low back condition unless it establishes that claimant sustained a "new compensable injury involving the same condition" while working for SAIF's insured. SAIF v. Drews, 318 Or 1 (1993). To establish a new injury, Crawford must show that claimant's employment activity on August 3, 1992 was the major contributing cause of claimant's disability or need for medical treatment. SAIF v. Drews, 318 Or at 9.[2] We conclude that Crawford has met that burden based on Dr. Nash's medical opinion.

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[1] Amended ORS 656.005(7)(a))(B) now 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, and 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."

Amended ORS 656.308(1) specifically provides that "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."

[2] We note SAIF's contention that, based on Dietz v. Ramuda, 130 Or App 397 (1994), the inquiry under former ORS 656.005(7)(a)(B) is whether the August 1992 incident is the major contributing cause of claimant's resultant condition, not simply the major cause of the immediate need for treatment. Although there is dicta in Dietz that supports SAIF's contention, the Court in Drews clearly articulated the test for shifting responsibility under the statute to be whether an incident in a subsequent employment is the major contributing cause of the claimant's disability or need for medical treatment. SAIF v. Drews, supra at 9; See also Tektronix, Inc. v. Nazari, 117 Or App 409, 412, (1992), mod 120 Or App 590, rev den 318 Or 27 (1993). Although ORS 656.005(7)(a)(B) was amended by Senate Bill 369, the focus is still on whether the compensable injury is the major contributing cause of the disability or need for treatment of the "combined condition," not on the "combined condition" itself. Therefore, we conclude that the amendments to ORS 656.005(7)(a)(B) do not significantly alter the Court's analysis in Drews.

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). In this case, we find no persuasive reason not to rely on Dr. Nash's medical opinion.

Dr. Nash opined that the major contributing cause of claimant's need for surgery was the August 1992 lifting incident. (Ex. 133-3). SAIF attacks Dr. Nash's medical opinion, asserting that: (1) he never weighed the contribution of claimant's extensive history of preexisting degenerative disc disease against the contribution of a single lifting incident in August 1992; (2) he based his opinion on the presumption that the precipitating cause of a need for treatment is necessarily the major contributing cause; and (3) his conclusion is illogical because a single lifting episode in August 1992 could not have caused claimant's degenerative foraminal stenosis condition. We are unpersuaded by these arguments.

Dr. Nash was aware of claimant's long history of injuries and degenerative disc disease. After acknowledging this history, Dr. Nash concluded that the August 1992 incident was the major contributing cause of claimant's need for treatment. (Ex. 127A-7, 8, 10). Dr. Nash explained that he had the opportunity to visualize the area of surgery. Dr. Nash determined that claimant had a herniated disc at L4-5 and observed reactionary tissue changes about the disc. He then performed a lumbar laminotomy and foraminal decompression at L4-5 and L5-S1 to treat the disc herniation. (Ex. 127A-9). In a subsequent medical report, Dr. Nash reiterated his opinion that the incident of August 3, 1992 was the major contributing cause of claimant's need for surgery. Dr. Nash related that this incident had resulted in nerve entrapment at L4-5 and L5-S1, and had caused the defects at those levels to become "symptomatic, clinically significant and constituted the need for his surgery offered him on August 10, 1993." (Ex. 133-4).

Accordingly, we conclude that Dr. Nash did weigh the relative contributions of claimant's history of prior injuries and degenerative disc disease against the contribution of the August 1992 incident. Dr. Nash persuasively explained that the August 1992 lifting incident was the major reason for claimant's need for treatment, consisting of surgery at L4-5 and L5-S1. Given Dr. Nash's explanation, we further conclude that Dr. Nash did not, as SAIF contends, rely on an erroneous presumption that the precipitating cause is necessarily the major contributing cause. Moreover, we do not interpret Dr. Nash's opinion as stating that the lifting episode caused claimant's foraminal stenosis, but rather that it caused nerve entrapment that necessitated claimant's need for medical treatment and surgery. Again, the issue is not whether the August 1992 lifting episode is the major factor in claimant's degenerative condition. Rather, it is whether the incident is the major factor in claimant's need for treatment. SAIF v. Drews, supra.

SAIF also challenges the ALJ's conclusion that claimant was "doing quite well" when he began work for SAIF's insured in June 1991. SAIF points out that claimant had just changed attending physicians a few days prior to that time, complaining of chronic back pain.

Claimant, however, took a preemployment physical in June 1991 during which he reported no back pain and the examining doctor reported a full range of back motion with no pain or muscle spasm. (Ex. 93A-5). We, thus, agree with the ALJ that claimant was not significantly impaired when he went to work for SAIF' s insured in June 1991. Claimant performed manual labor for more than a year without incident. The record does not document any medical treatment from June 1991 until after the August 1992 lifting incident.[3]

SAIF also contends that the ALJ erroneously applied a "but for" standard of causation in violation of Dietz, supra. SAIF asserts that the ALJ failed to properly evaluate the relative contribution of all causes of claimant's condition, including the precipitating cause, in determining that SAIF was responsible for claimant's current condition. We disagree.

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[3] We recognize that claimant may have had an incentive to minimize prior back problems during a physical examination designed to determine his suitability for employment. Nevertheless, the fact that claimant's spinal examination was normal and claimant did not voice any complaints of pain or demonstrate spasm leads us to conclude that the ALJ's assessment of claimant's condition in June 1991 was essentially accurate.

We do not find that the ALJ assigned responsibility to SAIF on the basis that the August 1992 incident was the precipitating cause of claimant's need for medical treatment. Rather, the ALJ determined that SAIF was responsible based on Dr. Nash's medical opinion, an opinion that we have also found to be persuasive because it was based on an evaluation of the relative contribution of all causes of claimant's need for treatment.

In conclusion, we find that the ALJ properly assigned responsibility for claimant's current low back condition to SAIF. Thus, we affirm.

Because compensability was at issue at hearing and was addressed by the ALJ's order, claimant's compensation remained at risk on de novo review. See Cigna Insurance Companies v. Crawford and Co., 104 Or App 329 (1990). Therefore, claimant's attorney is entitled to an assessed attorney fee for services on review. See ORS 656.382(2). 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 $1,000, to be paid 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 24, 1994 is affirmed. For services on review, claimant's counsel is awarded a $1,000 attorney fee, to be paid by SAIF.

July 25, 1995 Cite as 47 Van Natta 1399 (1995)

In the Matter of the Compensation of
ROBERT L. ARMSTRONG, Claimant
WCB Case Nos. 93-05161 & 93-09895
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Howell's order which: (1) declined to grant claimant's motion for a continuance of the hearing for the introduction of rebuttal evidence; (2) upheld the SAIF Corporation's denial of compensability and responsibility for claimant's current cervical condition on behalf of Bruce Packing Company, Inc.; (3) upheld SAIF's compensability and responsibility denial of the same condition issued on behalf of Stouder Construction, Inc.; and (4) affirmed the 1 percent (1.92 degrees) award of scheduled permanent disability for loss of use or function of the left arm granted in an Order on Reconsideration. On review, the issues are the ALJ's evidentiary ruling, compensability (potentially responsibility) and extent of scheduled permanent disability.

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

The ALJ continued the hearing to allow SAIF/Stouder an opportunity to cross-examine an examining physician, Dr. Ochoa, regarding the issue of responsibility. Following the deposition, claimant moved for a continuance for the production of rebuttal evidence in the form of depositions of Dr. Throop, a neurologist, and Dr. Lax, a neurosurgeon. Claimant asserted that new evidence had been introduced at Dr. Ochoa's deposition, consisting of Dr. Ochoa's nerve conduction studies.

The ALJ denied claimant's motion on the ground that Dr. Ochoa's interpretation of the EMG studies were previously made a part of the record and that claimant did not show due diligence in obtaining rebuttal evidence earlier. The ALJ, however, allowed claimant to obtain written rebuttal evidence from Dr. Throop in response to Dr. Ochoa's specific EMG findings.

Finally, the ALJ denied claimant's motion to strike portions of Dr. Ochoa's testimony on the ground that SAIF improperly used Dr. Ochoa's deposition to solicit medical evidence regarding compensability. The ALJ reasoned that the substance of Dr. Ochoa's opinion was presented in earlier medical reports and that claimant had not demonstrated due diligence in attempting to obtain rebuttal evidence. The ALJ, however, struck portions of Dr. Ochoa's testimony that cast aspersions on Dr. Throop's qualifications and expertise.

On review, claimant contends that the ALJ abused his discretion in not allowing rebuttal depositions of Drs. Lax and Throop. Claimant asserts that, pursuant to OAR 438-06-091(3), he has the right to present rebuttal evidence regarding compensability since he has the burden of proof with respect to compensability.

An ALJ "may continue a hearing ... [u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence ...." OAR 438-06-091(3). OAR 438-06-091(3) is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests within the ALJ's discretion. See Ronald D. Hughes, 43 Van Natta 1911, 1912 (1991). Further, an ALJ is not bound by technical or formal rules of procedure and may conduct the hearing in any manner that will achieve "substantial justice." ORS 656.283(7).

Inasmuch as the substance of Dr. Ochoa's "deposition" opinion was presented in earlier medical reports (Exs. 44, 58, 62, 64, 65), we conclude that it was not an abuse of discretion for the ALJ to deny claimant a continuance to depose Drs. Lax and Throop.[1] See Larry E. Fournier, 47 Van Natta 786, 788 (1995) (no abuse of discretion in denying continuance for rebuttal to depositions of examining physicians, when the claimant could have obtained rebuttal evidence prior to scheduled hearing and basic conclusions of examining physicians unchanged as a result of depositions).

Alternatively, even assuming that the ALJ abused his discretion in refusing to strike Dr. Ochoa's comments in his deposition regarding the compensability of claimant's cervical condition, we would still conclude, for the reasons cited in the ALJ's order, that claimant's cervical condition is not compensable. In other words, even without consideration of the disputed portion of Dr. Ochoa's testimony, the preponderance of the remaining record does not establish the compensability of claimant's cervical claim.[2]

Finally, claimant contends that he is entitled to a scheduled "chronic condition" award for his left arm. We disagree.

Claimant sustained a compensable left arm injury on or about July 2, 1991 while employed by Stouder. On May 7, 1993, a Notice of Closure awarded no permanent disability, which prompted claimant to request reconsideration. Dr. Stanford, an orthopedic surgeon, was appointed medical arbiter. Dr. Stanford concluded that claimant did not have a condition that would limit use of his left arm. (Ex. 84). On December 30, 1993, an Order on Reconsideration awarded 5 percent unscheduled permanent disability and 1 percent scheduled permanent disability.

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[1] Claimant argues that he could not have obtained rebuttal evidence regarding compensability prior to hearing because: (1) Dr. Ochoa raised compensability issues for the first time in his deposition; and (2), prior to Dr. Ochoa's deposition, responsibility was the only issue. Claimant is incorrect.

Dr. Ochoa's medical reports, in which he attributed claimant's symptomatology to a psychogenic condition instead of to either of claimant's compensable injuries, clearly addressed the compensability of claimant's cervical condition. (Exs. 44, 58, 62, 64, 85). Moreover, compensability was an issue both prior to and during the hearing. Both of SAIF's denials raised compensability as an issue. (Exs. 70, 79). Most importantly, the parties agreed that compensability was an issue at hearing. (Tr. 3).

[2] We emphasize that this decision pertains to the partial, current treatment denials of claimant's present cervical condition. Claimant's rights to benefits under the Act remain intact with respect to his compensable October 29, 1975 injury.

A worker may be entitled to scheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a scheduled body part due to a chronic and permanent medical condition. OAR 436-35-010(6). There must be medical evidence from which it can be concluded that claimant has at least a partial loss of ability to repetitively use the body part. See Weckesser v. Jet Delivery Systems, 132 Or app 325 (1995); Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

In this case, there is no medical evidence at the time of claim closure that claimant has a partial loss of ability to repetitively use his left arm. Dr. Lax, claimant's attending neurosurgeon, agreed that the 1991 left arm claim could be closed without permanent impairment. (Ex. 72). Moreover, the medical arbiter, Dr. Stanford, specifically stated that claimant did not have a condition that would limit use of his left arm. (Ex. 86-3).

Accordingly, we find that claimant has failed to prove entitlement to a scheduled "chronic condition" award. We affirm the ALJ's decision not to award additional scheduled permanent disability.

ORDER

The ALJ's order dated September 30, 1994 is affirmed.

July 25, 1995 Cite as 47 Van Natta 1401 (1995)

In the Matter of the Compensation of
GARY E. FRAZIER, Claimant
WCB Case No. 94-06685
ORDER ON RECONSIDERATION (REMANDING)
Robert G. Dolton, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

The insurer requests reconsideration of our July 7, 1995 Order on Review (Remanding) that vacated the ALJ's dismissal order, reinstated claimant's hearing request, and remanded for hearing. On reconsideration, the insurer disagrees with our conclusions because it asserts that the facts do not support our analysis. After considering the insurer's contentions, we adhere to our prior conclusions. However, we provide the following supplementation in response to the insurer's assertions.

According to the insurer, we concluded that the independent medical examination (IME) was not reasonable because the examination was in Portland. The insurer argues that that conclusion is not supported by the record since claimant himself did not object to going to Portland for the examination.

The insurer misconstrues our holding. Contrary to the insurer's assertion, we did not decide that the IME was not "reasonably convenient" solely because the examination was in Portland. In our order, we acknowledged that claimant was prepared to attend the Portland area IME. We stated that "[d]espite claimant's apprehension about the examination with Dr. Radecki, he had planned to attend the IME." (Order on Review at 4). We found that claimant failed to appear, however, because he did not have the funds to travel from Prineville to Portland, a distance of 400 miles, round-trip. Although claimant had requested advanced travel expenses and the insurer sent a check for such expenses, claimant asserted that he did not receive the check until the afternoon of the scheduled IME. We concluded that claimant's failure to appear because of a lack of funds necessary to travel from Prineville to Portland was justifiable. We found further that, under the facts of this case, the medical examination was not "reasonably convenient to the worker's * * * residence" under OAR 436-10-100(4), particularly without the receipt of pretravel expenses.

The insurer contends that our order is vague as to whether we concluded that claimant does not have to attend an examination in Portland or whether claimant must attend an examination in Portland so long as he receives advance travel expenses. Once again, we did not decide that the IME was not "reasonably convenient" solely because the examination was in Portland. Our decision was based on the fact that claimant's failure to appear because of a lack of funds necessary to travel from Prineville to Portland was justifiable, and that the medical examination was not "reasonably convenient" to claimant, particularly without the receipt of pretravel expenses.

The insurer also argues that we failed to attach appropriate significance to the circumstances leading up to claimant's failure to attend the first scheduled IME on July 27, 1994. We disagree.

In Kathy A. Schalk, 46 Van Natta 1043, on recon 46 Van Natta 1170 (1994), we found that, because the carrier no longer argued about the propriety of the first postponement, it could not be found that the initial postponement of the hearing was attributable to any unjustified delay on the claimant's part. Since the first postponement was not at issue, we concluded that the beginning date to calculate the "delay" in the hearing did not occur until July 31, 1992, when the hearing was again postponed.

In the present case, the insurer moved for an order requiring claimant to attend a rescheduled medical examination and postponing his case until he did so, or in the alternative, an order of dismissal. The ALJ granted the motion for postponement on August 29, 1994. The insurer did not argue below, and does not argue now, that the ALJ erred in granting the motion for postponement. Since the hearing was postponed and the insurer does not argue about the propriety of the first postponement, we do not find that the circumstances concerning the initial postponement of the hearing were attributable to any unjustified delay on claimant's part. See Kathy A. Schalk, supra. For that reason, we do not focus on claimant's actions before the postponement date to determine whether his conduct "resulted in an unjustified delay in the hearing of more than 60 days." See OAR 438-06-071(1). In any event, as the insurer points out, it is obvious from the dissenting opinion that we were aware of the facts leading up to claimant's failure to attend the first scheduled IME on July 27, 1994.

We withdraw our July 7, 1995 order. On reconsideration, as supplemented herein, we republish our July 7, 1995 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
KATHLEEN L. LIKOS, Claimant
WCB Case Nos. 94-08968, 94-06781 & 94-03441
ORDER ON REVIEW
Coons, Cole, & Cary, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Stoel, Rives, et al, Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Hall, Turner-Christian, and Haynes.

Liberty Northwest Insurance Corporation (Liberty Northwest), on behalf of United Parcel Services, requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) set aside its denial of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS) condition; and (2) upheld the denials of SAIF Corporation, on behalf of McLellan Temporaries, Inc. and Old Peak Construction, Inc., of the same condition. Claimant argues that SAIF, rather than Liberty, is responsible for her CTS condition. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order. See Beneficiaries of Strametz v. Spectrum Motorwerks, Inc., 135 Or App 67 (1995); Silveira v. Larch Enterprises, 133 Or App 297 (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 438-15-010(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 $950, payable by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 9, 1994, as amended December 12, 1994, is affirmed. Claimant's counsel is awarded an assessed attorney fee of $950, payable by Liberty Northwest.

Board Member Haynes dissenting.

Although I am bound by the principle of *stare decisis*, I write to express my agreement with the dissenting opinions of Judges Deits, Edmonds, and DeMuniz in the Strametz decision. I agree that a claimant should not be able to establish compensability of an occupational disease claim under the "last injurious exposure rule" where a portion of the employment exposure occurred either out-of-state or where, as here, claimant was self-employed.

July 25, 1995 Cite as 47 Van Natta 1403 (1995)

In the Matter of the Compensation of
ROBERT H. MAZZGA, Claimant
WCB Case No. 94-04505
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes, Turner-Christian, and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that affirmed an Order on Reconsideration which awarded 19 percent (28.5 degrees) scheduled permanent disability for loss of use or function of the right knee. On review, the issue is the extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed the Order on Reconsideration which awarded 19 percent scheduled permanent disability for loss of use or function of claimant's right knee. Contending that the disability found by the attending physician and the medical arbiter is not "due to" the compensable injury, the employer seeks a reduction in claimant's scheduled permanent disability award.

We recount the relevant facts. In 1984, claimant was involved in a noncompensable motorcycle accident. The accident resulted in a closed comminuted fracture of his right tibia and a laceration of the right knee. Claimant had fasciotomy surgery on the right leg in April 1984.

By 1985 claimant recovered use and function of the right knee and leg. In November 1992, claimant had the sudden onset of pain in the right knee at work. Claimant sought medical treatment and was eventually seen by Dr. Rubinstein in December 1992. Dr. Rubinstein diagnosed a torn lateral meniscus and noted an old posterior cruciate ligament injury with laxity. Dr. Rubinstein performed surgery to repair the torn meniscus on December 8, 1992.

Also in December 1992, the employer accepted claimant's claim for "right knee internal derangement."

Claimant became medically stationary on July 8, 1993 and the claim was closed by a Determination Order which awarded 21 percent (31.5 degrees) scheduled permanent disability.

In January 1994, the employer issued an amended acceptance and partial denial of "preexisting chronic posterior cruciate ligament laxity, preexisting posterior cruciate ligament injury, varus alignment at the old distal tibial fracture, early lateral degenerative changes, degenerative changes of the condyle, patellofemoral joint changes, degenerative changes of the lateral tibial plateau, chondromalacia wear of the lateral compartment, crepitus and early arthritis." The document further indicated that claimant's claim was accepted for right lateral meniscus tear. Claimant initially requested a hearing on the denial. However, he later withdrew his hearing request and the case was dismissed.

Both claimant and the employer requested reconsideration of the Determination Order. Dr. Gritzka was appointed as medical arbiter and examined claimant and issued a report. A March 23, 1994 Order on Reconsideration reduced claimant's scheduled award to 19 percent (28.5 degrees) scheduled permanent disability.

The employer concedes that claimant is entitled to a 5 percent award for his right knee surgery, but contends that the Order on Reconsideration's award for a chronic condition of the right knee and for lost ranges of motion in the knee are not "due to" the compensable injury. Rather, the employer contends that claimant's disability is related to the noncompensable motorcycle accident.

As an initial matter, we note that the ALJ found that claimant had the burden of proof to establish the extent of permanent disability due to the injury. However, on review, both parties agree that, because the employer requested a hearing on the extent of disability, the burden of proof is on the employer. See Roberto Rodriguez, 46 Van Natta 1722, on recon 46 Van Natta 2230, on recon 46 Van Natta 2530 (1994). (The Rodriguez decision was issued subsequent to the date of the ALJ's order).

In determining the extent of claimant's permanent disability, we apply the standards in effect on the date of the November 3, 1993 Determination Order. OAR 436-35-003(2). Those standards contained in WCD Admin. Orders 6-1992 and 17-1992 apply to claimant's claim.

The employer argues that the major contributing cause standard of ORS 656.005(7)(a)(B) should be applied in determining whether claimant's impairment is caused by the compensable injury. We disagree. ORS 656.005(7)(a), which defines a compensable injury, applies to initial determinations of compensability of a condition. Beck v. James River Corp., 124 Or App 484 (1993).

Here, claimant has a compensable accepted claim for acute right lateral meniscus tear. Compensability of that condition is not at issue. The standard for determining whether impairment is related to a compensable injury is specifically set out by statute. 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. ORS 656.214(2) (emphasis added). Thus, the only question before us is which impairment is "due to" the compensable injury as opposed to the prior noncompensable motorcycle accident.

The medical evidence concerning the extent of claimant's impairment comes from Dr. Rubinstein, claimant's attending orthopedist, and Dr. Gritzka, the medical arbiter, who is also an orthopedist.[1]

In his initial closing report, Dr. Rubinstein did not differentiate between impairment related to the compensable injury and impairment related to the preexisting injury. However, after issuance of the Determination Order, Dr. Rubinstein clarified his report and indicated that claimant's physical limitations and restrictions from heavy lifting, squatting, bending, jumping, and climbing, etc., are due to claimant's preexisting noncompensable motorcycle injury. Dr. Rubinstein further opined that claimant's limited right knee range of motion also probably resulted in major part from his preexisting underlying conditions.

Dr. Gritzka performed a medical arbiter examination of claimant. Dr. Gritzka found that claimant had decreased range of motion in the right knee. Dr. Gritzka further found that claimant had limitations in the ability to repetitively use his injured right knee due to a diagnosed chronic and permanent medical condition arising out to the accepted right lateral meniscus tear and surgery. Dr. Gritzka also indicated that 80 percent of claimant's impairment was attributable to the preexisting injury and 20 percent was due to the compensable injury.

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[1] We note that the record also contains medical evidence concerning the causation of claimant's right knee impairment which was generated subsequent to the date of the medical arbiter's report. We have previously held that such medical evidence is prohibited by ORS 656.268(7). See David B. Weirich, 47 Van Natta 478 (1995); see also Daniel L. Bourgo, 46 Van Natta 2505 (1994). ORS 656.268(7) was amended by the 1995 Legislature. SB 369, 68th Leg., Reg. Sess., §30 (June 7, 1995). Amended ORS 656.268(7)(g) now prohibits subsequent medical evidence after the date of the Order on Reconsideration rather than after the date of the medical arbiter's report. Here, the medical evidence in question was generated subsequent to the date of both the medical arbiter's report and the Order on Reconsideration. Thus, we have not considered this "post-reconsideration" and "post-medical arbiter" medical evidence in reaching our decision. Because the "post-reconsideration" medical evidence is inadmissible under either former or amended ORS 656.268(7), we need not determine whether the amended statute applies retroactively.

We find the report of the medical arbiter, Dr. Gritzka, to be most persuasive and well reasoned. Dr. Gritzka's report differentiates between the impairment caused by the compensable injury and that caused by the preexisting condition. Accordingly, we rely on his findings of impairment. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. Gritzka specifically indicated that claimant had limitations in the ability to repetitively use his injured right knee due to a diagnosed chronic and permanent medical condition arising out to the accepted condition. Based on Dr. Gritzka's explicit reference to the accepted condition in making that statement, we are convinced that he believed that claimant had a chronic condition due to the compensable injury and surgery rather than to the noncompensable motorcycle injury.

In reaching this decision, we are aware that Dr. Gritzka opined that 80 percent of claimant's total impairment resulted from the noncompensable motorcycle injury, whereas 20 percent resulted from the compensable injury. However, given Dr. Gritzka's specific statement in the same report that claimant had a chronic condition due to the accepted condition, we are persuaded that he believed that the chronic condition was entirely due to the compensable injury. Thus, we conclude that the employer has failed to establish that claimant is not entitled to an award for a chronic condition under the standards. Accordingly, we find that claimant is entitled to an award of 5 percent for a chronic condition in the right knee. OAR 436-35-010(6).

Based on the findings of both Dr. Rubinstein and Dr. Gritzka, however, we are persuaded that the employer has met its burden to prove that claimant's lost range of motion findings are not "due to" the compensable injury. Dr. Rubinstein believed that the lost range of motion in the right knee was probably the result of the noncompensable injury. Dr. Gritzka believed that 80 percent of the impairment was due to the off work injury. Under such circumstances, we are persuaded that the lost range of motion in the right knee is not due to the compensable injury.

The employer has indicated that it has never contested claimant's entitlement to a 5 percent award for his meniscal repair surgery. Accordingly, we agree that claimant is entitled to a 5 percent award for his right knee surgery pursuant to OAR 436-35-230(5).

Claimant's scheduled permanent disability under the standards is 10 percent (5 percent for surgery combined with 5 percent for a chronic condition). Thus, we conclude that the Order on Reconsideration award of scheduled permanent disability should be decreased from 19 percent (28.5 degrees) to 10 percent (15 degrees).

Finally, the parties argue over the effect and validity of OAR 436-35-007(2). That rule provides:

> "Where a worker's impairment findings are partially due to the accepted injury or accepted conditions and the findings are also due to other unrelated and/or noncompensable causes, only accepted compensable conditions and worsenings, as defined by ORS 656.005(7)(a) and 656.273 are rateable. The insurer shall provide documentation to establish the existence of pre-existing impairment through medical evidence."

Claimant contends that no medical evidence documenting claimant's preexisting impairment exists. The employer argues that if OAR 436-35-007(2) requires the employer to be responsible for permanent disability that is not due to an accepted injury, it is inconsistent with ORS 656.214(2).

First, contrary to claimant's contention, we conclude that the findings and opinions of claimant's attending physician and the medical arbiter constitute medical evidence documenting claimant's preexisting impairment due to the noncompensable injury. Both Dr. Rubinstein and Dr. Gritzka have given opinions concerning which impairment is attributable to the preexisting noncompensable injury and which is attributable to the compensable injury. Such medical evidence fulfills the requirement of OAR 436-35-007(2). Second, we disagree with the employer's argument that the rule is inconsistent with ORS 656.214(2). To the contrary, the rule does not conflict with ORS 656.214(2). Rather, consistent with the statute, the rule allows for the rating only of disability related to the compensable condition.

ORDER

The ALJ's order dated August 11, 1994 is modified. In lieu of the ALJ and Order on Reconsideration awards, claimant is awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the right knee. Claimant's counsel's out-of-compensation attorney fee award is adjusted accordingly.

Board Member Hall dissenting.

For the reasons which follow, I respectfully dissent from the majority's opinion.

Dr. Gritzka found that claimant had 100 degrees flexion in the right knee and 140 degrees in the uninjured left knee. Under the standards, claimant's loss of flexion would entitle him to 15 percent impairment. See OAR 436-35-220(1); 436-35-007(16). However, Dr. Gritzka opined that only 20 percent of claimant's impairment was "due to" his compensable injury and that the remaining 80 percent was due to the prior noncompensable injury.

As I read Dr. Gritzka's report, he has opined that 20 percent of the lost range of motion in claimant's right knee is "due to" the compensable injury. See ORS 656.214(2). Thus, I believe that claimant is entitled to an impairment award of 20 percent of the lost range of motion in the right knee. 20 percent of claimant's 15 percent impairment for lost range of motion equals 3 percent impairment. Accordingly, I would find that claimant is entitled to an additional 3 percent impairment for lost range of motion in his right knee and would modify claimant's permanent disability award accordingly.

July 25, 1995 Cite as 47 Van Natta 1406 (1995)

In the Matter of the Compensation of
FRANK A. SARMENTO, Claimant
WCB Case No. 94-12334
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order which set aside SAIF's termination of claimant's temporary total disability (TTD) benefits. On review, the issue is temporary disability.

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

Claimant worked as a long-haul truck driver. In November 1993 claimant compensably injured his low back (Ex. 3). On July 27, 1994, claimant's treating physician released claimant to light-duty clerical work on a half-time basis. (Ex. 5A).

On August 9, 1994, claimant was offered a full-time clerical job beginning on August 17, 1994. (Ex. 7). Claimant refused the offer of modified work.

In a letter dated August 17, 1994, claimant's job offer was amended to half-time employment which was consistent with his treating physician's work release. (Ex. 9). The "amended" offer stated that the starting date of claimant's modified work was to be August 17, 1994. Claimant failed to respond to the "amended" job offer and his TTD benefits were terminated as of August 17, 1994.

The ALJ determined that claimant's TTD benefits were improperly terminated because the job offer failed to comply with OAR 436-60-030(12)(c) (former OAR 436-60-030(5)). Specifically, the ALJ found that the "job offer" did not adequately specify a starting date.

On review, SAIF contends that the ALJ erred in holding that the job offer did not fully comply with OAR 436-60-030(12)(c).

Under former ORS 656.268(3)(c), TTD benefits may be terminated before claim closure if the "attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."[1] Former OAR 436-60-030(5) more specifically provided that the insurer shall cease paying TTD benefits when the injured worker "refuses or fails to begin wage earning employment prior to claim determination," under certain conditions.[2] Those conditions are as follows. The attending physician must be notified of the physical tasks to be performed and must agree that the employment appears to be within the worker's capabilities. Furthermore, the employer must confirm 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." Former OAR 436-60-030(5)(c) (emphasis supplied).

Substantial compliance with the procedural requirements of OAR 436-60-030(5) is insufficient to authorize a carrier to terminate TTD benefits. Fairlawn Care Center v. Douglas, 108 Or App 698 (1991); Safeway Stores, Inc. v. Little, 107 Or App 316 (1991); Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986).

After our review, we find that claimant's TTD benefits were terminated before the employer offered claimant a "job offer" which complied with the requirements of OAR 436-60-030(12)(c). On August 9, 1994, claimant was offered full time "employment." This offer did not comply with claimant's treating physician's work release for half-time work. On August 17, 1994, an amended offer was drafted offering claimant half-time "employment." It was at this time (August 17, 1994) that the "job offer" fully satisfied the requirements under OAR 436-60-030(12)(c).

However, according to the employer's testimony, claimant would not have received the amended "job offer" until after August 17, 1994.[3] (Tr. 44). On September 13, 1994, claimant's TTD benefits were terminated beginning as of August 17, 1994. Therefore, claimant's TTD benefits were terminated prior to his receipt of a job offer which complied with the requirements of OAR 436-60-030(12)(c). Consequently, claimant's TTD benefits were improperly terminated. See amended ORS 656.268(3)(c). Accordingly, we conclude that, because the employer failed to comply with the statute, it had no authority to terminate claimant's TTD benefits.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 25, 1995 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by SAIF.

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[1] We note that, subsequent to the ALJ's order, the legislature enacted Senate Bill 369 amending ORS 656.268(3)(c), effective June 7, 1995. However, the result in this case would be the same under either the former or amended versions of ORS 656.268(3)(c).

[2] Former OAR 436-60-030(5) (WCD Admin. Order 1-1992) has been renumbered OAR 436-60-030(12). (DCBS Admin. Order 94-055). No substantive changes were made to former OAR 436-60-030(5)(c).

[3] We note that evidence in the record tends to prove that claimant may not have received the "amended" offer by certified mail until September 22, 1994. (Tr. 42).

In the Matter of the Compensation of
JOHN A. ZURFLUH, Claimant
WCB Case No. 94-02570
ORDER ON REVIEW
Johnson, Cram & Associates, Claimant Attorneys
Beers, Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that granted the insurer's motion to dismiss claimant's request for hearing on the basis that his failure to submit to an independent medical examination caused an unjustified delay in the hearing of more than 60 days. On review, the issue is the propriety of the ALJ's dismissal order.

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

The ALJ is authorized to dismiss a proceeding under OAR 438-06-071(1) only if "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." We agree with the ALJ that there is no evidence that claimant had abandoned his request for hearing.

We further agree that claimant's failure to attend the three scheduled independent medical evaluations prevented the insurer from preparing its case and thus caused an unjustified delay of the hearing on the merits. See OAR 438-06-071(1); Ring v. Paper Distribution Services, 90 Or App 148 (1988); Mychael K. Foss, 45 Van Natta 1778 (1993). Accordingly, dismissal was proper.

ORDER

The ALJ's order dated January 27, 1995 is affirmed.

In the Matter of the Compensation of
ROBERT H. EVERS, JR., Claimant
WCB Case No. 94-12267
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that affirmed that portion of an Order on Reconsideration awarding claimant 7 percent (22.4 degrees) unscheduled permanent disability for his neck condition. On review, the issue is extent of unscheduled permanent disability.

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

Claimant asserts that the ALJ erred in giving his adaptability factor a value of zero. Particularly, claimant asserts that, because OAR 436-35-310[1] does not authorize the consideration of his disabling neck pain in determining the value of his adaptability factor, the rule is inconsistent with former ORS 656.214(5) (since amended by Senate Bill 369 (SB 369), 68th Leg., Reg. Sess., § 17 (June 7, 1995)) and 656.726(3)(f)(A).[2] We need not address that argument, because there is no medical evidence in this

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[1] Because claimant became medically stationary in February 1994, WCD Admin. Order 93-056 (November 29, 1993) governs this claim.

[2] The 1995 Legislature amended ORS 656.726(3)(f) to include a new subsection (D), which concerns the evaluation of a worker's impairment. That amendment applies to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. See SB 369, §§ 66(4), 69. Because this claim became medically stationary in 1994, the amendment does not apply to this case.

record that claimant has disabling neck pain. See ORS 656.726(3)(f)(B) (impairment established by medical evidence based on objective findings); see also OAR 436-35-310(5) (residual functional capacity based on medical opinion).[3] Moreover, in Michael E. Pelcin, 47 Van Natta 1380 (1995), we held that, under former ORS 656.214(5) and 656.726(3)(f)(A), the Director had authority to promulgate OAR 436-35-310. Accordingly, we reject claimant's arguments and affirm the ALJ's decision giving claimant's adaptability factor a value of zero.

ORDER

The ALJ's order dated January 26, 1995 is affirmed.

[3] Claimant does not challenge the rule to the extent that it requires medical evidence of adaptability.

In the Matter of the Compensation of
BILL C. LAUBER, Claimant
WCB Case No. 93-12674
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the insurer's "de facto" denial of claimant's claim for left knee replacement surgery. On review, the issues are claim preclusion and compensability. We affirm.[1]

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claim Preclusion

At hearing and on review, the insurer argues that claimant was barred from litigating the compensability of his claim for left knee replacement surgery because he failed to request a hearing on the insurer's April 7, 1993 denial of the same condition. We agree. The doctrine of claim preclusion operates to bar claimant's claim in this case.

Unlike issue preclusion, claim preclusion does not require that an issue actually be litigated. Rather, the claim preclusion doctrine applies when there is an opportunity to litigate an issue before a final determination of the proceeding. Drews v. EBI Companies, 310 Or 134, 140 (1990); Popoff v. J.J. Newberrys, 117 Or App 242, 244 (1992).

In this case, the insurer's April 7, 1993 denial stated, in pertinent part, as follows:

> "We have recently received information from your treating doctor that you are in need of a left knee replacement. Medical information generated to date indicates that the major contributing cause of your need for left knee replacement is your pre-existing left knee tri-compartmental arthritis.
>
> "Therefore without waiving further questions of compensability, we are issuing this partial denial of your left knee tri-compartmental arthritis including any medical and disability benefits that are due to this.

[1] We retain jurisdiction to resolve this medical services dispute under amended ORS 656.245(6) SB 369, 68th Leg., Reg. Sess. § 25 (June 7, 1995), because the insurer issued a formal denial of the compensability of the underlying claim.

"Please be advised that payment of medical benefits for your original accepted left knee medial meniscus tear will continue to be authorized pursuant to ORS 656.245."

We find that this denial presented claimant with the opportunity to litigate the compensability of his left knee replacement. The letter sets forth the insurer's position that the knee replacement is not compensable because it was caused in major part by claimant's pre-existing arthritis. Claimant could have, but did not, challenge this denial by timely requesting a hearing. Consequently, the denial became final. ORS 656.319(1).

Since this uncontested denial bars future litigation of the compensability of the denied condition, including medical services related to claimant's left knee replacement, claimant may not now assert this claim. See Popoff v. J. J. Newberrys, supra. There is no evidence that claimant's condition worsened or that his diagnosis changed since the April 7, 1993 denial, and, therefore, the issues raised by the insurer's alleged "de facto" denial are exactly the same as those presented by the earlier denial.

Compensability

Although we conclude that the doctrine of claim preclusion bars claimant from asserting his claim, we find, in the alternative, that the ALJ correctly determined that claimant's left knee replacement was not compensably related to his accepted torn medial meniscus, but was, instead, caused in major part by his preexisting tri-compartmental arthritis. We therefore adopt and affirm the ALJ's conclusions and opinion on this issue.

ORDER

The ALJ's order dated January 11, 1995 is affirmed.

July 26, 1995 Cite as 47 Van Natta 1410 (1995)

In the Matter of the Compensation of
MELINDA A. MARSHALL, Claimant
WCB Case Nos. 94-15460 & 94-14998
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that assessed a penalty pursuant to former ORS 656.268(4)(g). On review, the issue is penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

SAIF asserts that, because claimant has failed to establish that she is at least 20 percent disabled, the ALJ erred in awarding a penalty under former ORS 656.268(4)(g). We agree.

As a preliminary matter, we note that ORS 656.268(4)(g) has been amended by the 1995 Legislature. Senate Bill 369 (SB 369), 68th Leg., Reg. Sess., § 30 (June 7, 1995). Those amendments apply only to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. SB 369,§§ 66(4), 69. Claimant became medically stationary on March 14, 1994. (Ex. 2). Therefore, the amendments do not apply, and we analyze this matter under former ORS 656.268(4)(g). We turn to the merits.

SAIF argues that, under OAR 436-30-050(13), claimant is not entitled to a penalty, because she has not received 64 degrees of disability. We agree.

Former ORS 656.268(4)(g) provides that a penalty may be assessed when, inter alia, "the worker is found upon reconsideration to be at least 20 percent permanently disabled[.]" OAR 436-30-050(13) provides that, "[f]or the purpose to section (12)[1] of this rule, a worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20 percent disabled."

In Steven L. Cline, 46 Van Natta 512 (1994) (order on reconsideration), we declined to apply OAR 436-30-050(13), concluding that former ORS 656.268(4)(g)'s "20 percent permanently disabled" requirement could be satisfied by establishing a 20 percent disability of a particular body part. Id. at 512 n 1.

The Court of Appeals recently reversed our order in Cline. SAIF v. Cline, 135 Or App 155 (1995). The court reasoned that, because the text of former ORS 656.268(4)(g) refers to the disability of "the worker," not a particular body part, percentage of disability of a particular body part must be converted to a percentage of the whole worker before the statute may apply. Id. at 159. To determine the extent of disability to the whole worker when a worker suffers an impairment of a particular body part, the court instructed, the disability must be translated into degrees, the statutory measuring unit. Id. Accordingly, because 320 degrees comprises the whole worker, for a worker to be at least 20 percent permanently disabled for purposes of former ORS 656.268(4)(g), he or she must have suffered 64 degrees (20 percent of 320 degrees) of permanent disability. See id. at 160. Because OAR 436-30-050(13) comports with that reasoning, the court concluded that the rule was valid. Id.[2]

Here, claimant received a scheduled permanent disability award of 49.5 degrees for her left forearm (wrist). Because claimant has received less than 64 degrees of disability, she is not entitled to a penalty under former ORS 656.268(4)(g). SAIF v. Cline, supra; OAR 436-30-050(13). Accordingly, we reverse the ALJ's penalty assessment.

ORDER

The ALJ's order dated March 10, 1995 is reversed in part and affirmed in part. That portion of the order that assessed a penalty is reversed. The remainder of the ALJ's order is affirmed.

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[1] OAR 436-30-050(12) provides, in part:

"If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer shall be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation."

[2] In our order in Steven L. Cline, we relied on Nero v. City of Tualatin, 127 Or App 458 (1994). In reversing Cline, the Court of Appeals overruled Nero to the extent that it conflicted with the court's opinion in SAIF v. Cline. Id. at 160-61.

In the Matter of the Compensation of
GERALD E. MERCER, Claimant
WCB Case No. 94-01771
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Betsy Byers (Saif), Defense Attorney

Reviewed by Board Members Haynes, Turner-Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for his current respiratory condition. On review, the issues are aggravation and compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated September 23, 1994 is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that claimant has not established a compensable occupational disease claim for reactive airway disease (asthma). Therefore, I dissent.

In order to establish an occupational disease claim, a claimant must prove that employment conditions were the major contributing cause of the disease or its worsening. ORS 656.802(2). As a general rule, a worsening of symptoms alone is not sufficient to prove an occupational disease. See Weller v. Union Carbide, 288 Or 27, 35 (1979). However, the courts have recognized an exception to this rule: If the medical evidence establishes that the manifested symptoms are the disease, a worsening of symptoms is sufficient to prove an occupational disease. 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).

The record shows that claimant has an underlying asthma condition. However, there is no indication that claimant previously had any asthma symptoms or required treatment for asthma. As a result of inhaling asphalt fumes at work, claimant has now developed "occupational" asthma symptoms requiring treatment.

The ALJ (and the majority) found that work exposure was the major contributing cause of claimant's asthma symptoms. Yet they upheld the denial of claimant's asthma claim, finding that work exposure was not the major contributing cause of claimant's underlying asthma condition or its worsening.

I find, however, that claimant's asthma symptoms are the manifestation of the asthma condition. That is, but for the symptoms, claimant would not have a "condition" that requires treatment. Claimant's asthma is, without exposure to asphalt fumes, asymptomatic. It is exposure to asphalt fumes that produces a reaction and causes claimant to need treatment. This is truly a case of the symptoms being the disease. Thus, because work exposure caused the symptoms, the claim for treatment of those symptoms should be found compensable. Alternatively, I would find that the manifestation of symptoms following claimant's work exposure shows that the underlying asthma condition had worsened as a result of that exposure. Therefore, I would conclude that claimant has established a compensable occupational disease claim for asthma requiring treatment.

For these reasons, I must respectfully dissent.

In the Matter of the Compensation of
ROGELIO MUNOZ-MARTINEZ, Claimant
WCB Case No. 94-08482
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that declined to award an approved attorney fee, payable from future permanent disability awards, for his counsel's services rendered concerning the closure of claimant's claim. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the conclusions and reasoning as set forth in the ALJ's order with the following supplementation.

We begin by briefly summarizing the facts. Claimant was compensably injured in December 1992. On July 18, 1994, claimant's counsel requested a hearing seeking payment of temporary disability benefits and a penalty. Thereafter, claimant's counsel determined that claimant was medically stationary, but that his claim had not been closed. Claimant's counsel contacted the Director and the insurer and ultimately claimant's claim was closed by Determination Order with an award of permanent disability. Neither party requested reconsideration of the closure order.

The ALJ concluded that the Hearings Division was without authority to grant claimant's counsel an approved attorney fee, payable out of claimant's permanent disability, for services rendered in securing claim closure. We agree.

Former ORS 656.386(1) allows an attorney fee for services rendered without a hearing. However, that statute addresses attorney fees that may be awarded in denied claims for compensation. A claimant is entitled to attorney fees under that subsection only in an appeal from "an order or decision denying the claim for compensation." O'Neal v. Tewell, 119 Or App 329 (1993) (quoting Shoulders v. SAIF, 300 Or 606, 611 (1986)).[1]

The compensation out of which claimant's counsel seeks an attorney fee was not the result of a denied claim. Rather, it is the permanent disability awarded by the insurer's Notice of Closure. That compensation was neither awarded nor approved by the Workers' Compensation Board or the Hearings Division. Issues pertaining to the award of permanent disability must first go through the reconsideration process set forth in ORS 656.268. ORS 656.268(4)(e); OAR 438-09-005(1). Moreover, the Director has a procedure whereby issues arising out of claim closure and the reconsideration process may be resolved by stipulation. See former OAR 436-30-050(26). Claimant could have requested reconsideration of the Determination Order and then submitted a stipulation, regarding an attorney fee, along with a request for an affirming reconsideration order. Former OAR 436-30-050(26)(a). Thereafter, the stipulation would have been submitted to the Hearings Division for approval. Former OAR 436-30-050(26)(b). However, claimant did not avail himself of this procedure. Under these circumstances, we agree that the ALJ was without authority to provide the relief sought by claimant.

ORDER

The ALJ's order dated November 14, 1994, as reconsidered January 9, 1995, is affirmed.

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[1] ORS 656.386(1), was amended by SB 369. See SB 369, 68th Leg., Reg. Sess., § 43 (June 7, 1995). Inasmuch as our decision would not change under the amended version of the statute, we do not address which version of ORS 656.386(1) is applicable to this case.

In the Matter of the Compensation of
JENICE L. PALMER, Claimant
WCB Case No. 94-06433
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Turner-Christian and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order which set aside its "de facto" denial of claimant's right knee degenerative joint disease condition. On review, the issue is compensability.

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

Subsequent to the ALJ's order, the Legislature enacted Senate Bill 369 which amended various portions of ORS Chapter 656. Among the amended provisions was ORS 656.005(7)(a)(B). It now provides in relevant part that, if an otherwise compensable injury combines with a preexisting condition to cause disability or a need for treatment, the "combined condition" is compensable only if the otherwise compensable injury is the major contributing cause of the disability or of the need for treatment of the "combined condition." SB 369, 68th Leg., Reg. Sess., Sec. 1 (June 7, 1995). Under the former version of ORS 656.005(7)(a)(B), in cases where a compensable injury "combined" with a preexisting disease or condition, the "resultant condition" is compensable only to the extent that the compensable injury is and remains the major contributing cause of the disability or need for treatment.

In this case, the ALJ found that claimant had satisfied his burden of proof under former ORS 656.005(7)(a)(B). Assuming *arguendo* that the amended version of ORS 656.005(7)(a)(B) applies to this case, we would still conclude that claimant has satisfied her burden of proof. We agree for the reasons cited by the ALJ that the compensable injury is the major contributing cause of claimant's need for medical treatment. Accordingly, whether or not it is referred to as a "resultant condition" or as a "combined condition," we would still find that claimant's right knee 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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 7, 1994 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
CHANA D. STRADLEY, Claimant
WCB Case No. 94-08407
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Thomas J. Dzieman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of claimant's right shoulder injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In June 1994, claimant dislocated her right shoulder while performing work activities. Claimant previously had dislocated her right shoulder in summer 1993 and subluxed her right shoulder in December 1993. Applying former ORS 656.005(7)(a)(B), the ALJ found that claimant had not proved compensable her right shoulder condition.

Relying on Tony L. Rivord, 44 Van Natta 1036 (1992), claimant asserts that, although the recommended surgery may not be compensable, she showed that her need for treatment immediately following the work event was in major part caused by work activities. Thus, according to claimant, at least this portion of her medical services was proven to be compensable.

We first note that, following the ALJ's order, the legislature amended ORS 656.005(7)(a)(B). SB 369, 68th Leg., Reg. Sess., § 1 (June 7, 1995).[1] The statute now provides:

> "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or need for treatment, the combined condition is compensable 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."

Only claimant's treating physician, Dr. Naugle, offered an opinion concerning causation. In asserting that Dr. Naugle indicated that at least part of her need for treatment is compensable, claimant relies on the following colloquy from Dr. Naugle's deposition:

> Q. If [claimant] needed surgery in the future, clearly the original dislocation is the major cause of that need for treatment?
>
> A. [Nods head.]
>
> Q. In terms of the treatment for this particular dislocation, wouldn't the major cause be the activity at work, the putting the stress on her hand?
>
> A. The re--yeah, the re-dislocation, sure. You know, it could have happened at home but it happened at work. And she could just as easily have put her arm up on the kitchen counter and reached down to get a pan and had her arm in the extended abducted position with a little bit of force on it and she could have done it there, but it happened at work. (Ex. 7-11).

We disagree with claimant that such evidence shows that claimant's immediate need for treatment was in major part caused by her work activities. Prior to the deposition, Dr. Naugle concurred with two reports produced by SAIF's attorney stating that "the major contributing cause of [claimant's] most recent shoulder dislocation and need for medical treatment is a result of her original injury[.]" (Exs. 5, 6). There is no indication that claimant's "need for treatment" did not include the treatment immediately following the dislocation at work. Dr. Naugle reiterated this opinion during the deposition. (Ex. 7-10, 7-11).

Based on the totality of Dr. Naugle's opinion, we are not convinced that his agreement with counsel's statement indicated that at least a portion of claimant's need was in major part caused by work activities. Rather, we interpret Dr. Naugle as indicating that, although work was a factor in dislocating the shoulder, claimant's preexisting condition was the major contributing cause.

Consequently, finding no persuasive evidence that the major contributing cause of any of claimant's need for treatment of her right shoulder was a compensable injury, we conclude that she failed to prove compensability. ORS 656.005(7)(a)(B). Thus, we do not address claimant's legal argument concerning the statute.

ORDER

The ALJ's order dated December 30, 1994 is affirmed.

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[1] We need not decide if amended ORS 656.005(7)(a)(B) retroactively applies to this case, see SB 369, § 66(1), because we conclude the result in this case would be the same under either the former or amended revision of ORS 656.005(7)(a)(B).

In the Matter of the Compensation of
WARREN G. WEBBER, Claimant
WCB Case No. 94-09328
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for a low back condition. In his brief, claimant contends that the hearing should have been deferred until "the nature of his worsened condition" at the time of the medical arbiter examination could be determined. On review, the issue is extent of unscheduled permanent disability.

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

Claimant was compensably injured on May 3, 1993. The claim was accepted by the SAIF Corporation as a low back strain. Dr. Woolpert examined claimant on behalf of SAIF and attributed claimant's permanent disability to a prior 1986 back injury. Claimant's attending physician, Dr. O'Gara, concurred with Dr. Woolpert's report.

The May 3, 1993 injury claim was closed by a February 10, 1994 Notice of Closure that awarded no permanent disability. Claimant requested reconsideration, and on July 8, 1994, Dr. Potter performed a medical arbiter examination. Prior to the medical arbiter examination on June 16, 1994, claimant reinjured his low back while working for another employer. In his medical arbiter report, Dr. Potter opined, among other things, that claimant had worsened since the February 1994 closure.

On review, citing Steven P. Grossaint, 46 Van Natta 1737 (1994), claimant contends that litigation of the extent of his permanent disability should be deferred until it can be determined whether the worsening which Dr. Potter noted was the result of an aggravation of the May 3, 1993 compensable injury with SAIF. The parties acknowledge that whether the worsening is an aggravation of the May 3, 1993 injury or a new injury is the subject of separate litigation. For the following reasons, we conclude that rating of claimant's permanent disability due to the May 3, 1993 injury should not be deferred and we affirm the ALJ's order.

First, claimant did not seek deferral of the hearing before the ALJ. Because the issue was not raised at hearing, we are not inclined to address it on Board review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

In any event, even if the issue was properly before us, the worsened back condition noted by Dr. Potter has been determined in a Disputed Claims Settlement not to be an aggravation of the May 3, 1993 injury. Claimant's hearing request in that case has been dismissed. In addition, an ALJ has subsequently upheld a denial of claimant's claim for a "new injury" allegedly occurring on June 16, 1994. Accordingly, there is no hearing request with which to consolidate claimant's current hearing request and no reason to defer claimant's present hearing request since there has been no compensable aggravation of the May 1993 injury.

Finally, on the merits, we agree with the ALJ that Dr. Potter's medical arbiter examination is less persuasive than the opinion of Dr. O'Gara. Dr. O'Gara concurred with Dr. Woolpert's opinion that claimant's symptoms were the same before and after the May 1993 injury and that claimant's impairment was due to the prior 1986 injury.

Dr. O'Gara is in the best position to evaluate claimant's permanent impairment due to the May 1993 injury. Dr. O'Gara examined claimant in March 1993, before the May 1993 injury and has examined claimant after the May 1993. Under such circumstances, we find his opinion regarding the extent of claimant's impairment due to the May 1993 injury persuasive. See Kienows Food Stores v. Lyster, 79 Or App 416 (1986) (opinion of physician who was able to observe the claimant before and after injury more persuasive). Accordingly, we conclude that the ALJ's order should be affirmed.

ORDER

The ALJ's order dated November 25, 1994 is affirmed.

July 27, 1995 Cite as 47 Van Natta 1417 (1995)

In the Matter of the Compensation of
ROBERT R. BAGLEY, Claimant
WCB Case No. 94-00386
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian, and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as the City Recorder/Administrator for the City of Yamhill. In October 1993, he sought psychological treatment and eventually was diagnosed with major depression. The ALJ upheld the employer's denial of the claim for claimant's psychological condition on the basis that he did not satisfy ORS 656.802. According to claimant, he satisfied all the elements necessary for proving the compensability of his emotional condition.

Under ORS 656.802(1)(b), "occupational disease" includes any mental disorder that requires medical services or results in physical or mental disability. The worker must prove that employment conditions were the major contributing cause of the disease. ORS 656.802(2). Additionally, the employment conditions must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation; there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community; and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

Claimant's treating psychologist, Dr. Campbell, first indicated that claimant's mental condition was due to being "physically and emotionally threatened and harassed by people at his job." (Exs. 21-2, 22). Dr. Campbell later reported that, although claimant "had been experiencing several hassles and stressors on his job," a "significant event" occurred that was the "major precipitating event" of claimant's depression and need for treatment. (Exs. 26, 27). This "event" was a threat by then-Mayor Hill to shoot claimant with a gun. (Id.).

Although Dr. Campbell's opinion alludes to other "hassles and stressors," other than the "shooting" incident, he does not specify or explain to what job conditions he is referencing. Based on his characterization of the event involving Mayor Hill as the "major precipiting event" and the lack of explanation regarding other "hassles and stressors," we understand Dr. Campbell as indicating that the major contributing cause of claimant's depression was the "shooting" event involving Mayor Hill.

In deciding if employment conditions exist in a real and objective sense, we determine whether the events underlying claimant's mental condition are real, as opposed to imaginary, and are capable of producing stress. Duran v. SAIF, 87 Or App 509, 513 (1987). This question does not include whether claimant's perception of the events is reasonable or not, because the medical effect of the events is measured by the actual reaction rather than by an objective standard of whether the conditions would have caused disability of an average worker. Peterson v. SAIF, 78 Or app 167, 170, rev den 301 Or 193 (1986).

Here, claimant was informed that, following claimant's exit from a November 10, 1992 city council meeting, Mayor Hill shouted to Police Chief Gordon Rise: "Gordon, Gordon, hurry up. Shoot [claimant] before he gets away." (Tr. 52 (Day 1)). Claimant did not personally hear Mayor Hill make any statements after he left the meeting and subsequently was told by at least two persons, including his brother-in-law, of the remarks.

According to Mayor Hill, as claimant was leaving, he said to him, "Why don't you shoot me, put me out of my misery?" (Id. at 40). Julia Fenwick, who served on the city council and was present during the November 10 meeting, testified that Mayor Hill yelled, "Gordon, you may as well get your gun out and shoot me." (Id. at 71). Harold Shipler, another member of the city council during the November 10 meeting, similarly testified that Mayor Hill stated, "Why don't you shoot me?" (Id. at 96).

Other than claimant's brother-in-law, the only person present at the meeting who testified that Mayor Hill urged Police Chief Rise to shoot claimant was Frankie Richter, a reporter for a local newspaper. She stated that, following Mayor Hill's outburst, she approached Julia Fenwick because she personally only heard the words "stop" and "shoot." (Tr. 14-15 (Day 2)). According to Ms. Richter, Ms. Fenwick told her that Mayor Hill had shouted, "Shoot him before he gets away." (Id. at 33). In response to Ms. Richter's testimony, Ms. Fenwick denied making such a statement. (Id. at 79).

We are most persuaded by the testimony showing that Mayor Hill shouted to "shoot me" rather than claimant. The contrary version is supported only by claimant's brother-in-law and Ms. Richter; Ms. Richter, however, did not actually hear everything that Mayor Hill said, and Ms. Fenwick denied making the statement attributed to her by Ms. Richter. We find more persuasive testimony by Ms. Fenwick and Mr. Shipler, both of whom heard Mayor Hill's remarks.

Thus, having found as a factual matter that Mayor Hill did not shout to "shoot claimant," we conclude that such an event did not occur in the manner believed by claimant. Because we conclude that the incident was not as claimant believed, it cannot qualify as an employment condition that "exists in a real and objective sense." Consequently, we conclude that claimant failed to prove compensability of his mental disorder. ORS 656.802(3)(a).

ORDER

The ALJ's order dated October 3, 1994 is affirmed.

Board Member Gunn dissenting.

I disagree with the majority that claimant did not prove a compensable claim for his psychological condition. First, I do not construe Dr. Campbell's opinion as limiting causation to the so-called "shooting" event involving former Mayor Hill. By generally referring to claimant's "hassles and stressors on his job," I believe that Dr. Campbell was implicating the entire work experience as a cause of claimant's depression.

Furthermore, claimant showed that he suffered extensive "hassles and stressors on his job." Claimant was involved in the termination of a city employee for theft; that person and members of her family thereafter stalked claimant. Claimant also was disciplined for submitting a complaint to the Ethics Commission regarding the terminated employee's actions, even though he had a legal right to notify the Commission. In a separate incident, claimant was physically assaulted in his office by an angry citizen. Finally, claimant was the target of Mayor Hill's unpredictable and angry outbursts at city council meetings; during one meeting Mayor Hill charged through some chairs and threw a piece of furniture, requiring others to physically restrain him.

Inasmuch as I believe that these employment conditions, and others, were the major contributing cause of claimant's depression and are not of the type generally inherent in every working situation, I conclude that claimant proved his claim compensable.

In the Matter of the Compensation of
ANGELA M. CHIOTAKOS, Claimant
WCB Case No. 94-09793
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Adminstrative Law Judge (ALJ) Hoguet's order that: (1) admitted, over the insurer's objection, alleged "hearsay" testimony regarding witnesses' conversations with other individuals who did not testify; and (2) set aside the insurer's denial of claimant's injury claim for her neck, left shoulder, low back and hip conditions. On review, the issues are: (1) the ALJ's evidentiary ruling; and (2) whether claimant's injury arose out of the course and scope of her employment.

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

Claimant worked as a salesperson at the employer's pet store. On the morning of May 6, 1994 at about 7:45 a.m., claimant called the employer to find out when she was to begin working that day. An employee named Norm answered the phone and checked claimant's work schedule. After telling claimant that she was supposed to have been at work at 7:00 a.m., Norm asked claimant to pick up some paper towels for use in cleaning the animal cages.

On her way to work, claimant stopped to buy the paper towels at a convenience store. To get to the convenience store, claimant had to alter her normal route to work.

While purchasing the paper towels, claimant also bought a candy bar. While attempting to exit the store's parking lot and enter the adjoining street, claimant's vehicle was struck by another vehicle.

Applying the "dual purpose exception" to the "going and coming" rule, the ALJ found that claimant was injured "in the course of" her employment for the employer, while purchasing the paper towels for the employer's business. Consequently, the ALJ held that the claim was compensable.

The insurer contends that this case should have been analyzed as a "going and coming" case because claimant failed to establish a "business purpose" which is the threshold requirement to activate the "dual purpose" exception. According to the insurer, the ALJ also erred by relying on the hearsay testimony of the claimant which supported a finding that claimant's purchase of the paper towel was an authorized business purpose for the employer. Based on the following reasoning, we affirm the ALJ's evidentiary ruling and compensability decision.

At hearing, the ALJ admitted hearsay testimony from claimant concerning statements made by an employee who did not testify. The hearsay statements concerned an alleged phone conversation between claimant and a co-worker, Norm. According to claimant, Norm answered the employer's phone on the morning of the alleged accident and directed her to purchase paper towels on her way to work to be used in cleaning the employer's animal cages.

We review the ALJ's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). Hearsay evidence is generally admissible in worker's compensation proceedings, although such evidence may be excluded when it is in the interest of substantial justice to do so. Armstrong v. SAIF, 67 Or App 498 (1984). Evidence is not deemed inadmissible solely on the basis that it is hearsay. Armstrong v. SAIF, supra.

The insurer contends that the hearsay statements represent the only evidence that claimant's trip to the convenience store was a "business purpose" for the employer. Therefore, according to the insurer, the hearsay testimony should have been excluded from the record. Alternatively, the insurer argues that the hearsay testimony should be accorded very little weight.

After our review of the evidence, we conclude that it was not an abuse of discretion for the ALJ to admit the hearsay testimony. The probative value of the hearsay evidence was to establish a business purpose for claimant's trip to the convenience store. However, contrary to the insurer's contention, the ALJ's conclusion that claimant was purchasing the paper towels for the employer was not based solely on claimant's hearsay testimony.

The ALJ also considered the following facts: (1) claimant deviated from her normal driving route to buy the paper towels; (2) the employer reimbursed her for the cost of the paper towels; and (3) Bob Neal, employer's district manager, testified that he was aware that claimant was involved in a motor vehicle accident while purchasing paper towels for the employer. In light of this supporting evidence, we find that the ALJ did not err in admitting the hearsay evidence. Alternatively, even if we do not consider claimant's testimony, the remaining evidence supports a "business purpose."

A compensable claim is one "in the course of" and "arising out of" employment. ORS 656.005(7)(a). "In the course of employment" concerns the time, place and circumstances of the injury. "Arose out of employment" concerns the causal connection between the injury and the employment. Norpac Foods, Inc., v. Gilmore, 318 Or 363 (1993).[1] Generally, injuries sustained by employees when "going to and coming" from work are not considered to arise out of and occur in the course of employment. Philpott v. SIAC, 234 Or 37 (1963). One of the exceptions to this rule is the "dual purpose exception" under which trips to or from the workplace serving both personal and business purposes may be compensable. 1 Larson, Workmen's Compensation Law, Section 18.12 at 4-252 thru 4-267 (1985). However, if the accident happened after the business purpose had been completed and while claimant was on his way home, the injury would not be compensable. 1 Larson, supra, Section 19.24 at 4-344 thru 4-346; Gumbrecht v. SAIF, 21 Or App 389, 394 (1975).

The insurer contends that, even if the "dual purpose exception" applies, claimant's injury is not compensable because the business portion of claimant's trip was completed once she bought the paper towels and proceeded to drive to work. We disagree.

Here, after claimant purchased the paper towels, she drove out of the convenience store parking lot. As a result of the traffic situation at that time, claimant was unable to completely turn her car onto the traffic lane. Claimant was stopped, approximately 3-5 feet behind a van which was in front of her. It was at this time that claimant's automobile was struck by the van, when it backed up instead of going forward.

We find, as did the ALJ, that claimant's accident occurred while she was still fulfilling her business purpose. Not until claimant had returned to her normal route to work (which occurred subsequent to her accident) would the "dual purpose" of her activity have ended. Therefore, we conclude that claimant's motor vehicle accident occurred while she was still carrying out her "business purpose" for the employer. Accordingly, claimant's motor vehicle accident occurred "in the course of her employment" for the employer.

Having found that claimant was injured "in the course and scope of her employment" the ALJ applied the "Mellis test" to find claimant's motor vehicle accident "arose out of her employment." Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985).[2]

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[1] Subsequent to the ALJ's order, the Court of Appeals determined in First Interstate Bank of Oregon v. Clark, 133 Or App 712, 717 (1995), that the proper framework for our analysis under ORS 656.005(7)(a) was set forth in Norpac Foods, Inc., v. Gilmore, 318 Or 363 (1993). In Norpac Foods, the Court stated that the proper analysis to determine whether an injury was sufficiently work-connected to justify compensability consisted of a two prong test. The first prong considers whether the injury occurred "in the course of employment" and the second prong evaluates whether the "injury arose out of the employment." Norpac Foods v. Gilmore, supra. The Court determined that neither prong was dispositive, and the Board must consider the "totality of the circumstances" to determine if the claimant has shown a sufficient work connection. Id. at 366,369.

[2] The Court of Appeals held in First Interstate Bank of Oregon v. Clark, supra, that the Mellis test should no longer be used as an independent and dispositive test of work connection. Instead, we must consider the "totality of the circumstances" to determine if the claimant has shown a sufficient work connection. Id. at 366, 369.

Here, we find that the paper towels purchased by claimant were needed by the employer to clean out the animal cages. Norm, a co-worker, requested that claimant buy some paper towels for specific job duties. The employer reimbursed claimant for the three rolls of paper towels. Although claimant admits to also buying a candy bar while at the convenience store to buy the paper towels, it was not the reason why she deviated from her regular route to work. Rather, the primary purpose was to purchase paper towels which the employer needed in order to clean the employer's animal cages.

Therefore, considering the "totality of the circumstances," we find that claimant's motor vehicle accident occurred "in the course of " her employment and "arose out of her employment." Accordingly, we conclude that the claim 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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000 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 December 8, 1994 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

July 27, 1995 Cite as 47 Van Natta 1421 (1995)

In the Matter of the Compensation of
JOHN CODINO, Claimant
WCB Case No. 94-07720
ORDER ON REVIEW
Thomas A. Coleman, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that upheld the self-insured employer's 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 exception of the ALJ's finding of fact that claimant was seen by Dr. Rosenbaum on September 20, 1993. Rather, Dr. Rosenbaum performed a medical records review in connection with claimant's motor vehicle accident claim on that date. Furthermore, we provide the following supplementation.

The ALJ found that claimant did not establish by a preponderance of the evidence that his work activity was the major cause of his carpal tunnel syndrome. The ALJ gave greater weight to the opinion of Dr. Rosenbaum (who, based on his records review, felt that claimant's work was likely not the major cause) than that of treating physician, Dr. Puziss, (who initially attributed claimant's carpal tunnel syndrome to a motor vehicle accident and later attributed the cause to claimant's work) because the ALJ found that Dr. Puziss did not adequately explain his change of opinion. The ALJ determined that Dr. Puziss was inconsistent in his opinion on causation and also that his history of claimant's work activities may have been inaccurate.

On review, claimant argues that the ALJ erred in favoring the medical opinion of Dr. Rosenbaum, who never examined claimant, over that of Dr. Puziss, who saw claimant before, during and after his carpal tunnel release surgery. Claimant contends that Dr. Puziss' reports and opinions are sufficient to establish that claimant's part-time work as a data entry clerk in the employer's credit department was the major cause of his carpal tunnel syndrome. We disagree.

Subsequent to the ALJ's order and the parties' briefing on review, ORS 656.802(2) was amended by Senate Bill 369, 68th Leg., Reg. Sess. § 56 (June 7, 1995). We note, however, the result in this case would be the same under either version of the occupational disease statute, as amended 656.802(2)(a) still requires the worker to prove that employment conditions were the major contributing cause of the disease.

Here, we find that, even if we were to rely only on the medical opinions of Dr. Puziss and give no weight to the contrary opinions of Dr. Rosenbaum and Drs. Gambee and Rich (the employer-arranged examining physicians), claimant has not proven that his work activity was the major contributing cause of his carpal tunnel syndrome.

On March 17, 1994, in a letter to claimant's attorney, Dr. Puziss opined that the major cause of claimant's condition was the tenosynovitis, but that claimant's automobile accident caused some injury to the median nerve which gave rise to the carpal tunnel syndrome. (Ex. 47). On August 29, 1994, Dr. Puziss further explained that although claimant's work activities probably were a material contributing factor, the tenosynovitis was the major cause of his carpal tunnel syndrome. (Ex. 57).

In an October 19, 1994 letter responding to Dr. Rosenbaum's characterization of claimant's carpal tunnel syndrome as idiopathic, Dr. Puziss states: "[R]epetitive use of the right hand was a cause for tenosynovitis. I do not believe that tenosynovitis is usually idiopathic. I believe that tenosynovitis, instead, is a result of overuse when no other cause has been suggested." (Ex. 59). In this same report, Dr. Puziss explained that "there has been at least a material contributing factor to his carpal tunnel syndrome by virtue of [claimant's] work activities of data entry over 15 years."

Taking Dr. Puziss' series of medical reports as a whole, we understand his opinion to be that claimant's work activities were a material cause of the tenosynovitis,[1] and that the tenosynovitis was the major cause of the carpal tunnel syndrome. This indirect connection between claimant's work and his carpal tunnel syndrome does not meet the major contributing cause standard of amended ORS 656.802(2).[2] Moreover, in light of his earlier reports, we are unpersuaded by Dr. Puziss' subsequent conclusion that claimant's work as a data entry clerk was "a major cause" of claimant's condition.[3] Dr. Puziss did not adequately explain away his earlier opinions that the tenosynovitis was the major cause. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (an unexplained change of opinion is given little probative weight).

In conclusion, we are not persuaded by Dr. Puziss' medical reports that claimant's employment conditions were the major contributing cause of his carpal tunnel syndrome. All of the other medical evidence in the record, especially the reports of Dr. Rosenbaum and Drs. Gambee and Rich, indicate that claimant's work activity was not of sufficient intensity to be the major cause of his condition.[4] We therefore agree with the ALJ's conclusion that the weight of the medical evidence does not establish the compensability of claimant's carpal tunnel syndrome.

ORDER

The ALJ's order dated December 21, 1994 is affirmed.

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[1] At hearing claimant did not challenge the employer's June 22, 1994 denial of the claimant's tenosynovitis claim. The only issue before the ALJ was the employer's August 11, 1994 denial of the bilateral carpal tunnel syndrome and left cubital tunnel syndrome claims. (Tr. at 1). The tenosynovitis is therefore a noncompensable condition by operation of law. We note, however, that even if this denial had not become final, the medical evidence is insufficient to establish the compensability of the tenosynovitis under amended ORS 656.802(2), as Dr. Puziss stated only that claimant's work was a cause of the tenosynovitis.

[2] "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983).

[3] Dr. Puziss ultimately opined that "51% of [claimant's] problems are due to his work activities, at least, and probably the other 49% are due to factors such as other usage, susceptibility, idiopathic factors and so forth." (Ex. 59). This conclusion does not account for the effect of claimant's tenosynovitis in the development of carpal tunnel syndrome. Further, Dr. Puziss' use of the word "problems" in this context is somewhat problematic in itself, as it is not clear whether he is referring to the carpal tunnel syndrome or the tenosynovitis. This opinion therefore has little probative value.

[4] We find no merit to claimant's argument, based on Liberty Northwest v. Spurgeon, 109 Or App 566 (1992), that his predispositions to carpal tunnel syndrome should be treated as mere susceptibilities and not as causes of the condition. First, his characterization of the carpal tunnel syndrome is unsupported by the medical evidence. Second, given the definition of "preexisting condition" in amended ORS 656.005(24) (SB 369, § 1), it appears Spurgeon is no longer good law. Further, under amended ORS 656.802(2)(e), preexisting conditions are deemed causes in determining the major contributing cause of an occupational disease.

In the Matter of the Compensation of
BARBARA J. HARP, Claimant
WCB Case No. 93-14849
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Ray Myers (Saif), Defense Attorney

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) upheld the SAIF Corporation's current condition denial; (2) upheld SAIF's de facto denial of claimant's aggravation claim; (3) upheld SAIF's de facto denial of post-traumatic fibrositis and myofibrositis; and (4) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are compensability, aggravation, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

On May 23, 1984, claimant fell off a platform, hitting her head and right leg on the way down, and landing on her left hip. The initial diagnosis was "minor contusions/abrasions." Claimant filed a form 801 for a bruised right leg, left hip and head. SAIF, on June 22, 1984, issued a Notice of Claim Acceptance for minor contusions of the leg, hip and head as a nondisabling claim.

Other than the initial emergency room visit, claimant sought no further treatment until June 5, 1985, when she saw Dr. Jeppesen, her family doctor. Claimant testified that she sought treatment in June 1985 because of new symptoms of numbness and tingling in her left leg. (Tr. 11, 14). Dr. Jeppesen obtained a history of persistent pain in the left hip and of a two week history of numbness and tingling in the left leg, which claimant attributed to the May 1984 injury. Dr. Jeppesen diagnosed post-traumatic fibrositis and myofibrositis of the upper left sacroiliac region and adjacent buttocks. Claimant was subsequently diagnosed as having congenital scoliosis, L5-SI facet arthropathy and degenerative lumbar disc disease. Claimant also has a right leg length discrepancy due to the scoliosis for which Dr. Jeppesen prescribed a shoe lift. This leg length discrepancy was aggravating claimant's pain complaints.

Claimant contends that the contusions she sustained from her May 1984 injury are a different condition than her post-traumatic myofibrositis condition, but that the post-traumatic myofibrositis arose directly from her injury. Claimant, thus, alleges that SAIF denied "de facto" her post-traumatic myofibrositis condition and/or "de facto" denied an aggravation claim based on a worsening of that condition.

The ALJ found that, because claimant's current condition was the same condition that the insurer had accepted, claimant's claim for post-traumatic myofibrositis had not been "de facto" denied. We conclude that claimant's current condition is not the same condition which was accepted. In addition, we are not persuaded that claimant's current condition is compensable.[1]

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[1] After the ALJ's order, the legislature enacted Senate Bill 369. ORS 656.262(7)(a), as amended, provides, in part: "Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time." SB 369, 68th Leg., Reg. Sess., § 28(7)(a) (June 7, 1995). ORS 656.262(7)(a), as amended, further provides that the worker must clearly request formal written acceptance of any new medical condition and the carrier shall provide written notice of acceptance or denial within 90 days after receipt of the claim. See also ORS 656.262(6)(d), as amended (providing, inter alia, that a worker who believes a condition has been incorrectly omitted from the acceptance notice first must communicate in writing to the carrier the worker's objections to the notice). SB 369, 68th Leg., Reg. Sess., § 28(6)(d) (June 7, 1995).

We need not decide whether the amendments in ORS 656.262 apply retroactively in this case because the evidence does not support claimant's arguments that her post-traumatic myofibrositis condition was incorrectly omitted from SAIF's acceptance or that her current condition is compensably related to her accepted condition. Moreover, since SAIF has consistently objected to claimant's claim, we conclude that it would not achieve substantial justice to remand this case for compliance with the aforementioned procedural rules.

We base our conclusion on: (1) claimant's testimony that the left leg numbness and tingling were new and different symptoms; (2) the approximately 14-month gap in treatment after her injury; (3) the influence of scoliosis and leg length discrepancy on claimant's pain complaints; and (4) claimant's concession that her post-traumatic myofibrositis is a separate condition. We are, therefore, persuaded that the post-traumatic condition was not included in SAIF's acceptance.[2] See Craig E. Chamberlin, 47 Van Natta 226 (1995) (where two separate and distinct diagnoses, the insurer's acceptance of one did not constitute an acceptance of the other); cf. Elsie M. Culp, 47 Van Natta 760 (1995) (although CTS and tenosynovitis were separately diagnosed, tenosynovitis was a component of the accepted CTS; therefore, no "de facto" denial of tenosynovitis).

The ALJ found that claimant's current low back condition was related to her preexisting scoliosis and upheld SAIF's November 1993 current condition denial.[3] We agree.

In December 1985, Dr. Kho, neurologist, and Dr. Potter, orthopedic surgeon, examined claimant at SAIF's request. At that time, claimant complained of back pain and left hip pain. Drs. Kho and Potter diagnosed post-traumatic lumbar myofascial pain syndrome, congenital right convex scoliosis, lumbar lordosis, and mild lumbar spondylosis and facet arthropathy. As a result of the scoliosis, claimant's right leg is approximately 3/4 inch shorter than the left. They opined that claimant's pain was post-traumatic and was aggravated by her leg length discrepancy and lumbar lordosis. We interpret Drs. Kho and Potter's opinion to support the conclusion that claimant's preexisting scoliosis combined with her compensable injury to produce her current condition.

Under such circumstances, we conclude that ORS 656.005(7)(a)(B)[4] is applicable. Considering claimant's preexisting conditions, the causation issue is a complex medical question requiring competent medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Dr. Jeppesen, claimant's treating physician, opined that claimant had a chronic low back problem which was related to her May 1984 injury and which was aggravated by her right leg length discrepancy. (Exs. 14). Dr. Jeppesen explained that claimant did not have low back pain or problems with her right leg length discrepancy prior to her injury, but has had low back pain ever since. (Exs. 7, 14, 16).

We generally give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, there are a number of reasons not to defer to Dr. Jeppesen's opinion.

Dr. Jeppesen's analysis is based almost entirely on the sequential relationship between claimant's original injury and her subsequent symptoms. Furthermore, Dr. Jeppesen reported no history or objective findings as to the possible cause of claimant's complaints of leg numbness and tingling at the time of his June 1985 examination. See exs. 6, 25-16. Under such circumstances, we give Dr. Jeppesen's opinion little weight. See Allie v. SAIF, 79 Or App 284 (1986).

Dr. Jeppesen also failed to address the contribution of claimant's preexisting conditions, in particular, the scoliosis. After Dr. Jeppesen prescribed shoe lifts to treat the scoliosis, claimant's back pain improved. (Exs. A pp. 10, 13, 15; 10; 11; 15). In June 1986, Dr. Jeppesen reported that claimant's post-traumatic myofibrositis had resolved. (Ex. 10). He subsequently reported that claimant had no pain when she used her shoe lift when standing and walking, but she would have left low back pain when she sat or when bending without her shoe lifts. (Ex. 11-1). Although Dr. Jeppesen acknowledged

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[2] Claimant contends that SAIF accepted a low back strain in its November 1993 partial denial and, therefore, SAIF accepted a low back component of the claim. Because a "low back strain" was neither diagnosed nor claimed, we conclude that SAIF did not accept a "low back strain" when it issued its denial.

[3] Because the ALJ found claimant's current condition was not compensable, he did not address the aggravation issue. Since we have found that the post-traumatic myofibrositis condition is not encompassed within claimant's accepted condition, we do not reach the aggravation issue.

[4] Our ultimate conclusion of compensability would be unaffected regardless of whether the former or current version of ORS 656.005(7)(a)(B) was applied.

the presence of the preexisting scoliosis, he provided little or no explanation of the potential interrelationship, or lack thereof, between the 1984 work injury and claimant's preexisting condition. See Dietz v. Ramuda, 130 Or App 394 (1994) (the relative contribution of each cause, including the precipitating cause, must be evaluated to determine which is the major contributing cause).

Under these circumstances, we find Dr. Jeppesen's opinion is conclusory and not well-reasoned. Accordingly, we do not find his opinion persuasive. Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

We also find the opinion of Dr. Sacks, claimant's current treating physician, insufficient to carry claimant's burden of proof. Dr. Sacks first saw claimant in October 1993. Dr. Sacks initially opined that claimant's May 1984 injury had resolved and that her preexisting conditions were the major contributing cause of her current condition and need for treatment. (Ex. 22). After a more thorough review of claimant's medical records, Dr. Sacks opined that, on a temporal basis, claimant's injury contributed to her pain, but considering her congenital abnormality, some of her current symptoms could be independent of the injury. However, Dr. Sacks was unable to determine whether claimant's industrial injury or her preexisting conditions were the major cause of her current problems. (Ex. 25 pp. 20-21, 24, 29-31).

Dr. Hermens, orthopedic surgeon, provided a contrary opinion. Dr. Hermens analyzed the relationship between claimant's back pain and her scoliosis. He noted that claimant's back pain improved with use of the right shoe lift. This indicated that her back pain was more related to the scoliosis and leg length discrepancy. (Ex. 20). We find his opinion consistent with claimant's history. Because Dr. Hermens' opinion is based on an accurate history and is well-reasoned, we afford it the most weight. Somers v. SAIF, 77 Or App 259 (1986).

Consequently, we conclude that claimant failed to prove that her current condition is compensable.

Because we have concluded that claimant's current condition is not compensable, there are no amounts then due on which to base a penalty, under amended ORS 656.262(11), for SAIF's allegedly unreasonable claims processing. Likewise, there has been no unreasonable resistance to the payment of compensation for which to warrant an attorney fee award under ORS 656.382(1).

ORDER

The ALJ's order dated June 22, 1994 is affirmed.

July 27, 1995 Cite as 47 Van Natta 1425 (1995)

In the Matter of the Compensation of
JODY N. HAYES, Claimant
WCB Case No. 94-07627
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Moscato, et al, Defense Attorneys

Reviewed by Board Members Turner-Christian, Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the self-insured employer's denial of her injury claim; and (2) declined to assess penalties or attorney fees for failure to pay temporary disability benefits. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

The parties have stipulated to the following facts: claimant was assaulted within a half hour of finishing her work shift on a parking lot owned and controlled by the employer. The assault caused injuries which required medical treatment and resulted in disability. At the time she was assaulted, claimant's vehicle was parked in an area of the lot where the employer had specified that employees could park. (Tr. 7-9).

In addition to the facts stipulated to by the parties, we adopt the ALJ's "Notice Facts," and we make the following findings.

On March 20, 1994, claimant finished her shift working in the employer's apparel department at 8:00 PM. She did some personal grocery shopping in the employer's grocery department which took about 15 to 20 minutes. After completing her shopping, claimant left the store through the grocery exit and walked toward her car pushing a cart containing groceries. The parking lot was approximately half full of cars when claimant left the store. Claimant's car was parked approximately 72 yards from the grocery exit. (Tr. 63).

On the night of her injury, the upper parking lot was full and claimant parked in an area around the perimeter of the main lot in a space which the employer had designated for employees to park. (Ex. 16). The area where claimant parked on March 20, 1994 was not well lit. (Tr. 13). The closest lights were half way across the parking lot. (Tr. 14; Ex. 16).

As claimant approached her car, she was attacked by a man with a knife who apparently attempted to force her into his vehicle. The man had apparently driven his vehicle onto the employer's lot. Claimant resisted and the assailant stabbed claimant in the neck and right thumb. Claimant also fell during the struggle and hit her head. Claimant escaped and ran back into the store. Claimant did not know her attacker and the attacker was not known to have any connection with the employer or with claimant.

Claimant was taken by ambulance to a hospital and was treated in the emergency room for multiple stab wounds to the neck and right thumb. Claimant also had a contusion over the left eye. (Ex. 1). Claimant's right thumb injury later required surgery to repair an ulnar digital nerve laceration and a 90 percent transsection of the flexor pollicis longus tendon. (Ex. 10).

The employer required employees to park on the upper parking lot of the store where claimant worked, or if that lot was full, in areas specified by the employer around the perimeter of the main parking lot. (Ex. 16; Tr. 72). Employees could be disciplined if they parked in areas other than those specified by the employer. (Tr. 15). On the night claimant was assaulted, there was no security guard in the parking lot. Transients occasionally came onto the employer's premises including the parking lot area. If transients or other individuals bothered employees or customers, the employer took steps to ask them to leave or called the police. The employer has a policy to escort employees who wished such an escort out to their cars. (Tr. 74).

Claimant filed a workers compensation claim with the employer which was denied on June 17, 1994. (Ex. 14).

CONCLUSIONS OF LAW AND OPINION

Concluding that claimant had failed to establish that her injury arose out of her employment, the ALJ upheld the employer's denial.

On review, claimant contends that the "parking lot" exception to the "going and coming rule" applies and that her injuries from the assault had a sufficient relationship to her work activities to render those injuries compensable. The employer argues that claimant's injury did not originate in a risk associated with her employment and that the only connection between the injury and claimant's employment was the location of the attack on the employer's premises.

For an injury to be compensable, it must "aris[e] out of and in the course of employment." ORS 656.005(7)(a). The Supreme Court has treated the "arising out of" and "in the course of" elements as two elements in a single inquiry: whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Rogers v. SAIF, 289 Or 633 (1980). The "in the course of employment" element concerns the time, place and circumstances of the injury, while the "arising out of" element tests the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994).

Under the "going and coming rule" adopted by Oregon courts, injuries sustained while going to or coming from the place of employment normally are not compensable. SAIF v. Reel, 303 Or 210 (1987). There are, however, some exceptions to this general rule. One such exception is the "parking lot rule." Under that rule, injuries sustained on the employer's premises while the employee is proceeding to or from work have a sufficient work-connection to be considered to have occurred within the course of employment. Norpac Foods, Inc. v. Gilmore, supra.

In this case, instead of leaving work immediately, claimant grocery shopped briefly before leaving the employer's store and going out to the parking lot to go home. We do not find that claimant's brief grocery shopping after work was sufficient to sever the connection with claimant's employment. However, although we conclude that claimant was in the "course of her employment" when she was injured on the parking lot, the question remains whether claimant's injuries "arose out of" her employment.

In Barkley v. Corrections Division, 111 Or App 48 (1992), the claimant, a convenience store clerk, was sexually assaulted while working alone late at night. Reasoning that the work environment increased the claimant's exposure to people who might commit violent crimes, the court concluded that there was a sufficient relationship between the assault and a risk connected to the employment to conclude that the injury arose out of and in the course of her employment. In reaching its decision, the court stated that "an assault by a third person is deemed to arise out of a claimant's employment when the assault is the result of the nature of the work or when it originates from some risk to which the work environment exposes the employee." Larson similarly indicates that an assault may arise out of employment if the assault is motivated by something related to the employment, or if the work environment increased the risk of attack. 1 Larson, Workmen's Compensation Law 3-196 §11.11(b) (1995 supp).

We find a sufficient relationship between the assault in this case and a risk of claimant's employment. Claimant was required by the employer to park in an area on the perimeter of the parking lot. The closest lights were halfway between the area where claimant parked and the store. Claimant indicated that the area where her car was parked and where the attack took place was not well lit. In addition, witnesses testified that "transients" were sometimes a problem on the employer's parking lot and premises. We conclude that claimant's employment exposed her to an increased risk of the assault because the employer required claimant to park at the "fringes" of the parking lot in an area that was not well lit. These factors made claimant vulnerable to an attack and enhanced the risk that such an attack would occur. Under such circumstances, we conclude that claimant's injuries arose out of a risk to which her employment exposed her.

We distinguish this case from Pamela E. Fleischer, 44 Van Natta 1258 (1992), aff'd mem 118 Or App 540 (1993). In that case, the claimant arrived at work, at the suggestion of her supervisor, a half hour earlier than other employees and entered the workplace through a door which was partially hidden from view. The claimant was attacked and injured as she was unlocking the door to her workplace. The claimant's assailant was a man who had been stalking the claimant and had attempted to rape the claimant a year previously when she was working for a prior employer.

In Fleischer, we concluded that the injuries sustained in the attack did not "arise out of" the employment. We reasoned that the attack was directed at the claimant personally, since the attacker had previously stalked the claimant, rather than as a result of her position with the employer. In addition, we found a lack of proof that the work environment appreciably increased the risk of attack. We noted that the claimant testified that she did not feel threatened by arriving at work early. In addition, the claimant's supervisor testified that he considered the area safe at the time of the morning that the claimant was attacked. In light of these factors, we concluded that the claimant had failed to establish a sufficient employment nexus to render the assault compensable.

In the present case, unlike in Fleischer, the assault was not directed at claimant personally. The attacker was not known to claimant and had no known connection to the employer. In addition, unlike in Fleischer, we conclude that the work environment increased the risk of attack. In this regard, claimant's shift ended at night when it was dark outside. Employees were required to park at the perimeter of the parking lot away from the store so that customers could park in spaces nearer to the store. In addition, claimant testified that the area where she was attacked was not well lit. Finally, witnesses testified that "transients" frequented the areas surrounding the employer's premises and sometimes came onto the property. Claimant testified to feeling scared to walk outside the store at night. (Tr. 19). Under the circumstances, we conclude that the work environment increased claimant's risk of attack and that the attack "arose out of" claimant's employment. Accordingly, we set aside the employer's denial of her injury claim.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by the self-insured employer. 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.

Claimant seeks penalties and attorney fees in the event the denial is set aside. A penalty may be assessed when an insurer "unreasonably delays or refuses to pay compensation." Former ORS 656.262 (10) (now ORS 656.262 (11) (A)). The standard for determining unreasonable resistance to payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991).

Here, we conclude that the employer had a legitimate doubt concerning its liability for the claim. There is a legitimate legal question concerning whether claimant's injury arose out of and within the course and scope of her employment. Although we have concluded that the injury did arise in the course and scope of claimant's employment, we believe that there was a legitimate legal basis upon which the employer could question its liability for the claim. For these same reasons, we likewise conclude that there was no unreasonable resistance to the payment of compensation which would justify either a penalty under former ORS 656.262(10) or an attorney fee under ORS 656.382(1).

ORDER

The ALJ's order dated October 7, 1994 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the self-insured employer's denial is reversed. The denial is set aside and the claim is remanded to the 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.

Board Member Haynes dissenting.

As the majority correctly states, an injury must "aris[e] out of and in the course of employment" in order to be compensable. ORS 656.005(7)(a). However, the majority errs in this case by finding that either element of the unitary work connection test has been met.

After finishing her shift, claimant engaged in personal shopping in the employer's grocery department. This activity amounted to a personal mission and removed claimant from the course of her employment. This case is analogous to Douglas S. Methvin, 42 Van Natta 1291 (1990). There, the claimant was injured on the employer's premises while searching for his wallet after regular work hours. In Methvin, the Board found that the claimant was on a personal mission and found an insufficient work relationship between the claimant's after-hours search for his wallet and his employment.

Similarly here, claimant chose to engage in a personal activity on the employer's premises after her work was completed. There was no business purpose to claimant's shopping; it was a purely personal activity. Here, as in Methvin, claimant was on a personal mission and was no longer in the course of her employment. In fact, when claimant left the employer's premises, she was no different than any other member of the public who had chosen to shop in the employer's store. Certainly, had claimant left the employer's premises and shopped at a different store, this injury could not be said to have occurred within the course of claimant's employment. Once claimant engaged in the shopping activity, she was on a personal mission and was no longer in the course of her employment. Thus, I believe the shopping activity severed the connection between claimant's work and her injury, which occurred after she finished shopping. On this basis alone, I would affirm the ALJ's order.

However, there is a second reason to affirm the ALJ's order: claimant's injury did not "arise out of" her employment. The assault against claimant was an arbitrary criminal act by a third party. It was a crime that is deplorable and shocking, but it was not caused by claimant's work or any risk associated with her work. The only connection between the crime and claimant's work was the location of the assault.

There had been no similar crimes on the employer's premises. The area where claimant was parked was an area in which customers could park. The lot was not an isolated place which might engender an increased risk to claimant or other employees. In fact, according to claimant's testimony, there were customers in the parking lot at the time of the attack. (Tr. 26). The hour was not especially late; it was only 8:30 in the evening. Moreover, the assailant drove onto the employer's lot from outside. Thus, he was not one of the "transients" previously seen around the employer's premises. The assailant had no known association with the employer and was, as far as the record can establish, not a

customer. There is no evidence that establishes that the lighting on the lot contributed to the assault or played any role in the assault. There has been no proof that there was an increased risk of assault in this employer's parking lot. In short, the evidence does not establish that the employer's parking lot was a particularly dangerous place or that any act or failure to act on the part of the employer caused claimant to be injured. From this evidence, it can only be concluded that the assault did not arise from any risk associated with claimant's employment.

The majority's analysis is legally flawed. This claimant's injuries did not arise out of and in the course and scope of her employment. The fact that claimant engaged in personal shopping prior to the assault renders the connection between her injuries and her employment even more remote. For the reasons expressed herein, I respectfully dissent.

July 27, 1995 Cite as 47 Van Natta 1429 (1995)

In the Matter of the Compensation of
DUANE B. ONSTOTT, Claimant
WCB Case No. 94-12978
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order which affirmed an Order on Reconsideration's increase of scheduled permanent disability for loss of use or function of claimant's right wrist from 5 percent (7.5 degrees), as granted by a Determination Order, to 36 percent (54 degrees). On review, the issue is the extent of scheduled permanent disability.

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

Claimant compensably injured his right wrist in May 1993, a claim that the employer accepted for right wrist tendonitis. Claimant eventually came under the care of a hand specialist, Dr. Gill. Claimant's claim was closed on July 6, 1994, with an award of 5 percent scheduled permanent disability for a chronic condition limiting repetitive use of claimant's right wrist.

Claimant requested reconsideration, but withdrew his request for a medical arbiter examination. An October 10, 1994 Order on Reconsideration increased the scheduled permanent disability award to 36 percent. The increased permanent disability award was based on a finding of a loss of strength due to a disruption of a musculotendinous unit documented in a September 29, 1994 report from Dr. Gill. See OAR 435-35-110(8).

The employer requested a hearing challenging the increased award of permanent disability in the reconsideration order. The parties obtained considerable "post-reconsideration" order medical evidence, including medical reports and deposition testimony from Dr. Gill, as well as a follow-up report from an examining physician, Dr. Fuller, who had examined claimant prior to the July 1994 closure.

Considering the entire record, including "post-reconsideration" medical evidence, the ALJ rejected the employer's argument that claimant did not sustain permanent impairment for loss of grip strength from a disruption of a musculotendinous unit. Relying on Dr. Gill's September 29, 1994 rating of claimant's grip strength loss as 2/5, the ALJ determined that the Order on Reconsideration had correctly rated claimant's scheduled permanent disability and that the employer had failed to sustain its burden of proving by a preponderance of the evidence that the disability "standards" were incorrectly applied.

On review, the employer contends that Dr. Gill's medical opinion is flawed and that there is insufficient medical evidence that claimant suffered a disruption of a musculotendinous unit under the "standards." We disagree.

At the outset, we note that there have been significant changes in the law regarding the medical evidence which can be considered at hearing regarding extent of disability. At the time of hearing, the parties could present "post-reconsideration" medical evidence inasmuch as a medical arbiter had not been appointed pursuant to former ORS 656. 268(7). See Scheller v. Holly House, 125 Or App 454 (1993). The parties availed themselves of the opportunity to do so pursuant to former ORS 656.283(7).[1]

However, on June 7, 1995, Senate Bill 369 amended ORS 656.283(7) to provide in part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself. 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."

Section 66 of Senate Bill 369 is the provision that addresses the effective dates of the various amendments to the Act. Section 66 provides that:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

Inasmuch as this is a claim or cause of action "existing or arising on or after the effective date of this Act," the amendments to ORS 656.283(7) apply retroactively to this claim, unless there is a specific exception stated in Senate Bill 369. Because there is no specific exception for the aforementioned statute, those provisions would appear to be applicable to this claim. Accordingly, the medical evidence submitted after the October 1994 Order on Reconsideration would be inadmissible inasmuch as it pertained to an issue regarding a Determination Order and was not "submitted at the reconsideration required by ORS 656.268." Amended ORS 656.283(7); but see Ida M. Walker, 43 Van Natta 1402 (1991) (No retroactive application of legislation where result would be "unjust or absurd").

We need not determine, however, the issue of whether the amendments to ORS 656.283(7) apply to this claim. This is because, even if we were to limit our consideration to the "reconsideration record," or, alternatively, if we were to consider the entire record, as did the ALJ, we would reach the same conclusion: that the employer failed to establish by a preponderance of the evidence that the disability "standards" were incorrectly applied in the reconsideration order.

It is undisputed that the standards in WCD Administrative Order 6-1992 are applicable. The only issue in dispute is whether claimant has a "loss of strength due to . . . disruption of the musculotendinous unit..." OAR 436-35-110(8)(a). Prior to issuance of the reconsideration order, Dr. Fuller had diagnosed a probable partial tear flexor carpi ulnaris tendon and/or triangular fibrocartilage complex. (Ex. 22-5). Dr. Gill concurred with Dr. Fuller's report. (Ex. 23).

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[1] Former ORS 656.283(7) provided:

"Except as otherwise provided in this section and rules of procedure established by the board, the referee 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. Evaluation of the worker's disability by the referee 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 referee 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. 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 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. If the referee finds that the claim has been closed prematurely, the referee shall issue an order rescinding the determination order or notice of closure."

Dr. Gill was subsequently requested by claimant's counsel to rate loss of strength due to a "Disruption of a Musculotendinous Unit" and to enter "N/A" on the rating form if an injured flexor carpi ulnaris tendon was not equivalent to the disruption of a musculotendinous unit. (Ex. 25B-3). Dr. Gill did not enter "N/A" on the form, thereby indicating that an injured flexor carpi ulnaris tendon was equivalent to a disruption of a musculotendinous unit. Dr. Gill rated claimant's loss of strength as 2/5, which results in 33 percent impairment of the right wrist. This value was combined with a 5 percent "chronic condition" award in the Determination Order, an award not challenged on review, to arrive at a total disability rating of 36 percent in the October 1994 reconsideration order.

On review, the employer contends that we should find Dr. Fuller's neurological examination which "revealed grade 5 muscle strength" to be more accurate in rating claimant's loss of strength. We decline to do so.

We agree with the ALJ that Dr. Fuller's unexplained conclusion is insufficient to constitute a preponderance of evidence that the standards were incorrectly applied. Moreover, we find Dr. Fuller's opinion somewhat inconsistent. Dr. Fuller concludes that claimant has no loss of muscle strength, but elsewhere states that claimant has a 15 percent loss of use of the flexor carpi ulnaris, which he opined is one of the main power tendons stabilizing the wrist. (Ex. 22-6). Without more explanation from Dr. Fuller clarifying the seeming contradiction, we are not inclined to give much weight to his opinion on loss of muscle strength.

Accordingly, we conclude that, based on the "reconsideration record," the employer failed to establish that the "standards" were incorrectly applied.[2] We would reach the same result were we to consider "post-reconsideration" medical evidence.

Subsequent to the October 10, 1994 Order on Reconsideration, Dr. Gill reaffirmed his 2/5 rating for loss of strength and emphasized that it represented a "fair assessment" of claimant's grip strength loss. (Ex. 29-2). Dr. Gill was also deposed in December 1994.

Dr. Gill testified that, while he could not say that there had been a "true disruption" of claimant's wrist tendon, he also confirmed that a disruption of a musculotendinous unit would be the most appropriate description of claimant's wrist injury. (Ex. 31-36, 46). Dr. Gill emphasized that claimant's strength in his wrist tendon was "inhibited" by organically based pain. Since Dr. Gill agreed with Dr. Fuller's diagnosis of a partial tear of claimant's wrist tendon, we conclude that this organically based pain is due to the tear in the flexor carpi ulnaris tendon. (Ex. 31-40, 45). Therefore, we find that, based on Dr. Gill's "post-reconsideration" medical opinions, as well as the evidence he provided in "reconsideration record," claimant was appropriately awarded scheduled permanent disability for disruption of a musculotendinous unit pursuant to OAR 436-35-110(8)(a).

Accordingly, based on a de novo review of the entire record, we would also conclude that the employer failed to establish by a preponderance of the evidence that the standards were incorrectly applied. Former ORS 656.283(7). Thus, we affirm claimant's award of scheduled permanent disability.

ORDER

The ALJ's order dated January 25, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the employer.

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[2] In reaching this conclusion, we reject the employer's assertion that a "tear" cannot constitute a "disruption" of a musculotendinous unit under Vogel v. Liberty Northwest Ins. Corp., 132 Or App 7 (1994). While we agree that the court in Vogel defined a "disruption" as an "abnormal separation" caused by trauma, we do not agree that this definition necessarily precludes a "tear" from being an "abnormal separation." As claimant notes, Webster's Ninth Collegiate Dictionary defines a "tear" as to "separate parts of or pull apart by force . . . to divide or disrupt by the pull of contrary forces."

In the Matter of the Compensation of
ROSALIE A. PEEK, Claimant
WCB Case No. 93-12794
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Poland's order which set aside its denial of claimant's right ankle injury claim. On review, the issue is compensability.

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

Claimant, a bus driver, allegedly injured her right ankle on July 18, 1993, as a result of depressing the accelerator pedal of her bus in an abnormal manner. Claimant complained of pain on the top of her right foot/ankle, which she reported promptly to her supervisor. (Tr. 11). Claimant sought treatment that day from an emergency room physician, Dr. Kim, who diagnosed a right ankle sprain. (Ex. 3). Objective findings were limited. No swelling or erythema was detected, but claimant did demonstrate "reproducible tenderness" to palpation. (Ex. 3).

Dr. Henery provided follow-up care on July 22, 1994 and also diagnosed an ankle sprain. On examination, Dr. Henery noted "minimal ecchymosis" over the anterior ankle and range of motion limited by pain.[1] (Ex. 9-1). Dr. Henery eventually released claimant to regular work without permanent impairment on August 12, 1993. (Ex. 15).

While taking a driving test to determine if she could return to regular work, claimant experienced a flare-up of symptoms, causing her to seek care from Dr. Lisac on August 19, 1993. (Ex. 17). Dr. Lisac opined that claimant had a "simple strain" whereby she may have torn a few fibers of the retinaculum which led to a mild reflex sympathetic dystrophy. Dr. Higgins, a foot surgeon, also evaluated claimant's right ankle condition and was unable to identify any objective findings to support claimant's subjective complaints, but emphasized that he did not wish to suggest that claimant's complaints were not sincere. (Ex. 32).

The ALJ found that claimant had proven that operation of the accelerator of her bus on July 18, 1993 was a material contributing cause of her need for medical treatment and had, thus, established a compensable right ankle injury. In reaching this conclusion, the ALJ acknowledged that no physician had explicitly stated that claimant's right ankle symptoms were related to a work injury. However, the ALJ concluded that such an opinion was not necessary to establish compensability since the causation issue was not complex. See Barnett v. SAIF, 122 Or App 279 (1993).

On review, the employer contends that there are no objective findings to support claimant's claim and, further, that the ALJ erred in concluding that Barnett, supra, relieved claimant of the burden of producing expert medical evidence establishing medical causation. We disagree.

The ALJ rejected the employer's argument that there were no objective findings of injury, citing Dr. Henery's observation of bruising and reduced range of motion in his July 22, 1993 examination. The ALJ also noted that there was nothing in the record to suggest that claimant's ankle pain was not genuine.

The ALJ's determination was correct under the law in effect at the time of hearing. Under former ORS 656.005(19), claimant's reduced range of motion and bruising would constitute "objective findings."[2] However, ORS 656.005(19) has been amended to provide that "objective findings" of an injury are:

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[1] Dr. Henery would later confirm that "ecchymosis" was "bruising." (Ex. 34-36).

[2] Former ORS 656.005(19) provided:

"'Objective findings' in support of medical evidence include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings."

"verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

We need not determine the retroactive effect of this amendment, inasmuch as under the current, as well as the former, version of the statute, we would find that claimant's injury was supported by objective findings of injury. Specifically, Dr. Kim reported on July 18, 1993 that claimant had "reproducible tenderness." Inasmuch as this physical finding or subjective response to a physical examination was reproducible, it is not excluded as an objective finding under amended ORS 656.005(19). Moreover, Dr. Henery also detected bruising and reduced range of motion which are verifiable, observable indications of injury.[3]

We now turn to the issue of whether the ALJ properly determined that this claim did not involve a complex medical causation question, thereby relieving claimant of the burden of introducing expert medical evidence to satisfy her burden of proof. We conclude that the ALJ did not err in applying Barnett.

Expert testimony concerning causation may not be not required if: (1) the situation is uncomplicated; (2) symptoms appear immediately; (3) the worker promptly reports the occurrence to a superior; (4) the worker previously was free from disability of the kind involved; and (5) there is no expert testimony that the alleged precipitating event could not have been the cause of the injury. See Barnett v. SAIF, supra (citing Uris v. Compensation Department, 247 Or 420, 426 (1967)), on remand Betty Barnett, 46 Van Natta 9 (1994).

In this case, claimant immediately reported her symptoms to her supervisor on the same day that she experienced them. Claimant sought treatment on the day of her alleged injury. Although claimant reported a prior right ankle injury in 1989, her testimony is unrebutted that this injury resolved with no symptoms for three years prior to the alleged 1993 injury. (Tr. 15). Thus, we conclude that claimant was free from disability prior to the alleged injury. Finally, we find that there is no expert testimony that the alleged injury of July 18, 1993 could not have been the cause of claimant's right ankle sprain.[4]

Accordingly, we find that the ALJ properly applied Barnett in not requiring expert medical evidence on the causation issue. Moreover, even assuming this was a case involving a complex medical causation question, we would still find that claimant has satisfied her burden of proof.

As previously noted, Dr. Lisac opined that claimant had a simple strain in which she may have torn fibers of the retinaculum. In his deposition, Dr. Henery was asked to assume that claimant did use her accelerator abnormally and "overstretched" her right foot. Dr. Henery opined that, if that history were correct, then that could produce the injury that Dr. Lisac referred to. (Ex. 35-22).

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[3] The employer notes that claimant's bruise was not detected by Dr. Kim's examination on the date of injury. However, Dr. Henery testified that claimant's bruise was "traumatic" and that it was not unusual for such a bruise to take time to develop. (Ex. 35-42, 44). There is no evidence of a traumatic cause for claimant's bruise apart from claimant's work activity on July 18, 1993.

[4] Although the employer insists that the last criterion of Barnett is not satisfied, a close review of the medical evidence does not disclose a medical opinion that states the alleged injury could not have been the cause of claimant's symptoms. Dr. Henery testified that he was unable to say that claimant's bus driving was the cause of her symptoms, but was also not able to state that it could not have been. (Ex. 34-31). Dr. Lisac stated that claimant had a simple strain as a result of tearing a few fibers of the retinaculum. (Ex. 17-2). Although he did not expressly implicate the bus incident as the cause of claimant's condition, Dr. Lisac clearly implied that it was. Dr. Higgins stated that he was at a loss to explain claimant's symptoms, but he did not rule out her bus driving as a cause of the right ankle condition. (Ex. 29). Based on this evidence, we find that, employer's argument notwithstanding, claimant has satisfied the last requirement of the Barnett criteria.

It is well-settled that a physician need not use "magic words" in expressing an opinion on causation. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Given claimant's credible testimony and consistent history given to her physicians that she was required because of her short stature to operate her accelerator in an abnormal manner, we find that Dr. Lisac's and Dr. Henery's medical opinions would satisfy claimant's burden to show that her bus driving on July 18, 1993 was a material contributing factor in her need for medical treatment.[5] Therefore, we agree with the ALJ that claimant proved that she sustained a compensable injury, even if she was required to produce expert medical evidence.

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 438-15-010(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 $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 9, 1995 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,000, payable by the employer.

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[5] The employer does not dispute the ALJ's application of a material causation standard. Moreover, there is no medical evidence that an otherwise compensable injury "combined" with a "preexisting condition" to cause a need for treatment, which would require application of the major causation standard. Amended ORS 656.005(7)(a)(B).

In the Matter of the Compensation of
MICHAEL R. RYAN, Claimant
WCB Case Nos. 93-14535 & 93-14534
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes, Turner-Christian and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that upheld the self-insured employer's denial of his claim for a psychological condition as either an occupational disease or a compensable consequence of his accepted neck injury claim. With his brief, claimant has submitted a motion for oral arguments before the Board.[1] On review, the issue is compensability.

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

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[1] The Board may allow oral arguments where the case presents an issue of first impression which could have a substantial impact on the workers' compensation system. See Jeffrey B. Trevitts, 46 Van Natta 1767 (1994). Here, the issue is compensability of claimant's psychological condition. This is not an issue of first impression and the resolution of this case will not have a substantial impact on the workers' compensation system as a whole. Moreover, the parties have extensively briefed the issue presented. Under these circumstances, we are not persuaded that oral arguments would appreciably assist us in reaching our decision. Consequently, we decline to grant claimant's motion for oral arguments. See Glen D. Roles, 45 Van Natta 282, 283 (1993).

The ALJ found that Dr. Manfield's opinion was based in part on stressors (the death of a co-worker, claimant's having to work alone, and being under surveillance by the employer) which could not be considered under ORS 656.802(2) and (3) . Therefore, the ALJ did not find Dr. Manfield's opinion persuasive and concluded that claimant had not established that his psychological condition was compensable. Claimant contends that the ALJ erred in not considering the death of his co-worker, his working alone, and being under surveillance by the employer as work-related stressors. Claimant further contends that if those factors are considered, then Dr. Manfield's opinion is persuasive.

Assuming *arguendo* that all of the factors listed by Dr. Manfield are work-related stressors, we would still conclude that claimant has not met his burden of proving, by clear and convincing evidence, that his psychological condition arose out of and in the course of his employment. See ORS 656.802(3)(d). Like the ALJ, we do not find Dr. Manfield's opinion persuasive.

Generally, we rely on medical opinions which are well-reasoned and based on a complete and accurate history. See Somers v. SAIF, 77 Or App 259 (1986). Based on that standard, we find the opinions authored by Drs. Parvaresh and Klecan to be more persuasive than the opinion expressed by Dr. Manfield.

Both Dr. Parvaresh and Dr. Klecan noted that claimant had been prescribed Tenormin and Triavil as early as 1981. (Tr. 371, 499). They explained that the former was to control hypertension while the latter was a tranquilizer/anti-depressant. (Id.) Dr. Parvaresh diagnosed claimant's condition as psychological factor affecting physical condition; panic disorder with agoraphobia; and mixed personality. (Tr. 369). He indicated that claimant's condition was long-standing and explained that this was corroborated in reports from Drs. Achar, Berg, and Bouma following the 1983 off-work hotel fire. (Tr. 376. 428). Dr. Parvaresh concluded that while claimant's work exposure may have caused his condition to become symptomatic, it did not worsen his underlying psychological condition. (Tr. 435-439).

Dr. Klecan diagnosed claimant's condition as a longstanding personality disorder including anxiety. (Tr. 485). He noted that, while claimant had indicated that his fear of being fired began in 1993, claimant had exhibited the same fears in 1983. (Tr. 489). He agreed with Dr. Parvaresh that claimant was currently experiencing the same symptoms that he had exhibited in 1983 and concluded that claimant's work exposure was not the cause of his psychological condition. (Tr. 512).

By contrast, although Dr. Manfield initially diagnosed claimant's condition primarily as post-traumatic stress syndrome related to the 1983 hotel fire, he later opined that claimant's prior psychological difficulties had little causal relationship to his current condition. (Exs. 238; Tr. 99). He acknowledged that the history given to him by claimant was not consistent with the contemporaneous medical reports regarding the psychological treatment he received after the 1983 hotel fire. (Tr. 132-134). Despite this, he continued to opine that claimant's current psychological condition was due to his work exposure in 1992 and 1993. (Ex. 238; Tr. 93). Dr. Manfield does not adequately explain his conclusion in light of claimant's prior history of similar symptoms and treatment. For these reasons, we are not persuaded by his opinion.

Inasmuch as we do not find Dr. Manfield's opinion persuasive and in light of the contrary medical opinions from Drs. Parvaresh and Klecan, claimant has not established, by clear and convincing evidence, that his psychological condition arose out of and in the course of his employment.

ORDER

The ALJ's order dated October 25, 1994 is affirmed.

Board Member Gunn dissenting.

The majority concludes that claimant has failed to prove that his psychological condition is compensable. Because I believe that the record establishes that claimant's work exposure was the major cause of his psychological condition, I dissent.

The persuasive evidence establishes that claimant worked in a hostile environment. He was exposed to numerous work-related stressors including the employer's practice of falsifying DEQ and license records, as well as irregularities in the disposal of hazardous chemicals. There is no persuasive evidence that claimant was exposed to off-the-job stressors. Dr. Manfield, claimant's treating psychologist, opined that claimant's work exposure was the major contributing cause of his psychological condition. (Exs. 238, 286, 311). Arguably, this is where the inquiry should end as the evidence is overwhelming that claimant's work exposure, as opposed to his off-work exposure, was the source of his stress which caused his psychological condition.

The majority finds that Dr. Manfield's opinion is unpersuasive because he does not adequately discuss claimant's prior psychological condition and treatment. There is no question that claimant understandably suffered psychological difficulties following the 1983 hotel fire incident. However, from 1987 to 1993, claimant was able to perform his work duties and did not receive any psychological treatment. In conjunction with this, Dr. Achar, who treated claimant following the 1983 fire, reported that claimant did not suffer from agoraphobia (claimant's current psychological condition) when she treated him between 1983 and 1987. (Ex. 312D). This is consistent with Dr. Manfield's opinion that claimant's current psychological condition is not the same condition he suffered from in 1983. (Tr. 93-100). Consequently, there is no persuasive reason not to give the opinion of Dr. Manfield, who treated claimant on numerous occasions, more weight than the opinions of Drs. Parvaresh and Klecan, who only saw claimant a few times at the request of the employer. See Weiland v. SAIF, 64 Or App 810 (1983).

Claimant's testimony (which the ALJ found credible), in conjunction with Dr. Manfield's persuasive opinion, clearly establish that claimant's work exposure was the major contributing cause of his current psychological condition and need for treatment. On this record, I would conclude that claimant's psychological condition is compensable.

In the Matter of the Compensation of
SHIRRELINE J. BRAY-LODWIG, Claimant
WCB Case No. 93-00544
CORRECTED ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Schwabe, et al, Defense Attorneys

On July 13, 1995, we issued an Order on Review which affirmed an Administrative Law Judge's order that had upheld the self-insured employer's denial of claimant's migraine headache claim. On our own motion, we withdraw our prior order and replace it with the following order.

In our previous order, we applied the amended versions of the relevant statutes. SB 369, 68th Leg., Reg. Sess. (June 7, 1995). Specifically, we reasoned that we retained jurisdiction over the compensability dispute under Section 25 of SB 369 and that claimant's migraine headache condition was not compensable under either amended ORS 656.005(7)(a) or amended ORS 656.245(1).

On reconsideration, we consider it unnecessary to determine the applicability of the new law because, even if those provisions were applicable, our ultimate conclusions (i.e., that we retained jurisdiction over this dispute and that claimant's condition was not compensable) would be the same as those under the former law.

Accordingly, we withdraw our July 13, 1995 order. On reconsideration, as supplemented and modified herein, we republish our July 13, 1995 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
DAVID R. SULLIVAN, Claimant
WCB Case No. 92-02342
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Gunn and Turner-Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside an Order on Reconsideration awarding permanent total disability benefits; (2) awarded 3 percent (9.6 degrees) unscheduled permanent disability for his low back injury claim; and (3) awarded 57 percent (85.5 degrees) scheduled permanent disability for loss of use or function of the left leg. On review, the issue is extent of disability, including permanent total disability. We reverse.

FINDINGS OF FACT

We do not adopt the findings of fact or the ultimate findings of fact in the ALJ's order on remand. We adopt the ALJ's findings of fact in his initial order with the following exceptions and supplementation. We do not adopt the third, fourth, and fifth sentences of the last paragraph of the findings of fact. Regarding the ultimate findings of fact, we adopt only the last sentence of the first paragraph.

Claimant did not have a disabling, preexisting psychiatric condition at the time of his March 14, 1987 low back injury while working for Liberty Northwest Insurance Company's (Liberty) insured, the injury that is the subject of this claim.

Claimant underwent psychiatric testing and evaluation when he was evaluated at the OHSU Pain Management Clinic in September 1990 for a possible trial of spinal cord stimulation. (Ex. 171). As a result of this testing, Dr. Bedder, M.D., diagnosed a mild depressive reaction, which he opined arose from the March 1987 work injury. (Exs. 171, 191B). Dr. Bedder also opined that this psychiatric condition was disabling. (Ex. 191B).

On July 20, 1992, Dr. Gostnell, Ph.D., and Dr. Witczak, D.O., examined claimant on behalf of Liberty. Dr. Gostnell performed a psychiatric evaluation, including psychological testing, and diagnosed a somatoform pain disorder related to the injury. (Ex. 202). He opined that this disorder included symptoms of depression, among other factors. (Ex. 202-7).

In April and May 1989, claimant participated in pain management treatment at the Northwest Pain Center. (Exs. 133, 134, 135, 137, 138). Dr. Thompson, treating orthopedist, disagreed with the Northwest Pain Center's physical capacities evaluations that claimant was able to perform sedentary work with appropriate postural changes. (Exs. 152, 156). In August and September 1989, claimant participated in a work hardening program. (Exs. 148, 149, 150).

Following the March 1987 injury, claimant was provided with vocational services by Ms. Findley-Wiggall and Mr. Frank through Reigel Vocational Consultation and by Mr. Malone through R. Malone Vocational Consultants. These vocational services focused on possible employment in auto sales/leasing, auto accessory sales, and fleet and auto brokering. (Exs. 142, 144, 154, 160, 163, 165, 170, 191).

At the August 5, 1992 hearing, Mr. Stipe testified as Liberty's vocational expert and Ms. Nelson testified as claimant's vocational expert. At the January 19, 1994 hearing on remand, Mr. Stipe and Ms. Nelson testified again and Mr. Lageman also testified as Liberty's vocational expert. None of these three vocational experts had actually provided claimant with vocational services.

ULTIMATE FINDINGS OF FACT

The major contributing cause of claimant's consequential psychiatric conditions of mild depression and somatoform pain disorder was the March 14, 1987 compensable low back injury.

Claimant made reasonable efforts to find employment.

As a result of his compensable physical and psychiatric conditions, claimant is permanently incapacitated from regularly performing work at a suitable occupation.

CONCLUSIONS OF LAW AND OPINION

Claimant's claim regarding the March 14, 1987 low back injury was last closed by an October 11, 1991 Determination Order. That Determination Order awarded additional temporary disability benefits but no additional permanent disability benefits beyond those previously awarded for a 1978 compensable low back injury with an earlier employer. Claimant requested reconsideration. On January 21, 1992, an Order on Reconsideration issued awarding claimant permanent total disability benefits. Liberty requested a hearing regarding the Order on Reconsideration.

On August 5, 1992, the initial hearing in this matter was held. At hearing, claimant contended that he was permanently and totally disabled on a medical basis alone or, in the alternative, that he was permanently and totally disabled under the "odd-lot doctrine." In that regard, claimant contended that he was unable to regularly perform work at a suitable occupation, arguing that he was unable to perform the various jobs Mr. Stipe, Liberty's vocational expert, alleged he was capable of performing.[1] Claimant also argued that those occupations were not gainful.

On September 24, 1992, the ALJ set aside the award of permanent total disability and awarded additional scheduled and unscheduled permanent disability. The ALJ concluded that Liberty had met its burden of proving that claimant was not entitled to the permanent total disability award made by the Order on Reconsideration. In reaching this conclusion, the ALJ determined that claimant was capable of regularly performing work in a suitable and gainful occupation on a part-time basis in some sedentary or some light jobs. Claimant requested Board review of the order, raising the same arguments he raised at hearing. In addition, claimant requested that the matter be remanded to the ALJ in light of the Supreme Court's decision in Tee v. Albertsons, Inc., 314 Or 633 (1992).

Without addressing the question of whether claimant was able to regularly perform work at a suitable occupation, on July 15, 1993, we remanded the matter to the ALJ for consideration in light of Tee v. Albertsons, Inc., supra. David R. Sullivan, 45 Van Natta 1474 (1993).

On January 19, 1994, a second hearing was held, focusing on the issue of whether the occupations enumerated by Mr. Stipe in the first hearing constituted gainful occupations, i.e., occupations yielding "profitable remuneration." On May 3, 1994, the ALJ found that the jobs claimant was capable of performing constituted gainful occupations. In addition, the ALJ republished his first order, except to the extent that it was inconsistent with this second order, thereby incorporating his earlier finding that claimant was capable of regularly performing work at a suitable occupation. Claimant requested Board review of this order.

On review, claimant renews his arguments that: (1) he is permanently and totally disabled solely on a medical basis; or (2) in the alternative, he is permanently and totally disabled under the "odd-lot doctrine" in that he is not capable of regularly performing work at a suitable occupation or, alternatively, any work he might be able to perform is not a "gainful occupation" that will result in "profitable remuneration." We find claimant permanently and totally disabled solely on a medical basis or, alternatively, under the "odd-lot doctrine" due to his lack of ability to regularly perform work at a suitable occupation.[2]

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[1] Mr. Stipe contends that claimant is capable of performing the following sedentary/light jobs on a part-time basis: automobile sales, automobile broker, sales of R.V.'s and mobile homes, automobile accessories sales, dispatcher of cement or concrete products, automobile rental clerk, order clerk, cashier II, photo processing clerk, security guard or monitor, motel desk clerk, general/small parts assembly. (#1Tr. 21- 24).

[2] We recognize that our July 15, 1994 order remanded the matter to the ALJ for consideration of the Tee decision. As a result, the focus at the second hearing was directed to the question of "profitable remuneration." However, we did not address the "suitable occupation" issue nor did we adopt the ALJ's conclusions and reasoning regarding that issue in our order remanding. In any event, even if we had, an order remanding is not a final order on the merits. The current matter is back before us on de novo review. As a result, we consider the whole record before us, including the parties' briefs regarding both the first and second requests for review. The record is fully developed regarding the permanent total disability issue and we proceed with our review.

In order to establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Permanent total disability may be established through medical evidence of physical incapacity or under the "odd-lot doctrine." Under that doctrine, claimant may establish permanent total disability, even though not completely physically disabled, if nonmedical factors, such as age, education, adaptability to perform nonphysical labor, mental capacity and emotional condition foreclose him from gainful employment. Harris v. SAIF, 282 Or 683 (1982). Claimant must also prove that he is willing to seek regular work and has made reasonable efforts to obtain such employment, unless such efforts would be futile. SAIF v. Stephen, 308 Or 41 (1989). Moreover, in determining whether claimant is permanently and totally disabled, we consider only disability that preexisted or was caused by his compensable injury. See ORS 656.206(1)(a). Subsequent, noncompensable conditions are not considered. Emmons v. SAIF, 34 Or App 603 (1978).

Claimant met his burden of proving entitlement to permanent total disability in the Order on Reconsideration. When a carrier requests a hearing contesting an Order on Reconsideration which has awarded claimant permanent total disability pursuant to ORS 656.268, it is seeking to alter the status quo; i.e., eliminate claimant's permanent total disability award. As the proponent of that fact or position, it is the carrier's burden to prove that claimant is not permanently and totally disabled. See Harris v. SAIF, supra, 292 Or at 690; Earl D. Lesperance, 45 Van Natta 2133 (1993). Here, proceedings were initiated by Liberty; thus, Liberty bears the burden of establishing entitlement to the relief requested.

Claimant underwent three lumbar surgeries related to his 1978 compensable injury with a prior employer. He sustained another compensable low back injury at Liberty's insured in March 1987. As a result of that injury, claimant underwent a fourth lumbar surgery in January 1989. (Ex. 129). This surgery provided only short term reduction in claimant's pain, within several months his chronic, constant low back and left leg pain returned. (Ex. 171-2). In an effort to relieve claimant's constant low back and left leg pain, a spinal cord stimulator was surgically implanted in May 1991 and removed two days later when it failed to provide claimant with any relief. (Exs. 178, 179). None of the treatments rendered to claimant were successful in relieving his pain and he continues to suffer from severe, chronic low back and left leg pain. (Exs. 133-2, 138-4, 140, 153, 164, 167, 171, 186, 187-2, 201, 202). His pain is worsened by prolonged activity, including walking, standing, sitting, bending, and twisting. As a result, he must change positions frequently.

Liberty argues that claimant is not permanently and totally disabled either solely from a medical standpoint or under the "odd-lot doctrine." We disagree.

On July 10, 1991, Dr. Thompson, claimant's long term treating orthopedist, opined that claimant was permanently and totally disabled. (Ex. 186). He reaffirmed that opinion on May 7, 1992. (Ex. 200C).

On June 12, 1991, claimant was examined by Dr. Wilson, neurologist, and Dr. Tesar, orthopedist, on behalf of Liberty. (Ex. 184). They opined that claimant could return to work in the light category. (Ex. 184-7).

On July 20, 1992, claimant was examined by Dr. Gostnell, clinical psychologist, Dr. Witzak, orthopedist, and Dr. Morton, neurologist, on behalf of Liberty. (Exs. 201, 202). As part of this examination, claimant also underwent a physical capacities evaluation (PCE), which was conducted by an occupational therapist. (Ex. 203). Drs. Gostnell, Witzak, and Morton concluded that claimant was "capable of performing only sedentary work activities, but even within this range is incapable of sustaining an eight-hour work day." (Ex. 201-2).

When medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 801 (1983). Here, there are no persuasive reasons not to defer to Dr. Thompson's opinion. Dr. Thompson has been actively involved in claimant's treatment since August 1980 and performed claimant's first three lumbar surgeries. Therefore, Dr. Thompson is in a better position to evaluate claimant's medical condition than physicians who have only examined claimant on a very limited basis. Relying on Dr. Thompson's opinion, we find claimant permanently and totally disabled on a medical basis alone.

Alternatively, even if we did not defer to Dr. Thompson's opinion, we would find claimant permanently and totally disabled under the "odd-lot doctrine." In this regard, we find unpersuasive the conclusory opinion of Drs. Wilson and Tesar that claimant is capable of light work. Instead, if we did not rely on Dr. Thompson's opinion regarding claimant's physical capacity, we would find the opinion of Drs. Gostnell, Witzak, and Morton persuasive. Their opinion is based on more complete information than that of Drs. Wilson and Tesar in that Drs. Gostnell, Witzak, and Morton had a physical capacities evaluation (PCE) to evaluate. Somers v. SAIF, 77 Or App 259 (1986). Furthermore, we find that, after examining claimant and evaluating the PCE, they concluded that claimant was capable of performing sedentary, part-time work. (Ex. 201-2).

Three vocational experts testified regarding claimant's employability at a suitable occupation. Ms. Nelson testified as claimant's vocational expert. Mr. Stipe and Mr. Lageman testified as liberty's vocational expert. None of these experts actually provided claimant any vocational services.

On the date of the first hearing, claimant was 51 years old, had a high school degree and had completed some business courses. Testing revealed that claimant has a higher than average intelligence level. He had worked as a cement finisher for many years prior to his first back injury in 1978, including work as a supervisor. After the 1978 injury, claimant was unable to return to work as a cement finisher and successfully retrained as a automobile salesperson. Claimant had been working as an automobile salesperson for about 16 months at the time he injured his back again in March 1987. Claimant continued working until November 30, 1987, when he quit working because of disabling pain.

Based on the July 20, 1992 PCE, Mr. Stipe opined that claimant could perform part-time work in the sedentary range and some light work, although claimant could not perform the full range of light duty work. (#1Tr. 20-21). He listed several jobs within sedentary or light work that he opined claimant could perform. (See footnote 1 above). He acknowledged that he found no part-time automobile broker jobs; however, he opined that part-time work was available in the other possible occupations. (#1Tr. 56-58). He also opined that, at some level, severe chronic pain can impair the ability to work and to find work, depending on the display of pain. (#1Tr. 54).

Regarding claimant's psychological problems, Mr. Stipe opined that depression sometimes interferes with a job search but that mild depression would not prohibit the performance of a successful job search. (#1Tr. 32-33). He also stated that he did not take claimant's mental status into account in considering claimant's employability. (#1Tr. 50-51).

Mr. Lageman did not focus on claimant's employability, although he stated that he assumed claimant was capable of performing the jobs to which Mr. Stipe testified. (#2Tr. 54). Mr. Lageman testified that claimant had transferable skills in sales and that a higher intelligence level increased a person's earning capacity. However, he also testified that claimant would not be capable of performing every job within the list provided by Mr. Stipe. (#2Tr. 73-74). He opined that claimant's ability to do those jobs would depend on the specific employment needs of each job and he did not make that assessment. Id. He also testified that he did not know how many of those jobs would be excluded by claimant's physical limitations. (#2Tr. 79). Regarding claimant's psychological problems, Mr. Lageman testified that increased pain and agitation would adversely affect a person's ability to earn money in "people-oriented" jobs. (#2Tr. 89-91).

Ms. Nelson testified that claimant was not employable. (#1Tr. 72). She based this opinion on claimant's physical limitations, psychiatric problem, vocational reports, and labor market surveys. (#1Tr. 73-74). In making this decision, she considered sedentary and sedentary to light jobs. (#1Tr. 74). Her labor market survey indicated that both the automobile broker and automobile sales jobs involved long hours, with no part-time openings in the automobile broker job and, statistically, only 3 percent of the automobile jobs are part-time. (#1Tr. 75-76). Although acknowledging claimant has a higher than average intellect, she opined that his depression and severe pain would limit his ability to use that intellect. Considering the combined affects of claimant's physical limitations, his pain level, and his depression, Ms. Nelson opined that claimant was unemployable at any job, including those listed by Mr. Stipe. (#1Tr. 72, 79-81).

Liberty argues that Ms. Nelson's opinion is not persuasive because it improperly considers claimant's psychological condition. Preexisting conditions which were disabling at the time of the

compensable injury may be considered in determining entitlement to permanent total disability. See ORS 656.206(1)(a). Here, although there is some indication that claimant had some psychological problems following the 1978 injury, primarily depression, as discussed during his 1985 pain center treatment, there is no indication that these problems were disabling. (Exs. 14, 66, 67, 68, 73, 75, 78, 82). Specifically, claimant's final psychiatric evaluation at the pain center stated that claimant had no psychiatric disability due to the 1978 work injury. (Ex. 82-2). Therefore, claimant had no preexisting, disabling psychiatric condition that can be considered in determining eligibility to permanent total disability.

In addition, any subsequent, noncompensable psychiatric conditions may not be considered. Emmons v. SAIF, supra. In this regard, Liberty argues that claimant's psychiatric condition should not be considered. We disagree.

There is no indication that the 1987 work injury directly caused any psychological condition. Furthermore, any depression relating to the prior 1978 work injury had resolved without disability. (Ex. 82-2). Therefore, in order to be compensable, the consequential psychological condition must be caused in major part by the compensable injury. ORS 656.005(7)(a)(A).

In September 1990, claimant was examined by Dr. Bedder, M.D., as part of an evaluation for a possible trial of spinal cord stimulation for treatment of claimant's constant low back and left leg pain. (Ex. 171). Claimant underwent extensive psychiatric testing as part of the examination. Dr. Bedder specifically diagnosed dysthymia. (Ex. 171-9). In making this diagnosis, Dr. Bedder focused on the effects of claimant's constant pain as a result of the work injury. (Ex. 171). As noted above, the record is replete with references to claimant's severe, chronic pain. In addition, in response to a questionnaire from claimant, Dr. Bedder subsequently rated claimant as suffering from a class 2 mild depressive reaction "arising from the job." (Ex. 191B-4-7). In addition, Dr. Gostnell diagnosed "somatoform pain disorder, related to injury" and noted that the symptoms included depression. (Ex. 202-7).

We find that Dr. Bedder's opinion as a whole establishes that the constant pain from the work injury is the major contributing cause of claimant's depression. In making this determination, we note that Dr. Bedder indicated no other potential cause of claimant's impairment due to depression; therefore, we find his response to claimant's questionnaire is most reasonably construed as showing that claimant's depression is due to the accepted injury. Marvin L. Thrasher, 47 Van Natta 915 (1995); see, e.g., Edith N. Carter, 46 Van Natta 2400 (1994) and David J. Schafer, 46 Van Natta 2298 (1994) (in absence of evidence that a medical arbiter rated impairment due to other than claimant's compensable injury, we have attributed an arbiter's impairment findings as due to the compensable injury). In addition, Dr. Gostnell's opinion supports a finding that the depression is compensable.[3]

Given the fact that we find claimant's depression compensable, we find Ms. Nelson's vocational opinion most persuasive because she considered claimant's depression, along with his chronic pain and physical limitations, in opining that claimant was not capable of performing any suitable employment. Mr. Stipe did not consider the affects of claimant's depression. (#1Tr. 50-51). In addition, if we do not defer to Dr. Thompson's opinion, the persuasive medical evidence establishes that claimant is in the sedentary, part-time category, at most, and Mr. Stipe considered claimant capable of performing sedentary/light part-time work, which further limits the persuasiveness of his opinion. Finally, we do not find that Mr. Lageman's opinion supports Liberty's argument that claimant is capable of performing suitable employment. Specifically, Mr. Lageman acknowledged that he did not know how many jobs would be excluded by claimant's physical limitations. (#2Tr. 73-4, 79).

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[3] We note that, on April 13, 1989, Dr. Bates-Smith, psychologist, examined claimant as part of his evaluation for admission to the Northwest Pain Center for treatment of his chronic pain. (Ex. 133). Dr. Bates-Smith noted that claimant was "moderately depressed" and opined that he had "an underlying dysthymic disorder, secondary to multiple losses during childhood." (Ex. 133-8). She noted that this condition was aggravated by the work injury. Id. Given the subsequent opinions of Drs. Bedder and Gostnell, we find that the preponderance of the evidence is that the 1987 work injury is the major contributing cause of claimant's depressive condition.

Therefore, based on Ms. Nelson's opinion, we find claimant incapable of performing any suitable occupation. Because of this finding, we need not address the issue of whether the proposed suitable employment represent "gainful occupations." Harris v. SAIF, supra; Tee v. Albertsons, Inc., supra; Allethe P. Yngsdahl, 46 Van Natta 111 (1994).

Finally, we adopt the ALJ's reasoning and conclusions regarding his decision that claimant has demonstrated that he is willing to reenter the work force and has made reasonable efforts to do so. ORS 656.206(3).

On this record, we find that Liberty has failed to meet its burden of proving that claimant is not entitled to the award of permanent and total disability made by the January 21, 1992 Order on Reconsideration. Accordingly, we affirm the Order on Reconsideration in its entirety. Liberty is authorized to offset any permanent partial disability compensation paid subsequent to the ALJ's order as a prepayment of claimant's permanent total disability compensation. See Pacific Motor Trucking Co. v. Yaeger, 64 Or App 28 (1983).

Claimant's attorney is entitled to an assessed fee for services rendered in defending the permanent total disability award at hearing. ORS 656.382(2). 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 at hearing is $3,000, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearings record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated. We have also taken into consideration claimant's counsel's "out-of-compensation" attorney fee granted by this order.

ORDER

The ALJ's order dated September 24, 1992, as supplemented in the order on remand dated May 3, 1994, is reversed. The January 21, 1992 Order on Reconsideration is reinstated and affirmed in its entirety. Liberty Northwest Insurance Company (Liberty) is authorized to offset any permanent partial disability paid subsequent to the ALJ's order against claimant's permanent total disability benefits. For services at hearing, claimant's attorney is awarded an assessed fee of $3,000, payable by Liberty directly to claimant's attorney. Claimant's attorney is awarded a fee equal to 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, except that total out-of-compensation fees awarded by the ALJ's order and this Board's order shall not exceed $6,000.

In the Matter of the Compensation of
MARY J. KAMM, Claimant
WCB Case No. 93-09546
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Meyers, Radler, et al., Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian and Gunn.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that granted permanent total disability, whereas an Order on Reconsideration had awarded 30 percent (96 degrees) unscheduled permanent disability for a low back condition and 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of the left foot. In its brief, the employer objects to the ALJ's admission of "post-reconsideration" evidence. On review, the issues are evidence and permanent total disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except the next-to-last paragraph.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matters

The employer contends that the ALJ erred in admitting a May 16, 1994 letter from Dr. Long, treating physician (Ex. 115A); Dr. Long's Physical Capacities Evaluation, dated October 6, 1992 (Ex. 116, see Tr. 83-84); and vocational counselor Nelson's May 16, 1994 report, to the extent that it relies on Dr. Long's "post-reconsideration" physical restrictions (Ex. 117). In this regard, the employer argues that medical evidence of a worker's impairment generated after the medical arbiter's report is not admissible for the purpose of rating claimant's impairment. See ORS 656.268(7); Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993).

We need not determine whether the disputed evidence was improperly admitted because, even if it was, excluding it would not change the result in this case. In reaching this conclusion, we note that the record reveals "pre-reconsideration" evidence of claimant's physical limitations, including her need to recline. (See Ex. 97-2; see also Ex. 79-2).

The employer also argues that the Director's October 2, 1992 order finding claimant ineligible for vocational assistance, which was subsequently affirmed by an ALJ, precludes claimant from contending that she is permanently and totally disabled. (Ex. 95[1]). However, because neither the issues nor the claims in the two cases are the same, we conclude that the prior litigation does not preclude the present litigation.

Permanent Total Disability

The ALJ found that claimant's travel restrictions and her unpredictable but continual need to be recumbent for up to three hours each day incapacitated her from regularly working at a gainful and suitable occupation. We disagree.

In order to establish entitlement to permanent total disability compensation, claimant must prove either that: (1) she is completely physically disabled and therefore precluded from gainful employment; or (2) her physical impairment, combined with a number of social and vocational factors, effectively prohibit gainful employment under the "odd-lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). A determination of permanent total disability must be made based on conditions existing at the time of hearing. See Gettman v. SAIF, 289 Or 609, 614 (1980).

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[1] The Director found claimant ineligible for vocational assistances because the labor market for claimant's many transferable skills exists in Oregon. Thus the Director concluded that claimant does not have a substantial handicap to employment. (Ex. 95-3).

In this case, no physician opined that claimant is medically permanently and totally disabled.[2] Accordingly, we conclude that claimant is not precluded from gainful employment due to complete physical disability. Thus, her claim falls under the "odd-lot" doctrine. In addition, because there is no dispute about whether the jobs identified for claimant are "gainful," the question is simply whether claimant is "employable," i.e., whether she is currently able to sell her services on a regular basis in a hypothetically normal labor market. See Harris v. SAIF, 292 Or 683 (1982).

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Welch v. Bannister Pipeline, 70 Or App at 701.

Claimant was 53 years of age at the time of hearing. She is well educated, having obtained a B.A. in biology and an M.B.A. She has proven herself adaptable to nonphysical labor, having worked as a college professor's assistant and owned and operated her own consulting business for two years. There is no evidence that claimant's mental capacity or her emotional condition impede employment. Thus, the question is, more specifically, whether claimant is able to regularly sell her services in a hypothetically normal labor market, considering the conditions of that market.

In this regard, claimant relies[3] on vocational counselor Nelson who opined:

> "In my professional opinion anyone requiring a schedule flexible enough to allow for 2-3 hrs/day reclining, on an unpredictable schedule, is not competitively employable in any hired position. Due to [claimant's] symptoms and resulting need for recumbent breaks on an unpredictable basis there is no job available, whether or not she has vocational rehabilitation, in a theoretically normal labor market within her functional limitations and within reasonable geographic distance." (Ex. 117).

We do not find counselor Nelson's reasoning or conclusions persuasive, for the following reasons. First, there is no indication that any of the employers contacted on claimant's behalf stated that they would not employ claimant because of her need to be recumbent. Thus, counselor Nelson's general conclusion (that no one with a need to be recumbent is employable) is unsupported by her research regarding claimant, or by anything else in this record. Moreover, that conclusion is not corroborated by claimant's testimony regarding her abilities. In this regard, claimant indicated that she has a reclining chair at home and she is able to do phone and computer work while reclining in that chair. (Tr. 42-43). Thus, although we acknowledge that claimant often needs to be recumbent, the record does not establish that she is unemployable.

Counselor Nelson contacted or attempted to contact all potential employers within a 30-mile radius of claimant's residence, consistent with claimant's travel limitations. She was unable to find a job for claimant. Of the 182 attempted contacts, 66 employers had "no openings." However, the lack of openings says nothing about claimant's employability. The fact that over one-third of claimant's potential employers lacked openings, does not mean that claimant would not be competitive for an open position.[4] Thus, counselor Nelson's implicit reasoning that claimant is not employable (i.e., able to regularly sell her services) because she has not found a job, is unpersuasive.

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[2] She is permanently limited to sedentary work, with additional restrictions. (See Ex. 103). An appropriate work site for claimant will include modifications (such as an ergonomic chair) to allow for partial reclining and a lap top computer. (See Exs. 79-2, 97-2).

[3] Claimant argues that counselor Nelson's opinion regarding claimant's employability is more persuasive than counselor Scapiosa's opinion (that claimant is currently employable), because counselor Nelson has more extensive qualifications in the vocational area. We need not evaluate the counselors' relative qualifications, because we find counselor Nelson's opinion unpersuasive.

[4] Interestingly, when counselors Scopacasa and Ammerman evaluated barriers to claimant's employment and performed job search inquiries for her in 1992 (essentially utilizing claimant's current physical limitations, including the need to recline), several employers were identified who would consider hiring claimant as a business consultant, if they had openings.

Counselor Nelson also opined that claimant is seriously impeded by her lack of experience. (Ex. 107-2).[5] We are not persuaded by counselor Nelson's opinion concerning the impact of claimant's work history on her present employability, because we find that it does not comport with the record. Claimant has numerous transferable skills and extensive work experience. As a teacher's assistant and research laboratory assistant, claimant lectured an upper division accounting class; designed and graded tests; graded student projects; tutored students; developed graphics and transparencies; and programmed computers and entered computer data.[6] (Ex. 87-7). As owner and operator of a consulting service, claimant was responsible for operation of the business and provided cost management consulting, business planning consulting, computer and software consulting, and general business consulting. (Id.) Considering claimant's undisputed actual experience, we conclude that counselor Nelson's "lack of experience" opinion does not follow from the facts available to her.

In summary, we acknowledge that claimant is permanently limited to sedentary work, with additional restrictions including an unpredictable need to be recumbent to relieve back symptoms. However, because claimant has not established that her physical and nonphysical characteristics render her unable to regularly sell her services, we conclude that claimant has not established that she is permanently and totally disabled. Accordingly, the ALJ's order must be reversed.

ORDER

The ALJ's order dated June 24, 1994 is reversed in part and affirmed in part. The permanent total disability and attorney fee awards are reversed. The Order on Reconsideration is reinstated and affirmed. The remainder of the order is affirmed.

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[5] In this regard, counselor Nelson opined, "[I]t is my professional opinion that [claimant] would not be considered for any of those positions [i.e., among the job titles identified as suitable for claimant] based on lack of experience, even if openings had been identified for those goals, which was not the case." (Ex. 107-2). We reiterate that existing job openings are not determinative when a claimant has the physical and vocational capacity to perform a job in a hypothetical labor market.

[6] We find no indication that counselor Nelson's job search for claimant included any inquiries with an eye toward utilizing claimant's extensive computer skills.

Board Member Gunn dissenting.

Acknowledging that claimant needs to be recumbent on an unpredictable basis to relieve her back symptoms, the majority nevertheless concludes that claimant has not established she is permanently and totally disabled under the "odd-lot" doctrine because her education and experience as a business consultant make her capable of employment. I disagree.

Like the ALJ, I would find that claimant's inability to drive more than 30 minutes at any one time and her unpredictable but continual need to be recumbent for up to two or three hours a day renders her incapable of regularly performing work at a gainful and suitable occupation. I would therefore affirm the ALJ's conclusion that claimant is permanently and totally disabled.

The majority places great weight on claimant's advanced education and abundance of transferable skills but gives insufficient consideration to the fact that claimant is relatively immobile and often needs to be recumbent to relieve her pain. Indeed, in support of their conclusion that claimant is employable, the majority notes claimant's testimony that she is able to do phone and computer work at home while reclining in her reclining chair. However, I do not believe that claimant's ability to use her home phone or laptop computer while in a reclining position demonstrates that she is able to sell her services on a regular basis in a hypothetically normal labor market. See Harris v. SAIF, supra; see also Jean E. Stump, 44 Van Natta 662 (1992).

Unlike the majority, I find vocational counselor Nelson's opinion well-reasoned, complete and persuasive. Counselor Nelson made an exhaustive search for suitable employment for claimant. All 182 employer contacts were made and reviewed in light of claimant's functional limitations, i.e., sedentary, flexible work within the appropriate travel radius. Although counselor Nelson was unsuccessful in finding appropriate employment for claimant, I do not read counselor Nelson's report as implicitly

reasoning that claimant is not employable because she has not found a job. Rather, I understand counselor Nelson's reasoning to be as she stated it: in her professional opinion, there is no job available in a theoretically normal job market for a person who has a limited ability to sit, stand and walk and must spend a total of two or three hours of their working day in a reclining position to relieve symptoms of back and leg pain.

Further, although the other vocational experts (Scopacsa and Ammerman) opine that claimant is capable of work as a business consultant, the medical evidence and claimant's unrebutted testimony establish that claimant's persistent back symptoms preclude her continued employment in that position. With her uncontroverted physical limitations and restrictions, claimant is not able to travel to various job sites to meet with clients, nor can she lift and carry the necessary work materials, such as a computer and documents, to these sites. These same problems would exist whether claimant was self-employed (as she was at the time of aggravation) or employed at a consulting firm.

In sum, under these circumstances, I would find that claimant is no longer able to perform regular work at a gainful and suitable occupation. Like the ALJ, I would conclude that claimant is permanently and totally disabled.

In the Matter of the Compensation of
RAFAEL PINEDA, Claimant
Own Motion No. 95-0348M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Hilda Galaviz-Stoller, Claimant Attorney
Lawrence Mann (Wallace & Klor), Defense Attorney

The insurer requests reconsideration of our July 18, 1995 Own Motion Order on Reconsideration, in which we awarded claimant's attorney an out-of-compensation fee. That order approved an attorney fee for claimant's "attorney's services culminating in our July 7, 1995 Own Motion Order" authorizing the reopening of clamant's 1987 injury claim. The insurer contends that it did not resist compensation in the own motion matter, and that claimant's attorney did not timely provide appropriate medical information for which benefits could be paid.

Contrary to the insurer's implicit assertion, claimant's counsel need not establish a "resistance to compensation" in order to obtain an out-of-compensation fee. See OAR 438-15-080. In applying OAR 438-15-080 to this case, we find that claimant's attorney need only be "instrumental" in obtaining increased compensation for claimant. In addition, claimant's attorney submitted an Attorney Retainer Agreement, signed by claimant, which authorized claimant's attorney "to sign my name and in all other respects act for me." That agreement provides that "[i]f the compensation is awarded by the Workers' Compensation Board on its Own Motion, fees will be in an amount determined by the Board." Finally, that agreement also provides that, if claimant's attorney is unsuccessful in obtaining any benefits, there shall be no attorney fee. Inasmuch as claimant's attorney provided legal services culminating in claimant's award of benefits, we find that the attorney was instrumental in obtaining increased compensation in this case, thus entitling her to an out-of-compensation attorney fee. See amended ORS 656.386(2).[1]

Accordingly, we withdraw our July 18, 1995 order. On reconsideration, as supplemented herein, we adhere to and republish our July 18, 1995 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] ORS 656.386(2) was amended by Senate Bill 369. Or Laws 1995, ch 332 §43 (SB 369, §43). Those amendments are applicable to this case. See Volk v. America West Airlines, 135 Or App 565 (1995).

In the Matter of the Compensation of
NANCY SPAIN, Claimant
Own Motion No. 95-0170M
OWN MOTION ORDER ON RECONSIDERATION
Gatti, et al, Claimant Attorneys
Travelers Indemnity, Insurance Carrier

Claimant requests reconsideration of our April 26, 1995 Own Motion Order in which we declined to reopen her 1985 industrial injury claim for the payment of temporary disability compensation because she failed to establish that she remained in the work force when her compensable condition worsened requiring surgery or hospitalization.

On May 25, 1995, we abated our April 26, 1995 order, and allowed the insurer 14 days in which to file a response to the motion. After receiving no response from the insurer, we now 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.

Claimant has an accepted claim for a low back injury she sustained in 1985. She treated conservatively at first, but then developed increased low back pain and the onset of left leg pain. She eventually underwent surgery for removal of a herniated L5-S1 disc in 1990. Her low back and left leg symptoms improved following surgery. However, in November 1994, claimant sought treatment for a dramatic increase in left leg symptoms. Diagnostic studies revealed findings consistent with a recurrent herniated disc at L5-S1. On January 24, 1995, Dr. Mason, claimant's treating neurosurgeon, requested authorization to perform a lumbar laminectomy. Based on the medical evidence, we find that claimant's compensable condition worsened requiring surgery by January 24, 1995.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

The insurer contends that claimant removed herself from the work force for reasons unrelated to her current condition prior to the January 24, 1995 request for surgery, and thus, was not in the work force at the time of the current disability. Claimant contends that "she has not voluntarily withdrawn from the work force and was actively seeking employment until her pain from her injury grew to the point that looking for employment would be futile." Claimant has the burden of proof on this issue and must provide persuasive evidence, such as an undisputed sworn affidavit attesting to her willingness to work, and evidence of active work search efforts, 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.

In a February 20, 1995 recorded statement, claimant stated that she was employed at Harvest Homes until June 1994. She stated that she had to quit her job at Harvest Homes because her driver's license was suspended, and she "had no way back and forth to work." We find, therefore, that claimant left her employment in June 1994 for reasons unrelated to the compensable injury.

In a letter dated May 28, 1995, Angela Streater, owner and personnel director of the Wigwam Tavern, stated that claimant was seeking employment as a bartender at the tavern in July of 1994. In an undated, unsigned letter received by the Board on June 5, 1995, claimant advised that in August and September of 1994, she "put Application at payless, and Day light Doughnuts" and also at Meadow Park Nursing Home. Additionally, claimant stated that "I also had filed for unemployment on June 16th 1994, but was denide [sic] unemployment at that time."

We conclude that the evidence submitted by claimant is insufficient to carry her burden of proof. Claimant has not submitted an undisputed sworn affidavit stating that she was willing to work and was actively seeking work at the time her condition worsened in November 1994. Indeed, her unsworn, undated letter does not indicate that she continued to look for work after September 1994. Furthermore,

although the medical records show that claimant's condition worsened in November 1994, the record lacks any medical evidence establishing that claimant's worsened condition rendered further work search efforts futile.

Hence, based on the record submitted to us, we conclude that claimant has not carried her burden of proving that she was willing to work and actively looking for work at the time of her worsening in November 1994. We also conclude that claimant has not carried her burden of proving that further work search efforts after September 1994 were rendered futile by the worsened condition. Therefore, we continue to find that claimant was not in the work force at the time of her disability.

Accordingly, our April 26, 1995 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 26, 1995 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BILL H. DAVIS, Claimant
Own Motion No. 89-0660M
OWN MOTION ORDER
SAIF Legal Department, Defense Attorney

The SAIF Corporation requests authorization to suspend payment of claimant's temporary disability compensation pursuant to OAR 438-12-035(5). Based on the following, we deny SAIF's request.

OAR 438-12-035(5) provides that an own motion insurer may make a written request to the Board for suspension of temporary disability compensation, if the insurer believes that such compensation should be suspended for any reason. In addition, the insurer must send a copy of the request to the claimant by certified mail. Id. The claimant has 14 days within which to submit a written response to the Board, and the insurer has 14 days to submit a written reply to the Board regarding the claimant's response. Id. The insurer is not permitted to suspend compensation without prior written authorization by the Board. Id.

On June 26, 1995, SAIF requested authorization to suspend compensation under OAR 438-12-035(5), and sent a certified copy of the request to claimant. We have received claimant's written response. We have not received a reply from SAIF. However, because the time for replying to claimant's response has expired, and SAIF has not requested an extension of time, we proceed to address the merits of SAIF's request.

On February 7, 1995, the Board issued an Own Motion Order Reviewing Carrier Closure. Bill H. Davis, 47 Van Natta 219 (1995). In that order, we found that the claim was prematurely closed and set aside SAIF's August 2, 1994 Notice of Closure. Our finding of premature closure was based on the fact that, although claimant's compensable back condition was medically stationary, Dr. Mulchin, claimant's treating urologist, continued to recommend surgery for claimant's compensable neurogenic bladder condition at the time the claim was closed. Dr. Mulchin had first requested authorization for this proposed surgery in May 1993, and the surgery was authorized. However, Dr. Mulchin subsequently stopped performing this type of surgery and, by September 12, 1994, referred claimant to Dr. Sagalowsky for evaluation for this surgery. By letter dated June 13, 1994, Dr. Ryberg, claimant's treating neurologist, indicated that claimant was still planning on having the surgery. Under these circumstances, we concluded that claimant's bladder condition was not medically stationary at claim closure because the proposed surgery was reasonably expected to materially improve claimant's compensable bladder condition, and claimant was apparently pursuing this surgical option.

In reaching this conclusion, we found claimant's case distinguishable from those cases where we had held that a claim is not prematurely closed where a claimant's medically stationary status is

contingent upon undergoing recommended surgery and the claimant refuses the surgery. E.g. Stephen L. Gilcher, 43 Van Natta 319, 320 (1991); Karen T. Mariels, 44 Van Natta 2452, 2453 (1992). The distinction was that, here, claimant had not refused the surgery, although the surgery was delayed.

Finally, we emphasized that claimant is not required to undergo the proposed bladder surgery; that decision is up to him and his physicians. However, we noted that, should claimant fail to pursue the proposed surgery or decide not to undergo the surgery, the consequences of those actions could include: (1) suspension of his temporary disability benefits pursuant to OAR 438-12-035; or (2) if claimant was otherwise medically stationary, SAIF could close the claim under the reasoning in Gilcher, supra, and Mariels, supra.

On May 26, 1995, SAIF's claims adjuster sent a certified letter to claimant informing him that, to date, SAIF had not received an evaluation from Dr. Sagalowsky, or any indication that the proposed bladder surgery had been scheduled. The claims adjuster requested that claimant notify her of the date of the evaluation and scheduled surgery. On June 26, 1995, having received no response from claimant, SAIF requested authorization to suspend claimant's temporary total disability compensation based on the fact that claimant had not pursued the proposed surgery.

In an undated letter to SAIF, apparently received after SAIF had requested authorization to suspend compensation, claimant stated that he has had "delays" in seeing Dr. Sagalowsky for evaluation. He also stated that he had scheduled an August 2, 1995 appointment with a specialist, Dr. Nagley, for an evaluation regarding the bladder surgery. By letter dated July 5, 1995, claimant informed the Board about this appointment with Dr. Nagley. Claimant also stated that he has had no success in contacting Dr. Sagalowsky, and, following his scheduled appointment with Dr. Nagley, claimant will know more about the proposed surgery.

Under these circumstances, we conclude that claimant is pursuing the surgical option discussed in our February 7, 1995 order. Therefore, we deny SAIF's request for authorization to suspend claimant's temporary disability compensation.

We again emphasize that it is claimant's decision whether he should undergo the proposed surgery. However, we note that the consequences summarized above remain applicable, should claimant fail to pursue the proposed surgery or decide not to undergo the surgery. In other words, our decision today does not preclude SAIF from pursuing the options listed above, under the appropriate circumstances.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES R. HOKLAND, Claimant
WCB Case No. C5-01934
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Coons, Cole & Cary, Claimant Attorneys
Liberty Northwest Insurance Corp., Insurance Carrier

Reviewed by Board en banc.

On July 14, 1995, the Board received the parties' Claim Disposition Agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The proposed CDA provides:

> "This 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." (Pg. 3, item 15) (emphasis added).

We recognize that the above-quoted language is taken directly from amended ORS 656.236(1)(a). SB 369, 68th Leg., Reg. Sess., § 24 (June 7, 1995).[1] However, in the context of this specific CDA, the use of the plural "claims" implies that more than one claim is being disposed of, or that all potential future claims are being settled. To avoid potential misunderstanding, we clarify our understanding of the above-quoted paragraph.

In any particular CDA, the parties can resolve all matters pertaining to that particular claim, but no other claims. ORS 656.236(1)(a) ("The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except medical services, as the parties consider reasonable[.]" (emphasis added)). We have recently held that a CDA resolves only those matters related to a claim, not unrelated claims or conditions. Danny R. Degrande, 47 Van Natta 1098 (1995); see also Christopher J. Kaufman, 47 Van Natta 433 (1995) ("new injury" claim not barred by CDA because, as a separate and distinct claim, it could not have been subject to the CDA).

If more than one claim is to be resolved, the CDA must so indicate. OAR 436-60-145(1). Here, the summary page indicates only one claim is being resolved.

Because the above-quoted CDA language was taken directly from the amended statute, we consider whether the legislature intended the plural "claims" to refer to multiple claims (which are unrelated to the initial accepted claim) where the CDA indicates only a single claim is being settled. To resolve this question, we must ascertain what the legislature intended when it enacted the third sentence of amended ORS 656.236(1)(a). We begin with the text and context of the statute. ORS 174.020; Porter v. Hill, 314 Or 86, 91 (1992). If those sources do not reveal the legislature's intent, we resort to legislative history and other extrinsic aids. See PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993). In construing the text and context of the statute, we bear in mind that each part or section of a statute should be construed in connection with every other part or section so as to produce a harmonious whole, animated by one general purpose and intent. Davis v. Wasco IED, 286 Or 261, 267 (1979) (citing 2A Sands, Sutherland Statutory Construction 56, § 46.05 (4th ed. 1973)).

We do not understand amended ORS 656.236(1)(a) to imply that all potential future claims (unrelated to the initial accepted claim) are settled by a CDA, or that multiple claims may be settled by a single CDA unless specifically so indicated. We understand the plural "claims" in amended ORS 656.236(1)(a) to refer to all claims generally that are resolved by CDA, which are actually or potentially related to the previously accepted claim.

We find support for our interpretation in the context in which the term appears. The first sentence of amended ORS 656.236(1)(a) speaks of the right of the parties to a claim to dispose of all matters regarding a claim, except medical services. See n.1, supra. The sixth sentence of amended ORS 656.236(1)(a) states that submission of a CDA stays all proceedings on that claim. See n.1, supra. Considering the text and context within which the term "claims" appears in the third sentence of amended ORS 656.236(1)(a), we do not believe the legislature intended to authorize resolution of all matters pertaining to multiple and unspecified claims which are not actually or potentially related to the previously-accepted, initial claim in the context of a CDA which resolves a worker's rights to benefits under a single previously-accepted initial claim. Therefore, in light of our understanding of amended ORS 656.236(1)(a) as it pertains to a particular CDA, we interpret the above-quoted CDA language to

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[1] Amended ORS 656.236(1)(a) provides, in pertinent 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).

refer only to the release of claimant's rights to benefits actually or potentially related to the previously-accepted initial claim being resolved by this particular CDA.[2]

Consequently, we hold that the CDA is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. SB 369, § 24(1)(a); OAR 438-09-020(1). Therefore, the parties' claim disposition agreement is approved.

IT IS SO ORDERED.

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[2] A review of other CDA provisions confirms our interpretation. The CDA's caption refers to a specific claim number and date of injury which coincides with the June 2, 1994 accepted initial claim. Moreover, the parties expressly agree that the CDA pertains to all conditions and consequences arising out of the June 2, 1994 accepted injurious exposure. (Page 2, Section 6). Finally, the CDA lists the date of first claim closure and claimant's permanent disability award under the accepted claim. In light of these circumstances, we conclude that the CDA is designed to resolve all matters and future non-medical service claims regarding claimant's accepted June 2, 1994 claim.

In the Matter of the Compensation of
JACK D. LEE, Claimant
WCB Case No. 93-15069
ORDER ON REVIEW
Bottini, et al, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order which declined to award claimant permanent total disability due to his back condition. On review, the issue is permanent total disability.

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

On review, claimant contends that his treating physician, Dr. Corkill, has never released him to return to work. Therefore, claimant contends, he remains totally disabled from working. We disagree.

We recognize that Dr. Corkill has at times indicated that claimant is unable to work. However, at the same time, he has indicated that claimant is capable of working in a sedentary capacity. (See Exs. 35, 39, 45, and Ex. 46 at 21, 23-24, 28). Moreover, other evidence in the record, including a functional capacity evaluation, a medical arbiter examination, and a medical examination requested by the insurer, all indicate that claimant retains at least the capacity for working in a sedentary occupation. (See Exs. 34, 35, 36, 42). Under these circumstances, we conclude that the preponderance of the evidence establishes that claimant is capable of work in a sedentary capacity.

Claimant contends that he is unable to work without vocational assistance, because Dr. Corkill has consistently indicated that he can work in a sedentary capacity only after retraining. We do not consider Dr. Corkill's opinion persuasive on the question of whether claimant requires vocational assistance in order to return to work, because his expertise is limited to medical questions. We look to vocational evidence for guidance regarding vocational questions. Peggy S. Charpilloz, 42 Van Natta 125, 127 (1990).

Here, there is no expert vocational evidence in the record. Claimant has the burden of proving the extent of his disability. ORS 656.266. In order to prove entitlement to permanent total disability, claimant must establish that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683 (1982). When, as here, the evidence establishes that claimant retains at least some residual functional capacity to perform work, claimant must prove that he is unable to regularly perform work at a gainful and suitable occupation consistent with his physical limitations. Id. The statute further provides that a "suitable occupation" is "one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation." ORS 656.206(1)(a).

In the present case, the medical evidence establishes that claimant has the physical capacity to perform no more than"sedentary" work. Thus, he is unable to return to his occupation at injury, which required "medium" strength. Similarly, he cannot return to those prior occupations that required greater than "sedentary" strength. Having proven that he cannot return to his prior occupations which required greater than "sedentary" strength, it remains for claimant to prove that he lacks the ability, training or experience to perform work at a "sedentary" occupation without retraining. See Gettman v. SAIF, 289 Or 609 (1980).[1] On this record, we are not persuaded that claimant has carried his burden.

Claimant's burden under ORS 656.206(1)(a) is to prove his prima facie case; that is, that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation, a suitable occupation being one which the worker has the ability, training or experience to perform, either presently or after rehabilitation. In the present case, where the evidence establishes that claimant retains the physical capacity to perform at least "sedentary" work, claimant must prove that he is unable to perform "sedentary" work for which he has the education, training and experience. While claimant need not prove that he cannot perform all possible sedentary jobs in order to establish his prima facie case, he must, nevertheless, prove he cannot perform sedentary work he has, in fact, performed in the past.

Here, claimant has 13 years of education. (Ex. 41-3). There is no evidence that claimant's actual skills and abilities do not match his formal educational level. Based on his past work experience, claimant is entitled to a Specific Vocational Preparation (SVP) rating of 5 under the disability standards, which indicates that he has successfully performed work in an occupation which requires 6 months to 1 year of training time. (Id.). An SVP of 5 also indicates that claimant can successfully perform occupations that require less training time (SVP less than 5). There is no persuasive contrary evidence in the record. Accordingly, we conclude that claimant has skills and abilities consistent with his educational level and his prior vocations.

Claimant testified that he is unable to regularly work in either a full-time or part-time occupation due to his pain. (Tr. 12-13). Claimant also testified to the prior jobs he has performed, all of which apparently required greater than "sedentary" physical capacity.[2] (Tr. 9, 32-33). Impeachment evidence, however, suggests that claimant may have performed sedentary work in the past.[3]

The ALJ found claimant not credible. After our review of the record, we agree that claimant is not credible. While we may not agree with all the specific reasons cited by the ALJ, nevertheless, we are unable to reconcile claimant's testimony with the impeachment evidence in the record, and we conclude that claimant is not credible. There is no other persuasive evidence of claimant's previous occupations.

Therefore, on this record, we find no persuasive evidence describing claimant's previous jobs and their strength demands. However, we are persuaded that claimant has certain skills and abilities that qualify him to perform "sedentary" work. Given these findings, we are unable to conclude that claimant cannot perform any of his previous occupations. Therefore, we conclude that claimant has failed to establish that he is unable to regularly perform work at a gainful and suitable occupation.

Moreover, were we to find that claimant had established that he is permanently disabled from working, claimant must still prove that, but for his compensable injury, he is willing to work. SAIF v. Stephen, 308 Or 41 (1989). After our review of the record, we conclude that claimant failed to prove that he is willing to work.

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[1] We recognize that under Gettman, supra, our evaluation of claimant's ability to perform work at a gainful and suitable occupation cannot be based on speculation about his future training. Consequently, our evaluation is not speculatively based on claimant's ability, training and experience after retraining which he has not yet received.

[2] Claimant testified that all his previous occupations involved "heavy, physical labor." (Tr. 9). Later, claimant testified that he had also worked as a dump truck driver and correctional officer. (Tr. 33). We take administrative notice of the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor, Employment and Training Administration (4th ed., revised 1991), which indicates that the jobs of dump truck driver (DOT #902.683-010) and correctional officer (DOT #372.667.018) require "medium" strength.

[3] Impeachment evidence indicates that claimant has worked as a "yard clerk" for a railroad. (Ex. A-12). The DOT classifies this job as requiring only "sedentary" physical capacity (DOT #209.367-054).

Claimant sustained a compensable back injury in 1988, for which he has had four surgeries, the last one being in December 1992. In April 1993, claimant's attending physician, Dr. Corkill, declared him to be medically stationary and capable of sedentary work. (Exs. 33, 35). Claimant has made no efforts to obtain employment since 1989, after his first surgery, when he was receiving vocational assistance. (Tr. 14, 21). He has never gone to the unemployment department to seek work, nor has he made other job search efforts. (Tr. 21). Claimant admitted feeling depressed because he did not know what kind of work he could do, but he did not testify that he would be willing to work, but for his compensable injury. (Tr. 25; see generally Tr. 7-56). Claimant did make an effort in 1991 to engage in gainful employment by purchasing a backhoe with the idea of starting his own business running a backhoe. However, claimant immediately found that he was unable to do that kind of work, due to his back pain. (Tr. 13, 54). Since the 1991 effort at employment, claimant has made no further efforts to obtain employment. Specifically, we focus on claimant's employment efforts since his last medically stationary date in April 1993, following his last surgery in December 1992. Since April 1993, claimant has made no efforts to obtain employment. Under such circumstances, we conclude that claimant has not established that he is willing to work.

We agree with the ALJ's determination that claimant is not permanently and totally disabled.

ORDER

The ALJ's order dated June 29, 1994 is affirmed.

August 2, 1995 Cite as 47 Van Natta 1453 (1995)

In the Matter of the Compensation
LOYD D. LONG, Claimant
WCB Case Nos. 94-06167, 94-06166, 94-06165, 94-06164, 94-06163, 94-05787, 94-04388, 94-04183 & 94-02921
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Janelle Irving (Saif), Defense Attorneys
David Horne, Defense Attorney
John E. Snarskis, Defense Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes

The self-insured employer requests review of Administrative Law Judge (ALJ) Holtan's order that: (1) set aside its denial of responsibility for claimant's hearing loss condition; and (2) upheld the denials of the SAIF Corporation, Fireman's Fund, Employers Insurance of Wausau (Wausau), and Industrial Indemnity of responsibility for the same condition. On review, the issue is responsibility.

We adopt and affirm the ALJ's order.[1] See Beneficiaries of Strametz v. Spectrum Motorwerks, Inc., 135 Or App 67 (1995) (Responsibility for a claimant's condition remains with last employer/insurer whose work exposure could have caused claimant's condition).

ORDER

The ALJ's order dated November 8, 1994 is affirmed.

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[1] Subsequent to the ALJ's order, the Legislature amended ORS 656.307. See SB 369, 68th Leg., Reg. Sess., § 36 (June 7, 1995). Under the former version of the statute, the Board reviewed an "Arbitrator's" order for errors of law. Pursuant to amended ORS 656.307, the Board reviews the ALJ's order *de novo*. Inasmuch as we agree with the ALJ's factual findings and factual resolution of this case, we need not address which version of the statute is applicable.

In the Matter of the Compensation of
WALTER J. REZNICSEK, Claimant
Own Motion No. 93-0572M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Scott McNutt, Claimant Attorney
John M. Pitcher, Defense Attorney

On November 7, 1994, claimant, pro se, requested review of the self-insured employer's (Weyerhaeuser Company's) July 1, 1994 Notice of Closure, which closed his cervical injury claim with an award of temporary disability compensation from May 7, 1993 through June 10, 1994, and declared claimant medically stationary as of April 18, 1994. Subsequently, the July 1, 1994 Notice of Closure was withdrawn, and Weyerhaeuser issued a corrected Notice of Closure on December 1, 1994 which awarded temporary disability compensation from May 6, 1993 through April 17, 1994, and declared claimant medically stationary as of April 18, 1994.

On December 20, 1994, claimant (now represented) requested review of Weyerhaeuser's December 1, 1994 corrected Notice of Closure, contending that he is entitled to additional benefits as he was not medically stationary when his claim was closed. In the alternative, claimant requested that his "time loss should extend further than April 17, 1994."

Subsequently, on February 15, 1995, the Board postponed action on claimant's request for review of the claim closure. We took this action because litigation was pending at the Hearings Division regarding claimant's low back condition which claimant alleged was either a new injury with a subsequent employer, RLC Industries (RLC), or a compensable consequence of the 1973 cervical injury with Weyerhaeuser. (WCB Case Nos. 95-00597 and 94-15357). Both employers (Weyerhaeuser and RLC) denied the current low back condition claim. In postponing action on the review of Weyerhaeuser's closure of the 1973 claim, the Board reasoned that, if the Administrative Law Judge (ALJ) found that claimant's current low back condition is a compensable consequence of his 1973 injury claim, the finding could have an effect on the Board's review of Weyerhaeuser's closure of the 1973 claim.

In an April 6, 1995 Opinion and Order, ALJ Nichols upheld the denials issued by both employers, finding neither workers' compensation carrier responsible for claimant's current low back condition. Claimant, pro se, appealed ALJ Nichols' order to the Board. On May 26, 1995, the Board dismissed claimant's request for review. The dismissal order was not appealed and became final. Therefore, based on ALJ Nichols' final order, it has been finally determined that claimant's low back condition is not a compensable component of his 1973 claim. For that reason, our review of Weyerhaeuser's closure shall be limited to claimant's accepted cervical condition.

To proceed with our review of Weyerhaeuser's December 1, 1994 claim closure, OAR 438-12-055(1) provides that a claim may not be closed unless the claimant's compensable condition is medically stationary. The term "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 December 1, 1994 Corrected 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.

In a June 28, 1994 letter to Weyerhaeuser, Dr. Bert, claimant's treating physician, opined that "I do believe [claimant] is medically stationary as of his last visit on 4/18/94. He has waxing and waning of his symptoms..." In his July 6, 1994 chart note, Dr. Bert opined that claimant's "neck will not improve with time," but he noted that worsening low back problems would require further treatment. Based on the aforementioned evidence, we find that claimant's compensable cervical condition was medically stationary by April 18, 1994. Inasmuch as claimant's compensable condition was medically stationary on the date of claim closure, we conclude that Weyerhaeuser's December 1, 1994 corrected Notice of Closure was not premature.

We turn now to claimant's request for additional temporary disability benefits past the medically stationary date or beyond April 17, 1994. Weyerhaeuser was "procedurally" required to pay temporary disability benefits until claim closure, or until termination of such benefits was authorized by the terms of ORS 656.268. See OAR 438-12-035(4). However, claimant's "substantive" entitlement to temporary disability benefits terminated as of the date claimant's condition became medically stationary. See ORS 656.278(1)(a). We are precluded from imposing on a carrier an administrative "overpayment" (i.e., retroactively awarding benefits beyond claimant's substantive entitlement). See Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Accordingly, we may not order Weyerhaeuser to pay additional temporary disability benefits beyond April 18, 1994, claimant's medically stationary date.

Although we are not authorized to award claimant temporary disability benefits for any period beyond April 18, 1994, Weyerhaeuser may be liable for a 25 percent penalty under former ORS 656.262(10)(a) (now ORS 656.262(11)(a)) for its unreasonable delay or unreasonable refusal to pay compensation. See Lebanon Plywood v. Seiber, supra; Lela K. Mead-Johnson, 45 Van Natta 1754 (1993); Pascual Zaragoza, 45 Van Natta 1221 (1993). Weyerhaeuser has offered no explanation for its refusal to pay temporary disability benefits until claim closure or until termination of benefits was authorized by ORS 656.268. In this regard, we note the absence of evidence that claimant has successfully returned to, or been released for, regular work. See ORS 656.268(3). Therefore, we find that Weyerhaeuser's refusal was unreasonable, and assess a penalty equal to 25 percent of the temporary disability benefits Weyerhaeuser should have paid claimant from April 18, 1994 through December 1, 1994. See Lela K. Mead-Johnson, supra; Pascual Zaragoza, supra. This penalty will also be paid in equal shares to claimant and his attorney.

IT IS SO ORDERED.

August 3, 1995 Cite as 47 Van Natta 1455 (1995)

In the Matter of the Compensation of
OTIS H. BROWN, Claimant
WCB Case No. 94-00612
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Hoffman, Hart, et al, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) found that "issue preclusion" did not foreclose the self-insured employer from denying claimant's consequential L4-5 stenosis condition; (2) upheld the employer's partial denial of that claim; (3) declined to assess a penalty or attorney fee for an allegedly unreasonable denial; and (4) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's low back condition. Claimant argues that: (1) assuming that the employer is not foreclosed by "issue preclusion" from denying his L4-5 stenosis condition, the scope of the employer's acceptance of the low back strain injury claim included the L4-5 herniated disc condition; and (2) his low back injury claim was prematurely closed. On review, the issues are issue preclusion, scope of acceptance, compensability, penalties, scope of review (premature closure), and extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order, except for the first paragraph on page 4, with the following supplementation.

The current claim is for an L4-5 stenosis condition. Claimant's theory is that his L4-5 stenosis condition is an indirect result of his 1990 compensable low back strain injury, via an L4-5 herniated disc, which is either compensable by virtue of prior litigation or encompassed within the employer's acceptance of the 1990 injury claim.

We agree with the ALJ that the current issue is not precluded by the prior litigation.[1] Moreover, we need not determine whether the employer's acceptance included the L4-5 herniation because, even if

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[1] As the ALJ noted, the prior litigation determined that claimant's L4-5 herniated disc condition is compensable, but did not address whether claimant's low back stenosis condition is compensable. (See Exs. 4B, 4C).

it did, we would not find that claimant has established the compensability of his current stenosis condition.

Under ORS 656.005(7)(a)(A), claimant must establish that his 1990 compensable injury was the major contributing cause of his consequential stenosis condition. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Based on the following reasoning, we are not persuaded that claimant met the requisite burden of proof.

The only medical evidence supporting the claim is provided by Dr. Lewis, current treating physician, who initially stated that claimant's compensable injury was the major cause of his L4-5 stenosis condition. (Ex. 22; see Ex. 21-1). However, Dr. Lewis later opined, more specifically, that the compensable injury was probably the major cause of an "acceleration" of claimant's preexisting degenerative condition. (Exs. 24-11; 24-27-28).

Dr. Lewis acknowledged that claimant had degenerative disease before the 1990 work injury (which did include L4-5 disc injury) and that such disease (whether initially idiopathic or traumatic), worsens naturally over time. (See Ex. 24-9-10). Lewis further explained that trauma also worsens and accelerates degenerative disease, including stenosis.[1] (Ex. 24-10).

As we understand Dr. Lewis' opinion, all the above-mentioned factors were likely causal contributors to claimant's condition. Thus, the question is whether Dr. Lewis evaluated the relative contributions of compensable as opposed to noncompensable causes, and persuasively supports claimant's contention that the 1990 work injury was the major contributing cause of a consequential L4-5 stenosis condition. See Dietz v. Ramuda, 130 Or App 397 (1994) (The relative contributions of each cause must be compared to establish major causation). We agree with the ALJ that Dr. Lewis' conclusions are insufficient to carry claimant's burden for two reasons.

First, Dr. Lewis' initial conclusion that the compensable injury is the major cause of the current condition is not consistent with his later statement that the same injury is the major cause of an acceleration of the preexisting condition. See Gormley v. SAIF, 52 Or App 1055 (1981). Second, noncompensable preexisting degeneration and time-related worsening contribute to claimant's current stenosis (as do the 1990 strain and disc injury), but Dr. Lewis did not quantitatively distinguish these noncompensable contributors from injury-related contributors. (See Ex. 24-27-28). Under these circumstances, we agree with the ALJ that Dr. Lewis' opinion does not persuasively support the claim. See Dietz v. Ramuda, supra.

We do not address claimant's contention that his 1990 injury claim was prematurely closed, because that issue was not raised at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Finally, we agree with the ALJ that claimant has not established that his low back impairment is related to the compensable injury. See ORS 656.214(5). In reaching this conclusion, we note that Dr. Ferguson, then-current treating physician, concurred with an August 28, 1993 report by Western Medical Consultants regarding claimant's low back impairment. (Exs. 14, 15). See Tektronix v. Watson, 132 Or App 483 (1995) (A medical report authored by a physician other than the medical arbiter or the treating physician is admissible for purposes of rating permanent impairment if the treating physician ratifies it). Based on this evidence, we find that claimant does have lost lumbar range of motion. However, there is no indication that claimant's low back impairment results from his compensable L4-5 herniated disc condition, rather than his noncompensable L2-5 stenosis condition. On the contrary, the same evidence indicates that claimant's permanent low back impairment is not related to his 1990 work injury. (Ex. 14-4). Consequently, claimant has not established entitlement to permanent disability compensation for his low back condition. See ORS 656.214(5).

ORDER

The ALJ's order dated December 9, 1994 is affirmed.

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[2] A herniated disc may cause symptoms similar to that associated with non-disc related stenosis and that is also suspected in claimant's case. (Ex. 24-22).

In the Matter of the Compensation of
DANIEL S. FIELD, Claimant
WCB Case No. 94-07086
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Turner-Christian, Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Black's order which set aside its denial of claimant's injury claim for a thoracic spine strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that, on January 10, 1994, he injured his mid-back at work while continuously driving a forklift over a large bump at the beginning of a ramp on a "busier-than-usual" day. The insurer argues that, because claimant did not seek medical treatment until he was laid off, nearly two months after the alleged incident, claimant did not sustain a work injury on the date stated. The ALJ concluded that claimant had established compensability of his mid-back injury claim. We disagree.

On March 5, 1994, claimant sought medical treatment from Dr. Andresen, treating physician.[1] Dr. Andresen noted tenderness over the left thoracic musculature, and diagnosed thoracic spine sprain. (Ex. 1). She also requested radiologic review of x-rays because she noted irregularity of one vertebral body. Id. Subsequent x-rays taken on March 7, 1994, showed degenerative arthritis, disc space narrowing and small osteophytes. (Ex. 1-2).

In May 1994, claimant returned to Dr. Andresen. At that time, she diagnosed thoracic sprain, osteoarthritis of the spine, and degenerative disc disease, and she encouraged claimant to pursue a different type of work. (Ex. 1-2).

In July 1994, Dr. Andresen explained that she had originally thought that claimant "had a thoracic spine sprain on top of a spine which had obvious spondylosis." (Ex. 8). Dr. Andresen opined that claimant's work activities on the day he had the bumpy forklift ride had probably initiated some of his pain, and caused the underlying condition to become symptomatic. Id. However, she stated that the major cause of claimant's current need for treatment is the underlying spondylosis. Id. In September 1994, Dr. Andresen added that the forklift driving, as described by claimant, had caused claimant's thoracic spine sprain in the first place. (Ex. 9).

On May 12, 1994, claimant was examined by physicians from Impartial Medical Opinions, Inc. (Ex. 4). The physicians believed that claimant was exaggerating his pain complaints, and voluntarily limiting motions. (Ex. 4-4). It was their opinion that claimant would continue the subjective complaints until he was retrained for another occupation. Based on their history and examination, the physicians stated that they had no information that would allow them to specifically attribute claimant's disability and need for treatment to "any incident or injury on or off the job." (Ex. 4-5).

On June 1, 1994, Dr. Matteri examined claimant. (Ex. 5). Dr. Matteri diagnosed "back pain, probably secondary to dorsal spondylosis with symptomatic exacerbation." (Ex. 5-4).

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[1] The record contains discrepancies in Dr. Andresen's reports concerning the date of injury. In her first, typed chart note, Dr. Andresen notes that claimant jarred his back driving a forklift about "two weeks ago." (Ex. 1-1). However, in handwriting at the top of the same page, there is an entry that states "2 mos. ago." Id. Subsequently, the "two week" notation was repeated in a July 1994 letter from Dr. Andresen.

Relying on Dr. Andresen's opinion, claimant contends that he is contesting only the denial of "thoracic spine strain," and that the only condition subject to review is the strain, not the underlying degenerative disease. We disagree.

Our "first task is to determine which provisions of the Workers' Compensation Law are applicable." Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994)); see also Michelle K. Dibrito, 47 Van Natta 970 (1995). Each of those holdings support the proposition that it is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim.

Here, the medical evidence indicates that claimant's work incident combined with his preexisting spondylosis.[2] (See Ex. 8)(thoracic spine sprain on top of a spine which had obvious spondylosis). Accordingly, claimant has the burden of proving that his work incident was 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).

Here, although Dr. Andresen has stated that she initially felt that the forklift driving activity caused claimant's thoracic spine sprain, she did not address the effect of the sprain combining with the underlying degenerative condition, or whether it was the work injury or the underlying condition that was 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. Furthermore, the record contains no other evidence to support claimant's burden of proof.

Accordingly, we conclude that claimant has failed to meet his burden of proving that his work injury was the major contributing cause of the disability or need for treatment of the combined condition.

ORDER

The ALJ's order dated September 16, 1994 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] This case is governed by ORS 656.005(7)(a)(B). The Legislature amended that statute, effective June 7, 1995. Senate Bill 369 (SB 369), 68th Leg., Reg. Sess., §§ 1, 66, 69 (1995). Both the former and amended versions of that statute contain the "major contributing cause" test of compensability. Because the evidence fails to meet that test, we conclude that claimant's claim fails under either version of ORS 656.005(7)(a)(B).

Board Member Hall dissenting:

Claimant requested a hearing because the insurer issued a denial of claimant's injury claim for a thoracic back strain. In his order, the ALJ focused only on compensability of a mid-back strain. Because I believe that claimant is the "master of his claim," when he requested a hearing and framed the issue, the scope of his claim was a strain only. In light of the fact that he did not make a claim for a "resultant" or "combined" condition, the applicable standard was whether claimant's work activities were a material contributing cause of his disability and need for treatment for the strain. Because I conclude that the majority applied the incorrect standard, I respectfully dissent.

In the Matter of the Compensation of
CORAL M. GREEN, Claimant
WCB Case No. 93-14250
ORDER ON REVIEW (REMANDING)
James L. Edmunson, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that set aside its "de facto" denial of claimant's medical services claim related to a low back condition. The employer also seeks remand to the ALJ for a hearing regarding the compensability of claimant's L3-4 disc herniation and subsequent treatment. On review, the issues are remand, and, alternatively, jurisdiction, compensability and medical services. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The employer asserts that, because claimant's December 1993 hearing request contested only its "de facto" denial of medical services for a low back condition, the ALJ erred by allowing the parties to proceed to litigate the compensability of claimant's L3-4 disc herniation, which was not diagnosed until February 1994. Accordingly, the employer asserts that we should remand this matter to the ALJ to allow it an opportunity to defend against the disc compensability issue. We agree.

Claimant has a long history of work-related low back problems. He sustained a work-related low back injury in 1979, which the employer accepted. The claim was closed and reopened several times.

In 1993, claimant began to experience low back pain again. The employer received, but did not respond to, claimant's medical bills for the 1993 treatment. On December 2, 1993, claimant filed a request for hearing, contesting the employer's "de facto" denial of his recent low back medical services.

Claimant continued to treat for low back complaints. In February 1994, an MRI for the first time revealed a large L3-4 disc protrusion. Claimant underwent surgery for that condition in March 1994.

This matter came to hearing in November 1994. Before the hearing, the parties disputed the issues to be addressed. Claimant asserted that he wished to litigate his entitlement to all of the medical services he had received, including the March 1994 surgery. The employer asserted that it was prepared to proceed regarding the "pre-December 1993 hearing request" medical services issue, but not the "post-hearing request" medical services and/or compensability of the L3-4 disc herniation. The ALJ declined to continue the proceedings. The ALJ further concluded that the employer's initial 1979 acceptance included degenerative disc disease and, hence, because there was some evidence that claimant's disc herniation was the result of a degenerative condition, the employer had accepted the L3-4 disc herniation. Addressing the merits of the medical services issue, the ALJ set aside the employer's "de facto" denial. We disagree with the ALJ's reasoning and conclusion.

Here, claimant's written December 1993 hearing request challenged the employer's "de facto" medical services denial and sought mileage/reimbursements, penalties and attorney fees. At hearing, claimant's counsel verbally amended the hearing request to cover all of the unpaid medical bills. (Tr. 13). Assuming that claimant's verbal amendment was sufficient to constitute a hearing request regarding the compensability of the L3-4 disc herniation, we conclude that it was an abuse of discretion for the ALJ to decline to continue the proceedings.

OAR 438-06-036 provides, in part:

> "If, during the hearing, the evidence supports an issue or issues not previously raised, the referee may allow the issue(s) to be raised during the hearing. The referee may continue the hearing upon motion of an adverse party if the party is surprised and prejudiced by the additional issue(s) and a continuance is necessary to allow the party an opportunity to cure the surprise and prejudice."

We review rulings pursuant to that provision for an abuse of discretion. See Richard N. Wigert, 46 Van Natta 486 (1994) (in absence of contention that ALJ had abused discretion by refusing to permit carrier to raise particular issue, Board declined to consider challenge to ALJ's procedural ruling).

Here, neither claimant's December 1993 hearing request nor the 1993 medical evidence contained any reference to a disc condition, which was not diagnosed until February 1994. Subsequent to the hearing request and prior to the November 1994 hearing, there is no correspondence from claimant's counsel regarding the disc issue; that issue was first raised when claimant's counsel orally amended the hearing request at hearing. There is a general relationship between the unpaid medical services for claimant's low back condition and the disc herniation. However, considering the lack of correspondence and a written hearing request regarding the disc herniation, the record supports the employer's contention that it was surprised and prejudiced by claimant's raising of the disc herniation issue so late in the proceedings. Therefore, the employer was entitled to a continuance to afford it the opportunity to defend against the disc herniation issue. Consequently, it was an abuse of discretion for the ALJ to decline to continue to proceedings for that purpose.[1]

Accordingly, we vacate the ALJ's order and remand this case to ALJ Nichols for further development regarding the disc herniation issue. On remand, the parties are also advised to consider the impact of Senate Bill 369, 68th Leg., Reg. Sess. (1995) (SB 369) on this case. Particularly, the parties should consider the impact of those sections pertaining to unpaid medical bills, SB 369, §§ 25, 26 (amending ORS 656.245(6) and 656.248(13)), claim acceptance and denial, SB 369, § 28 (amending ORS 656.262(6)(d) and (7)(a)), and retroactivity. SB 369, §§ 66, 69. The ALJ may proceed in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order addressing the issues raised at hearing.

Because we reach this conclusion, we do not address the remaining issues on review.

ORDER

The ALJ's order dated November 28, 1994 is vacated. The matter is remanded to ALJ Nichols for further proceedings consistent with this order.

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[1] In reaching this conclusion, we recognize that, well before hearing, the employer had notice of claimant's February 1994 MRI and March 1994 surgery. However, there is no indication that claimant intended to litigate the compensability of the disc condition or surgery until the November 1994 hearing convened.

In the Matter of the Compensation of
ALAN L. HUSSEY, Claimant
WCB Case No. 94-00729
ORDER ON RECONSIDERATION
Emmons, Kropp, et al, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our July 5, 1995 order that set aside its denials of claimant's claims for an exposure to airborne/bloodborne pathogens and a right hand injury. Contending that our order could be interpreted as a determination that claimant was actually exposed to airborne or bloodborne pathogens, SAIF seeks clarification of the conditions for which it is liable. We grant SAIF's request for reconsideration.

In our prior order, we concluded that claimant had established compensability of his right hand injury. By setting aside SAIF's denial of claimant's injury claim, we found that medical treatment necessitated by the hand injury, such as the gamma globulin injection, was compensable. In addition, the diagnostic testing necessary to determine whether claimant's exposure to another person's blood and vomit caused a condition requiring treatment is compensable.

In reaching our conclusions, we did not determine that claimant was exposed to nor that he had contracted any air/blood borne pathogens (including hepatitis B or the AIDS virus). In light of such circumstances, it would be inaccurate to interpret our decision as a finding that any such pathogens were compensable.

Accordingly, we withdraw our July 5, 1995 order for reconsideration. As supplemented herein, we republish our July 5, 1995 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
RONALD L. LEDBETTER, Claimant
WCB Case No. 92-04603
ORDER ON REMAND
Jolles, Sokol, et al, Claimant Attorneys
Steve R. Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Ledbetter v. SAIF, 132 Or App 508 (1995). The court has reversed our prior order, Ronald L. Ledbetter, 45 Van Natta 2316 (1993), which upheld the SAIF Corporation's denial of claimant's right leg osteomyelitis condition. Reasoning that SAIF accepted claimant's osteomyletis when it accepted the "right thigh condition," the court concluded that medical treatment related to the osteomyelitis condition was compensable provided that it satisfied the requirements of ORS 656.245. Consequently, the court remanded for reconsideration.

We begin with a brief summary of the relevant facts. In the early 1960s, claimant sustained an injury to his right leg as the result of an automobile accident. He developed osteomyelitis in the right leg which was treated with antibiotics. Claimant continued to receive treatment for his right leg until 1968 when he was released as fully healed.

In 1982, claimant sustained a work-related injury to his right thigh and right arm when he fell off a scaffolding. SAIF accepted claimant's injury claim. Claimant continued to experience right thigh symptoms following the injury and his condition was ultimately diagnosed as a reactivation of chronic osteomyelitis. Thereafter, claimant requested a hearing raising various issues including the compensability of his right thigh condition. The matter was resolved by a July 28, 1983 stipulation in which SAIF accepted claimant's claim for his right thigh condition as an exacerbation of a preexisting injury.

By letter dated February 14, 1992, SAIF denied claimant's treatment for osteomyelitis on the basis that his 1982 injury was not the major cause of the current osteomyletis condition and need for treatment. Claimant requested a hearing concerning SAIF's denial which is at issue in the present case. Claimant contended that SAIF was precluded from issuing the denial because it had previously accepted claimant's osteomyelitis condition by virtue of the July 1983 stipulation. In affirming an Administrative Law Judge's(ALJ) order, we rejected claimant's contention and upheld SAIF's denial on the basis that claimant had not established that the compensable injury was the major contributing cause of his current condition as required by former ORS 656.005(7)(a)(B). However, as noted above, the court has concluded that SAIF had previously accepted claimant's osteomyelitis condition.

On remand, SAIF continues to assert that claimant's condition is not compensable under either the former or current version of ORS 656.005(7)(a)(B).[1] We disagree.

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[1] Subsequent to the court's decision, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.005(7)(a)(B) which now provides that where a compensable injury combines with a preexisting condition, a worker must establish that the 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." SB 369, 68th Leg., Reg. Sess., § 1 (June 7, 1995). Assuming that the amendments to ORS 656.005(7)(a)(B) are applicable to this case, the result would not change as claimant's "preexisting condition" (osteomyelitis) has been found compensable by the court. Consequently, there is currently no "combined" condition under either version of the statute.

In order for either the former or current version of ORS 656.005(7)(a)(B) to apply, a compensable injury must combine with the preexisting condition. Claimant's osteomyelitis condition was found compensable by the court. Thus, there is no preexisting condition; only claimant's compensable osteomyelitis condition which the court found that SAIF previously accepted. Moreover, there is no evidence that the compensable osteomyelitis condition combined with any other preexisting condition. Consequently, neither the current nor former version of ORS 656.005(7)(a)(B) applies to this case.[2] See Joyce E. Soper, 46 Van Natta 740 (1994) (Former ORS 656.005(7)(a)(B) not applicable where the claimant's preexisting degenerative arthritis condition was ordered accepted by a prior litigation order).

The record does not establish that the medical treatment provided for claimant's osteomyelitis condition was improper or unnecessary. Moreover, SAIF has only contested claimant's medical treatment for the osteomyelitis condition on the basis that is was not causally related to the compensable injury. Based on this record and in light of the court's decision, we conclude that claimant's medical treatment for his osteomyelitis condition is compensable under ORS 656.245.

Claimant has finally prevailed on the compensability issue. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing, on Board review, and before the court is $4,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration of our December 7, 1993 order, the ALJ's order dated February 26, 1993 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant's counsel is awarded an assessed attorney fee of $4,500, payable by SAIF.

IT IS SO ORDERED.

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[2] Senate Bill 369 also contains a new provision, ORS 656.262(6)(c) which provides that a carrier is not precluded from later denying a "combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition." SB 369, § 28. However, as with ORS 656.005(7)(a)(B), a "combined" condition is a prerequisite for application of the statutory provision. As noted in our order, claimant's osteomyelitis condition is the compensable condition and has not combined with any other preexisting condition or disease. Consequently, ORS 656.262(6)(c) is likewise not applicable to this case.

In the Matter of the Compensation of
DEBRA M. SANSBURN, Claimant
WCB Case No. 94-02433, 93-13949
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requested review of Administrative Law Judge (ALJ) Black's order that: (1) found that claimant's August 1992 cervical strain claim had been prematurely closed; (2) awarded an out-of-compensation attorney fee (not to exceed $1,050) for claimant's counsel's services regarding the premature closure issue; (3) set aside as premature the insurer's denial of claimant's somatization disorder; and (4) awarded a $1,000 assessed attorney fee for claimant's counsel's services regarding the premature denial issue. On March 24, 1995, we approved the parties' Claim Disposition Agreement (CDA), in which claimant fully released all past, present and future rights to benefits (except compensable medical services) related to the August 1992 claim.

The premature closure and out-of-compensation attorney fee issues pertain to benefits that claimant released pursuant to the approved CDA. Therefore, the insurer's appeal of those issues has been rendered moot. Accordingly, the Order on Reconsideration closing claimant's claim is reinstated. We limit our review to the propriety of the insurer's denial of the somatization disorder and the assessed attorney fee.[1]

We adopt and affirm those portions of the ALJ's order that pertain to the somatization disorder denial and attorney fee issues, with the following supplementation.

A carrier may issue a "precautionary" denial to avoid the appearance of having accepted a condition, when it is put on notice of a possible claim for that condition. E.g., Chaleunsak S. Xayaveth, 47 Van Natta 942 (1995). A denial is premature if there is no claim for the denied condition. See William H. Waugh, 45 Van Natta 919 (1993) (claimant can establish that denial is premature if he can show that he did not make a claim for the denied condition). An examining physician's diagnosis and recommendation of treatment does not, by itself, constitute a claim. See Thomas A. Weaver, 47 Van Natta 131,132 (1995) (examining physician's reports alone would not put carrier on notice of potential claims); Buck E. Sims, 47 Van Natta 153, 154 (1995) (observation in examining physician's report does not constitute a claim).

Here, in the process of evaluating claimant regarding a work-related injury claim, Dr. Mead, examining neuropsychiatrist, diagnosed somatization disorder. (Exs. 103-8, 105, 108). He recommended psychiatric therapy for that disorder. (Ex. 103-8). No treating or consulting physician made such a diagnosis or concurred in Mead's diagnosis or recommendation for treatment. Under the circumstances, Dr. Mead's diagnosis and treatment recommendation do not, by themselves, constitute a claim. See Thomas A. Weaver, supra. In the absence of a claim for somatization disorder, the insurer's denial of that condition was premature. See William H. Waugh, supra.

The insurer seeks to escape this logic by arguing that there existed a claim for somatization disorder, because claimant's psychological and physical complaints were "inextricably intertwined," and because, in its view, the medical evidence indicates that many of claimant's physical complaints were the result of her somatization disorder. (Insurer's Appellant's Brief at 2). We disagree. The gist of the insurer's argument is that claimant's current complaints are caused by her somatization disorder, not her work injury. Because causation comes into play only after a worker has asserted a claim, and because, for the reasons stated earlier, claimant has not asserted a claim for somatization disorder, we reject the insurer's argument.

For these additional reasons, we agree with the ALJ's decision setting aside the insurer's denial of claimant's somatization disorder as premature.

Claimant's attorney is entitled to an assessed fee for services on review regarding the denial issue. ORS 656.382(2). 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 regarding the denial issue is $1,225, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's orders dated September 26, 1994 are affirmed, as modified. The Order on Reconsideration closing claimant's claim is reinstated. For services on review, claimant's counsel is awarded $1,225, payable by the insurer.

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[1] In its appellant's brief, the insurer states that the premature closure and out-of-compensation attorney fees issues have either become irrelevant, or are subsumed by the CDA. (Insurer's Appellant's Brief at 1). It concedes that the only remaining issues on review concern the allegedly premature denial and the assessed attorney fee. (Id.)

In the Matter of the Compensation of
WANDA E. SCANLON, Claimant
WCB Case No. 94-11492
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that affirmed an Order on Reconsideration which awarded claimant 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left forearm and 7 percent (13.44 degrees) scheduled permanent disability for loss of use or function of the right forearm. On review, the issue is extent of scheduled permanent disability.

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

Claimant seeks an increased award based on loss of strength. Claimant's loss of strength is not due to peripheral nerve damage, loss of muscle or disruption of the musculotendinous unit. Therefore, the ALJ properly concluded that claimant's loss is not ratable under the existing standards for rating permanent disability. See OAR 436-35-007(14)(a); 436-35-110(8) and (8)(a) (Admin. Order No. 6-1992).

Alternatively, claimant contends that although the applicable standards do not provide an impairment rating for decreased grip strength due to surgical resection of the carpal ligament, temporary rule OAR 436-35-500, G55-5440 (WCD Admin. Order No. 95-050) addresses this identical situation. Claimant therefore requests that the Board "apply the existing temporary rule" to rate her impairment.

ORS 656.726(3)(f)(C) provides that where the standards do not adequately address a worker's disability, the Director shall adopt temporary rules amending the standards to accommodate the worker's impairment. Here, claimant did not request that the Director adopt a temporary rule to rate her loss of strength nor did she make a remand request to the ALJ at hearing. Consequently, such a request on Board review would be rejected as untimely. Brian G. Vogel, 46 Van Natta 83, on recon 46 Van Natta 225 (1994). Moreover, on review, claimant affirms that she is not seeking remand for adoption by the Director of a temporary rule to address her disability. (Claimant's reply brief at 2).

Claimant cites no authority, and we have found none, that would permit us to apply in this case a temporary rule promulgated by the Director to rate another worker's impairment to rate claimant's impairment. To the contrary, WCD Admin. Order No. 95-050 expressly recites that "OAR 436-35-500, G55-5440, as adopted by this Order of Adoption of Temporary Rules, addresses this worker's disability[.]" (Emphasis supplied). Further, subsection G55-5440 expressly provides that "[n]otwithstanding OAR 436-35-003, this rule applies to only WCD file no. G55-5440." (Emphasis supplied). Under the circumstances, we decline to apply temporary rule OAR 436-35-500, G55-5440 to rate claimant's impairment.

ORDER

The ALJ's order dated January 20, 1995 is affirmed.

In the Matter of the Compensation of
MARSHA BROWN, Claimant
Own Motion No. 94-0137M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Hedges & Mitchell, Claimant Attorneys

Claimant requests review of the insurer's June 16, 1995 Notice of Closure, which closed her claim with an award of temporary disability compensation from February 22, 1994 through June 16, 1995. The insurer declared claimant medically stationary as of June 16, 1995. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

Claimant's claim may not be closed until her compensable condition has become medically stationary. See OAR 438-12-055. "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 June 16, 1995 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. Claimant bears the burden of proving that she was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981).

Claimant has an accepted claim for temporomandibular joint (TMJ) disorder for which she has been treating with oral surgeon, Dr. Yanney. The insurer's position in this case is that claimant was not under "active treatment" since April 6, 1995, as she was not treating with an "appropriate" physician, i.e., a physician who is a member of the managed care organization (MCO), Vantage Onsite. The insurer reasons that, because claimant was not under "active" treatment with an "appropriate physician," she is presumed to be medically stationary. The insurer notified claimant that she was enrolled in Vantage Onsite as of May 1, 1995, and that Dr. Yanney was not a member of Vantage Onsite.

However, the issue in our review of the Notice of Closure is not whether the insurer is required to pay for medical benefits provided by a non-participating physician or when an MCO contract became effective; rather, it is our duty to determine whether claimant's condition was medically stationary on the date of claim closure. In reviewing the insurer's claim closure, we consider all relevant medical evidence in the record, including Dr. Yanney's opinions, to determine whether a premature closure has occurred.

Claimant began treating with Dr. Salmassy in June of 1994. In his December 1994 chart note, Dr. Salmassy noted that he and claimant discussed surgical reconstruction of the jaw joints as a procedure to help alleviate her pain. Dr. Salmassy left the practice in January 1995, and claimant then began treating with Dr. Salmassy's associate, Dr. Yanney. In his January 31, 1995 chart note, Dr. Yanney referred claimant to physical therapy, noting that claimant had continued visual blurriness, and significant pain. Claimant was wearing a mandibular splint at that time.

In a February 8, 1995 Supplemental Medical Report, Dr. Yanney responded to a question on a form regarding claimant's anticipated medically stationary date, by opining that the medically stationary date could be "6-9 months if patient has favorable response to further treatment." In a February 28, 1995 report, Dr. Mayer, consulting radiologist, noted that "marked degenerative changes in both TM joints, loose bodies or residual prosthetic material on left" appeared in a CT scan. In his March 8, 1995 chart note, Dr. Yanney noted claimant's continued "severe restrictive painful dysfunction," and opined that "[claimant] is not medically stationary presently." Further in that chart note, Dr. Yanney refers to cartilage reconstruction, and offers several procedures under his consideration. In a March 30, 1995 letter to the insurer regarding claimant's return-to-work progress, Dr. Yanney noted that claimant has "such a significant response in reference to pain that her recovery time from each attempt at doing even simple fine motor tasks makes her functional capabilities quite limited presently."

In an April 5, 1995 note entitled "Physician's Telephone Orders," Dr. Yanney referred claimant to more physical therapy, and stated that claimant was to "continue P.T. 3x/wk til surgery." (Emphasis supplied). In an April 6, 1995 chart note, Dr. Yanney stated that claimant was slightly improved, and that the physical therapy and splint were helpful. He again noted the surgical procedures he and claimant were considering to correct existing deficiencies.

The insurer issued its Notice of Closure on June 16, 1995. Four days later, on June 20, 1995, Dr. Yanney wrote:

> "It appears that the [claimant] per her report has been deemed by Workmans [sic] Comp (EBI - D. Johnston) as being medically stable. I am uncertain as to how he can make this determination since the patient is quite medically unstable. It is extremely concerning that these decisions are adding to the [claimant's] dysfunction significantly and increasing her long term risks. [Claimant] is to be seen for an IME [independent medical evaluation/examination] in the near future."

Finally, in a June 29, 1995 letter (signed on July 6, 1995 by Dr. Yanney) summarizing a conversation between claimant's attorney and Dr. Yanney, Dr. Yanney opined that claimant's TMJ condition and balance problem, which is secondary to the TMJ condition, "in all medical probability should materially improve from further medical treatment and the passage of time."

The medical evidence in this record supports claimant's contention that she was not medically stationary on June 16, 1995, the date of claim closure. The recommendations for surgery throughout the record, beginning in December of 1994 through Dr. Yanney's June 29, 1995 letter, persuade us that there was a reasonable expectation of further material improvement in claimant's condition. There are no contrary medical opinions in the record. Based on this record, therefore, we conclude that claimant has carried her burden of proving that her condition was not medically stationary on the date of claim closure.

Accordingly, we set aside the insurer's June 16, 1995 Notice of Closure as premature. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDGAR L. EDINGTON, Claimant
WCB Case No. 94-09889
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) affirmed an Order on Reconsideration awarding 23 percent (73.6 degrees) unscheduled permanent disability for a neck condition; and (2) declined to award an assessed attorney fee pursuant to ORS 656.382(2). On review, the issues are extent of unscheduled permanent disability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

The ALJ found that claimant was entitled to 23 percent unscheduled permanent disability. In reaching this conclusion, the ALJ rejected claimant's argument, based on England v. Thunderbird, 315 Or 633 (1993), that he was entitled to a value for adaptability. On review, claimant continues to assert that, under England v. Thunderbird, the Order on Reconsideration and ALJ erroneously applied a value of 0 for adaptability and that he is entitled to at least a value of 1 for such factor.

We adopt the ALJ's order concerning this issue and provide the following supplementation.

Because the claim closed with a January 13, 1994 Notice of Closure, the applicable standards for determining claimant's entitlement to unscheduled permanent disability are contained in WCD Admin. Order 93-056. OAR 436-35-003(1). Under those rules, the "factor for adaptability, age and education will be given a neutral value of zero when the worker's wage earning capacity is not affected." OAR 436-35-280(1). A worker's wage earning capacity is not affected when the "worker's residual functional capacity as determined pursuant to OAR 436-35-310(5) is equal to or greater than the worker's base functional capacity as determined pursuant to OAR 436-35-310(4)."

The residual functional capacity is evidenced, in part, by the attending physician's release. OAR 436-35-310(5)(a). Here, claimant's attending physician released him to his regular welder job. (Exs. 25-1, 28). The base functional capacity is based, in part, on the DOT strength category for the most physically demanding job that the worker has successfully performed in the 5 years prior to determination. OAR 436-35-310(4)(a). The record here shows that claimant has worked as a welder for the 5 years preceding determination, which has a strength category of medium. DOT 819.384-010. (Ex. 25).

Based on this evidence, claimant's residual functional capacity is equal to his base functional capacity. OAR 436-35-310(6). Consequently, the factors for adaptability, age and education are given the value of 0. OAR 436-35-280(1), 436-35-310(6).

In Michael E. Pelcin, 47 Van Natta 1380 (1995), we addressed whether the standards in WCD Admin. Order 93-056 conflicted with England v. Thunderbird, supra, because they give a value of 0 for adaptability, age and education when the worker's residual functional capacity is greater than or equal to the base functional capacity. In Pelcin, we continued to adhere to the holding in Michelle Cadigan, 46 Van Natta 307 (1994), that giving a value of zero to adaptability was a permissible "modification" under former ORS 656.726(3)(f)(A) (since amended by SB 369, 68th Leg., Reg., Sess., § 55 (June 7, 1995).[1] In reaching this conclusion, we reasoned that the standards addressed in Cadigan (which were in effect before those applicable here) were similar to those contained in WCD Admin. Order 93-056. Id. Accordingly, we rejected the claimant's argument that the standards conflicted with England v. Thunderbird. Id.

Thus, based on Michael E. Pelcin, we find no conflict between the standards contained in WCD Admin. Order 93-056 and England v. Thunderbird, supra.

Attorney Fees

Claimant next contends that the ALJ "erred when she failed to award claimant's attorney an assessed attorney fee for prevailing on the carrier's motion for a reduction in unscheduled permanent disability award pursuant to ORS 656.382(2)." We agree.

Claimant's request for hearing challenged the scheduled and unscheduled permanent disability awards provided by the Order on Reconsideration. The insurer then cross-appealed, also contesting the Order on Reconsideration. Specifically, the insurer asserted that the "awards of scheduled and unscheduled PPD pursuant to Order on Reconsideration dated 07-21-94 should be reduced." The ALJ affirmed the Order on Reconsideration's unscheduled permanent disability award for claimant's cervical condition, but reduced the scheduled permanent disability award for the left hand.

When conditions are considered separately for purposes of rating permanent disability, the carrier appeals the compensation awarded for every condition, and the compensation for at least one condition is not reduced, we award an assessed attorney fee for the claimant's counsel's efforts with regard to that condition. E.g., Debra Cooksey, 44 Van Natta 2197, 2198 (1992). We take this approach even though compensation for the other conditions was reduced (perhaps resulting in an overall reduction of permanent disability) on the basis that claimant must defend against separate and distinct arguments for each condition. Id.

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[1] Because amended ORS 656.726(3)(f)(A) applies to claims that become medically stationary on or after June 7, 1995, the effective date of the Act, SB 369, § 66(4), and claimant was medically stationary prior to that date, we do not apply the amended version of the statute to this case.

Here, claimant prevailed over the insurer's request for hearing to reduce the unscheduled permanent disability award. Even though claimant's scheduled disability award was reduced by the ALJ, because each award was for separate and distinct conditions, claimant's attorney is entitled to an assessed fee with regard to the unscheduled permanent disability award. Debra Cooksey, supra.

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 at hearing regarding the unscheduled disability award is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 13, 1994 is affirmed in part and reversed in part. That portion of the order that declined to award an assessed attorney fee with regard to the unscheduled disability award is reversed. For services at hearing concerning this issue, claimant's attorney is awarded $1,000, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
DAVID L. GOODING, Claimant
WCB Case No. 94-04300
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order that: (1) found that the employer's responsibility disclaimer pursuant to former ORS 656.308(2) was untimely; (2) set aside the employer's denial of claimant's injury claim for a herniated disc at L5-S1; and (3) directed the employer to pay interim compensation from February 20, 1994 through April 21, 1994. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty or attorney fee against the employer for an allegedly unreasonable denial. On review, the issues are compensability, responsibility, interim compensation and penalties and attorney fees.

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

The ALJ found that the employer's responsibility disclaimer was untimely and concluded that the employer was precluded from arguing that another employer was responsible. The employer contends that its responsibility disclaimer was timely and that it is entitled to assert that the fire department where claimant worked as a volunteer fire fighter is responsible for his L5-S1 disc condition.[1]

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[1] Subsequent to the date of the ALJ's order, the legislature amended ORS 656.308(2). Or Laws 1995, ch 332, § ___ (SB 369, § 37). The statute, as amended, no longer requires carriers to issue responsibility disclaimers. Instead, the statute now requires the carrier to issue a denial of responsibility. In addition, the amended statute allows carriers to argue that responsibility lies with another carrier regardless of whether the worker has filed a claim against that carrier. Because this case involves a procedural time limit, the changes made by SB 369 are not applicable. See Motel 6 v. McMasters, 135 Or App 583 (1995). Alternatively, even if the statutory changes were applicable and even if the employer could assert responsibility as a defense, we would reach the same conclusion. In other words, we find no medical evidence which establishes that claimant's L5-S1 condition is causally related to his work as a volunteer fire fighter. Accordingly, we find no basis to conclude that any other carrier besides the employer is responsible for claimant's condition.

Even if the employer's disclaimer was timely, we find no medical evidence in the record which relates claimant's L5-S1 condition to his work activities as a volunteer fire fighter. The only medical evidence in the record relates claimant's L5-S1 condition to his January 21, 1994 injury while working for the employer. Under such circumstances, there is no evidence that any other carrier is responsible for claimant's L5-S1 condition. Accordingly, we conclude that the self-insured employer is responsible for claimant's L5-S1 condition.

The employer contests the ALJ's award of interim compensation from February 20, 1994 to April 21, 1994, the date of the employer's denial of claimant's L5-S1 disc condition. A claimant is entitled to temporary disability compensation if he or she has sustained wage loss as a result of his compensable injury. See RSG Forest Products v. Jensen, 127 Or App 247, 250-51 (1994) (worker is entitled to interim compensation when he left work or suffered a loss of earnings as a result of a work injury).

Here, claimant was released only to modified work at the time he left his employment. He had not been released by Dr. Nagel, his attending physician, to his regular job. Because his disability was partial, claimant is entitled to interim compensation in the form of temporary partial disability benefits (TPD) during the period in question. Amended ORS 656.212; Ricardo Morales, 47 Van Natta 1394 (1995). Accordingly, we agree with the ALJ that claimant is entitled to TPD from February 20 to April 21, 1994.[2] However, we note that claimant's rate of TPD may well be zero under the amended statute.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's statement of services), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee award for his counsel's services devoted to claimant's unsuccessful cross-request.

ORDER

The ALJ's order dated October 1, 1994 is affirmed, as modified. For services on Board review, claimant's attorney is awarded $1,000, payable by the employer.

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[2] Under amended ORS 656.212, TPD is calculated based on a comparison of claimant's wages at modified employment and his at-injury wages. SB 369, § 16. We have determined herein that claimant is entitled to interim compensation (in the form of TPD) from February 20, 1994 to April 21, 1994. It is up to the self-insured employer to process the claim and determine what is the correct rate of TPD under amended ORS 656.212. It is possible that the rate of TPD may be zero under the amended statute. In any event, if claimant disagrees with the self-insured employer's eventual processing of his claim, claimant may request a hearing challenging the employer's conduct.

In the Matter of the Compensation of
MELVIN TEFFT, Claimant
Own Motion No. 93-0623M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Pozzi, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The Board issued an Own Motion Order on Reconsideration in this matter on November 9, 1994, which authorized the reopening of claimant's 1979 injury claim. Additionally, in that order, the Board authorized an attorney fee in the amount of 25 percent of claimant's increased temporary disability benefits, not to exceed $1,050, payable by SAIF directly to claimant's attorney. (OAR 438-15-010(4); 438-15-080). On July 31, 1995, claimant's attorney notified the Board that he requests "no further deductions for attorney fees be taken."

Pursuant to OAR 438-12-065(2), claimant had 30 days from the mailing date of our final order in which to file a request for reconsideration, or 60 days from that mailing date if he could establish good cause for failure to file the request within 30 days. However, in extraordinary circumstances we may, on our own motion, reconsider a prior order notwithstanding these filing deadlines. Id. Under the particular circumstances of this case, we conclude that an exception to the deadline is appropriate. We withdraw our prior order for the purposes of reconsideration and issue the following order in its place.

The Board grants claimant's attorney's request to waive any further attorney fee payments from claimant's temporary disability benefits effective July 31, 1995.

Accordingly, as amended herein, we adhere to and republish our November 9, 1994 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

August 4, 1995 Cite as 47 Van Natta 1470 (1995)

In the Matter of the Compensation of
DICK A. VELDSMA, Claimant
WCB Case No. 94-02182
ORDER ON REVIEW
James Edmunson, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Niedig and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Holtan's order that: (1) upheld the insurer's denial of claimant's "new injury" claim for a low back condition; and (2) directed the insurer to continue to process claimant's claim as an aggravation of his 1987 accepted low back injury claim. On review, the issue is claims processing.

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

The ALJ found that claimant's low back condition should be processed as an aggravation of the 1987 claim rather than as a "new injury." On Board review, claimant contends that his claim should be processed as a "new injury" occurring on November 11, 1993. The insurer has conceded that claimant's low back condition is materially related to his 1987 accepted injury. However, the insurer contends that claimant did not sustain a "new compensable injury" in November 1993.

Claimant first contends that the ALJ erred in applying the major contributing cause test to determine whether the November 11, 1993 incident constituted a new compensable injury. We disagree and conclude, based on the following reasoning, that the major contributing cause standard is the correct legal standard.

Where a claimant has worked for the same employer who has been covered by the same carrier, we apply the "responsibility" principles of ORS 656.308(1) in determining under which claim, new injury or aggravation, the claimant's condition will be processed. Dan D. Cone, 47 Van Natta 1010 (1995); David L. Large, 46 Van Natta 96 (1994); Peggy Holmes, 45 Van Natta 278 (1993). Under the responsibility law, the major contributing cause standard of ORS 656.005(7)(a)(B) applies to shifting of responsibility under ORS 656.308(1). SAIF v. Drews, 318 Or 1 (1993).[1] Thus, in determining under which claim claimant's low back condition should be processed, we apply the major contributing cause standard to determine whether claimant sustained a "new injury" such that responsibility would shift to that claim.

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[1] Effective June 7, 1995, ORS 656.308(1) has been amended. Those amendments do not alter our analysis in this case. SB 369, 68th Leg., Reg. Sess., §37, §66. (June 7, 1995).

Claimant argues that the insurer's denial was "expressed in terms of compensability for the current condition -- not its relationship to the 1987 claim or responsibility for processing as between the two." Based on this assertion, claimant next argues that the insurer may not amend the express terms of its denial by "creative argument at hearing or on appeal." To the extent that claimant is arguing that the insurer could not "amend" its denial at hearing in order to litigate the processing issue, we disagree.

At the hearing, the ALJ summarized the issues by stating that claimant wished to establish a new injury or disease while the insurer contended that the condition was an aggravation of the accepted 1987 claim. (Tr. 8). Claimant did not object to this characterization of the issues before the ALJ and did not argue that the denial precluded the insurer from contending that the low back condition was an aggravation as opposed to a new injury. Since the parties agreed to try the processing issue without objection, we conclude that that issue was properly before the ALJ. See Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990) (the parties to a workers' compensation proceeding may, by agreement, try an issue that falls outside the express terms of a denial). In other words, claimant did not object to the insurer's "amendment" of the denial and agreed to litigate the issue of whether the low back claim should be processed under the 1987 claim or as a new injury. See Dolph M. Wiedenmann, 46 Van Natta 1584 (1994) (where the claimant objected to proceeding on a basis not raised by the denial, the insurer was not allowed to orally amend its denial).

Finally, claimant appears to contend that the insurer has the burden to establish that a "new injury" did not occur. In light of Holmes and its progeny which apply the analysis set forth in ORS 656.308(1), we have serious doubts regarding claimant's contention, however, we need not address this argument, because regardless of which party has the burden of proof, for the reasons given by the ALJ, we conclude that the evidence does not support the occurrence of a "new compensable injury" on November 11, 1993.

ORDER

The ALJ's order dated December 23, 1994 is affirmed.

August 4, 1995 Cite as 47 Van Natta 1471 (1995)

In the Matter of the Compensation of
ROBERT K. WARREN, Claimant
WCB Case No. 93-06052
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
R. Thomas Gooding, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order which: (1) affirmed an Order on Reconsideration that awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the right leg; (2) declined to award a penalty, pursuant to ORS 656.268(4)(f), for an allegedly unreasonable Notice of Closure; and (3) declined to direct the SAIF Corporation to pay an attorney fee awarded by a prior ALJ's order. In its brief, SAIF argues that a "post-reconsideration order/hearing" letter from the medical arbiter is admissible. On review, the issues are evidence, extent of permanent disability, penalties, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and findings of ultimate fact with the following correction.

Dr. Fuller, medical arbiter, examined claimant on March 4, 1993. (Ex. 18).

CONCLUSIONS OF LAW AND OPINION

Evidence

On April 1, 1992, claimant suffered his compensable injury when he fell from a roof and fractured his right calcaneous. On November 2, 1992, his claim was closed by a Notice of Closure that awarded no permanent disability. SAIF relied on the opinion of Dr. Vriesman, attending physician, to close the claim. (Ex. 12).

Claimant requested reconsideration. On March 4, 1993, claimant was examined by Dr. Fuller, medical arbiter. Based on the arbiter's report, an Order on Reconsideration awarded claimant a total of 10 percent (15 degrees) for loss of use or function of the right leg, including 7 percent for loss of range of motion, and 3 percent for Class I vascular damage. (Ex. 19-3).

In his arbiter's report, Dr. Fuller stated that claimant has "ankylosis of the subtalar joint where he has only 10 degrees of total motion, compared to 40 degrees of total motion on the left." (Ex. 18-5). Finding that portion of Dr. Fuller's report ambiguous, the ALJ subsequently requested clarification from Dr. Fuller. (See Ex. 22). Dr. Fuller replied that the report should have stated that claimant "has a partial ankylosis of the subtalar joint where he has only 10 degrees of total motion." Id. Accordingly, after receiving clarification, and determining that claimant was not entitled to an award for ankylosis under OAR 436-35-190(3), the ALJ affirmed the Order on Reconsideration.

SAIF argues that the ALJ properly considered the arbiter's clarifying letter. Citing former ORS 656.268(7),[1] SAIF contends that it is not relying on the clarification letter for the purpose of making a finding of impairment. Rather, it asserts that it is relying on the clarification to explain a finding of impairment previously made in the arbiter's report. In making this distinction, SAIF attempts to distinguish Daniel L. Bourgo, 46 Van Natta 2505 (1994), issued after the ALJ's order. In Bourgo, we interpreted former ORS 656.268(6)(a)[2] and former ORS 656.268(7) to permit admission of an initial medical arbiter report that was requested, but not completed, before expiration of the statutory time limit for the Department's reconsideration. We have also held that, unless a medical arbiter's report is incomplete (as represented by the arbiter or the Department), a medical arbiter's "supplemental" or "clarifying" report is not admissible under ORS 656.268(7). Daniel L. Bourgo, supra; Ryan F. Johnson, 46 Van Natta 844 (1994); Anne M. Younger, 45 Van Natta 68 (1993). Here, there is no indication that the arbiter's report was not completed.

Furthermore, in Bourgo, we concluded that, when both statutory provisions are considered in light of the legislative history, neither provision allows the admission of a "supplemental" or "clarifying" medical arbiter's report. Bourgo, supra at 2507. Accordingly, we conclude that the ALJ improperly considered the arbiter's clarifying letter. See also John M. Ames, 44 Van Natta 684 (1992) (ALJ should not exercise discretion to cure a basic failure of proof by soliciting a "post-hearing" medical report when it is the claimant's responsibility to establish extent and nature of any permanent disability). Additionally, although we have discussed the "post-reconsideration order/hearing" report, we have not considered it for the purpose of rating the extent of claimant's permanent disability.

Extent of Disability

Claimant contends that he is entitled to a permanent disability award for subtalar inversion ankylosis of the right ankle.[3] He further contends that the ALJ's interpretation of the medical arbiter's opinion is erroneous or, alternatively, if the provisions of OAR 436-35-190(3) do not sufficiently define claimant's impairment, new regulations[4] should be adopted. However, for the followings reasons, after our de novo review of the record, we conclude that the ALJ properly affirmed the Order on Reconsideration's award of scheduled permanent disability.

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[1] Former ORS 656.268(7) was renumbered pursuant to SB 369, 68th Leg., Reg. Sess., § 30 (June 7, 1995). See ORS 656.268(7)(g). Notwithstanding the change, under either version of the statute, we would reach the same result here.

[2] Former ORS 656.268(6)(a) provided, in pertinent part: "Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding." The statute was renumbered ORS 656.268(6)(e) by SB 369, 68th Leg., Reg. Sess., § 30 (June 7, 1995).

[3] OAR 436-35-005(2) defines ankylosis as "a bony fusion or arthro-desis. Ankylosis does not include pseudarthrosis or articular arthropathies or fibrous unions."

[4] Claimant did not request that the Director adopt a temporary rule. Claimant also failed to make such a remand request at hearing. Rather, claimant's remand request is made for the first time on Board review. We do not consider issues raised for the first time on review or reconsideration. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Brian G. Vogel, 46 Van Natta 225 (1994).

On October 15, 1992, Dr. Vriesman, attending physician, discharged claimant. (Ex. 12). At that time, Dr. Vriesman noted that claimant's calcaneous was showing good healing with minimal deformity, and that claimant had no disability. Id. Lacking persuasive evidence to the contrary, we find no reason not to rely on the attending physician's opinion. See Weiland v. SAIF, 64 Or App 810 (1983).

Furthermore, Dr. Fuller's opinion (as medical arbiter), does not support an award for ankylosis. In measuring range of motion, Dr. Fuller specifically stated that subtalar motion is limited on the right, in comparison with the left. (Ex. 18-3) (emphasis added). Additionally, Dr. Fuller stated "with repeated inversion and eversion, the joint was palpated, but no crepitus was noted at this point." Id. We interpret that statement to refer to repeated movement of the joint.

Accordingly, in light of this evidence, we conclude that claimant is not entitled to a permanent disability award for subtalar inversion ankylosis of the right ankle. Consequently, we affirm the ALJ's decision to affirm the Order on Reconsideration award of 10 percent scheduled permanent disability for the right leg.

Penalty

Claimant contends that he is entitled to a penalty under ORS 656.268(4)(f) for an unreasonable Notice of Closure because SAIF failed to obtain a thorough closing examination from the attending physician. The ALJ concluded that it was not unreasonable for SAIF to rely on the statements of claimant's attending physician concerning impairment at the time of claim closure. We agree.

Claimant is entitled to a penalty under ORS 656.268(4)(f) if the insurer unreasonably closed the claim. 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). If so, the closure is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

On October 15, 1992, Dr. Vriesman examined claimant. Dr. Vriesman discharged claimant, stating that he was "able to work," his foot was "sometimes tender after all day walking," and that claimant could "start doing sports." (Ex. 11). In a letter to SAIF, Dr. Vriesman stated that claimant's heel was showing good healing with minimal deformity. He also stated that claimant was discharged without any disability. (Ex. 12).

Here, in light of the evidence that was available to SAIF at the time it closed the claim, and in the absence of any persuasive reason to the contrary, we affirm the ALJ's decision that SAIF's conduct in closing the claim was not unreasonable.

Attorney Fee

We adopt the ALJ's reasoning and conclusion with regard to this issue.

ORDER

The ALJ's order dated November 25, 1994 is affirmed.

In the Matter of the Compensation of
FRANK A. SARMENTO, Claimant
WCB Case No. 94-12334
ORDER OF ABATEMENT
Coughlin, et al, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

On July 25, 1995, we affirmed an Administrative Law Judge's order which set aside the SAIF Corporation's termination of claimant's temporary total disability benefits. Subsequent to the issuance of our order, we received SAIF's announcement that the parties had resolved their dispute and would be submitting a proposed agreement for our consideration.

In order to retain jurisdiction to consider the parties' forthcoming settlement, we withdraw our July 25, 1995 order. On receipt of the parties' agreement, we shall proceed with our review. In the meantime, the parties are requested to keep us fully advised of any further developments in this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS R. YON, JR., Claimant
WCB Case Nos. 94-07517 & 94-07397
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On July 20, 1995, we abated our June 22, 1995 order that: (1) affirmed an Order on Reconsideration which found that claimant's claim had been prematurely closed; and (2) assessed a penalty for the insurer's allegedly unreasonable failure to pay temporary disability benefits. We took this action to consider claimant's contention we erred by failing to award claimant's counsel an assessed attorney fee pursuant to ORS 656.382(2). Having received the insurer's response, we proceed with our reconsideration.[1]

ORS 656.382(2) provides for an assessed attorney fee award if a carrier requests a hearing and it is found that the compensation awarded to claimant should not be disallowed or reduced. See Kordon v. Mercer Industries, 308 Or 290 (1989).

Here, the insurer requested a hearing seeking to set aside the Order on Reconsideration which had found claimant's claim prematurely closed. The finding of premature closure necessarily entitled claimant to further temporary disability benefits. The ALJ reversed the Order on Reconsideration, reinstating the closure of the claim. Thus, no attorney fee was awarded under ORS 656.382(2).

Our order reversed the ALJ's order and reinstated and affirmed the Order on Reconsideration. Although our order awarded an "out-of-compensation" attorney fee, we neglected to grant an attorney fee under ORS 656.382(2) for claimant's services at hearing for defending against the insurer's request for hearing from the Order on Reconsideration. Therefore, inasmuch as the insurer requested a hearing and claimant's compensation was not disallowed or reduced, claimant is entitled to an attorney fee pursuant to ORS 656.382(2).

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 is $1,500, payable by the insurer . In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We have further taken into consideration claimant's counsel's "out-of-compensation" attorney fee award.

On reconsideration, as supplemented herein, we adhere to and republish our June 22, 1995 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] On July 19, 1995 the insurer petitioned for judicial review of our June 22, 1995 order. We withdrew our June 22, 1995 order for reconsideration the following day, July 20, 1995. Notwithstanding the insurer's appeal, since we withdrew our June 22, 1995 order for reconsideration within 30 days of its issuance, we retain jurisdiction over this case. ORS 656.295(8); SAIF v. Fisher, 100 Or App 288 (1990).

In the Matter of the Compensation of
SCOTT S. FROMM, Claimant
WCB Case No. 93-07187
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig, Turner-Christian and Hall.

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

FINDINGS OF FACT

Claimant, an electrical apprentice, injured his left thumb at work at approximately 11:45 a.m. on May 13, 1993. He was on a ladder, working on an electrical box, when he lost his balance and his left hand came into contact with a large fan that was rotating directly in front of him.

Claimant drinks at least four beers per day. The night before his accident, he had been out drinking alcohol and dancing. He gave varied accounts as to the amount of alcohol he consumed.[1] He failed to meet Mr. DeWitt, a co-worker, at 6:00 a.m. on the morning of May 13 to carpool to work. Rather, he arrived at the work site, a chicken farm in Creswell, at approximately 9:00 a.m. (nearly two hours late) and told DeWitt that his alarm clock had been "messed up" by an electrical storm the previous night. He then began working on the same project he had begun the day before, installing conduit and wire for additional fans in the barn.

Following the accident, claimant was taken to the hospital in Eugene by another co-worker, Mr. Daily, driving a company van. At the hospital, claimant initially denied he had consumed alcohol. He later revised his story and admitted to drinking one beer on the way to the hospital. He then admitted to the hand surgeon, Dr. Dreyer, that he had drunk two beers.

Claimant was assessed as being alert and oriented at the hospital. Prior to undergoing left thumb surgery, routine blood testing was administered. Those tests, taken less than 1 1/2 hours after the accident, indicated that claimant had a blood alcohol level of .34.

Neither co-worker Daily, nor co-worker DeWitt, who administered first aid at the work site, noted any alcoholic odor, slurred speech, or signs of intoxication by claimant at any time before or after the incident. Neither co-worker had much close contact or interaction with claimant prior to the accident, however, as they were working at opposite ends of the barn. Further, because the stench of chickens was overpowering, they were wearing respirators to do their work. Claimant was also chewing tobacco the morning of the accident.

Dr. Jacobsen, an expert in addiction medicine, reviewed claimant's medical records. Based on the results of claimant's blood alcohol level tests and his review of the records, Dr. Jacobsen opined that claimant was significantly impaired by alcohol at the time of his injury and that consumption of alcohol was the major contributing cause of the accident.

It is the employer's (unwritten) policy that, as a safety precaution, the electrical equipment being worked on should be turned off while the work is in progress. The bank of fans in the area where Daily and DeWitt were working had been shut off by DeWitt. Claimant did not turn off the fans in his work area.

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[1] He told his employer on June 4, 1993 that he had consumed about 8 whiskeys the night before his accident. (Ex. 7). He testified at hearing that he had one or more 12 ounce glasses of beer and at least three mixed drinks (bourbon and Coca-Cola) between 8:00 and 11:30 p.m.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant established a prima facie case of compensability, in that the injury to claimant's left thumb occurred while he was at work. The ALJ further found that SAIF failed to carry its burden of proof under former ORS 656.005(7)(b)(C), and did not establish by clear and convincing evidence that claimant's consumption of alcohol was the major contributing cause of the injury. Finding that claimant was credible based upon his demeanor, the ALJ determined that claimant had not consumed any alcohol before his injury occurred. The ALJ further concluded that even if claimant had consumed alcohol or other intoxicants, claimant was not impaired at the time of the accident. Finally, the ALJ held that even if claimant was intoxicated, SAIF failed to establish by clear and convincing evidence that the intoxication was the major cause of the accident.

On review, SAIF contends that the ALJ's ultimate conclusion, that claimant did not begin consuming alcohol until after the accident occurred, is not supported by the record. SAIF also argues that the unrebutted expert medical testimony establishes that claimant's consumption of alcohol was the major contributing cause of the accident.

Subsequent to the ALJ's order and the parties' briefing on review, Senate Bill 369 was enacted, which amended ORS 656.005(7)(b)(C). Or Laws 1995, ch 332, § ___ (SB 369, § 1). The amended version changed the burden of proof in drug and alcohol consumption cases from "clear and convincing" to a "preponderance of the evidence."[2]

As an initial matter, we disagree with the ALJ's finding that claimant was a credible witness. Although we generally defer to an ALJ's demeanor-based credibility findings, we do not do so where inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. See Erck v. Brown Oldsmobile, 311 Or App 519, 528 (1991). Because this is such a case, we do not defer to the ALJ's credibility findings. See Davies v. Hamel Lumber Co., 67 Or App 35 (1984); see also William K. Porter, 44 Van Natta 937 (1992).

Unlike the ALJ, we are not persuaded by claimant's version of events. It is inconsistent with the medical evidence as well as the other witnesses' testimony.[3] For example, claimant testified that following the accident, when co-workers DeWitt and Daily were determining how to get him to the hospital, he walked over to his truck, retrieved a relatively full pint bottle of whiskey and stashed it in his pants. He also testified that on the ride to the hospital, he had Daily stop twice to purchase beer. He claimed that while Daily went into the stores (two different convenience stores, about a mile and a half apart) he drank several swallows of whiskey and nearly finished the bottle. He also testified he tossed the pint bottle in the garbage container near the entrance to the hospital without any of his co-workers noticing.

Conversely, co-workers Daily and De Witt both testified that claimant did not have the opportunity, either before he reported the accident to them or when they were deciding how to transport claimant to the hospital, to retrieve the pint of whiskey from his truck. Further, Daily testified that claimant did not have the opportunity to surreptitiously consume significant amounts of whiskey enroute to the hospital. Daily testified that he reluctantly made one stop for beer on the way, and that it was claimant who went into the store and purchased the beer. He did not see claimant with any whiskey.

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[2] Section 66 of SB 369 provides, with few exceptions, that it is intended to be retroactive, and applies to all claims or causes of action existing or arising after the effective date, regardless of the date of injury or date of the claim. Volk v. America West Airlines, 135 Or App 565 (1995). We need not resolve which version of the statute is applicable because we would find that SAIF has established, by clear and convincing evidence, that claimant's consumption of alcohol was the major contributing cause of the injury.

[3] The ALJ also found witnesses DeWitt and Daily to be credible based on demeanor, despite discrepancies between their testimony and claimant's.

Claimant's supervisor, Mr. Paslay, testified that upon claimant's arrival at the hospital, he was there to help claimant out of the truck. He walked claimant into the emergency room and was with him until claimant was turned over to the nurse. Paslay did not see claimant holding or disposing of a whiskey pint. Further, the hospital records mention nothing about claimant consuming whiskey after the accident. Indeed, the record indicates claimant first mentioned that he consumed some whiskey after the accident when he met with his employer on June 4, 1993.

Dr. Jacobsen opined that even if claimant did, as he stated to his employer, drink two beers and two shots of whiskey between the accident at 11:45 a.m. and the blood screen at 1:02 p.m., those drinks would only raise his blood alcohol level .06 to .08. Factoring in these 4 post-accident drinks, Dr. Jacobsen determined, based on claimant's size and the manner in which alcohol is absorbed by the body, that claimant's blood alcohol would have been in the range of .26 to .28 at the time of the accident. (Ex. 6). Dr. Jacobsen explained that this level is equivalent to between 11 1/2 to 16 unmetabolized drinks in his body at the time of the injury.[4]

Under these circumstances, we find that claimant was under the influence of alcohol at the time of the accident. Given this conclusion, we must determine whether SAIF has met its burden of proof under ORS 656.005(7)(b)(C). To defeat a finding of compensability under the former version of the statute, SAIF must show, by clear and convincing evidence, that claimant's consumption of alcoholic beverages was the major contributing cause of the injury. SAIF cannot meet its burden by merely showing that claimant consumed alcohol. Rather, SAIF must establish that claimant was impaired by the alcohol and that such impairment was the major contributing cause of the injury. Grace L. Walker, 45 Van Natta 1273 (1993) aff'd mem 126 Or App 313 (1994) (interpreting former ORS 656.005(7)(b)(C)); Dave D. Hoff, 45 Van Natta 2312 (1993) aff'd mem, Hoff v. Leavitts Freight Service, 131 Or App 363 (1994) (same). The issue is, then, one of causation.

Dr. Jacobsen reviewed claimant's medical records and opined that an individual with claimant's admitted drinking habits would have a high tolerance for alcohol and would be able to function at a blood alcohol level of .34, whereas most non-tolerant individuals would pass out or fall asleep with a level of about .20. Dr. Jacobsen then explained that even though claimant could function and appeared not to demonstrate signs of gross motor impairment generally associated with intoxication (slurred speech, staggering gait and marked incoordination) he would still be severely impaired by alcohol at this level.[5] Dr. Jacobsen concluded that claimant was significantly impaired by alcohol at the time of his injury and that use of alcohol was the major contributing cause of the accident. Dr. Jacobsen also explained that with claimant's admitted history of drinking the night before, sleep deprivation resulting from the heavy use of alcohol could be another factor increasing his level of impairment. (Ex. 6-4).

The ALJ did not find Dr. Jacobsen's report persuasive because Dr. Jacobsen believed that at such a high blood alcohol level, claimant would have emanated the smell of alcohol on his breath. Dr. Jacobsen's report does note his surprise that none of claimant's co-workers reported such a smell. The ALJ determined that the reason why neither DeWitt nor Daily smelled alcohol on claimant's breath was because there was no such odor. We are not persuaded that is why no odor was detected. Rather, given the fact claimant and his co-workers were surrounded by the foul smell of the chicken farm, we

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[4] Claimant argues Dr. Jacobsen's opinion is flawed because it assumes that claimant consumed two beers and two shots of whiskey on the way to the hospital (as claimant reported to his employer) rather than the nearly full pint of whiskey (as claimant testified to at the hearing). Admittedly, Dr. Jacobsen did not consider this second scenario. However, as noted above, we are not persuaded by claimant's testimony that he retrieved a full whiskey bottle after the accident and consumed and disposed of it without Daily or another co-worker noticing. We therefore accept Dr. Jacobsen's assessment that claimant had consumed a substantial amount of alcohol before the accident and reject claimant's speculation that the rapid consumption of alcohol after the accident could have elevated his blood alcohol level to .34.

[5] Dr. Jacobsen noted that although claimant would not "necessarily be 'falling down drunk (my term).' Impairment as measured by lack of judgment, decreased inhibitions, decreased attention, decreased coordination and impaired balance would still be present." He explained that even with tolerance, "at a .34 blood alcohol level Mr. Fromm would have demonstrated muscular incoordination if this were specifically tested." (Ex. 6-2).

consider it understandable that they did not notice an alcoholic smell emanating from claimant even when they were standing outside of the barn administering first aid.[6]

We acknowledge that co-workers DeWitt and Daily reported that claimant did not appear intoxicated. We further recognize the hospital chart note that claimant appeared alert and oriented. These observations do not alter our conclusion that claimant was impaired at the time of the work accident. In fact, we find the hospital staff's determination that claimant appeared alert and oriented upon his arrival is consistent with Dr. Jacobsen's assessment that claimant could still function at such a high blood alcohol level even though his judgment and muscular coordination was significantly impaired.

We held under similar facts in Grace L. Walker, supra,[7] that the cause and effect of the use of alcohol or controlled substances is a medical question requiring competent medical evidence. As in Walker, we find persuasive the medical expert's conclusion that claimant was impaired at the time of his accident.

We also conclude that claimant's impairment was the major cause of the injury. Claimant himself gave varying accounts of how the accident occurred. He told the emergency room physician that while working on the ladder, he dropped something and caught his hand in the fan as he bent down to pick it up. (Ex. 2). He told his employer that he slipped and lost his balance as he was putting a screw in. (Ex. 7-1). He testified at hearing: "I was up on a ladder running some PVC pipe and drilling a box, and I slipped and lost my balance and my . . . thumb went in the fan." He later elaborated that the screw came off the drill bit, the drill slipped in his right hand and his left hand came up and into the fan. (Tr. 12, 21-22).

In Ronald Martin, 47 Van Natta 473 (1995), we disagreed with the claimant's argument that a carrier could not prove that alcohol consumption was the major cause of the injury where there was more than one plausible explanation for the accident. There, based on the employer's assessment of how the accident occurred, we held that the claimant's skidder accident was attributable to the claimant's error in judgment. We then found that the claimant's consumption of alcohol and drugs was the cause of this error in judgment.

In Richard A. Perry, 46 Van Natta 302 (1994), the claimant injured his hand while removing a jammed piece of wood from a wood planer. We determined that the claimant's consumption of marijuana was the major contributing cause of the injury, given the fact the claimant was familiar with the operation of the machinery. Although the claimant alleged he was distracted by a co-worker, we found the alleged distraction was not a plausible explanation for the accident.

In Duane A. Menestrina, 47 Van Natta 694 (1995), we held the claimant's consumption of alcohol was the major cause of the claimant's accident where he lost control of the straddle lumber carrier he was driving while negotiating an "S" curve. There, as here, the claimant was a chronic drinker with a high tolerance for alcohol, who was found to have a blood alcohol level of at least .16 at the time of the accident. Relying on the expert medical opinion, we determined that considering other potential factors such as the carrier's low tire and the claimant's alleged fatigue, the claimant's alcohol impairment was the major contributing cause of the accident.

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[6] We note that co-worker Daily also testified he did not notice the smell of alcohol emanating from claimant on the ride to the hospital, which seems not only inconsistent with Dr. Jacobsen's assessment that claimant would have emanated such a smell but also claimant's testimony that he consumed a pint of whiskey and two beers during that time. This apparent inconsistency does not cause us to reject Dr. Jacobsen's opinion nor Daily's testimony, however. We find Dr. Jacobsen's report to be persuasive based on its completeness and thorough explanations and reasoning.

[7] In Walker, the claimant sustained a near amputation of her finger while operating a bandsaw. She had been working for approximately 2 hours without any intervening breaks, Shortly after the incident, she tested positive for marijuana, cocaine, morphine and methamphetamines. Relying on the medical expert's opinion, we held that the claimant was impaired as a result of the toxic effects of the drugs, and that her impairment was the major cause of her inattention and poor judgment, which led to the accident.

In this case, as noted above, we find by clear and convincing evidence, that claimant was alcohol impaired at the time of the accident. We similarly find, by clear and convincing evidence, that claimant's alcohol impairment was the major cause of the accident. The work claimant was doing, standing on a ladder and installing electrical wire and conduit, involves small muscle coordination and balance. His decision to work directly in front of an operating fan, when the employer's policy dictated that such equipment be shut off involved an error in judgment. Based on Dr. Jacobsen's opinion that claimant's judgment, coordination and balance were impaired at the time of the accident as a result of alcohol consumption, we are persuaded, by clear and convincing evidence that claimant's alcohol consumption was the major contributing cause of his injury. Indeed, like the claimant in Perry, claimant was performing a familiar task. He had performed the same job at the same site the day prior without incident, and had previous experience performing the same work at other locations.[8]

We recognize this type of accident could occur with a non-intoxicated worker. Indeed, the accidents at issue in Walker (finger caught in bandsaw), Perry (fingers caught in wood planer), Martin (log skidder rolled over onto claimant) and Menestrina (lumber carrier toppled over on "S" curve) also could have occurred in the absence of the operator's intoxication.[9] We conclude, however, that as in the cases cited above, SAIF (as the employer's insurer) has established by clear and convincing evidence that claimant's consumption of alcohol was the major contributing cause of his injury.

In sum, we find SAIF has established that claimant's injury is not compensable. Consequently, we reinstate and uphold its denial.

ORDER

The ALJ's order dated November 30, 1994 is reversed. The SAIF Corporation's denial of claimant's left thumb injury claim reinstated and upheld. The ALJ's $6,000 attorney fee is also reversed.

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[8] Claimant's supervisor, Mr. Paslay, testified that he had worked with claimant on several occasions when they installed similar wiring for fans at ranches in Washington. On each of those occasions, the fans were shut off while the equipment was being installed. (Tr. 87).

[9] Compare claimant's accident with that in Charles D. Turner, 46 Van Natta 1541 (1994), aff'd mem, 134 Or App 217 (1995). There, the claimant injured his right leg when a tree fell on him while he was operating a Cat. We held that even though the claimant had consumed marijuana prior to the accident, his marijuana consumption was not a major cause of his injury. Rather, he just happened to be in the wrong place (off the designated skid trails) at the wrong time.

Board Member Hall dissenting.

I disagree with the majority's conclusion that SAIF has carried its burden of proof on the issue of causation and thus, respectfully dissent. As set forth in my dissent in Ronald Martin, 47 Van Natta 473 (1995), we cannot let evidence of a claimant's impairment, even if overwhelming, color our separate determination of whether that impairment was the major cause of the accident which resulted in claimant's injury. By statute, the test has two elements; impairment and causation. Both elements must be satisfied.[1]

In this case, there were no eyewitnesses to the accident and the only evidence regarding how the injury occurred came from claimant. I submit the majority errs in relying upon the opinion of Dr. Jacobsen to find that the employer/carrier carried its burden of proving causation. See Ronald Martin, supra, dissent at p. 476 (question of causation, how the accident happened, beyond scope of Dr.'s expertise).

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[1] The recent statutory amendment to ORS 656.005(7)(b)(c), whereby the burden of proof was lowered from clear and convincing to a preponderance of evidence, did not eliminate the two separate elements.

The majority also relies on Grace Walker, 45 Van Natta 1273 (1993) aff mem 126 Or App 313 (1994) for the proposition that the " * * * cause and effect of the use of alcohol or controlled substances is a medical question requiring competent medical evidence." (Majority opinion at p. 6.) I agree with that holding; the cause and effects of substances in the human body is a medical question. A qualified medical expert may certainly offer testimony of the functional impairment resulting from consumption of substances. How a piece of machinery operates (or is operated) and other such non-medical issues surrounding the "cause" of an accident are not, however, within the qualifications of a medical expert. The majority notes Walker, supra, for reliance on the medical expert (majority opinion, p. 6, fn. 7). It should be noted, however, that there was another expert involved in Walker, a mechanical engineer (Henry Edel). Indeed, in Walker, the Board majority stated:

> "In light of the safety features on the machine, Mr. Edel's explanation of the proper method for safe operation of the saw, and Dr. Jacobsen's opinion regarding the toxic effects of claimant's drug use, we are persuaded by clear and convincing evidence that claimant's consumption of the controlled substances was the major contributing cause of her injury. Therefore, the insurer has established that the injury is not compensable." (45 Van Natta at 1275)

The purpose of this dissent is not to register disagreement with the majority's factual determinations. The purpose is to acknowledge the two separate statutory elements involved (impairment and causation) and the need for proper evidence on each element.

August 9, 1995 Cite as 47 Van Natta 1481 (1995)

In the Matter of the Compensation of
FRANK L. KORKOW, Claimant
WCB Case Nos. 93-10088 & 93-09538
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Lundeen, et al, Defense Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

On July 11, 1995, we reversed that portion of the Administrative Law Judge's (ALJ) order that set aside the SAIF Corporation's denial of compensability and responsibility for claimant's current low back strain. Claimant seeks reconsideration. Noting that he requested Board review of other portions of the ALJ's order, and stating that both insurers specifically sought to have the ALJ's order affirmed, claimant asks that we vacate that portion of our order which reversed that portion of the ALJ's order which found that claimant experienced a new low back strain injury on May 17, 1993 while working for SAIF's insured.

Pursuant to our de novo review, our authority on review extends to all issues and arguments raised by the ALJ's order. ORS 656.295(6); see Destael v. Nicolai Co., 80 Or App 596 (1986); Miller v. SAIF, 78 Or App 158 (1986). Thus, we were authorized to address the issue concerning whether claimant's May 17, 1993 injury combined with his preexisting condition.

Nevertheless, because no party challenged the ALJ's compensability finding regarding claimant's low back strain, and because SAIF expressly sought affirmation of the ALJ's order, we conclude that we should not have exercised our authority to alter that portion of the ALJ's order.

Accordingly, we withdraw our July 11, 1995 order. On reconsideration, in lieu of our July 11, 1995 order, we adopt and affirm the ALJ's September 7, 1994 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
DANA J. RHYNE, Claimant
WCB Case No. 94-03924
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order which upheld the SAIF Corporation'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 allegedly injured her low back on December 3, 1993, pulling a small safe out from a wall to retrieve some mail. Claimant did not experience any low back symptoms until awakening the next day. In addition, claimant did not seek treatment for several days, when she consulted Dr. Harvey on December 8, 1993. Dr. Harvey diagnosed a lumbar muscular strain, which he related to claimant's work activity.

The ALJ upheld SAIF's denial, concluding that the medical causation question was complex, requiring expert medical evidence. Finding that Dr. Harvey relied on an erroneous history that claimant experienced low back symptoms immediately after moving the safe, the ALJ concluded that Dr. Harvey's medical opinion was unpersuasive. Therefore, the ALJ upheld SAIF's denial.

On review, claimant contends that the medical causation issue is not complicated and, thus, she was not required to present expert medical evidence in order to establish a compensable claim. Moreover, claimant asserts that, even if this was a complicated case, Dr. Harvey's uncontradicted medical opinion is persuasive evidence that she sustained a low back injury as a result of the "safe" incident. We disagree.

In Barnett v. SAIF, 122 Or App 279 (1993), the court reversed a Board order that upheld a back injury denial because no physician had offered a medical opinion relating the claimant's back condition to her work activities. Citing Uris v. Compensation Dept., 247 Or 420 (1967), the court listed five relevant factors for determining whether expert evidence of causation is required: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a supervisor; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any contrary expert evidence.

In Barnett, the claimant had not experienced low back pain previously, had suffered immediate low back pain after the injury, sought medical treatment within 24 hours, and had reported the incident to her employer the next day. In addition, there was no medical evidence which indicated that the injury did not cause the back condition. Under those circumstances, the court held that the claimant was not required to introduce expert medical testimony to prove causation.

We find this case distinguishable from Barnett because claimant, here, did not promptly seek medical treatment and, more importantly, claimant did not experience low back symptoms immediately after moving the safe. As claimant testified, she did not experience any low back symptoms until the following day. Under these circumstances, we find that, unlike Barnett, this case did not present an uncomplicated situation. Accordingly, we conclude that the ALJ properly required expert evidence to establish medical causation.[1]

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[1] Claimant cites numerous cases in support of her argument that this is an uncomplicated matter, including Rollie Clark, 45 Van Natta 2144 (1993); Damon R. Robinson, 46 Van Natta 138 (1994); Jody L. Williams, 46 Van Natta 58 (1994); Brett D. Adair, 46 Van Natta 378 (1994); Jann L. Quick, 46 Van Natta 1133 (1994). From our review of their facts, none of these cases involved a delay in the onset of symptoms similar to what is presented in this case.

The ALJ determined that Dr. Harvey's medical opinion relating claimant's muscular strain to her work activity was unpersuasive because his history was inaccurate. We agree with the ALJ's assessment.

First, Dr. Harvey assumed a history that claimant "lifted" the safe and that this lifting was "heavy." (Exs. 5, 8, 9). Neither assumption is supported by the evidence in this case. Claimant testified that she "moved" the two-foot high safe, which was mounted on rollers. (Trs. 10, 15, 24). There is no evidence to indicate the weight of the safe. Thus, we are unable to conclude that claimant participated in work activity that was either "heavy" or involved "lifting."

Second, and most important, we agree with the ALJ that Dr. Harvey had an inaccurate and, at best, imprecise history. The most detailed history provided to Dr. Harvey is contained in a letter from claimant's counsel's office to Dr. Harvey. The letter states that claimant noted pain in the low back and left leg "after moving [the] safe." The letter continued: "On the morning following this incident, [claimant's] pain had increased significantly and become disabling." (Ex. 8A, emphasis added). Based on this history, Dr. Harvey opined that claimant was injured as described in counsel's letter by "lifting" a small safe. (Ex. 9).

We agree with SAIF that the history in counsel's letter clearly implies that claimant experienced an immediate, contemporaneous onset of symptoms in conjunction with moving the safe. However, this is not true. Claimant herself testified that the onset of symptoms did not occur until the next day. (Tr. 11). Given the delayed onset of symptoms, and the apparent confusion regarding the alleged mechanism of injury, we do not find Dr. Harvey's medical opinion, even though uncontradicted, to be persuasive.[2] See Somers v. SAIF, 77 Or App 259 (1986) (persuasiveness of medical opinion depends on accurate and complete history). Therefore, we agree that the ALJ properly upheld SAIF's denial.

ORDER

The ALJ's order dated January 18, 1995 is affirmed.

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[2] We recognize that there is no evidence of another cause of claimant's low back condition and that there is no indication that claimant's current complaints are related to her previous back problems. However, given the significant delay in the onset of low back symptoms following the alleged mechanism of injury, we are unwilling to find Dr. Harvey's medical opinion persuasive in the absence of an opinion that clearly manifests an awareness of the lack of immediate symptomatology.

In the Matter of the Compensation of
DEANNA J. KASKELA, Claimant
WCB Case No. 94-14061
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Gunn and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order which reduced the award of scheduled permanent disability in an Order on Reconsideration from 40 percent (60 degrees) for loss of use or function of claimant's right hand and 14 percent (21 degrees) for loss of use or function of her left hand to 9 percent (13.5 degrees) for the right hand and 8 percent (12 degrees) for the left 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

Claimant has a compensable bilateral carpal tunnel syndrome claim resulting from her employment as a supervisor for a poultry business. A June 17, 1994 Determination Order awarded 5

percent scheduled permanent disability for claimant's left hand and 5 percent scheduled permanent disability for her right hand. These awards were based on the closing examination of claimant's attending physician, Dr. Yamanaka.

Claimant requested reconsideration of the Determination Order. Dr. Smith performed a medical arbiter's examination that was used in a November 2, 1994 Order on Reconsideration as the basis to increase the scheduled permanent disability awards to 14 percent for the left hand and 40 percent for the right hand.

At hearing, the only dispute concerned the sensory findings used to rate claimant's permanent disability. Dr. Yamanaka had considered his two-point discrimination test unreliable and "skipped" the sensory portion of the examination. (Ex. 24). Dr. Smith wrote in his arbiter's report that his sensory examination was "difficult to do for her" and that the "accuracy may be open to question." (Ex. 27). However, Dr. Smith listed his sensory findings and noted that claimant's sensory abnormalities "tend to follow the median nerve distribution on the right side" and that the abnormality on the left side "apparently includes the median nerve." Smith also noted that Dr. Yamanaka had trouble interpreting two-point discrimination.

Reasoning that there were no reliable findings on which to assign an impairment value for sensory loss, the ALJ concluded that an impairment value could not be assigned for this factor. The ALJ cited Beverly L. Cardin, 46 Van Natta 770 (1994). Accordingly, the ALJ reduced claimant's scheduled permanent disability to 9 percent for the right hand and 8 percent for the left hand.[1]

On review, claimant contends that the ALJ erred in reducing her awards, asserting that Dr. Smith's sensory findings are sufficient evidence to support the awards of scheduled permanent disability in the reconsideration order. Claimant, therefore, requests that we reinstate the awards of permanent disability in the Order on Reconsideration. We find claimant's request to be well-taken.

OAR 436-35-007(9) specifically provides that 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.[2] We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but rather we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. Kenneth W. Matlack, 46 Van Natta 1631 (1994). Furthermore, absent persuasive reasons to do otherwise, we give greater weight to the conclusions of a claimant's attending physician. Weiland v. SAIF, 64 Or App 810 (1983).

In this case, the attending physician, Dr. Yamanaka, "skipped" the sensory portion of his examination because he did not consider that portion of the examination to be reliable. Because we cannot determine the extent to which Dr. Yamanaka completed his closing examination, we are inclined to reduce the weight we might otherwise give Dr. Yamanaka's report. Instead, we must closely examine the other medical evidence bearing on claimant's permanent impairment. Thus, we turn to the issue of whether Dr. Smith's arbiter's examination is adequate to support the scheduled permanent disability awards in the reconsideration order. We conclude that it is for the following reasons.

Although Dr. Smith reported that the accuracy of his sensory findings "may" be open to question, he, nevertheless, completed his examination and reported his sensory findings. He did not state that his sensory findings were unreliable. Moreover, we find it significant that Dr. Smith reported that claimant's sensory findings corresponded to the median nerves affected by claimant's compensable carpal tunnel syndrome. Under these circumstances, we conclude that Dr. Smith's sensory findings were reliable. Therefore, the ALJ erred in finding them unreliable and in reducing claimant's scheduled permanent disability awards.[3]

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[1] Neither party disputed any of the other physical findings and impairment values.

[2] The disability standards define preponderance of the evidence as meaning "the more probative and reliable medical opinion based upon the most accurate history, on the most objective findings, on sound medical principles and expressed with clear and concise reasoning." OAR 436-35-005(10).

[3] We recognize that Dr. Yamanaka's decision to "skip" the sensory portion of his examination casts doubt on the reliability of the sensory findings in this case. However, given the arbiter's findings and his failure to conclude that his sensory findings were unreliable, we are still persuaded that claimant has suffered compensable sensory impairment.

Neither Beverly L. Cardin, supra, nor Ruben D. Carlos, 43 Van Natta 605 (1991), require a different result. In Cardin, a medical arbiter measured the claimant's cervical range of motion, but reported that his findings were unreliable owing to the claimant's marked pain behavior and almost hysterical fear of moving her neck. We found that a preponderance of medical evidence did not support a finding of permanent impairment due to reduced range of motion where the claimant's treating physician released the claimant to regular work without restrictions and the medical arbiter considered his impairment measurements to be unreliable.

In Carlos, we found that two persuasive medical opinions made explicit findings of inconsistencies and functional overlay. Further, both opinions concluded that there was no reliable data upon which to rate permanent impairment. Consequently, we concluded that, under the "standards," the claimant was not entitled to an award of permanent disability.

However, in this case, Dr. Smith did not report pain behavior or hysteria as was noted by the arbiter in Cardin. Moreover, Dr. Smith did not report inconsistencies or functional overlay as was noted in Carlos. While Dr. Smith stated that the accuracy of his testing "may" be open to question, he was not deterred from reporting his findings and did not state that they were unreliable. In short, we do not consider Dr. Smith's findings to have risen to the level of unreliability that prompted us to discount impairment findings in Cardin and Carlos.

Therefore, unlike the ALJ, we do not reject Dr. Smith's impairment findings concerning claimant's sensory loss. Thus, we reverse the ALJ's order and reinstate the permanent disability awarded in the Order on Reconsideration.

We now turn to the issue of attorney fees. The insurer requested a hearing, seeking reduction of the Order on Reconsideration's award of permanent disability. By this order, we have found that claimant's award (as granted by that Order on Reconsideration) should not be disallowed or reduced. Under such circumstances, claimant is entitled to an attorney fee award under ORS 656.382(2) for successfully defending her scheduled award at hearing. 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 counsel's services at hearing is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Because we have modified the ALJ's order which reduced claimant's permanent disability award and we have reinstated the scheduled awards made by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is also entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by our order, not to exceed $3,800. See ORS 656.386(2); OAR 438-15-055(1). In the event that this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), aff'd Volk v. America West Airlines, 135 Or App 565 (1995).

ORDER

The ALJ's order dated March 1, 1995 is reversed. The Order on Reconsideration is reinstated and affirmed. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. In the event the scheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk, supra. Claimant's attorney is also awarded an assessed fee of $1,500 for services at hearing regarding the permanent disability issue, payable by the insurer.

In the Matter of the Compensation of
GLOW I. MEISSNER, Claimant
WCB Case No. 94-11741
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that upheld the SAIF Corporation's denial of her current low back condition. On review, the issue is compensability.

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

Claimant compensably injured her low back in August 1978. She was suffering from degenerative disc disease at the time of the injury. On May 12, 1981, surgery was performed on claimant's low back. The original claim was closed by a January 15, 1982 Determination Order that awarded 5 percent unscheduled permanent disability for the low back.

In July 1982, claimant was admitted to a hospital for treatment of complaints of low back pain that radiated into her right foot. Claimant continued to experience low back symptoms. On August 12, 1991, as amended on December 5, 1991, SAIF issued a partial denial of claimant's low back condition. (Exs. 16, 17). By Opinion and Order dated January 23, 1992, ALJ McWilliams upheld the partial denial, concluding that claimant's 1978 compensable injury was not the major contributing cause of her current low back condition. (Ex. 18). The Board affirmed the ALJ's order on January 13, 1993. (Ex. 19).

On August 30, 1994, Dr. Miller recommended fusion surgery to treat claimant's low back complaints. (Ex. 26). On September 20, 1994, SAIF issued a partial denial and amended its denial on October 24, 1994. (Exs. 27, 28).

The ALJ found that the condition for which Dr. Miller recommended fusion surgery was the same condition that was the subject of the January 13, 1993 Order on Review. The ALJ reasoned that claimant's condition had not changed since the issue of causation was litigated in 1992, and, therefore, the question of causation remained unchanged. The ALJ concluded that claimant's condition was not subject to relitigation.

Claimant agrees that her degenerative disc disease predated her 1978 injury. She contends, however, that the ALJ failed to address whether the degenerative condition was a factor in her disabling condition when the injury claim was closed. Citing Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995), claimant argues that SAIF is precluded from denying the compensability of degenerative disease that was a basis of the unappealed permanent disability award in 1982.

In Messmer v. Deluxe Cabinet Works, supra, the claimant injured his neck and right shoulder at work. The claim was closed by a Determination Order which awarded permanent disability based in part on the effects of surgery that treated the claimant's degenerative disc disease. The employer did not appeal the Determination Order. The claimant later filed an aggravation claim for a worsening of his degenerative condition, which the employer denied. The claimant argued that the employer was barred from denying the compensability of his degenerative condition because the employer had failed to appeal the Determination Order's award of permanent disability for his degenerative condition.

In Richard J. Messmer, 45 Van Natta 874 (1993), we concluded that the carrier was not precluded from denying the compensability of the claimant's aggravation claim, on the ground that neither the carrier's approval of surgery nor its failure to challenge the Determination Order constituted an acceptance of the claimant's degenerative neck condition. The court disagreed, reasoning that the scope of the compensable claim was inseparable from the determination of extent of disability. 130 Or App at 258. Inasmuch as the employer did not challenge the permanent disability award in the Determination Order, the court determined that the employer was barred from later arguing that the condition for which the award was made was not part of the compensable claim. The Messmer court emphasized that the result was not that the degenerative condition was accepted, but that the employer was barred by claim preclusion from denying that it was part of the compensable claim. Id.

In Olson v. Safeway Stores, Inc., 132 Or App 424, 428 n.1 (1995), the court distinguished that case from Messmer because the Board had not made a finding that the Determination Orders awarded compensation for a degenerative condition. The court found that "it [was] not obvious from [the] review of the determination orders and the evaluators' worksheets that the award included any compensation related to the degenerative condition." Id.

Here, claimant asserts that, because the degenerative condition was present and was the reason for surgery, the permanent disability award can only be interpreted to reflect permanent impairment due to the degenerative disc disease because disc surgery is not necessary to treat a muscle strain. We disagree.

There is no formal acceptance or denial of claimant's degenerative disc disease in the record. Although SAIF asserts in its brief that it accepted a claim for an L4-5 herniated disc, neither the acceptance nor the January 15, 1982 Determination Order is in the record. Claimant relies on the contemporaneous medical records to determine what condition existed at the time of the disability determination.

The January 21, 1981 chart notes from the Eugene Hospital and Clinic reported that claimant was complaining of severe low back pain. (Ex. 2). X-rays apparently done on January 4, 1981 were reported as "normal except for minimal degenerative changes at the L4, L5 level." (Id.) The physician suspected a possible ruptured intervertebral disc. Claimant was examined by Dr. Robertson on March 16, 1981 and he suspected a possible L4-5 herniated disc. (Ex. 4). On May 12, 1981, Dr. Robertson performed a lumbar laminectomy at L4-5 on the left and a discectomy. (Ex. 7). His final diagnosis was L4-5 herniated disc. (Id.)

On October 12, 1981, Drs. Heusch, Holm and Ebert performed an examination on behalf of SAIF and diagnosed "[c]hronic lumbosacral strain by history" and "[s]tatus post left L4-5 laminectomy and discectomy." (Ex. 8). X-rays performed that day demonstrated narrowing at L4-5 and evidence of a laminectomy defect. (Id.) The report did not mention degenerative disc disease. On January 7, 1982, Dr. Robertson reported that claimant had "[c]ontinued low back pain from the degenerative L4, 5 disc." (Ex. 9). He recommended medication and weight loss. (Id.). The original claim was closed by a January 15, 1982 Determination Order that awarded 5 percent unscheduled permanent disability for the low back.[1]

We are not persuaded that the degenerative low back condition was the reason for surgery. Dr. Robertson's reports indicate that the reason for surgery was to treat the herniated disc. Moreover, the medical evidence does not indicate that claimant's herniated disc was caused by the degenerative disc disease. To the contrary, x-rays taken January, 1981 indicated only "minimal" degenerative changes at the L4, L5 level. (Ex. 2). Although Dr. Robertson mentioned after surgery that claimant had low back pain from the degenerative L4-5 disc, we are not persuaded that the degenerative condition was the reason for surgery. Based on this record, we are not persuaded by claimant's argument that the 5 percent unscheduled permanent disability award can only be interpreted to reflect permanent impairment due to the degenerative disc disease.

Unlike Messmer, this record is insufficient to establish that claimant's January 15, 1982 Determination Order awarded compensation for a degenerative low back condition. See Olson v. Safeway Stores, Inc., supra, 132 Or App at 428 n.1. Therefore, Messmer v. Deluxe Cabinet Works, supra, is not controlling.[2]

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[1] Claimant relies on a July 1982 medical report that diagnosed degenerative disc disease and degenerative arthritis as the source of her low back symptoms. (Ex. 10). The report also noted a "possible significant emotional overlay." (Id.) Under Messmer, the critical inquiry is whether claimant received treatment for the degenerative disc disease before claim closure. See Wayne L. Duval, 46 Van Natta 2423, 2424 n.2 (1994). Since the July 1982 report was prepared after the January 15, 1982 Determination Order, we do not rely on it. Similarly, we do not rely on Dr. Miller's August 30, 1994 opinion in determining whether claimant received treatment for the degenerative disc disease before claim closure.

[2] In light of our holding that Messmer v. Deluxe Cabinet Works, supra, is not controlling, we need not decide whether amended ORS 656.262(10) applies to this case. Amended ORS 656.262(10) provides, in part: "Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." SB 369, 68th Leg., Reg. Sess., § 28(10) (June 7, 1995).

We agree with the ALJ's reasoning and conclusion that the condition for which Dr. Miller has recommended fusion surgery is the same condition which was the subject of the January 13, 1993 Order on Review. Claimant acknowledges that her current condition is the same as she suffered in 1986. Therefore, we hold that claimant is precluded from establishing the compensability of his current low back condition. See Edwin W. Pearle II, 46 Van Natta 1568 (1994) (the claimant was precluded from relitigating the issue of a causal relationship between the original injury and his current low back condition, where the evidence failed to establish that his current low back condition was different from the condition previously determined to be unrelated to the original injury); Dean L. Watkins, 44 Van Natta 1003 (1992).

ORDER

The ALJ's order dated January 23, 1995 is affirmed.

August 10, 1995 Cite as 47 Van Natta 1488 (1995)

In the Matter of the Compensation of
WALTER J. REZNICSEK, Claimant
Own Motion No. 93-0572M
OWN MOTION ORDER OF ABATEMENT
Scott McNutt, Claimant Attorney
John M. Pitcher, Defense Attorney

The self-insured employer requests reconsideration of our August 2, 1995 Own Motion Order Reviewing Carrier Closure, in which we affirmed the employer's December 1, 1994 Corrected Notice of Closure as appropriate. In that order, the Board also found that, although we are not authorized to award temporary disability benefits beyond claimant's medically stationary date, we are authorized to award a penalty under former ORS 656.262(10)(a) (now ORS 656.262(11)(a)) for the employer's unreasonable delay or unreasonable refusal to pay compensation. Therefore, the Board assessed a penalty equal to 25 percent of the temporary disability benefits Weyerhaeuser should have paid claimant from April 18, 1994 through December 1, 1994. That penalty was assigned in equal shares to claimant and his attorney. With its request for reconsideration, the employer contends that: (1) the Board ignored evidence in the record that would support the employer's contention that it did not fail to pay time loss until claim closure; (2) the Board lacked jurisdiction under ORS 656.278 to consider the penalty issue; and (3) it was improper for the Board to have raised this issue which does not involve former findings, orders or awards *sua sponte*.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. Claimant is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MORRIS W. SALTEKOFF, Claimant
WCB Case Nos. 91-18484, 90-22377 & 91-01510
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Alan L. Ludwick (Saif), Defense Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order which: (1) admitted evidence offered by Roseburg Forest Products (RFP), subject to an offer of proof; (2) upheld RFP's denials of claimant's aggravation claim for his current low back condition; and (3) upheld the SAIF Corporation's acceptance of the same condition. On review, the issues are evidence, compensability and responsibility.

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

Evidence

At hearing, for purposes of impeaching claimant's testimony, RFP submitted a video and accompanying testimony. Claimant objected to the admission of the evidence on the basis that it was not relevant. (Tr. of June 24, 1992 at 74) (Tr. I). The ALJ granted the objection, but took the testimony and video as an offer of proof. (Tr. I 91, 92). On review, claimant contends that the evidence should be stricken from the record.

Since the evidence to which claimant objects was submitted as an offer of proof, neither we nor the ALJ have considered the submission. This is particularly the case where, as here, the party who advanced the offer of proof (RFP), does not seek our consideration of the submission, as part of our de novo review.

Additionally, claimant contends that all evidence except depositions submitted after June 24, 1992 (the initial date of hearing) be stricken because such exhibits are irrelevant and unnecessarily complicate the record. We reject this contention.

At the reconvened hearing, no objections were made on the record to the exhibits submitted after June 24, 1992. (Tr. of April 15, 1994 at 3). Inasmuch as the record does not establish that claimant registered an objection to the ALJ's consideration of this "post-June 24, 1992" evidence, we decline to consider claimant's contention that it was an abuse of discretion for the ALJ to have admitted such evidence. See ORS 656.283(7).

Low Back Condition

In 1976 claimant injured his low back while working for SAIF's insured. Claimant's condition was diagnosed as acute lumbosacral sprain. (Ex. OA). X-rays showed evidence of degenerative disc disease at L3-4. (Ex. OB-2). A myelogram indicated L5-S1 herniated nucleus pulposus. (Ex. 2). Claimant had a L5-S1 laminectomy and a left L4-5 hemilaminectomy. (Exs. 3,7). SAIF accepted claimant's claim in October 1976. (Ex. 1D). A Determination Order awarded claimant 20 percent unscheduled permanent partial disability. (Ex. 8F). A Stipulation order granted claimant an additional 12.5 percent unscheduled permanent disability. (Ex. 10B).

In 1989 claimant reinjured his low back while working for RFP. An MRI indicated degenerative disc disease at L3-4 and a bulging disc at the L4-L5 level with no evidence of bulging pulposus. (Ex. 24). A February 1990 lumbar myelogram found mild central stenosis and possible lateral recess encroachment on the left at L4-5. (Ex. 26-1). RFP accepted claimant's claim for "low back strain." (Ex. 32). Claimant's 1989 injury claim was closed on September 21, 1990 with an award of 8 percent unscheduled permanent partial disability. (Ex. 51). Subsequent to closure, claimant's low back worsened resulting in lumbar surgery at the L4-L5 level. RFP denied a claim for aggravation of claimant's low back. (Ex. 59). SAIF accepted claimant's medical services claim for the low back condition. Thereafter, claimant requested a hearing contending that RFP was responsible for his low back condition.

The ALJ determined that SAIF was responsible for claimant's low back condition. The ALJ reasoned that claimant's 1989 injury with RFP, when combined with his preexisting degenerative disease, was not the major contributing cause of his disability or need for surgery.

ORS 656.308(1) applies if a worker sustains a "new compensable injury" involving the same condition as that previously processed as part of an accepted claim. SAIF v. Yokum, 132 Or App 18 (1994).[1] Responsibility is then assigned to the carrier with the most recent accepted claim for that condition. Smurfit Newsprint v. DeRosset, 118 Or App 368, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993). In the responsibility context, ORS 656.005(7)(a)(B) applies in determining whether or not a worker sustained a "new compensable injury" under ORS 656.308.[2] The appropriate standard to determine if claimant sustained a "new compensable injury" under ORS 656.308(1) and ORS 656.005(7)(a)(B) is whether an accidental injury combined with a preexisting compensable condition and whether that injury is the major contributing cause of the need for treatment and/or disability for the resultant condition. See SAIF v. Drews, supra, 318 Or at 9.

Here, the persuasive medical evidence establishes that claimant's current disability is related to his condition accepted by SAIF in 1976. Specifically, claimant's 1976 claim with SAIF involved degenerative disc disease at L3-4 and surgery at L5-S1 and L4-5. In 1991 claimant underwent a laminectomy at L4-5. (Ex. 77-3). Dr. Wahls, who treated claimant from 1986 until 1990, opined that claimant's need for lumbar surgery in 1991 was due to his 1976 injury and its sequelae including the degenerative disease and scar tissue from the prior surgeries. (Ex. 101). See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988).

Based on this persuasive medical evidence, we find that claimant's current disability and need for surgery is related to his condition accepted in 1976 by SAIF. Therefore, SAIF is responsible for claimant's current condition, unless it can show that claimant sustained a new compensable injury at RFP that involved the "same condition."

Claimant's 1976 condition accepted by SAIF involved degenerative disc disease, herniations and resulting surgeries. However, claimant's 1989 injury while working for RFP was accepted as "low back strain." Dr. Wahls, treating physician for claimant's 1989 injury, diagnosed claimant's condition at that time as primarily a muscular strain/sprain. (Ex. 101). Dr. Wahls was of the opinion that claimant's 1989 injury did not require lumbar surgery. Dr. Wahls opined that the major contributing cause of claimant's 1991 surgery was his 1976 injury and resulting surgeries. Id. at 2. Based on Dr. Wahls' persuasive opinion, we find that claimant's 1976 and 1989 claims do not involve the "same condition." Consequently, we conclude that ORS 656.308(1) does not apply. Smurfit Newsprint v. DeRosset, supra.

Claimant contends that SAIF and RFP did not accept the "same condition" thereby asserting that ORS 656.308(1) does not apply to shift responsibility. (App. Br. 8). Instead, relying on Raymond H. Timmel, 47 Van Natta 31 (1995), claimant argues that if RFP and SAIF accepted the "same body part" but not the exact "same condition," then RFP is presumptively responsible for claimant's current condition because RFP accepted claimant's last claim. Claimant relies on the opinion of Drs. Johnson and Campagna to support his contention.

Assuming that claimant is correct that the "Kearns presumption" applies to the present case, we find that the medical evidence adequately rebuts the presumption by establishing that there was no causal connection between claimant's current L4-5 condition and RFP's "last accepted claim" for a low back strain. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984).

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[1] Amended 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." SB 369, 68th Leg., Reg. Sess., § 37 (June 7, 1995).

We note that amended ORS 656.308(1) specifically provides that "the standards for determining the compensability of a combined condition under ORS 656.005(7) shall be also used to determine the occurrence of a new compensable injury or disease under this section."

[2] We note that the outcome would be the same whether we relied on the former or amended versions of ORS 656.308(1) and ORS 656.005(7)(a)(B) to decide the present case.

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). In this case, we find persuasive reasons not to rely on the opinions from physicians who supported a causal relationship between claimant's 1989 injury and his current condition.

Dr. Johnson, treating physician, opines that the sole cause of claimant's current condition and 1991 surgery was his 1989 industrial accident. (Ex. 87). Dr. Campagna, who examined claimant on referral by Dr. Wahls, found claimant's lumbar spondylosis secondary to his 1989 injury. (Ex. 64-3).

We find, as did the ALJ, that Dr. Johnson's opinion fails to consider claimant's preexisting degenerative disc disease. As for Dr. Campagna's opinion, we find it conclusory because it states only that claimant's 1989 injury caused his lumbar spondylosis, without explanation. (Ex. 64-3). See Moe v. Ceiling Systems, 44 Or App 429 (1980).

On the other hand, we find the opinion of Dr. Wahls, claimant's treating physician in 1989, persuasive. In Dr. Wahls' opinion, claimant's need for lumbar surgery in 1991 was due to his 1976 injury and its sequelae, including the degenerative disc disease. (Ex. 101). This conclusion is consistent with Dr. Wahls' earlier opinion of claimant's 1989 condition of mild spinal stenosis at L4-L5, for which the 1989 injury was not strictly an aggravation of claimant's 1976 injury. (Exs. 29, 30).

Therefore, we find Dr. Wahls' opinion persuasive because he was in the best position to evaluate claimant's history of prior injuries and degenerative disc disease in regard to claimant's 1991 need for lumbar surgery. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986). Consequently, we conclude that claimant's 1989 injury did not independently contribute to his need for treatment for his current treatment. See Raymond H. Timmel, supra; Industrial Indemnity Co. v. Kearns, supra. Accordingly, even if the "Kearns presumption" applied, responsibility would continue to vest with SAIF.

Cervical Condition

The ALJ found that the major contributing cause of claimant's cervical condition and need for cervical fusion surgery in 1991 was due to claimant's preexisting degenerative disc condition. Consequently, the ALJ upheld RFP's denial of claimant's cervical condition. In reaching this conclusion, the ALJ relied on the opinions of Drs. Wahls, Kirkpatrick and Seres.

Claimant contends that the major contributing cause of his current cervical condition was the October 1990 injury he sustained while working for RFP. Claimant has the burden to prove that his October 1990 injury, when combined with his degenerative disc condition, was the major contributing cause of his disability or need for medical treatment of his "combined [cervical] condition." See ORS 656.005(7)(a)(B).[3] Claimant supports his contention with the opinions of Drs. Johnson and Campagna.

Dr. Johnson, treating physician, opined that claimant's cervical condition was due to an aggravation of his 1990 industrial injury. (Ex. 72-2). Dr. Campagna diagnosed claimant's cervical condition as spondylosis C5-C6 with spinal cord compression secondary to the industrial accident of 1990. (Ex. 64-3). Dr. Campagna based his opinion on the fact that claimant's preexisting neck condition was asymptomatic until the October 1990 injury.

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, supra. In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, supra. In this case, we find persuasive reasons not to rely on Dr. Johnson's opinion.

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[3] We note that under either the amended or former version ORS 656.005(7)(a)(B), the outcome of this case would remain the same.

Dr. Johnson's opinion is based on the erroneous conclusion that claimant's preexisting cervical disc disease was asymptomatic prior to claimant's October 1990 industrial accident. (Ex. 87). However, the record shows that claimant has had chronic neck problems since 1976 and a diagnosis of degenerative arthritis since 1982. (Exs. 1B, 2B, 8, 13, 15). Therefore, we find Dr. Johnson's opinion unpersuasive because it based on incomplete and inaccurate information. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

We also afford Dr. Campagna's opinion little weight because his opinion is also based on the erroneous conclusion that claimant's degenerative cervical condition was asymptomatic prior to his October 1990 injury. (Ex. 78). Consequently, since Dr. Campagna's opinion is based on inaccurate information, it is of little persuasive force. Miller v. Granite Construction Co., supra.

We find the opinions of Drs. Seres, Kirkpatrick and Wahls persuasive. Dr. Seres reviewed the medical record and explained that, if claimant's spinal cord compression occurred acutely as a result of his October 1990 injury, claimant would have exhibited spinal cord signs. (Ex. 134-7). Based on his review of the record, Dr. Seres found no such "signs" reported in the medical reports of claimant's examining physicians. Dr. Seres opined that claimant's October 1990 injury resulted in a cervical sprain superimposed on his degenerative cervical disc disease.

Dr. Kirkpatrick, on referral from Dr. Johnson, explained that claimant's cervical spondylosis causes the canals through which the nerves pass to constrict. Therefore, according to Dr. Kirkpatrick, claimant's October 1990 injury could have aggravated his cervical spondylosis because such a "blow" to the head would cause the tissues around the nerves to inflame, further constricting the nerve within its already constricted passage. However, Dr. Kirkpatrick opined that this type of "aggravation" would be immediately apparent rather than result in a delayed onset of symptoms with gradual worsening.

Dr. Wahls examined claimant on December 13, 1990 and found that there was no evidence of cervical spine injury. (Ex. 101-2). Dr. Wahls stated that the October 1990 injury did not affect claimant's long-standing fibromyalgia in his spine.

The opinions of Drs. Kirkpatrick and Seres (which stated that, had claimant's October 1990 injury been the major contributing cause of his cervical condition and need for treatment, claimant's neck problems would have been immediately apparent) are consistent with claimant's history of complaints. Although claimant eventually mentioned the injury some two months later, he did not tell Dr. Johnson of the October 7, 1990 injury during an examination approximately two weeks after the accident. (Ex. 53). Additionally, claimant did not exhibit any evidence of cervical spine injury when examined by Dr. Wahls on December 13, 1990. (Ex. 101-2).

Under such circumstances, we are not persuaded that claimant's October 1990 was the major contributing cause of his cervical disability and need for medical treatment. ORS 656.005(7)(a)(B). Consequently, we agree with the ALJ's decision to uphold RFP's denial.

ORDER

The ALJ's order dated November 1, 1994 is affirmed.

In the Matter of the Compensation of
RONALD L. TIPTON, Claimant
WCB Case No. 94-10202
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's carpal tunnel syndrome (CTS). On review, the issue is the propriety of the insurer's denial. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the insurer had accepted claimant's general condition of strain, contusion, and overuse of the left forearm. The ALJ, thus, determined that the insurer's denial of claimant's CTS was not a partial denial of an unrelated condition. The ALJ further reasoned that since the insurer had accepted a constellation of symptoms, that its denial of the CTS was an impermissible prospective denial. We disagree that the denial was prospective and reverse.

A partial denial occurs "when a claimant makes a single claim encompassing two separate injuries or conditions, the insurer then may partially deny that claim by specifically denying one injury or condition while accepting the other." Johnson v. Spectra Physics, 303 Or 49, 58 (1987). An insurer may partially deny any condition which it reasonably believes could be a claim. Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989). If, however, a claimant factually establishes that he is not making a claim for the denied condition, the denial will be set aside as prospective and ineffective until such time as claimant actually makes a claim for such a condition. Shannon M. Evans, 42 Van Natta 227 (1990).

Here, on January 27, 1994, claimant sought treatment for complaints of left elbow, forearm and hand pain from constantly hitting his hand against a metal table. Dr. Woods diagnosed contusion and muscle strain of the left forearm and hand, and prescribed a wrist splint and medication. Claimant filed a claim for left arm/hand sprain.

On April 18, 1994, Dr. Coe became claimant's treating physician. Dr. Coe reported that, clinically, claimant had probable CTS, recommended EMG and NCV studies and prescribed conservative treatment. The report from Dr. Coe constituted a claim for CTS, which the insurer had a legal duty to accept or deny. See Scott C. Rice, 47 Van Natta 373 (1995) (no premature denial where claim for CTS made based on a treating physician's diagnoses of probable CTS, which was later diagnosed as upper extremity overuse syndrome).

On May 9, 1994, the insurer issued a written notice of acceptance of claimant's left forearm and hand muscle strain and contusion as a disabling claim. The next day, the insurer issued a partial denial of claimant's CTS on the ground of insufficient evidence that the diagnosis of left CTS existed. Accordingly, the insurer's partial denial of claimant's CTS, which it reasonably believed was encompassed in the claim, was procedurally appropriate. Weyerhaeuser Co. v. Warrilow, supra.[1]

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[1] The ALJ's reliance on Boeing Aircraft Co. v. Roy, 112 Or App 10 (1992), is misplaced. In Roy, the insurer's denial of the claimant's claim for left arm and shoulder pain was a denial of the entire claim. In upholding the Board's decision that the denial should be set aside, the court stated that the employer could limit its liability for claimant's undiagnosed pain by making the claim acceptance more specific than the claim. Here, in contrast, the insurer accepted claimant's pain symptoms related to the left forearm strain and contusion, and at the same time, denied symptoms it believed could be related to CTS. Thus, we interpret the denial to be a partial denial.

Dr. Grant subsequently performed electrodiagnostic studies which delineated no neurophysiologic abnormalities to correlate with claimant's complaints. Dr. Grant opined that claimant had significant pain behavior and inconsistencies suggesting a significant functional component. He concluded that claimant had left upper extremity pain syndrome of unknown etiology. Based on Dr. Grants' findings, Dr. Coe reported that, at the time of his April 1994 examination, claimant's subjective test findings indicated significant nerve dysfunction and suggested CTS. However, subsequent objective tests ruled out CTS. Thus, we find that the medical evidence establishes that claimant does not have CTS, and therefore, the denial must be upheld.[2] See Calvin E. Bigelow, 45 Van Natta 1577 (1993).

ORDER

The ALJ's order dated December 16, 1994 is reversed. The insurer's May 10, 1994 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] Because we have found that the denial was not premature, we need not address the issue of whether claimant waived the procedural defect of the denial.

In the Matter of the Compensation of
MERRIE E. VANDINTER, Claimant
WCB Case No. 94-11534
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found that the insurer correctly calculated the rate of claimant's temporary disability benefits; and (2) declined to assess penalties or attorney fees for the insurer's allegedly unreasonable calculation of the rate of temporary disability. On review, the issues are the rate of temporary disability and penalties and attorney fees.

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

The ALJ declined to consider claimant's wages from her prior employment in calculating the rate of claimant's temporary disability. We agree.

We conclude that the ALJ correctly held that claimant's rate of temporary disability should be based solely on the wages she received at the employment where she was injured and could not be based partially on the wages she earned at her prior employment. Bolton v. Oregonian Publishing Co., 93 Or App 289 (1988) (an injured worker's temporary disability rate must be based only on the wages of the job where the injury occurred) ; see also Terrie G. Palumbo, 44 Van Natta 2090 (1992) (wages from another job could not be used in determining the rate of a claimant's temporary disability benefits).

In Bolton, the court noted that employers cannot be required to pay greater benefits for temporary disability than the maximum benefits that would be due on the basis of wages that the claimant was receiving in their employ. Accordingly, based on the holdings of Bolton and Palumbo, as well as on the ALJ's reasoning, we conclude that the insurer correctly calculated the rate of claimant's temporary disability.

ORDER

The ALJ's order dated January 18, 1995 is affirmed.

In the Matter of the Compensation of
JENNIFER R. HARRISON, Claimant
WCB Case No. 94-04786
ORDER ON RECONSIDERATION
Goldberg & Mechanic, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On July 12, 1995, we affirmed the Administrative Law Judge (ALJ) order that upheld the self-insured employer's denial of claimant's low back injury claim and declined to assess a penalty for allegedly unreasonable claim processing. Contending that our decision was based on an erroneous factual finding, claimant seeks reconsideration.

We acknowledge that our order misstated a fact. In our prior order, we stated that claimant experienced excruciating pain in her buttock radiating into her right leg while bowling. In actuality, claimant experienced excruciating pain in her buttock radiating into her right leg, the morning following her bowling activity.

Notwithstanding our misstatement, for the reasons expressed in our prior order, we continue to find the opinion of claimant's treating physician, as well as the other examining physicians, unpersuasive. In addition to our prior reasoning, we offer the following supplementation.

Although claimant did not experience excruciating pain in her buttock and right leg until the morning after her bowling activity, it is the absence of claimant's bowling activity itself in the histories of the examining physicians which we find dispositive. (Exs. OA-1, 1, 5, 8, 13BB, 14, 15, 16). We reach this conclusion because the "excruciating pain" which caused claimant to seek medical treatment occurred shortly after her night of bowling. Therefore, the physicians' opinions, which do not have the benefit of even considering the implications of claimant's bowling activity, are unpersuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Accordingly, we withdraw our July 12, 1995 order. On reconsideration, as supplemented and corrected herein, we adhere to and republish our July 12, 1995 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
JO W. ORMAN, Claimant
Own Motion No. 91-0707M
OWN MOTION ORDER
Darris K. Rowell, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests enforcement of our Own Motion Order on Reconsideration dated November 25, 1992, asserting that she is entitled to additional temporary disability benefits. She also seeks an approved attorney fee payable out of the additional temporary disability benefits, as well as penalties and related attorney fees for the SAIF Corporation's allegedly unreasonable failure to pay temporary disability benefits pursuant to the November 25, 1992 order.

We briefly summarize the relevant facts as follows. Claimant has an accepted claim for injuries to her neck, shoulders and upper back sustained in December 1976. In July 1990, she was hospitalized for psychiatric treatment. She filed a claim for that treatment, which was denied by SAIF. By Opinion and Order dated September 18, 1991, as reconsidered on October 25, 1991, Administrative Law Judge (ALJ) Holtan set aside SAIF's denial of the psychiatric treatment, concluding that the treatment was compensably related to the accepted 1976 injuries. Claimant subsequently filed a claim for own motion relief, seeking the payment of temporary disability benefits from the date of hospitalization through the date her condition became medically stationary. We postponed action on the own motion request pending Board review of ALJ Holtan's order.

By Order on Review dated September 29, 1992, we affirmed ALJ Holtan's order. By Own Motion Order dated October 16, 1992, we also ordered SAIF to pay claimant temporary disability benefits beginning July 7, 1990, the date she was hospitalized for psychological treatment. SAIF subsequently moved for reconsideration of our October 16, 1992 order, and we abated the order on October 30, 1992. After considering SAIF's motion, we issued our Own Motion Order on Reconsideration on November 25, 1992, which adhered to and republished (with minor supplementation) our October 16, 1992 order.

On March 8, 1993, SAIF paid claimant temporary total disability benefits for the period from July 7, 1990 to July 10, 1990. In addition, SAIF closed the claim by Notice of Closure dated March 9, 1993, which declared claimant medically stationary as of July 10, 1990. Claimant requested Board review of the closure notice; it was affirmed by Own Motion Order Reviewing Carrier Closure dated August 10, 1993, as reconsidered on September 9, 1993 and November 29, 1993.

Temporary Disability Benefits

Claimant contends that our November 25, 1992 reconsideration order, by republishing the October 16, 1992 order awarding temporary disability benefits beginning July 7, 1990, effectively ordered SAIF to pay two types of temporary disability benefits: (1) temporary disability benefits due from the date of hospitalization (July 7, 1990) to the date of the November 25, 1992 order; and (2) temporary disability benefits from the date of the November 25, 1992 order to the date of claim closure (March 9, 1993).

At the time that claimant filed her own motion request, our administrative rules provided that the first payment of temporary disability benefits must be made within 14 days from the date of an order of the Board reopening the claim. Former OAR 438-12-035(1) (WCB Admin. Order 11-1990). Our rules further required that payment of temporary disability benefits be continued "until termination of such benefits is authorized by the terms of ORS 656.268." Former OAR 438-12-035(2).

Because temporary disability benefits payable for the period from July 7 through July 10, 1990 were retroactive, SAIF was required to pay those benefits no later than January 8, 1993, the 14th day after our November 25, 1992 order became final (e.g., 14 days after the 30-day period for appealing the November 25 order had expired). See former OAR 436-60-150(4)(f). However, SAIF did not begin payment of benefits until March 1993, resulting in a two month delay. SAIF was also required to continue payment of temporary disability benefits until termination was authorized by ORS 656.268. There is no evidence in the record showing that termination of benefits was authorized by the terms of

ORS 656.268 prior to issuance of SAIF's March 9, 1993 closure notice. In this regard, we note the absence of evidence indicating that claimant has returned to, or been released for, regular work. See ORS 656.268(3). Therefore, SAIF was required by our rules to continue the payment of temporary disability until March 9, 1993.

However, claimant's substantive entitlement to temporary disability benefits has been finally determined by our Own Motion Order Reviewing Carrier Closure dated August 10, 1993, as reconsidered on September 9, 1993 and November 29, 1993, which affirmed SAIF's closure notice in its entirety (without modification). Because our order affirming the closure notice has become final, claimant may not collaterally attack the order and is, therefore, precluded from establishing substantive entitlement to temporary disability benefits beyond those awarded under the closure notice. In addition, although SAIF was required to pay ("procedural") temporary disability benefits until claim closure, we are precluded from imposing an administrative "overpayment" (i.e., awarding benefits beyond claimant's substantive entitlement) on SAIF. See Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Accordingly, we may not order SAIF to pay any additional temporary disability benefits beyond those awarded under the closure notice.

Claimant argues that Seiber is distinguishable from this case, citing to Anodizing, Inc. v. Heath, 129 Or App 352 (1994), and Georgia-Pacific v. Piwowar, 305 Or 494 (1988). We are not persuaded. Heath and Piwowar addressed the carrier's obligation to pay benefits pending an appeal of the order awarding the benefits. The courts in Heath and Piwowar held that the claimant in each case was statutorily entitled to the payment of benefits under ORS 656.313 pending an appeal of the order awarding the benefits. The courts therefore concluded that no administrative overpayment results from ordering the payment of benefits not stayed under ORS 656.313. This case, on the other hand, does not involve the payment of benefits pending appeal of an order, nor is there any contention that claimant is statutorily entitled to the payment of benefits under ORS 656.313. Rather, the benefits at issue were payable pursuant to SAIF's obligation to process the reopened claim to closure pursuant to our November 25, 1992 order and own motion rules. Hence, we do not find this case is distinguishable from Seiber. Because we are unable to award claimant additional temporary disability benefits, we likewise are without authority to award claimant's counsel an approved attorney fee payable out of compensation.

Although we are not authorized to award claimant temporary disability benefits for any period beyond July 10, 1990, SAIF may be liable for a 25 percent penalty under former ORS 656.262(10)(a) (now ORS 656.262(11)(a)) for its unreasonable delay or unreasonable refusal to pay compensation. See Lebanon Plywood v. Seiber, supra; Lela K. Mead-Johnson, 45 Van Natta 1754 (1993); Pascual Zaragoza, 45 Van Natta 1221 (1993). Here, SAIF has offered no explanation for its two month delay in paying temporary disability benefits for the period from July 7, 1990 to July 10, 1990. Therefore, we find that its delay was unreasonable, and assess a penalty of 25 percent of those benefits, payable in equal shares to claimant and her attorney.

SAIF also has offered no explanation for its refusal to pay temporary disability benefits from July 10, 1990 through March 9, 1993. Accordingly, we assess a penalty in the amount of 25 percent of the temporary disability benefits SAIF should have paid claimant from July 10, 1990 through March 9, 1993. See Lela K. Mead-Johnson, supra; Pascual Zaragoza, supra. This penalty will also be paid in equal shares to claimant and her attorney.

IT IS SO ORDERED.

Board Member Hall dissenting.

I respectfully disagree with the majority's conclusion that Lebanon Plywood v. Seiber, 113 Or App 651 (1992), authorized SAIF to ignore the clear mandate of our November 25, 1992 order which awarded claimant temporary disability benefits. I therefore dissent.

The majority analogizes this case to Seiber. In that case, however, there was no order to pay benefits to the claimant. Rather, the employer accepted and processed an aggravation claim but refused to pay temporary disability benefits beyond the claimant's medically stationary date (to the date of claim closure). Thereafter, the Board ordered the employer to pay benefits through the date of claim closure.

The Court of Appeals reversed. Noting that the claimant's substantive entitlement to temporary disability benefits did not extend beyond his medically stationary date, the court held that the Board improperly ordered an administrative overpayment, which typically results from the delay in processing the claim to closure. Id. at 654.

Unlike in Seiber, in this case, there was a prior Board order directing SAIF to pay temporary disability benefits. That fact brings this case closer to Anodizing, Inc. v. Heath, 129 Or App 352 (1994). There, the employer refused to pay temporary disability benefits pursuant to an order which it had appealed. Because payment of those benefits was not stayed under ORS 656.313 pending the appeal, the Board ordered the employer to pay benefits that were due pending the appeal. The Court of Appeals affirmed, reasoning that the claimant was statutorily entitled to the payment of benefits pending its appeal and that, therefore, the Board's order to pay those benefits did not create an administrative overpayment. Id. at 357.

The majority in this case attempts to distinguish Heath on the basis that, whereas the claimant in Heath was statutorily entitled to the disputed benefits under ORS 656.313, the claimant in this case is not so entitled. I am not persuaded.

An order to pay temporary disability benefits does not result in an administrative overpayment due to claim processing delays, as was the case in Seiber. On the contrary, an order to pay benefits creates a substantive entitlement to benefits which may not be ignored, just as the statutory obligation to pay benefits pending an appeal (as was the case in Heath) may not be ignored. Interestingly enough, the language of ORS 656.313--which requires payment of temporary disability benefits "accru[ing] from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs"--is similar to the mandate imposed by our October 16, 1992 and November 25, 1992 orders in this case, i.e., to pay temporary disability benefits until closure or until the orders are reversed.

The aforementioned similarity, I believe, brings this case closer to Heath, than to Seiber. For this reason, I would order SAIF to comply with our 1992 orders to pay temporary disability benefits to the date of claim closure. To do otherwise, I submit, would essentially reward SAIF for its unjustified refusal to comply with our orders.

In the Matter of the Complying Status of
PRODUCTION CUTTERS, INC., Employer
WCB Case No. 91-02258
and, In the Matter of the Compensation of
JOHN W. BONES, JR., Claimant
WCB Case Nos. 92-09976 & 91-04564
ORDER ON RECONSIDERATION
The Law Firm of Michael B. Dye, Claimant Attorneys
Bonnie V. Laux (Saif), Defense Attorney
Robert J. Thorbeck, Attorney

Production Cutters, Inc., requests reconsideration of our July 17, 1995 Order on Review. Specifically, Production Cutters seeks an attorney fee award for prevailing on review over the Director's order which had found Production Cutters to be a noncomplying employer.

Citing ORS 183.480, the SAIF Corporation[1] contends that we have no authority to award a fee under that statute. We agree. However, we do have authority to award a fee pursuant to ORS

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[1] On August 4, 1995, SAIF filed a petition for judicial review of our July 17, 1995 Order on Review. We nevertheless retain the authority to withdraw our order for the purpose of reconsideration at the request of a party or on our own motion, provided that we do so before the order becomes final under ORS 656.295(8), regardless of whether a petition for judicial review has been filed. SAIF v. Fisher, 100 Or App 288, 291-92 (1990). Because our June 17, 1995 order has not yet become final, we have the authority to withdraw and reconsider our order.

656.740(5)[2]. SAIF also contends that Production Cutters is precluded from receiving an attorney fee because counsel failed to meet the provisions of OAR 438-15-029(2). OAR 438-15-029(2) assists us in determining the amount of an attorney fee award; it has no application to a party's entitlement to an attorney fee award. Consequently, Production Cutters' counsel's failure to file a petition does not preclude an attorney fee award to which it is statutorily entitled.

Here, Production Cutters sought a hearing contesting the Director's order under ORS 656.054 which found that Production Cutters was a noncompyling employer. When the Administrative Law Judge affirmed the Director's order, Production Cutters requested Board review. After conducting our review, we found that Production Cutters was not a noncomplying employer. Thus, we set aside the Director's order. Inasmuch as Production Cutters has prevailed on appeal against a Director's order issued in accordance with ORS 656.740, its counsel is entitled to a reasonable attorney fee for services at hearing and on review. ORS 656.740(5).

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 Production Cutters' attorney's services at hearing and on review for prevailing against the Director's order is $3,000, payable by the Director. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and Production Cutters' appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Accordingly, we withdraw our July 17, 1995 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our July 17, 1995 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] ORS 656.740(5) provides: "If a person against whom an order is issued pursuant to this section prevails at hearing or on appeal, the person is entitled to reasonable attorney fees to be paid by the director from the Consumer and Business Services Fund."

In the Matter of the Compensation of
MANUEL ALTAMIRANO, Claimant
WCB Case No. 91-00697
ORDER ON REMAND
Michael B. Dye, Claimant Attorney
Beers, Zimmerman, et al, Defense Attorneys

Reviewed by Board en banc.

This matter is before the Board on remand from the Court of Appeals. Altamirano v. Woodburn Nursery, Inc., 133 Or App 16 (1995). The court has reversed our decision that upheld the insurer's denial of his current condition and declined to award interim compensation. Finding that a chiropractor qualified as an attending physician for claimant's aggravation claim and, therefore, could authorize time loss, the court has remanded for further proceedings.

FINDINGS OF FACT

We adopt the findings of fact contained in the Administrative Law Judge's (ALJ) order.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back strain on February 22, 1990 while working as a nursery worker. A September 25, 1990 Determination Order closed the claim and awarded no permanent disability.

In October 1990, claimant experienced increased back pain which radiated down the left leg. He left work on October 31, 1990. On November 16, 1990, claimant treated with Dr. Poulson, who released him to return to modified work. Dr. Poulson last treated claimant on December 6, 1990, with the expectation that claimant would be medically stationary the next month.

On December 10, 1990, claimant sought treatment from Dr. Buttler, a chiropractor and naturopath. Dr. Buttler diagnosed chronic lumbosacral sprain and myalgia with intervertebral disk derangement, bilateral sciatica and cervical and thoracic myofascitis. On a Form 829, Dr. Buttler indicated that claimant's injury condition had worsened and that claimant was unable to work. The insurer received that form on December 27, 1990.

On August 15, 1991, the insurer issued a denial of claimant's aggravation claim and a denial of a L5-S1 disc bulge, functional overlay and then-current condition. The ALJ set aside the aggravation denial, but upheld the denial of claimant's claim for L5-S1 disc bulge, functional overlay and then-current condition. Reasoning that Dr. Buttler was not an "attending physician," the ALJ declined to award interim compensation. The court reversed our order that upheld the unspecified "current condition" denial and declined to award interim compensation. Altamirano v. Woodburn Nursery, Inc., supra. Consequently, the court has remanded to determine claimant's entitlement to interim compensation. Consistent with the court's mandate, we proceed with our reconsideration.

To begin, the court has concluded that "[b]ecause there was no claim that claimant's unspecified current condition requires medical treatment or resulted in disability, employer's attempted denial was ineffective." Determining that we erred in upholding the insurer's denial, the court has remanded for reconsideration. In light of the court's holding, the insurer's denial must be set aside.

We next proceed to the interim compensation issue. In an aggravation claim, the first installment of interim compensation shall be paid no later than the 14th day after the insurer had notice or knowledge of a medically verified inability to work in the form of a medical report that constitutes prima facie evidence of a compensable worsening. ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991), aff'd Stanley Smith Security v. Pace, 118 Or App 602 (1993). Medical verification of an inability to work so as to trigger the insurer's obligation to begin paying interim compensation must come from claimant's attending physician. SAIF v. Christensen, 130 Or App 346, 348 (1994).

Here, claimant first sought treatment from Dr. Buttler on December 10, 1990, at which time Dr. Buttler indicated that claimant's condition was not medically stationary and that he was not released for work. The court has determined that, under ORS 656.005(12)(b)(B), Dr. Buttler qualified as claimant's attending physician for 30 days after the date of his first visit on the aggravation claim.

In reaching its holding, the court determined that the term "claim" in ORS 656.005(12)(b)(B) was an inexact statutory term subject to agency interpretation. The court further determined that the Department's interpretation[1] of "claim" to mean "initial claim" was incorrect. The court reasoned that the definition of claim provided in ORS 656.005(6) did not apply because it would make the 30-day limitation in ORS 656.005(12)(b) wholly meaningless. The court, therefore, gave the term "claim" its commonly understood meaning: to refer to the initial claim for compensation and to requests to reopen a claim for aggravation. The court concluded that OAR 436-10-005(1) impermissibly limited the terms of ORS 656.005(12)(b)(B).

We are mindful of the court's mandate to us. However, subsequent to the court's decision, effective June 7, 1995, the legislature enacted SB 369, amending ORS 656.005(12)(b)(B). SB 369, 68th Leg., Reg. Sess., § 1 (June 7, 1995). Finding no relevant exceptions to this amendment, Section 1 of SB 369 applies retroactively to this case. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995); Walter L. Keeney, 47 Van Natta 1387 (1995) (retroactive application of SB 369 to deprive Board of jurisdiction over medical treatment disputes is not absurd or unjust).

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[1] OAR 436-10-005(1)(b) provides that a chiropractor may be an attending physician "[f]or a period of thirty (30) days from the date of the first visit on the initial claim or for twelve (12) visits, whichever comes first." "Initial claim means the first open period on the claim immediately following the original filing of the occupational injury or disease. It does not mean 'aggravation' claim or 'own motion' claim." OAR 436-10-005(19).

The legislature amended ORS 656.005(12)(b)(B) to provide that a chiropractor may be an attending physician "[f]or a period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever first occurs." SB 369, 68th Leg., Reg. Sess., § 2 (June 7, 1995) (emphasis supplied). We find that unambiguous language of the statute effectively overrules the court's holding in this case. It is clear that the legislature intended that amended ORS 656.005(12)(b)(B) be construed to adopt the Department's definition of a "claim." Consequently, Dr. Buttler did not qualify as an attending physician who could authorize time loss on claimant's aggravation claim.

However, on January 9, 1991, claimant changed his attending physician to Dr. Mitchell. Dr. Mitchell qualified as an attending physician under ORS 656.005(12)(b) who could authorize time loss. Although not expressly authorizing time loss, Dr. Mitchell did not alter Dr. Buttler's prior release from work. To the contrary, noting reduced ranges of motion, tenderness and increased pain, Dr. Mitchell reported that claimant's treatment was curative and that his condition was not medically stationary. We find that this was sufficient medical verification, from an attending physician, of claimant's inability to work.

The insurer received Dr. Mitchell's report on January 16, 1991. Since the aggravation claim is compensable, the insurer was, thus, obligated to begin paying interim compensation on January 16, 1991 until termination of those benefits were authorized by statute. See Filogonia Reyes-Cruz, 46 Van Natta 1294 (1994); Sandra L. Berkey, 41 Van Natta 944, 945 (1989). However, the insurer did not pay any interim compensation through the date of its August 15, 1991 denial.

Dr. Mitchell released claimant to light duty work on March 5, 1991. Claimant returned to such work on March 25, 1991. Claimant's return to modified work is a basis for terminating temporary disability benefits. ORS 656.268(3)(a); Viking Industries v. Gilliam, 118 Or App 183 (1993). Accordingly, we conclude that the insurer was obligated to pay interim compensation from January 16, 1991 to March 25, 1991. Stanley Smith Security v. Pace, supra; Kim D. Wood, 46 Van Natta 1827, 1830 (1994).

Because our order awards additional temporary disability compensation, claimant's counsel is entitled to an "out-of-compensation" attorney fee equal to 25 percent of claimant's increased interim compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. OAR 438-15-055(1). In addition, claimant is entitled to a reasonable attorney fee award for every prior forum for finally prevailing on the current condition denial issue. ORS 656.388(1).

Here, since the court remanded the case for reconsideration, claimant did not prevail on his claim until the issuance of our remand order. ORS 656.388(1). Consequently, we proceed to a determination of a reasonable attorney fee award.

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 at hearing, on Board review and before the court is $2,000, 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 appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, the ALJ's order dated June 30, 1992 is modified. The insurer's August 15, 1991 denial, to the extent it denied claimant's current condition, is set aside. Claimant is awarded interim compensation from January 16, 1991 to March 25, 1991. Claimant's counsel is awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. Claimant's counsel is awarded an assessed attorney fee of $2,000 for services at hearing, on Board review and before the court, to be paid by the insurer.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY J. McKENZIE, Claimant
WCB Case Nos. 93-11096 & 93-10078
ORDER ON RECONSIDERATION
Gary L. Tyler, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

On July 20, 1995, we withdrew our June 22, 1995 order that had : (1) affirmed an Administrative Law Judge's (ALJ) order that found that claimant's psychological claim was prematurely closed; and (2) modified the ALJ's award of temporary disability. We took this action to consider the self-insured employer's contention that the claim was not prematurely closed. After issuance of our abatement order, we received claimant's motion for reconsideration of that portion of our decision which declined to direct the employer to pay temporary disability between August 8, 1990 and November 16, 1992. Having received both parties responses to each other's motions, we proceed with our reconsideration.

We begin with the premature closure issue. Asserting that Dr. Fleming's opinion is conclusory and based on examinations/evaluations which are not contemporaneous with the March 1993 closure of the claim, the employer challenges our reliance on this psychologist's opinion. In place of Dr. Fleming's opinion, the employer argues that we should have deferred to the opinion of Dr. Parvaresh, psychiatrist. In this regard, the employer disagrees with our reasoning that the opinion authored by Dr. Parvaresh (as well as that from Dr. Glass) should be discounted because they concluded that claimant did not suffer from a compensable psychological condition. Noting that both Parvaresh and Glass opined that claimant had a psychological condition (albeit not work-related), the employer argues that these psychiatrists' opinions (particularly Dr. Parvaresh's) are still valid regarding the question of whether claimant's psychological condition was medically stationary as of the May 1993 claim closure.

After conducting a further review of this record, we acknowledge the existence of gaps of treatment/evaluation between claimant and Dr. Fleming, some of which involve the period surrounding the May 1993 claim closure. Nevertheless, Dr. Fleming's opinion has remained steadfast throughout the history of this claim; i.e.; claimant requires psychological treatment which is likely to improve her condition. When this opinion is compared with the countervailing opinions from Drs. Parvaresh and Glass we find it to be more persuasive. Not only is it consistent with claimant's history, but, unlike the contrary opinions, it is based on the premise that the psychological condition is compensable. On this point, we do not totally reject the opinions of Drs. Parvaresh and Glass because they did not consider claimant's psychological condition to be work-related. Nonetheless, it is a significant factor that, when coupled with Dr. Fleming's consistent observations, leads us to conclude that the opinion offered by Dr. Fleming is more persuasive.

Consequently, as supplemented above, we adhere to our prior conclusion that claimant's psychological claim was prematurely closed. We proceed to a review of claimant's challenge to our temporary disability award.

In light of our finding that the May 7, 1993 Determination Order prematurely closed claimant's psychological claim, claimant challenges our decision to eliminate the ALJ's award of temporary disability between August 8, 1990 and November 16, 1992. Noting that "stay" provisions under ORS 656.313 are no longer applicable to this period (because the employer's unsuccessful appeal of our prior compensability decision has become final), claimant argues that she is entitled to receipt of such temporary disability benefits.

Our decision not to award temporary disability for the aforementioned period was based on the following premise. Pending resolution of the employer's appeal of our November 17, 1992 decision regarding the compensability of her psychological condition, any "pre-litigation" temporary disability benefits were stayed under ORS 656.313. Once the court's July 14, 1993 affirmance of our compensability decision became final, the stay was lifted. However, by that time, the May 7, 1993 Determination Order had closed the claim with temporary disability ending effective August 7, 1990. Thus, the employer was not required to pay "pre-litigation order" temporary disability subsequent to August 7, 1990 and prior to our November 17, 1992 compensability decision.

Relying on our affirmance of the ALJ's decision to set aside the May 7, 1993 Determination Order, claimant argues that he is now entitled to temporary disability throughout the disputed period because the "stay" has been lifted and his claim has returned to open status. Claimant's assertion may

well eventually prove to be justified. However, such a determination would be premature for us to make at this time.

In other words, since the claim has been remanded to the employer for further processing, it is required to determine its continuing obligations under the law. Such obligations would necessarily include, but not be limited to, evaluating claimant's entitlement to temporary disability for particular time periods and, determining whether claimant's condition has become medically stationary since the May 1993 premature claim closure for purposes of reclosing the claim. See OAR 436-60-150(4)(h) David W. Woodard, 42 Van Natta 615 (1990). All such actions, as well as any further appellate options, could have an impact on claimant's entitlement to temporary disability for the disputed period.

Since our review is confined to the circumstances that existed at the time of the September 6, 1994 closure of this hearing record, we are presently unable to make such a determination regarding claimant's entitlement to the disputed temporary disability benefits. Such an evaluation must await the occurrences of several of the "post-ALJ/Board" claim processing actions previously discussed. In the event that another claim processing dispute ensues as a result of the employer's actions or inactions, that would be a matter for another hearing separate from this proceeding.

Accordingly, on reconsideration, as supplemented, we republish our June 22, 1994 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

August 17, 1995 Cite as 47 Van Natta 1503 (1995)

In the Matter of the Compensation of
MICHAEL G. BRUNSON, Deceased, Claimant
WCB Case No. 94-07140
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Roberts, et al, Defense Attorneys

Claimant, through his surviving spouse, requests reconsideration of our July 26, 1995 order that adopted and affirmed an Administrative Law Judge's order that upheld the insurer's denial of claimant's bilateral carpal tunnel syndrome (CTS) occupational disease claim.[1] Contending that recent amendments to ORS chapter 656, Or Laws 1995, ch 332, violate Article I, section 10, of the Oregon Constitution and the Americans With Disabilities Act (ADA), 42 USCA § 12101 et seq., claimant asks us to find that his CTS is compensable.

We withdraw our July 26, 1995 order for reconsideration. After considering claimant's request and reviewing the record, we continue to find that claimant's CTS is not compensable.

Claimant asserts that the "major contributing cause" standard set forth in amended ORS 656.005(7)(a)(A) and (B) and 656.802(2)[2] effectively deprives injured workers of a remedy in violation of Article I, section 10's "remedy by due course of law" provision. Claimant also asserts that preexisting condition language set forth in amended ORS 656.005(24), 656.005(7)(a)(B) and 656.802(2) violates the ADA. The gist of claimant's arguments is that, to pass constitutional muster and to avoid running afoul of the ADA, we should apply the "material contributing cause" standard to determine whether his CTS claim is compensable.

We do not address these arguments because, even under the material contributing cause standard, claimant's claim fails for lack of persuasive medical evidence.

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[1] Before claimant filed his reconsideration request, he filed a supplemental brief and Motion For Supplemental Brief, regarding the effect of the recent amendments to ORS chapter 656. We have considered all of claimant's briefs in reconsidering this matter.

[2] The former versions of those statutes also contained the "major contributing cause" language.

Accordingly, our July 26, 1995 order is withdrawn. On reconsideration, as supplemented here, we republish our July 26, 1995 order in its entirety. The parties' appeal rights shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES CHAPMAN, Claimant
WCB Case No. 93-05128
ORDER ON REVIEW
James Edmunson, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) McWilliams' order which found that claimant was entitled to temporary partial disability benefits from March 1, 1993 until July 20, 1993. On review, the issue is temporary disability compensation. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following modifications.

The January 26, 1994 Opinion and Order directed the insurer to pay claimant temporary partial disability from March 1, 1993 until July 20, 1993, not July 29, 1993.

The insurer's July 20, 1993 partial denial of claimant's medial meniscus tear was set aside by an August 15, 1994 Opinion and Order. (Ex. 20).

CONCLUSIONS OF LAW AND OPINION

Procedural Posture

The ALJ issued a January 26, 1994 Opinion and Order which directed the insurer to pay claimant temporary partial disability from March 1, 1993 until July 20, 1993. In an October 11, 1994 Order on Review (Remanding), we vacated the ALJ's order and remanded this case to the ALJ for further development of the record concerning claimant's "earning power at any kind of work," in light of the Court of Appeals' holding in Stone v. Whittier Wood Products, 124 Or App 117 (1993); Charles Chapman, 46 Van Natta 2323 (1994).

The ALJ made findings concerning claimant's work history and found that modified work, as approved by a physician, was not available. The ALJ concluded that, therefore, claimant was entitled to temporary total disability until the date of his termination on March 1, 1993, for reasons unrelated to the injury, at which time he became eligible for temporary partial disability. The ALJ remanded the claim to the insurer for the calculation of temporary partial disability benefits in accordance with Stone.

Entitlement to Temporary Disability

We begin by briefly summarizing the facts of the case. Following his compensable disabling injury, claimant returned to work for the employer performing modified duties. His wages were not affected by the change in his work assignment. While performing his work, claimant fell several times while trying to negotiate his crutches over the floor, which was strewn with rivets, screws, trimmings, miscellaneous debris, air hoses, and occasional spills of radiator, transmission, hydraulic and diesel fluids. On February 22 and 23, 1993, claimant informed the employer that he had reinjured his knee when his crutches slipped and was fearful that he would continue to injure his leg because of the condition of the floor in his work area. Claimant asked the employer to permit him to recuperate at home until he was off crutches. The employer instructed claimant to relocate his work area to one less congested and closer to the restroom.

On February 23, 1993, claimant received a written modified work release by Dr. Fletchall, whom he had seen on February 17, 1993. Also on February 23, 1993, claimant sought treatment from Dr. Jansen, who continued to release claimant to modified work. Claimant did not return to work on February 24, 1994. On March 1, 1993, the employer terminated claimant for testing positive for drug use. Claimant requested a hearing on the employer's failure to pay temporary disability compensation from March 1, 1993 until July 20, 1993.

On review, the insurer contends that claimant was not entitled to temporary disability during the period in dispute because he had been terminated for reasons unrelated to the injury. Claimant contends that he left work because he was unable to perform the modified work.

To begin, we note that the insurer does not contest the ALJ's conclusion that claimant was entitled to temporary total disability benefits from February 24, 1993 to March 1, 1993. In any event, we agree with and adopt that portion of the ALJ's opinion that claimant left work on February 24, 1993 as a result of his injury. Consequently, claimant became eligible for temporary total disability as of that date. The question then becomes whether it was appropriate for the insurer to terminate claimant's temporary disability benefits March 1, 1993, when the employment relationship was terminated.

Under ORS 656.268(3)(c)[1], temporary total disability benefits may be terminated if the "attending physician gives the worker a written release to return to modified employment, such employment is offered in writing, and the worker fails to begin such employment."

Here, claimant was released to modified work and did attempt to perform such work. However, due to his compensable injury, claimant was unable to perform the "offered" modified work and, as found by the ALJ, became entitled to temporary total disability as of February 24, 1993. Once claimant became entitled to temporary total disability benefits, the insurer could terminate such benefits only if the requirements in ORS 656.268(3) or ORS 656.262(4) were met. Neither of those statutes provide that termination of the employment relationship is a basis for terminating temporary total disability benefits. See James Edmonds, 47 Van Natta 230 (1995) (the claimant's termination of employment prior to being offered modified work not relevant where the employer's modified work offer did not meet the requirements of ORS 656.268(3)(c)).

Similarly, while claimant remained released for modified work, that fact in and of itself does not allow a carrier to terminate temporary total disability benefits. Rather, the worker must either return to modified work, or be offered modified work in writing and fail to begin such employment. ORS 656.268(3)(a) and (c). As noted above, claimant was offered modified work, but could not perform such work due to his injury. The employer did not make any further offer of modified work to claimant and in fact he was terminated March 1, 1993. In light of this, the insurer had no basis for terminating claimant's temporary total disability benefits, nor for reducing such benefits to temporary partial disability. Consequently, we modify the ALJ's opinion and find that claimant was entitled to temporary total disability benefits from March 1, 1993 through July 20, 1993.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $950, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 30, 1994 is modified. Claimant is awarded temporary total disability benefits from March 1, 1993 through July 20, 1993. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the compensation created by this order, payable directly to claimant's counsel. However, the total "out-of-compensation" attorney fee award granted by this order and the ALJ's order shall not exceed $3,800. For services on review, claimant's counsel is awarded an assessed attorney fee of $950, payable by the insurer.

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[1] We note that ORS 656.268 was amended by Senate Bill 369. See Or Laws 1995, Ch. 332, § 30 (SB 369, § 30). However, none of the amended provisions affect the outcome of this case.

In the Matter of the Compensation of
ESPERANZA DELACRUZ-MARTINEZ, Claimant
WCB Case No. 94-10667
ORDER ON REVIEW
H. Galaviz-Stoller, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig, Turner-Christian and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) concluded that claimant had timely filed a claim for a right knee injury; (2) set aside the employer's denial of that claim; and (3) assessed a penalty for the employer's allegedly unreasonable claim processing. On review, the issues are the timeliness of claimant's claim filing, compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We begin with the compensability issue. Claimant's theory is that she injured her right knee during a work accident in early September 1993. Claimant must, therefore, establish the accident was a material contributing cause of her right knee condition. ORS 656.005(7)(a); 656.266. Claimant has failed to meet that burden.

Claimant relies on the reports of Dr. Pelmas, treating surgeon. Dr. Pelmas initially responded "yes" to the question propounded in a concurrence report, "In your opinion was the described injury of September 4, 1993 the major contributing cause of [claimant's] current right knee injury and need for treatment?" (Ex. 19-2). Thereafter, however, Dr. Pelmas agreed with another concurrence report, which stated that, based on her examination, Pelmas was "unable to state within a reasonable medical probably [sic] that her knee condition is either related or not related to a specific incident on September 4, 1993." (Ex. 21-1). Because Dr. Pelmas' final opinion reveals her inability to determine the probable cause of claimant's right knee condition, claimant has failed to establish the compensability of that condition.

Claimant asserts that this case does not involve a complex medical question. We disagree.

Expert testimony of causation may not be not required if: (1) the situation is uncomplicated; (2) symptoms appear immediately; (3) the worker promptly reports the occurrence to a superior; (4) the worker previously was free from disability of the kind involved; and (5) there is no expert testimony that the alleged precipitating event could not have been the cause of the injury. See Barnett v. SAIF, 122 Or App 279, 283 (1993) (citing Uris v. Compensation Department, 247 Or 420, 426 (1967)), on remand Betty Barnett, 46 Van Natta 9 (1994).

Here, claimant did not seek medical treatment until over a week after the alleged September 4, 1993 work incident. (Ex. A). After two clinic visits for a suspected meniscus tear, claimant went without treatment for several months. (Cf. Exs. A and 1). When she resumed treatment, her meniscus tear was confirmed; she underwent surgery for that condition over a year after the alleged work incident. (Ex. 17A).

Under the circumstances, we find the situation sufficiently complicated to require proof of causation by expert medical opinion. See SAIF v. Barnett, supra. That conclusion is supported by evidence that claimant did not promptly report the September 4 incident to her supervisor,[1] and the medical evidence concluding that claimant's current right knee condition was not causally related to the September 4 incident. (Ex. 18A). Accordingly, we reject claimant's expert testimony argument.

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[1] Claimant asserts that she promptly reported the injury to her supervisor; the supervisor denies this assertion. (Tr. 11-12; 45-47).

In sum, claimant has failed to establish the compensability of her right knee condition. Therefore, we reverse the ALJ's decision setting aside the employer's denial of that condition. In view of that conclusion, we need not address the timeliness of claim filing issue.

Penalties

Because we have concluded that claimant's right knee condition is not compensable, we further conclude that there exists no basis for a penalty. Therefore, we reverse the ALJ's penalty assessment.

ORDER

The ALJ's order dated December 22, 1994 is reversed. The self-insured employer's denial is reinstated and upheld in its entirety. The ALJ's attorney fee and penalty awards are also reversed.

Board Member Gunn dissenting.

The issue in this case is whether claimant's injury involves a simple or complex medical question. The majority concludes that this is a complex case, while I would conclude that it is a simple one. Therefore, I dissent.

As the majority correctly states, the controlling legal standard is set forth in Barnett v. SAIF, 122 Or App 279 (1993), on remand Betty Barnett, 46 Van Natta 9 (1994). Under that case, expert testimony of causation may not be not required if: (1) the situation is uncomplicated; (2) symptoms appear immediately; (3) the worker promptly reports the occurrence to a superior; (4) the worker previously was free from disability of the kind involved; and (5) there is no expert testimony that the alleged precipitating event could not have been the cause of the injury. 122 Or App at 283.

This is an uncomplicated case. Claimant fell at work. Although she did not seek medical treatment until several days later, she experienced symptoms immediately. (See Tr. 11, 12, 30). She promptly reported the incident to a supervisor. (Tr. 8, 11-12; see Ex. B).[1] Moreover, there is no evidence that claimant suffered from right knee problems before the accident. (Tr. 10, 29). Last, in my view, the persuasive medical evidence consistently supports the compensability of claimant's right knee condition.[2] Accordingly, because this case satisfies all the elements of the Barnett test, I would hold that claimant need not adduce expert medical evidence to establish the compensability of her claim. Rather, I would rely on claimant's testimony as proof that her right knee condition is compensably related to her fall at work. Because the majority concludes otherwise, I dissent.

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[1] I recognize that the supervisor denied that claimant promptly reported the injury to him. On this record, however, I find claimant a credible witness; therefore, I rely on her version of the events surrounding her injury.

[2] I am not persuaded by Dr. Tesar's contrary medical report, because it is based on an inaccurate history of claimant not promptly reporting her work injury to the employer. (See Ex. 18A-5). Further, I discount Dr. Pelmas' final report, because it alternatively states that claimant related her right knee problems to her work accident and that claimant's medical examination did not disclose the probable medical cause of claimant's right knee condition. (See Ex. 21-1). In my opinion, that report fails to reconcile claimant's history and medical findings and, consequently, is worthy of little, if any, weight.

In the Matter of the Compensation of
GARY E. FRAZIER, Claimant
WCB Case No. 94-06685
SECOND ORDER ON RECONSIDERATION (REMANDING)
Robert G. Dolton, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

The insurer requests reconsideration of our July 25, 1995 Order on Reconsideration (Remanding) that vacated the Administrative Law Judge's (ALJ's) dismissal order, reinstated claimant's hearing request, and remanded for hearing. On reconsideration, the insurer argues that we failed to consider the recent amendments to ORS 656.325

The insurer contends that amended ORS 656.325 essentially eliminates the original basis for our decision. Amended ORS 656.325(1)(a) provides, in part:

> "Any worker entitled to receive compensation under this chapter is required, if requested by the Director of Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the Director." (Emphasis added). Or Laws 1995, ch 332 section 40 (SB 369, section 40).

Former ORS 656.325(1)(a) provided that "[a]ny worker entitled to receive compensation under this chapter is required * * * to submit to a medical examination at a time and from time to time at a place reasonably convenient for the worker * * *." According to the insurer, since the only thing remaining under amended ORS 656.325(1)(a) is that the medical examination be scheduled at a time reasonably convenient for the worker, the ALJ's order dismissing the case should have been affirmed.

In concluding that dismissal was appropriate because claimant did not attend the second medical examination, the ALJ relied on OAR 438-06-071 and ORS 656.325(1). On review, we noted that the ALJ's reliance on ORS 656.325(1) was misplaced. Former 656.325(1)(a) provided, in part, that if a worker refused to submit to a medical examination requested by the insurer, "the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place." That statute applied to "any worker entitled to receive compensation." We concluded that former ORS 656.325(1)(a) had no application in this case because claimant has no compensation to suspend. See Ring v. Paper Distribution Services, 90 Or App 148 (1988); David M. Foote, 45 Van Natta 270 (1993).

Amended ORS 656.325(1)(a) still provides that if a worker refuses to submit to a medical examination requested by the insurer, "the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place." Here, the claim for compensation is an initial claim for benefits. The insurer was not paying compensation and therefore, there is no compensation to suspend. Claimant is not a "worker entitled to receive compensation under this chapter" pursuant to amended ORS 656.325(1)(a). Consequently, neither former nor amended ORS 656.325(1)(a) applies to this case.[1]

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[1] Although the insurer does not raise any arguments concerning OAR 436-10-100(4), we discussed that rule in our previous orders. In the Order on Review and the Order on Reconsideration, we relied in part on OAR 436-10-100(4) (WCD Admin. Order 13-1992), which provides that medical examinations on behalf of the insurer "shall be at places, times, and intervals reasonably convenient to the worker's place of employment or residence." See also OAR 436-10-100(4) (WCD Admin. Order No. 94-064) (eff. 2-1-95). We found that, under the facts of this case, the medical examination was not "reasonably convenient" under OAR 436-10-100(4), particularly without the receipt of pretravel expenses.

In light of amended ORS 656.325(1)(a), even if OAR 436-10-100(4) must now be interpreted to provide merely that the medical examination must be at a time reasonably convenient for the worker, the examination at issue in this case did not meet that criteria. Claimant failed to appear at the medical examination because of a lack of funds necessary to travel from Prineville to Portland. Although claimant had requested advanced travel expenses, he did not receive the check until the afternoon of the scheduled examination. Under these circumstances, we conclude that the medical examination was not at a time reasonably convenient to claimant.

We withdraw our prior orders. On reconsideration, as supplemented herein, we republish our July 7, 1995 order on review in its entirely, as well as our July 25, 1995 order on reconsideration. 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
GERALD A. KEIPINGER, Claimant
WCB Case No. 94-12626
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Neal's order which: (1) awarded a $2,600 attorney fee for claimant's counsel's services in obtaining the pre-hearing rescission of the employer's denial; (2) awarded temporary disability from October 3, 1994 to November 15, 1994; (3) assessed a 25 percent penalty under former ORS 656.262(10) for the employer's allegedly unreasonable denial; (4) awarded an assessed attorney fee under former ORS 656.382(1) for the employer's allegedly unreasonable refusal to pay temporary disability; (5) set aside the employer's alleged ["de facto"] denial of a right hand condition; and (6) awarded an assessed attorney fee for claimant's counsel's services in setting aside the alleged ["de facto"] denial. On review, the issues are attorney fees, penalties, temporary disability and claim processing. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Attorney Fees for Rescission of Denial

The employer contends that the ALJ's assessed attorney fee award of $2,600 for claimant's counsel's services in obtaining the pre-hearing rescission of the employer's October 13, 1994 denial is excessive.[1] We disagree.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree that a reasonable fee for claimant's attorney's pre-hearing services concerning the rescission of the employer's denial is $2,600, payable by the employer directly to claimant's current counsel only.[2] In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and counsel's statement of services), the complexity of the issue , the value of the interest involved, and the risk that counsel may go uncompensated.

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[1] The ALJ made her attorney fee award under former ORS 656.386(1). On June 7, 1995, Senate Bill 369 amended ORS 656.386(1). Amended ORS 656.386(1) now explicitly provides for an attorney fee in such cases involving denied claims "where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge." Pursuant to Section 66(1) of that Act, the amendments to ORS 656.386(1) are applied retroactively. However, we need not determine the applicability of those amendments to this claim, since claimant's counsel is entitled to an attorney fee under either version of the statute.

[2] The ALJ apportioned the attorney fee award between claimant's current counsel and his former attorney. However, the ALJ should not have divided the attorney fee award. The attorney fee should have been awarded to claimant's current attorney of record, with the particular apportionment of the award to be resolved amongst them. See Gabriel Zapata, 46 Van Natta 403, 405 (1994).

Penalty for Unreasonable Denial

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

Temporary Disability

Claimant sustained a compensable right hand injury on September 14, 1994. Claimant initially sought treatment from Dr. Browning, who returned claimant to modified duty. Claimant testified that he returned to work on September 20, 1994. (Tr. 13). On September 23, 1994, the employer accepted a nondisabling right hand "contusion."

On September 29, 1994, claimant sought treatment from Dr. Hamburg, a chiropractor. He authorized temporary total disability from September 29, 1994 to October 10, 1994. (Ex. 11). However, this release was modified to no work using the right hand. (Ex. 11a). Claimant apparently did not miss any time from work. He continued to work until October 3, 1994, when he reported for work, but disappeared without informing the employer.

Claimant returned to Dr. Hamburg's office on October 3, 1994, but Dr. Hamburg was apparently not working that day. Thus, Dr. Gudmundsen, Dr. Hamburg's wife and partner, treated claimant and authorized temporary total disability to October 7, 1994. (Ex. 14).[3] Claimant saw Dr. Hamburg the next day on October 4, 1994, but Dr. Hamburg did not address claimant's disability status in that chart note or in subsequent chart notes through the course of his treatment which concluded in early November 1994. (Ex. 12). Dr. Gudmundsen, however, authorized additional temporary disability to October 14, 1994 when she treated claimant on October 7, 1994. (Ex. 16).

On October 13, 1994, the employer denied claimant's current condition, as well as his temporary disability beginning October 3, 1994, on the grounds that the compensable injury was not the major contributing cause of his temporary disability. The denial was issued in response to surveillance film that showed claimant using his right hand and arm normally. The employer also terminated claimant's employment on October 13, 1994, on the grounds that claimant had misrepresented his physical condition and ability to work.

Claimant began treating with Dr. Steinhauer on October 20, 1994 for carpal tunnel syndrome. Dr. Steinhauer released claimant for regular work on November 15, 1994.

At hearing, claimant sought temporary disability from October 3, 1994 to November 15, 1994 and penalties for the employer's allegedly unreasonable cessation of temporary disability after October 3, 1994. The ALJ found that claimant was entitled to temporary disability for the period in dispute. The ALJ reasoned that, although Dr. Gudmundsen was not claimant's attending physician, her temporary disability authorization came from Dr. Hamburg's office. The ALJ determined that there was nothing in the statutes or administrative rules that required Dr. Hamburg to personally sign a work release.

On review, the employer contends that the ALJ erroneously awarded additional temporary disability in the absence of an authorization from the attending physician, Dr. Hamburg. The employer asserts that Dr. Gudmundsen's temporary disability authorization was invalid under Francisco J. Delacerda, 46 Van Natta 1021 (1994).

In Delacerda, the issue was whether the insurer could reduce the claimant's temporary total disability to temporary partial disability under former ORS 656.268(3)(c) based on the claimant's refusal to perform modified work. We agreed with the ALJ that the modified work release was no more than contingent and that the attending physician, Dr. Stringham, had never provided a modified work release. In reaching this conclusion, we rejected the insurer's contention that Dr. Stringham could "delegate" the responsibility for work releases to another physician, Dr. French.

We noted that, while there was evidence that Dr. Stringham deferred work issues to Dr. French, there was no "delegation" provision in former ORS 656.268(3), which required the attending physician to provide the modified work release. In addition, we observed that, although Dr. Stringham subsequently agreed with the modified release, he neither authored the release nor signaled his agreement with it prior to the effective date of the modified job.

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[3] Dr. Hamburg and Dr. Gudmundsen had an arrangement whereby they would work alternating days. (Ex. 34-5)

We agree with the employer that Delacerda is instructive. Granted, we are not concerned in this case with the termination of temporary disability under amended ORS 656.268(3)(c), but are instead faced with the issue of whether the insurer should have reinstated claimant's temporary disability pursuant to Dr. Gudmundsen's authorization. Nevertheless, we are aware of no statutory authority that allows Dr. Hamburg to defer authorizations of temporary disability to a partner.

Moreover, as the employer correctly notes, there is no evidence that Dr. Hamburg approved the authorization prior to its issuance or that he conferred with Dr. Gudmundsen before she gave her temporary disability authorization. Dr. Hamburg testified that he did not discuss the authorization with Dr. Gudmundsen on the day it was issued. (Ex. 34-17, 22). There is also no indication in Dr. Hamburg's chart notes that he subsequently ratified Dr. Gudmundsen's authorization of temporary disability. (Ex. 12). It was not until his January 16, 1994 deposition that Dr. Hamburg confirmed that he would "defer" to Dr. Gudmundsen with regard to work restrictions. (Ex. 34-36).[4]

Under these circumstances, we find that claimant's temporary disability authorization was not given by an "attending physician" and that, therefore, claimant was not entitled to temporary disability for the period from October 3, 1994 to November 15, 1994.[5] Thus, we reverse the ALJ's temporary disability award.

Attorney Fee for Failure to Pay Temporary Disability

The ALJ found that the employer's failure to pay temporary total disability after claimant left work on October 3, 1994 was unreasonable. Inasmuch as she found the employer's October 13, 1994 denial to have been unreasonable, the ALJ had already assessed a 25 percent penalty under former ORS 656.262(10) on unpaid temporary disability. Therefore, the ALJ awarded a separate attorney fee pursuant to ORS 656.382(1) for the employer's unreasonable failure to pay temporary disability.

In light of our conclusion with respect to the temporary disability issue, we find that the employer's conduct was not unreasonable. Accordingly, we reverse the ALJ's attorney fee award.

Right Hand "Sprain/Strain"

As previously noted, claimant's right hand injury was initially diagnosed and accepted as a right hand "contusion." On October 7, 1994, Dr. Hamburg diagnosed a "sprain/strain" along with the contusion. Dr. Hamburg continued to diagnose both the contusion and sprain/strain in subsequent chart notes. (Ex. 12). In a January 10, 1995 report to claimant's counsel, Dr. Hamburg opined that claimant's compensable injury had resulted in a sprain/strain of the right hand as well as a contusion. (Ex. 32). In his deposition, Dr. Hamburg testified that claimant had sustained a contusion primarily evidenced by swelling. (Ex. 34-6). Dr. Hamburg also confirmed that claimant had sustained a separate right hand sprain/strain based primarily on lack of range of motion, the area of claimant's sprain and claimant's description of his injury. (Ex. 34-6, 7).

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[4] Claimant argues that it is unrealistic to require a claimant to change attending physicians each time his attending physician is unavailable and is required to be treated by a substitute physician. Our decision should not be construed as requiring a change of attending physician whenever a claimant's attending physician is unavailable to illness, vacation, etc. However, the "attending physician" should endeavor to approve any temporary disability authorizations given in his absence as soon as is practicable. Claimant in this case provides no justification for Dr. Hamburg's failure to promptly approve Dr. Gudmundsen's temporary disability authorization when Dr. Hamburg treated claimant the day after Dr. Gudmundsen provided the temporary disability authorization. Moreover, we do not consider Dr. Hamburg's lack of expressing disagreement with his partner's action to amount to a implicit authorization of temporary total disability.

[5] We note that on June 7, 1994, Senate Bill 369 amended ORS 656.262(4)(g) to provide:

"Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

Claimant contended that the employer had failed to accept his right hand sprain/strain. The ALJ agreed after rejecting the employer argument that the condition was encompassed in the acceptance of the right hand "contusion." The ALJ reasoned that a sprain/strain is not the same thing as a contusion and that claimant was entitled to a written acceptance.

On review, the employer contends that the ALJ erred because the employer never denied the compensability of the hand sprain/strain, had always treated the condition as accepted and had paid all medical bills. Moreover, citing Leslie C. Muto, 46 Van Natta 1685 (1994), and Karen S. Boling, 46 Van Natta 2522 (1994), the employer contends that there was no "de facto" denial inasmuch as the sprain/strain diagnosis was merely a different diagnosis for the same condition. We disagree.

The fact that the employer never denied the right sprain/strain and paid all medical bills does not preclude a finding that the employer had denied "de facto" claimant's right hand sprain/strain. See Patricia L. Row, 46 Van Natta 1794 (1994); Wesley R. Craddock, 46 Van Natta 713 (1994). Moreover, we find this case distinguishable from Muto and Boling.

In Boling, we found that the carrier did not deny the claimant's shoulder condition "de facto" where, despite the use of different medical terminology, there was no medical evidence that the claimant sought treatment for a new or different medical condition from the one the carrier had accepted. In Muto, we agreed with the ALJ that the insurer did not deny the claimant's left wrist condition "de facto" where the medical evidence did not establish that the claimant had received treatment for a condition different from the one that was accepted or that there were separate conditions resulting from the compensable injury.

In contrast to Boling and Muto, the medical evidence from Dr. Hamburg is clear that claimant in this case has two separate conditions in his right hand: a contusion and a sprain/strain. Thus, claimant has a condition in his right hand different and separate from that accepted by the employer. See Geana K. Cannon, 47 Van Natta 945 (1995) (insurer "de facto" denied cervical condition where it was found to be separate from condition initially diagnosed and treated). Accordingly, we conclude that the employer failed to accept claimant's right hand sprain/strain claim.

ORS 656.262(6)(d), as amended, provides, inter alia, that a worker who believes a condition has been incorrectly omitted from a notice of acceptance first must communicate in writing to the carrier the worker's objections to the notice. Or Laws 1995, ch 332, § (SB 369, § 28(6)(d)). ORS 656.262(6)(d), as amended, also provides that the worker may initiate objection to the notice of acceptance at any time.

Inasmuch as these statutory amendments would appear to pertain to procedural time limits, they likely cannot be retroactively applied. See Motel 6 v. McMasters, 135 Or App 583 (1995). Nevertheless, we need not resolve that question because, considering the employer's consistent opposition to claimant's "sprain/strain" claim, we conclude that it would not be necessary to remand this case for compliance with the aforementioned procedural rules. See Rene Willshire, 47 Van Natta 1339 (1995).

Attorney Fee/Hearing

The ALJ awarded a $700 attorney fee for claimant's counsel's efforts in establishing the compensability of claimant's right hand sprain/strain condition. On review, the employer contends that, if we affirm the ALJ's compensability finding, then the fee should be reduced. We disagree and affirm the ALJ's attorney fee award.[6]

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree that a reasonable fee for claimant's attorney's services at hearing regarding the right hand "sprain/strain" compensability issue is $700, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[6] We note that an attorney fee would be granted under either version of ORS 656.386(1). Under the former version, claimant would be entitled to an attorney fee for prevailing over the employer's "de facto" denial. SAIF v. Allen, 320 Or 192 (1994). Under the current version, claimant would receive an attorney fee award for prevailing over the employer's denial, which was expressly based on the ground that the asserted claim was not compensable or did not give rise to an entitlement to any compensation.

Attorney Fees On Review

Claimant's attorney is entitled to an assessed fee for services on review regarding the "sprain/strain" issue. ORS 656.382(2). 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 regarding the sprain/strain issue is $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 counsel's statement of services), the complexity of the issue, and value of the interest involved. We further note that claimant is not entitled to an attorney fee for his counsel's unsuccessful services on review regarding the temporary disability issue, or for counsel's successful defense of the ALJ's penalty and attorney fee awards. Saxton v. SAIF, 80 Or App 631(1986); Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 1, 1995 is affirmed in part, modified in part and reversed in part. That portion which awarded temporary disability from October 3, 1994 to November 15 1994 and an "out-of-compensation" attorney fee is reversed. The ALJ's assessment of a $500 attorney fee under ORS 656.382(1) is also reversed. The ALJ's $2,600 employer-paid attorney fee award is modified to award the entire fee to claimant's current attorney of record, with the apportionment of that fee to be resolved between claimant's current and former attorneys. The remainder of the ALJ's order is affirmed. For services on review regarding the "sprain/strain", claimant's attorney is awarded $500, to be paid by the self-insured employer.

August 17, 1995 Cite as 47 Van Natta 1513 (1995)

In the Matter of the Compensation of
GARY G. KOKER, Claimant
WCB Case No. 94-12146
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Daughtry's order that dismissed his request for hearing. With his brief, claimant submitted two documents that were not part of the hearing record, and, in lieu of argument, rested on the record. We treat claimant's submission as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (2985). On review, the issues are jurisdiction, remand and interim compensation. We reverse the dismissal order, deny remand and deny interim compensation.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The ALJ concluded that, since claimant was not off work during the period in question, the issue before him was not a claim for interim compensation, but instead, was a claim classification matter over which the Hearings Division has no jurisdiction. Consequently, the ALJ dismissed claimant's request for hearing and remanded the claim to the insurer for referral to the Department to consider possible reclassification from nondisabling to disabling for the period in question. We disagree with the ALJ's analysis and reinstate claimant's hearing request.

On September 8, 1994, claimant filed a claim for an injury to the fourth finger of his right hand. Dr. Ayers released claimant to modified work. Claimant returned to his regular work. He missed no days from work. On October 7, 1994, within the 90-day period the insurer had to accept or deny the

claim, claimant requested a hearing on the issue of "temporary disability." On October 25, 1994, claimant was taken off work for surgery. On November 3, 1994, the insurer issued a Form 1502 notifying the Department that the claim had been nondisabling until October 24, 1994 and disabling thereafter. Temporary total disability benefits were commenced effective October 25, 1994. The insurer had not issued a claim acceptance by the time of hearing.

A claim is not deemed to be in nondisabling status unless and until it is accepted and classified as nondisabling. Donald R. Dodgin, 45 Van Natta 1642 (1993); Thomas L. Runft, 43 Van Natta 69 (1991).

In Dodgin, the insurer had listed the claimant's injury as nondisabling on the same 801 form by which it denied the claim. We concluded that such a "classification" did not trigger the claimant's statutory right to seek reclassification. Instead, we found that a claimant is advised by the insurer of his right to object to a nondisabling classification by issuance of the notice of claim acceptance.

Here, the insurer had not issued a notice of claim acceptance prior to hearing. As in Dodgin, the "classification" provided by the insurer to the Department on Form 1502 is analogous to that listed on the 801 form and, as such, does not give rise to claimant's statutory right to seek reclassification. Moreover, the significance of the formal classification of a claim as part of the claim acceptance is to establish the date from which aggravation rights are calculated, not to establish claimant's entitlement to interim compensation. Cf. ORS 656.273(4) and ORS 656.262(4)(a). Consequently, because claimant's claim was not accepted or classified as nondisabling as of the date of hearing, we conclude that claimant's request for hearing regarding "temporary disability" was not an objection to a nondisabling classification. Thus, the ALJ's dismissal for lack of jurisdiction was inappropriate.

"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 claimant's entitlement to interim compensation is triggered by the carrier's notice or knowledge of the claim. Stone v. SAIF, 57 Or App 808, 812 (1982).

Here, the employer had notice of the injury, but, as noted above, had neither accepted nor denied the claim. Accordingly, claimant's entitlement to interim compensation was triggered by the carrier's notice or knowledge of the claim and was appropriately before the ALJ. See, e.g., Kenneth W. Metzker, 45 Van Natta 1631 (1993) (The ALJ has jurisdiction over a claimant's procedural entitlement to temporary disability). Because the ALJ declined to exercise jurisdiction of claimant's entitlement to interim compensation, we reverse.

Before proceeding to the merits of claimant's claim for interim compensation, however, we must decide whether remand to the ALJ is appropriate.

Remand

We may remand a case to the ALJ for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983).

In addition, 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 pp 245, 249 (1988).

Claimant submitted two documents with his brief. The first is a February 7, 1995 letter from the insurer to DCBS requesting reclassification of claimant's claim from nondisabling to disabling from the period September 4, 1994 to October 25, 1994, pursuant to the ALJ's January 23, 1995 Opinion and Order. The second is a March 13, 1995 letter from DCBS to the insurer, dismissing the reclassification request on the basis that notice had been provided to DCBS from the insurer by means of a Form 1502 received on December 6, 1994, indicating that the claim had been accepted as disabling. We consider these submissions as a request for remand for their admission. ORS 656.295(5). We decline the request.

Because the proffered evidence was generated as a result of the hearing, it was not available or obtainable prior to the hearing. However, since claimant's entitlement to interim compensation does not turn on the claim classification issue, we do not find that remand for the admission of these documents is reasonably likely to affect the outcome of the case. Moreover, after review of the record, we conclude that the case was sufficiently developed in regard to evidence needed to establish entitlement to interim compensation from September 7, 1994 to October 25, 1994, and because that issue was litigated at hearing, we deny remand for the further development of the record. See ORS 656.295(5); Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Interim Compensation - Merits

In order to qualify for interim compensation, a claimant must establish that he or she left work or suffered a loss of earnings as a result of an injury. RSG Forest Products v. Jenson, 127 Or App 2478 (1994). It is not necessary for a worker to be totally disabled in order to receive interim compensation. Id. Claimant contends that his hours were reduced as a result of his injury and that, thereby, he experienced a loss of earnings. Claimant has failed to prove his case. The record shows that claimant was hired to work on an hourly basis. (Ex. A; Tr. 12). Before his injury, claimant worked from 22.25 hours to 42 hours a week, averaging a little over 30 hours per week. After the injury, claimant worked from 25.75 to 37. 25 hours, continuing to average a little over 30 hours per week. There is no showing that the fluctuation in claimant's hours was due to his injury. Consequently, claimant is not entitled to interim compensation from September 7, 1994 to October 25, 1994.[1]

ORDER

The ALJ's order dated January 13, 1995 is reversed. We reinstate claimant's request for hearing. Claimant's request for interim compensation from September 7, 1994 to October 25, 1994 is denied.

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[1] ORS 656.262(4)(a), which governs entitlement to interim compensation, was amended by the 1995 legislature. Or Laws 1995, ch 332, § 28 (SB 369,) 328. Amended ORS 656.262(4)(a) provides that: "[t]he first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." Assuming without deciding whether Dr. Ayers' release to modified work was an authorization of the payment of temporary disability compensation, we nevertheless need not decide the retroactivity of the statute, as claimant has failed to prove that he lost time from work as a result of his injury.

In the Matter of the Compensation of
MARSHA BROWN, Claimant
Own Motion No. 94-0137M
OWN MOTION ORDER OF ABATEMENT
Hedges & Mitchell, Claimant Attorneys
EBI Companies, Insurance Carrier

The insurer requests reconsideration of our August 4, 1995 Own Motion Order, in which we set aside its June 16, 1995 Notice of Closure in the above claim as premature. Specifically, the insurer contends that there was no medical evidence available to it prior to closure, and therefore, based on claimant's failure to seek medical treatment, claimant should be declared medically stationary.

By letter dated August 14, 1995, claimant responded to the insurer's motion. In order to allow sufficient time to consider the motion for reconsideration, we abate our order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOYCE A. CRUMP, Claimant
WCB Case No. 94-04732
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order which: (1) admitted a "post-reconsideration" report from a medical arbiter; and (2) awarded claimant 12 percent (38.4 degrees) unscheduled permanent disability for her low back condition, whereas an Order on Reconsideration had not awarded permanent disability. On review, the issues are extent of unscheduled permanent disability and evidence.

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

Claimant became medically stationary on October 19, 1993, and a Notice of Closure issued February 9, 1994, which awarded no permanent partial disability. (Ex. 22). Claimant requested reconsideration and a medical arbiter examination was scheduled for April 1, 1994. (Ex. 23C). Claimant failed to keep the appointment. (Ex. 23C, 23D). On April 7, 1994, an Order on Reconsideration issued which affirmed the Notice of Closure. (Ex. 24). Claimant requested a hearing on April 15, 1994. On May 17, 1994, pursuant to a request by claimant and arrangement by the Department, her medical arbiter's examination was rescheduled for June 8, 1994. (Ex. 27).

The ALJ, relying on the arbiter's report, awarded claimant 12 percent unscheduled permanent disability for her low back condition. On review, the employer contends that the ALJ erred in considering the arbiter's report because claimant forfeited her statutory right to the examination. Specifically, the employer argues that claimant's testimony that she attempted to keep her appointment was not credible. Therefore, according to the employer, claimant's failure to keep her appointment, without a showing of mitigating circumstances or just cause, amounted to a waiver of her right to a medical arbiter's examination. Additionally, the employer argues that the Department had no authority to arrange the medical arbiter's examination after claimant filed her request for hearing.

Failure to attend a medical arbiter's examination, without mitigating or just cause, waives a claimant's statutory right to the examination. Craig K. Witt, 45 Van Natta 1285 (1993); OAR 436-30-050(11)(a) (if the worker or the worker's representative requests reconsideration and the worker fails to appear for the medical arbiter exam, the record developed at the time of the closure will be used to issue the reconsideration order).

Claimant testified that she did not keep the original appointment with the medical arbiters because she could not find their office. The arbiter's examination was scheduled for 3:00 pm on April 1, 1994. (Ex. 23C). Claimant testified that she left her home in Cottage Grove, Oregon, at 7:00 am to drive to Portland on the day of her appointment. (Tr. 25, 26). After arriving in Portland at about 2:00 pm, claimant went to her mother-in-law's home, in order to acquire assistance from her, in finding the arbiter's office. While at her mother-in-law's home claimant testified that she called the arbiter's office to let them know of her intent to keep the appointment. (Tr. 28-29). During this call claimant testified she was told, that if she was more than 20 minutes late for her appointment she would have to reschedule. (Tr. 29). Claimant testified that she and her mother-in-law spent two hours searching for the arbiter's office. (Tr. 19). Finally, claimant testified that she called the arbiter's office and was told that she would have to make another appointment because she was over 20 minutes late. (Tr. 19, 29). Claimant's mother-in-law's testimony supports claimant's position. (Tr. 49).

The employer offered the testimony of Glenda Robinett, the medical arbiter's receptionist, to contradict claimant's testimony. Relying on the arbiter's phone reception records, Ms. Robinette testified that she talked to claimant at 2:47 on the day of her appointment. Ms. Robinett testified that she explained the arbiter's 20-minute cancellation policy to claimant. Further, she testified that it was not the arbiter's standard practice to tell an individual not to attend their appointment. (Tr. 42).

Based on this record, we are not persuaded by the employer's contention that claimant was not credible in regard to attempting to keep her arbiter's appointment. For instance, it is uncontradicted that claimant drove from Cottage Grove to Portland to attend her arbiter examination. Furthermore,

claimant and her mother-in-law testified that they attempted to find the arbiter's office for two hours on the day of the appointment. The arbiter's receptionist testified that claimant called at 2:47 (some 13 minutes before the scheduled exam) on the day of her appointment to ask for directions to the office. The receptionist testified that she explained the 20-minute cancellation policy to claimant at the time of the phone call. On these facts, we conclude that claimant did attempt to keep her appointment. Therefore, we conclude that claimant did not waive her right to a medical arbiter exam, because she has adequately shown "mitigating circumstances and/or just cause" for failing to keep the examination. See Craig K. Witt, supra.

Next, the employer argues that, once claimant requested a hearing, the Department lost jurisdiction to order a medical arbiter's examination. We disagree.

Claimant was scheduled for a medical arbiter's examination for April 1, 1994, which, as explained above, she did not attend. An Order on Reconsideration was issued and claimant then requested a hearing in response to the reconsideration order. Subsequent to claimant's request for hearing, the Department rescheduled claimant's medical arbiter examination. On June 8, 1994, claimant was examined by the medical arbiters.

Former ORS 656.268(6)(a) allows for the admission of a medical arbiter's report as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceedings.[1]

Here, claimant was actually "referred" by the Director for a medical arbiter's examination prior to the Order on Reconsideration and her request for hearing. At the time of the referral, the Director properly had jurisdiction over this claim. However, because claimant could not keep the original appointment for just cause, the arbiter's examination had to be rescheduled. Thus, we find that, regardless of the fact that the examination was not "rescheduled" or actually performed until after the hearing request, the Department still had jurisdiction to "refer" claimant for an arbiter's examination. Indeed, former ORS 656.268(6)(a) contemplates that the arbiter's report may not be prepared in time for the reconsideration proceeding, though it may be considered at hearing. Consequently, we conclude that the medical arbiter's report was admissible evidence at hearing.

Alternatively, the employer argues that if the arbiter's report is admissible, then the deposition of Dr. Dinneen (Exhibit 32), should have been considered by the ALJ. Dr. Dinneen, one of the medical arbiters, opined that claimant's loss of lumbar ranges was not related to her industrial injury.

The ALJ, relying on Daniel L. Bourgo, 46 Van Natta 2505 (1994), found that the "post-arbiter" medical evidence (Dr. Dinneen's "clarifying report") could not be considered in regard to the cause of claimant's loss of lumbar ranges of motion. The employer contends that the ALJ erred in relying on Bourgo because, in that case, the "post-arbiter report" concerned the issue of rating that claimant's impairment. However, the employer asserts that, in this case the "clarifying" report concerns the issue of causation. Therefore, the employer argues that Bourgo does not apply in this case to prevent the admission of Dr. Dinneen's "clarifying report."

Subsequent to the parties' briefing in this case, we held in David B. Weirich, 47 Van Natta 478 (1995), that any "post-arbiter report" medical evidence is not admissible at hearing under former ORS 656.268(7), regardless of whether the proposed medical evidence concerns "impairment" or "causation of impairment" for purposes of rating permanent disability.[2] Therefore, in light of our decision in Weirich, we find that Dr. Dinneen's "post arbiter" report clarifying his position in regard to the causation of claimant's lumbar condition was not admissible. Consequently, the ALJ correctly declined to consider Dr. Dinneen's opinion in his order.

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[1] After the ALJ's order, the legislature enacted Senate Bill 369 which renumbered ORS 656.268(6)(a) as ORS 656.268(6)(e), without making any substantive change to the provision itself. Or Laws 1995, ch 332 § 30 (SB 369 § 30). We need not decide whether amended ORS 656.268(6)(e) applies retroactively to this case, because the outcome would be the same under either the former or amended versions of ORS 656.268.

[2] We note that ORS 656.268(7) was also amended by Senate Bill 369. SB 369 § 30. However, we need not decide whether amended ORS 656.268(7) applies retroactively, because the outcome in this case would be the same under either the former or amended versions of ORS 656.268(7).

Finally, the employer contends that the medical evidence shows that claimant's loss of lumbar ranges of motion are not related to her industrial injury. According to the employer, the opinions of Drs. Reimer and Fuller are persuasive. They opined that claimant had no permanent impairment as a result of her lumbar strain. (Ex. 20-4). We disagree.

Here, we find that the preponderance of the evidence supports a conclusion that claimant's losses in lumbar ranges of motion are due to her industrial injury. Claimant sustained an industrial injury to her low back. There was no evidence that claimant had any problems or injuries to her low back prior to her industrial accident. However, following her industrial injury, the medical arbiters found that claimant had loss of lumbar ranges of motion and a bulging disc in her back. Therefore, we find, as did the ALJ, that the cause of claimant's loss of ranges of motion in her back was due to her industrial injury. Consequently, claimant is entitled to a permanent disability rating due to her industrial injury.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $500, payable by the self-insured employer . In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated January 19, 1995 is affirmed. For services on review, claimant's attorney is awarded $500, payable by the self-insured employer.

In the Matter of the Compensation of
WESTON C. FOUCHER, Claimant
WCB Case No. 94-12329
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order which affirmed an Order on Reconsideration awarding 12 percent (38.4 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability.

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

Relying on Michelle Cadigan, 46 Van Natta 307 (1994), the ALJ determined that the administrative rules (WCD Admin. Order 93-056) adopted subsequent to England v. Thunderbird, 315 Or 633 (1993) governed the rating of claimant's disability. Specifically, the ALJ affirmed the Order on Reconsideration award of 12 percent unscheduled permanent disability, which was based on an adaptability of zero, because claimant had returned to his regular work. See OAR 436-35-280(1) and 436-35-310.

Claimant contends that: (1) the Director's "post-England" rules are invalid; and (2) we should stay further proceedings until the court reviews the issue decided in Cadigan. We disagree with both contentions.

First, we decline to hold this matter in abeyance indefinitely pending resolution of the pending court appeal in another case. As an adjudicative body, our function is to resolve disputes brought to us by the litigants. In performing these duties, we apply the relevant statutory, administrative, and judicial precedents as they exist at the time of our review. Were we to follow claimant's suggestion and hold this matter in abeyance, resolution of this dispute, as well as numerous others, would be deferred for an indeterminate period awaiting another appellate forum's decision. We do not consider such an action consistent with our statutory role as a decision-maker. Accordingly, we deny claimant's request to stay our review. See Alonso S. Alvarado, 43 Van Natta 1303 (1991).

Second, we are bound by the rules promulgated by the Director insofar as they are consistent with the Workers' Compensation Act, and the authority granted the Director by the Act. Bill R. Offill, 47 Van Natta 833 (1995); Eileen N. Ferguson, 44 Van Natta 1811 (1992), aff'd 127 Or App 478 (1994) (citing Miller v. Employment Division, 290 Or 285 (1980)).

Here, claimant does not argue, nor do we find, a conflict between the rule and the substantive provisions of the statute. Rather, in light of Cadigan, we conclude that the Director appropriately promulgated the rules set forth in WCD Admin. Order 93-056. In accordance with Ferguson, we are statutorily required to apply the standards adopted by the Director at the relevant time. Robert W. Banks, 45 Van Natta 1161 (1993); Eileen N. Ferguson, supra.

In response to the Court's decision in England, the Director amended OAR 436-35-280 through 436-35-310, to allow a value for age, education and adaptability, subject to other criteria, where a worker has returned to his regular work. WCD Admin. Order 93-052. Those temporary rules expired on December 14, 1993. See Cornell D. Garrett, 46 Van Natta 340 (1994), aff'd mem Garrett v. Still Water Corporation, 130 Or App 679 (1994). In their place, the Director has adopted permanent rules set forth in WCD Admin. Order 93-056. The permanent rules apply to those claims in which a worker is medically stationary on or after July 1, 1990 and the claim is closed after December 14, 1993, the effective date of the rules. OAR 436-35-003(1). All other claims in which the worker is medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268 are subject to the standards in effect at the time of the Determination Order or Notice of Closure. OAR 436-35-003(2).

Here, claimant became medically stationary on May 11, 1992 and a March 23, 1994 Determination Order closed his claim. The standards in effect on the date of the Determination Order control. Thus, the standards contained in WCD Admin. Order 93-056 apply to claimant's claim. Cornell D. Garrett, supra; Michelle Cadigan, supra. Based on those standards, we agree with the ALJ's decision to affirm claimant's 12 percent unscheduled permanent disability, as granted by the Order on Reconsideration.

ORDER

The ALJ's order dated February 17, 1995 is affirmed.

August 18, 1995 Cite as 47 Van Natta 1519 (1995)

In the Matter of the Compensation of
MICHAEL D. HOGAN, JR., Claimant
WCB Case No. 94-09023
ORDER OF DISMISSAL
Hoffman, Hart & Wagner, Defense Attorneys

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Johnstone's order that dismissed claimant's request for hearing. We have reviewed the request to determine whether we have authority to consider the matter. Because we conclude that the request is untimely, we dismiss.

FINDINGS OF FACT

Claimant filed a request for hearing challenging the self-insured employer's April 12, 1994 denial of his claim for a chest contusion injury. In the hearing request, claimant gave his address as 6515 S.W. Garden Home Road, Portland Or 97223. The Board received claimant's request for hearing on July 27, 1994 and a hearing was scheduled for October 25, 1994. The hearing was postponed so that claimant could retain legal counsel. The hearing was reset for April 4, 1995.

Claimant did not appear at the April 4, 1995 scheduled hearing. In a May 2, 1995 order, the ALJ granted the employer's motion for dismissal. The dismissal order was addressed to claimant at the address he had provided to the Board in his hearing request. The ALJ's dismissal order was later returned to the Board as undeliverable.

Subsequent to the date of the ALJ's May 2, 1995 dismissal order, in a letter dated June 24, 1995, claimant wrote the Board requesting review of the dismissal order. The Board received claimant's

request on July 5, 1995. Claimant's letter indicated that claimant had never received a copy of the ALJ's May 2, 1995 dismissal order. In his letter, claimant asserted that he did not receive the dismissal order because he had moved and the Post Office had not processed his address change.

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 a review by the Board. ORS 656.289(3). Here, claimant's request for review of the ALJ's order was not received by the Board within 30 days of the date the order was mailed to the parties. Under such circumstances, the ALJ's order is final unless it was not mailed to all parties as required by ORS 656.289(2).

Pursuant to ORS 656.289(2), an ALJ's order must be mailed to all parties in interest. If an ALJ's order is not mailed to all parties, the order is not final and is not subject to Board review. Ernest L. Vaughn, 40 Van Natta 1574 (1988); Douglas Meuler, 40 Van Natta 989 (1988).

When an order has been mailed to a party at an address other than that previously provided to the forum, the order has not been mailed to a party and is not final. Mary J. Gates, 42 Van Natta 1813 (1990). A claimant's failure to receive a copy of the ALJ's order is not determinative. Rather the determinative issue is whether the order was mailed. Joyce E. Mitts, 42 Van Natta 972 (1990); see also Coralee J. Puckett, 45 Van Natta 1757 (1993).

In Mitts, the claimant provided her current address to the Hearings Division in another case, but did not provide her new address to the Board in the case being reviewed. The Board's order was mailed to the address provided to the Board by the claimant and the order was not returned to the Board as undeliverable. Under those circumstances, we concluded that the order had been mailed to all parties and was final.

In Coralee J. Puckett, supra, the ALJ's order was mailed to the claimant at the address given in her hearing request. More than 30 days after the date of the ALJ's order, the claimant requested Board review contending that the owner of the property where the claimant previously lived had not forwarded her mail. On Board review in Puckett, we concluded that the ALJ's order was mailed to all parties and was final. In reaching our decision, we also noted that the claimant had received the ALJ's order 3 days prior to the expiration of the 30-day statutory appeal period.

Here, claimant asserts that he never received a copy of the ALJ's dismissal order. The dismissal order was, in fact, returned to the Board as undeliverable. However, the address to which the ALJ's dismissal order was sent was the same address that claimant gave on his request for hearing. The file does not indicate, and claimant does not assert, that he notified the Hearings Division that his address had changed.

Because a current address for claimant was not provided to the Hearings Division and because the ALJ's order was mailed to claimant at the last correct address given to the Hearings Division, we conclude that the order was mailed to all parties and has become final by operation of law. Our decision is consistent with the holdings of Mitts and Puckett where the parties in question failed to apprise the Board or Hearings Division of their current addresses. In both cases, we held that the orders were mailed to the parties and were final. We reach the same conclusion here. Accordingly, we conclude that the ALJ's dismissal order is final.

We distinguish the present case from Mary J. Gates, supra. In Gates, a Board order was mailed to the address given by the claimant at the time of her hearing request and at the time of Board review. A copy of the order was returned to the Board as undeliverable and marked "unable to forward." Although we noted that the claimant could have been more vigilant in keeping the Board apprised of her current address, we also noted that the Board's file contained correspondence from the claimant, dated prior to the Board's order, which contained the claimant's current return address. We concluded that the Board had a document indicating the claimant's current address in its file and that the Board's staff's inattentiveness effectively prevented the claimant from learning of the Board's decision. Under those circumstances, we concluded that the Board's order was not mailed to a party in interest to the proceeding and was not final.

In the present case, as in Gates, the order in question had been returned as undeliverable. Nevertheless, here, unlike in Gates, claimant had not provided the Hearings Division with his current address prior to issuance of the disputed order. It is unfortunate that the postal service neglected to forward claimant's mail to his new address. Nonetheless, claimant offers no explanation for his failure to notify the Board of his change of address. Since that responsibility must ultimately rest with the party, we hold that, in accordance with the rationale expressed in Mitts and its progeny, that the ALJ's order was mailed to all parties and is now final by operation of law. Thus, we do not have authority to review that order. See ORS 656.289(3); Coralee J. Puckett, supra (An ALJ's order is final unless Board review is requested within 30 days of the date the order is mailed to the parties). Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

August 18, 1995 Cite as 47 Van Natta 1521 (1995)

In the Matter of the Compensation of
MICHAEL E. PELCIN, Claimant
WCB Case No. 94-11456
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that upheld the insurer's denial of his claim for degenerative joint disease of the right shoulder. The insurer challenges that portion of the order that awarded an assessed attorney fee under former ORS 656.386(1) for claimant having prevailed over the insurer's "de facto" denial of claimant's claim for a pulmonary embolism. On review, the issues are compensability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability of Degenerative Joint Disease

Applying ORS 656.005(7)(a) and former ORS 656.005(7)(a)(B),[1] the ALJ found that claimant failed to establish that his right shoulder degenerative joint disease was compensably related to his May 18, 1993 industrial injury. We agree, and adopt the ALJ's reasoning and conclusion. Claimant's treating surgeon, Dr. Brenneke, opined that claimant's degenerative AC joint was not a result of the industrial injury. Although the degenerative condition was diagnosed and treated as part of claimant's right shoulder surgery, Dr. Brenneke explained that it was "pre-existing and coincidental." In the absence of any persuasive medical evidence to the contrary, we find that claimant has not sustained his burden of proof.[2]

Attorney Fee - Pulmonary Embolism Claim

Finding that the claimant's attorney was instrumental in obtaining a declaration of compensability of the claim for pulmonary embolism, the ALJ awarded an assessed attorney fee under former ORS 656.386(1). On review, the insurer argues that no assessed fee is authorized because at the

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[1] Subsequent to the ALJ's order, ORS 656.005(7)(a)(B) was amended by Senate Bill 369 (SB 369), 68th Leg., Reg. Sess., § 1 (1995). In this case, however, our determination as to the compensability of claimant's degenerative joint disease would be the same regardless of whether we apply the former or current version the law.

[2] A significant portion of claimant's briefing on review concerns the alleged unreasonableness of the insurer's "de facto" denial of the claim for degenerative AC joint disease. Since we find the condition is not compensable, we do not address claimant's penalty and attorney fee arguments.

time claimant requested a hearing on this claim, there had been no "de facto" or express denial of this condition.[3] We agree.

The ALJ specifically found that Dr. Dreisin's September 13, 1994 report was the first documentation of this claim, although the record does not establish when the insurer received this report. The insurer accepted the claim on December 18, 1994. Although the condition may not have been accepted within 90 days, there is nothing in the record to indicate that claimant made a request for hearing on the "de facto" denial of that condition after the 90 day period expired. Further, claimant's September 21, 1994 request for hearing was ineffective on this issue because it was premature. See Michael A. Dipolito, 44 Van Natta 981 (1992) (a prematurely filed request for hearing is ineffective and void). Accordingly, in the absence of a valid request for hearing on the alleged "de facto" denial, no attorney fee may be awarded.[4]

ORDER

The ALJ's order dated January 10, 1995 is affirmed in part and reversed in part. That part of the order awarding a $750 attorney fee for services in obtaining acceptance of the pulmonary embolism claim is reversed. The remainder of the order is affirmed.

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[3] We do not consider the insurer's "Reply Brief" on review (which was filed in response to claimant's reply brief) because the insurer did not file a cross-request for review in this case. See OAR 438-11-020(2). While we may consider issues raised in a respondent's brief in the absence of a cross-request for review, see Kenneth Privatsky, 38 Van Natta 1015 (1986), the respondent has no right to file a cross-reply to appellant's reply brief unless the respondent has timely filed a cross-request for review.

[4] Inasmuch as we would reach the same ultimate conclusion under either version of ORS 656.386(1), we need not determine which version is applicable.

In the Matter of the Compensation of
JORDICE C. SAVAGE, Claimant
WCB Case No. 93-14180
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Bostwick, et al, Defense Attorneys

The insurer has requested abatement and reconsideration of our June 16, 1995 Order on Review which affirmed the Administrative Law Judge's conclusion that claimant had established a compensable aggravation. We previously abated our order to allow adequate time to consider the motion. We now proceed with our reconsideration.

On reconsideration, the insurer argues that, because our decision was predicated on the scope of its acceptance, amended ORS 656.262(10) compels a different result. See Or Laws 1995, ch 332 § 28 (SB 369, § 28). However, our decision that the claim is compensable was not based on the acceptance, but on the merits, i.e., the medical evidence. Consequently, amended ORS 656.262(10)[1] does not apply.

The insurer also argues that we misinterpreted the medical evidence and ignored evidence that claimant had a preexisting low back condition. However, because our prior order adequately explained our interpretation of the medical evidence (including relevant discussion of an alleged preexisting condition), we do not address these contentions on reconsideration.

Accordingly, our June 16, 1995 Order on Review is withdrawn. On reconsideration, as supplemented herein, we republish our June 16, 1995 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] The statute provides, in part: "Payment of permanent disability benefits pursuant to determination order, notice of closure, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted."

In the Matter of the Compensation of
DAVID L. DODSON, Claimant
WCB Case No. 94-11238
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order which upheld the SAIF Corporation's denial of his claim for a myocardial infarction. On review, the issue is compensability.

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

Applying the major contributing cause standard of ORS 656.005(7)(a)(A), the ALJ determined that claimant's compensable 1975 injury involving multiple injuries to the spine, left shoulder and neck was not the major contributing cause of his myocardial infarction in 1993. Accordingly, the ALJ upheld SAIF's denial of claimant's cardiac condition.

On review, claimant contends his chiropractor and orthopedist misinterpreted his neck, left arm and chest pain as resulting from his compensable injury, rather than his cardiac condition, thus delaying diagnosis and pre-myocardial infarction treatment of his cardiac condition (atherosclerosis). According to claimant, the "natural consequence" of the delay in treatment of his cardiac condition caused by his compensable injury was a myocardial infarction. Citing Beck v. James River Corp., 124 Or App 484 (1993), claimant asserts that his treatment for his myocardial infarction is compensable because treatment for his compensable neck injury is a material contributing cause of his myocardial infarction. However, we do not find Beck applicable to this claim.

Citing Roseburg Forest Products v. Ferguson, 117 Or App 601, rev den 316 Or 528 (1993), the court in Beck determined that medical services for conditions resulting from a compensable injury are compensable if the need for treatment bears a material relationship to the compensable condition. The court explained that ORS 656.005(7)(a), which defines a compensable injury, applies to initial determinations of compensability of a condition, i.e., to claims for new injuries or conditions different from an already accepted claim. The statute does not apply to a claim for continued medical treatment of a compensable condition under ORS 656.245(1). 124 Or App at 487.

Beck is not controlling here, inasmuch as claimant seeks treatment for a myocardial infarction, which is a different condition from the accepted 1975 claim. Instead, we agree with the ALJ that, since claimant is seeking treatment for a new or different condition, an initial determination of compensability must be made under ORS 656.005(7)(a). Therefore, because claimant's myocardial infarction is related, if at all, to the compensable injury as an indirect consequence of that injury, the major contributing cause standard of ORS 656.005(7)(a)(A) applies. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Claimant must, thus, prove that the compensable 1975 injury is the major contributing cause of his consequential condition (myocardial infarction).

We agree with the ALJ that the medical opinion of the only physician to comment on the causation issue, Dr. Baker, establishes that claimant's underlying atherosclerosis is the major contributing cause of the consequential condition, rather than the compensable 1975 injury or reasonable and necessary medical treatment for that injury. (Ex. 22-16, 17); Cf. Barrett Business Services v. Hames, 130 Or App 190, 196, rev den 320 Or 492 (1994) (where reasonable and necessary treatment of 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)). Accordingly, we find that claimant has failed to sustain his burden of proof under ORS 656.005(7)(a)(A). We, therefore, affirm the ALJ's order.

ORDER

The ALJ's order dated February 15, 1995 is affirmed.

In the Matter of the Compensation of
TOMMY V. DRENNEN, Claimant
WCB Case No. 94-12119
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) decreased claimant's unscheduled permanent partial disability for a low back and right wrist injury from 18 percent (57.6 degrees) to 14 percent (44.8 degrees); and (2) awarded claimant's counsel an assessed attorney fee under ORS 656.382(2) for prevailing against the employer's request for a reduction of permanent disability benefits. On review, the issues are unscheduled permanent disability and attorney fees.

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

The employer argues that the ALJ erred in relying on the medical arbiter's findings in evaluating claimant's permanent impairment. In support of this argument, the employer asserts that the findings made by Dr. Stewart, an examining physician, render the medical arbiter's report less persuasive. However, medical evidence from a non-treating physician may not be used to impeach the opinion of a treating physician or medical arbiter. Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994); Jerome D'Arcy, 46 Van Natta 416 (1994). Moreover, the medical arbiter's report is based on an examination that is closer in time to the date of the Order on Reconsideration than is the report of the treating physician. Consequently, we agree with the ALJ that the findings of the medical arbiter are persuasive.

The employer also asserts that the ALJ erred in awarding claimant's counsel an attorney fee pursuant to ORS 656.382(2). We disagree.

The Order on Reconsideration awarded claimant 18 percent unscheduled permanent disability. The employer requested a hearing seeking a reduction of claimant's permanent disability award. At hearing, during the opening statements, the counsel for the employer and counsel for claimant stipulated that the Order on Reconsideration's award of 18 percent was incorrectly calculated. (Tr. 3, 4). The parties further stipulated that, assuming the medical arbiter's report was relied upon, claimant award should be 14 percent. (Tr. 3, 4).

OAR 438-09-001(3) allows for oral stipulations between the parties if made on the record and approved in writing by the ALJ. Here, the parties' stipulated agreement was made on the record and documented by the ALJ in his order. In light of that agreement, the only remaining issue was whether claimant's award should be decreased from 14 percent to zero. The employer continued to assert that claimant's award should be reduced. Claimant's award was not reduced by the ALJ, but rather by stipulation of the parties. Under these circumstances, claimant is entitled to an attorney fee under ORS 656.382(2) as the employer requested a hearing, continued to seek reduction of claimant's permanent disability award beyond the 14 percent stipulated award, and claimant's compensation was not subsequently reduced by the AJL beyond the stipulated amount as a result of that hearing.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review for services concerning the extent of permanent disability issue is $1,300, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved. We note that claimant is not entitled to an attorney fee for services on review in responding to the employer's appeal of the attorney fee issue. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated February 1, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,300, payable by the self-insured employer.

In the Matter of the Compensation of
WALTER L. KEENEY, Claimant
WCB Case No. 94-09191
ORDER DENYING RECONSIDERATION
James L. Edmunson, Claimant Attorney
Alan Ludwick (Saif), Defense Attorney

Claimant requests abatement and reconsideration of our July 21, 1995 Order on Review which: (1) held that jurisdiction over claimant's hearing request regarding the parties' medical services dispute rested with the Director under amended ORS 656.327(1)(a) and amended ORS 656.245(6); and (2) vacated an Administrative Law Judge's order which had addressed the parties' dispute. Asserting that the Director is presently developing rules to address these "Director-only" issues, claimant seeks abatement of our decision "until such time as a permanent [Director] rule has been promulgated regarding this jurisdictional issue."

We deny claimant's request. As discussed in our prior decision, since jurisdiction over medical service disputes such as this has retroactively vested with the Director, the question of what action to take in response to requests for Director review which were previously timely presented to the Board's Hearings Division likewise properly rests with the Director. Inasmuch as this Board no longer retains jurisdiction over this type of dispute, we decline claimant's invitation to withdraw our decision to await whatever action the Director eventually chooses to take. Instead, the answer to the procedural and substantive questions posed by claimant's request for relief will presumably be addressed and resolved by the Director at such time as claimant's request for review of the medical services dispute is filed with the Director.

Accordingly, the motion for abatement and reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our July 21, 1995 order.

IT IS SO ORDERED.

Board Member Hall dissenting.

As expressed in my prior dissenting opinion, we should not base our decisions on speculative future acts. Rather, we should premise our reasoning on the current state of the law. In keeping with that rationale, I would grant claimant's motion for reconsideration which merely seeks abatement of our decision until such time as the Director has adopted administrative rules which pertain to "medical service/jurisdiction" disputes such as those that are presented in this case. Consequently, I respectfully dissent.

In the Matter of the Compensation of
ROBERT H. MAZZGA, Claimant
WCB Case No. 94-04505
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

The self-insured employer requests reconsideration of our July 25, 1995 order which reduced claimant's scheduled permanent disability award for loss of use or function of the right knee from 19 percent (28.5 degrees), as awarded by an Order on Reconsideration (and affirmed by an Administrative Law Judge), to 10 percent (15 degrees). On reconsideration, the employer seeks clarification of that portion of our order which pertains to attorney fees.

Specifically, the employer points out that our prior order contains language indicating that claimant's attorney's "out-of-compensation" attorney fee should be adjusted. Noting that no "out-of-compensation" fee was awarded by the ALJ's order, the employer seeks reversal of the ALJ's award of a $1,600 assessed attorney fee under ORS 656.382(2) (for claimant's then-successful defense of the employer's hearing request from the Order on Reconsideration) and requests clarification that no "out-of-compensation" attorney fee is owed.

After conducting our further review, we conclude that the language in our order which refers to adjustment of an "out-of-compensation" attorney fee was included in error. No "out-of-compensation" attorney fee was awarded by the ALJ's order or our order. In addition, claimant's attorney is not entitled to the ALJ's $1,600 attorney fee award since our prior order has reduced claimant's award of compensation for which the employer had requested a hearing. See ORS 656.382(2).

Consequently, we withdraw the "Order" portion of our July 25, 1995 order and replace it as follows: "The ALJ's order dated August 11, 1994 is modified in part and reversed in part. In lieu of the ALJ and Order on Reconsideration awards, claimant is awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the right knee. The ALJ's award of a $1,600 attorney fee is also reversed."

Accordingly, our July 25, 1995 order is withdrawn. On reconsideration, as modified and supplemented herein, we republish our July 25, 1995 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
DALE S. WEITMAN, Claimant
WCB Case Nos. 94-01114, 93-07410 & 93-03162
ORDER ON RECONSIDERATION
Rasmussen & Henry, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorneys

The SAIF Corporation requests reconsideration of our July 24, 1995 Order on Review, which affirmed Administrative Law Judge (ALJ) Baker's order setting aside its compensability and responsibility denial of claimant's "new injury" claim for a low back condition issued on behalf of its insured, Willamina Lumber Co. SAIF contends that we erred in relying on the medical opinion of Dr. Nash, claimant's current attending physician, in concluding that responsibility for claimant's low back condition shifted to SAIF. SAIF also asserts that finding that claimant was not significantly impaired prior to his employment for SAIF's insured is incorrect and that our legal analysis is contrary to Dietz v. Ramuda, 130 Or App 397 (1995).

In our original order, we found no persuasive reason not to rely on Dr. Nash's medical opinion that claimant's August 1992 lifting incident while employed by SAIF's insured was the major contributing cause of claimant's need for medical treatment. SAIF asserts that Dr. Nash's medical opinion is not persuasive because it is neither well-reasoned nor based on an accurate history. We disagree.

We have reviewed SAIF's contentions and, upon further consideration, continue to find that Dr. Nash's opinion is based on a sufficiently accurate history and is well-reasoned. As noted in our original order, Dr. Nash was aware of claimant's long history of injuries and degenerative disc disease when he opined that the August 1992 incident was the major reason for claimant's need for surgery in August 1993. Moreover, we continue to find that Dr. Nash weighed the relative contributions of claimant's prior injuries and degenerative disc disease in arriving at his conclusion as to the major contributing cause of claimant's need for treatment.

SAIF continues to emphasize the extensive nature of claimant's back problems prior to his employment with SAIF's insured in June 1991. We recognize that claimant had significant prior back problems. However, as noted in our order, claimant did not seek treatment from June 1991 until after the August 1992 lifting incident and was able to perform manual labor during that time. Moreover, we continue to find that claimant's pre-employment physical in June 1991 supports our conclusion that claimant was not significantly impaired prior to becoming employed by SAIF's insured.

Finally, SAIF asserts that we mistakenly drew a distinction between claimant's combined condition and his need for treatment under ORS 656.005(7)(a)(B). SAIF contends that our legal analysis necessarily focuses on the precipitating cause of claimant's need for treatment in contravention of Dietz, supra, and will result in the "defeat" of legislative policy to make it more difficult to shift responsibility to a subsequent employer. We disagree.

As noted in our original order, our legal analysis is soundly based on the language of both former and amended ORS 656.005(7)(a)(B), as well as the Supreme Court's decision in SAIF v. Drews, 318 Or 1 (1993). We continue to find that the ALJ properly assigned responsibility to SAIF, not on the basis that the August 1992 incident was the precipitating cause of claimant's need for treatment, but rather on Dr. Nash's medical opinion which we have found to be persuasive because it involved an evaluation of the relative contribution of all causes of claimant's need for treatment.

Accordingly, we withdraw our July 24, 1995 order. On reconsideration, as supplemented herein, we adhere to and republish our July 24, 1995 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
GAYLE L. CLINGENPEEL, Claimant
WCB Case Nos. 93-10116 & 94-07775
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order which upheld the self-insured employer's partial denial of claimant carpal tunnel syndrome (CTS) claim. On review, the issue is compensability

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

Claimant contends that his symptoms of CTS are the disease and, therefore, his carpal tunnel condition is compensable. The medical evidence does not support claimant's argument.

Dr. Karasek opined that claimant had a preexisting, asymptomatic median nerve injury at the wrist, which was the pathology of CTS. The symptoms of CTS, however, include numbness, loss of grip strength and pain. The pathology and the symptoms go together to make up CTS, but Dr. Karasek reiterated that there was a distinction between the two. Based on Dr. Karasek's opinion in this case, we find that the symptoms of claimant's CTS are not the disease. See Matthew R. Ross, 47 Van Natta 698 (1995)(where distinction drawn between carpal tunnel symptoms and the underlying condition, the symptoms are not the disease).

Dr. Karasek further opined that claimant's compensable cervical strain syndrome caused the median nerve injury at the wrist to become symptomatic. Dr. Karasek, thus, concluded that the cervical strain injury was the precipitating cause of claimant's CTS, but was not the major contributing cause of a worsening of the preexisting median nerve condition. (Exs. 33, 36-33).

Based on Dr. Karasek's opinion, we conclude that the February 1993 cervical strain injury precipitated claimant's CTS symptoms, but that claimant's preexisting median nerve condition was the major contributing cause of her CTS. ORS 656.005(7)(a)(B)[1] ; see Alec E. Snyder, 47 Van Natta 838 (1995)(ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause, including the precipitating cause, to establish the major cause). Accordingly, we affirm the ALJ's order.

ORDER

The ALJ's order dated October 11, 1994 is affirmed.

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[1] Our ultimate conclusion of compensability would be unaffected regardless of whether the former or current version of ORS 656.005(7)(a)(B) was applied.

In the Matter of the Compensation of
SHARON A. DAQUILANTE-RICHARDS, Claimant
WCB Case No. 93-12931 & 93-12181
ORDER ON REVIEW
Susan D. Isaacs, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) found that claimant's claim was not prematurely closed; and (2) declined to assess penalties or attorney fees for the insurer's allegedly unreasonable claim closure. On review, the issues are premature closure and penalties and attorney fees.

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

On review, claimant contends that her accepted left rotator cuff syndrome and left lateral epicondylitis conditions were not medically stationary on September 3, 1993, the date of the Notice of Closure. We disagree.

The insurer accepted claimant's claim for left rotator cuff syndrome and left lateral epicondylitis. Subsequent to the date of acceptance, claimant was discovered to have degenerative disc disease in the cervical spine including a disc herniation at C4-5. The insurer partially denied claimant's cervical degenerative disc disease at C4-5 and C6-7 and, after a hearing, a prior ALJ upheld the insurer's partial denial of the cervical condition. The Board adopted and affirmed the prior ALJ's order. (Exs. 114; 129).

Claimant argues, based on the opinions of Drs. Irvine and Misko, that her left rotator cuff syndrome and left lateral epicondylitis claim was prematurely closed. It is claimant's burden to prove that her claim was prematurely closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). 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).

Dr. Irvine, claimant's attending physician, initially diagnosed claimant's condition as left rotator cuff syndrome and left lateral epicondylitis. Later, Dr. Irvine indicated that claimant had cervical radiculopathy that had been present all along and accounted for claimant's upper extremity symptoms. (Ex. 57-2). Dr. Irvine explained that it became obvious that his initial diagnoses were in error and that claimant was in fact presenting with signs and symptoms consistent with a left upper extremity cervical radicular syndrome. Dr. Irvine later stated that claimant did, in fact, have epicondylitis but that this condition was secondary to her C4-5 disc herniation. (Ex. 126-10). Dr. Irvine did not believe that any of claimant's conditions were medically stationary at claim closure. (Ex. 126-16).

We do not find Dr. Irvine's opinion concerning claimant's medically stationary status persuasive. First, Dr. Irvine's various opinions are inconsistent concerning whether claimant even has epicondylitis and rotator cuff syndrome. In this regard, Dr. Irvine initially opined that he had misdiagnosed claimant's condition and that the diagnosis was actually radicular pain from claimant's herniated cervical disc. Later, Dr Irvine opined that claimant did in fact have epicondylitis which was secondary to the C4-5 cervical disc herniation. We conclude that Dr. Irvine did not adequately explain how claimant's C4-5 cervical disc herniation caused either epicondylitis or rotator cuff pathology. Finally, like the ALJ, we are not persuaded that Dr. Irvine distinguished between the accepted conditions and the noncompensable cervical condition when he rendered his opinion concerning claimant's medically stationary status on the date of closure. Accordingly, we find Dr. Irvine's opinion that claimant's condition was not medically stationary on the date of closure to be unpersuasive.

Dr. Misko, the neurosurgeon who removed claimant's herniated C4-5 disc, also initially opined that claimant's condition was a C4-5 disc herniation rather than tendinitis or epicondylitis. (Exs. 110; 123; 127). Dr. Misko later signed a statement indicating that he agreed with Dr. Irvine that claimant's left rotator cuff syndrome and left lateral epicondylitis did in fact exist; he further indicated that they

were not primary conditions but were secondary to claimant's cervical disc condition. (Ex. 128). Ultimately, at his deposition, Dr. Misko indicated that he deferred to Dr. Irvine's opinion concerning whether claimant had true left lateral epicondylitis or rotator cuff syndrome. (Ex. 130, pages 6 to 8). In March 1994, Dr. Misko opined that claimant was recovering from an anterior cervical fusion and was not medically stationary.

We find Dr. Misko's opinion unpersuasive. Dr. Misko opined that claimant's noncompensable cervical condition was not medically stationary. However, Dr. Misko never addressed whether or not the accepted rotator cuff syndrome and epicondylitis conditions were medically stationary. Accordingly, Dr. Misko's opinion is not persuasive concerning whether or not the accepted condition was medically stationary on the date of closure.

After reviewing the medical evidence, we are not persuaded that claimant has met her burden to prove that her epicondylitis and rotator cuff syndrome claim was prematurely closed. In this regard, we find the opinions of Drs. Irvine and Misko to be inconsistent and lacking in explanation concerning whether the accepted rotator cuff syndrome and epicondylitis were medically stationary at claim closure.

Claimant argues that her left arm symptoms resulting from her C4-5 disc herniation are part of her accepted claim. The insurer contends that claimant is barred by res judicata from relitigating the issue of whether claimant's degenerative disc condition at C4-5 was part of her accepted claim. We agree.

In prior litigation, claimant argued that the insurer had accepted the cervical condition when it accepted left lateral epicondylitis and rotator cuff syndrome. The prior ALJ concluded that the insurer's acceptance did not include claimant's cervical degenerative disc disease at C4-5. (Ex. 114). On Board review, we adopted and affirmed the prior ALJ's order. (Ex. 129). Our order was not appealed and has become final.

Issue preclusion bars future litigation between the same parties concerning an issue that was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). In this case, the same parties litigated the issue of whether the insurer accepted the degenerative disease at C4-5 when it accepted left rotator cuff syndrome and left lateral epicondylitis. Because the issue was actually litigated and determined and was essential to the final decision reached, we conclude that claimant is barred by issue preclusion from relitigating her contention that her cervical degenerative disease is part of the accepted claim.

ORDER

The ALJ's order dated December 13, 1994 is affirmed.

In the Matter of the Compensation of
RICHARD A. JOHNSON, Claimant
WCB Case No. 94-06893
ORDER ON REVIEW
Phil H. Ringle, Jr., Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall, Turner-Christian and Neidig.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's denial of claimant's left knee 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

While returning to work at the end of an unpaid lunch break, claimant walked by two co-workers; claimant teased one man by making a comment about being a "brown noser." That man rose and physically forced claimant to the ground. As a result of the incident, claimant injured his left knee.

The ALJ concluded that the injury did not arise out of or occur in the course of claimant's employment and, therefore, was not compensable. In reaching this conclusion, the ALJ applied the seven factors provided in Mellis v. McEwen, Hanna, Gisvold, 74 Or App 572, rev den 300 Or 249 (1985). Claimant, relying on the same factors, asserts that his injury was in the course and scope of employment. Specifically, according to claimant, verbal taunting and teasing was sufficiently common that retaliatory horseplay should be considered incidental to employment.

Subsequent to the ALJ's order, the Court of Appeals issued First Interstate Bank of Oregon v. Clark, 133 Or App 712 (1995), which considered the impact of Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), on the seven-factor "Mellis test." In Clark, the court determined that the framework set out in Norpac Foods did not significantly change the nature of the inquiry for determining whether an injury arose out of and was in the course of employment because it essentially incorporated the Mellis factors. However, the court further found that reliance on the Mellis test was inconsistent with Norpac Foods because it did not necessarily allow for consideration of the totality of the circumstances. Thus, the court concluded that, although some or all of the Mellis factors would remain "helpful inquiries", the test should no longer be used as an independent and dispositive examination of work-connection. Id. at 717.

Therefore, based on Clark, we rely only on the framework provided in Norpac Foods to determine whether claimant's injury arose out of and occurred in the course of employment. This framework consists of a two-part test. The first element refers to any causal relationship between the injury and employment; that is, the worker must show a causal link between the injury and a risk connected with the job. 318 Or at 366, 368-69. The second factor concerns the time, place, and circumstances of the injury. Id. at 366. Moreover, although an evaluation of both elements is necessary to assess compensability, neither is dispositive. Id. at 366.

We first address whether claimant's injury occurred in the course of his employment. At the time that the co-worker attacked claimant, claimant was returning to his work station after an unpaid lunch break. Claimant was on the employer's premises. Under such circumstances, we conclude that the injury occurred in the course of employment. See id. (the claimant's injury in an employer-owned parking lot immediately after shift ended fell within "parking lot rule" and, therefore, occurred in the course of employment).

We proceed to determine if the injury is causally linked to a risk connected with the job. In doing so, we determine whether the conditions of claimant's employment put him in a position to be injured. Henderson v. S.D. Deacon Corp., 127 Or App 333, 338-39 (1994). Considering all the circumstances, we conclude that they did.

As found by the ALJ, there was evidence that it was common for employees to verbally tease and taunt one another. Under such circumstances, we find that the conditions of claimant's employment put him in a position to be the target of retaliatory actions resulting in physical injury. Hence, claimant has satisfied the "arising out of employment" element. See Mark Hoyt, 47 Van Natta 1046 (1995) (the claimant was injured in the course of employment when a co-worker accidentally stabbed him with an open knife).[1]

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated September 21, 1994 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the insurer.

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[1] We disagree with the dissent that we are finding this claim compensable merely because it occurred on the employer's premises. First, we find the employer's policy prohibiting horseplay to have little relevance inasmuch as claimant was a victim of such behavior. Furthermore, as we previously discussed, although the "Mellis test" no longer controls our inquiry, its factors continue to provide guidance. Thus, the totality of the circumstances are instructive. Here, claimant's work circumstances included teasing and taunting, creating a risk of physical retailiation.

Board Chair Neidig dissenting.

I agree with the majority's statement of the law concerning course and scope of employment. I take issue, however, with its application of that law to conclude that claimant's injury arose out of his employment. Accordingly, I dissent.

As the majority states, causation must be proved by showing that the injury is related to a job risk; that is, the conditions of the worker's employment must put him in a position to be injured. Henderson v. S.D. Deacon Corp., supra. The majority states that, because it was "common for employees to verbally tease and taunt one another[,] * * * the conditions of claimant's employment put him in a position to be the target of retaliatory actions resulting in physical injury." Although unclear, I understand the majority as holding that, because the employer allowed verbal teasing and taunting amongst the employees, it put claimant in a position to be injured because it was foreseeable that someone would physically retaliate.

I find a complete absence of legal authority for this approach. Here, although it was common for employees to verbally tease and taunt, the employer's safety policy expressly prohibited horseplay and roughhousing and the employer disciplined such conduct. In view of this fact (which the majority fails to address or discuss), there is no basis for finding that any physical assault by an employee is a condition of employment. On the contrary, the coworker who assaulted claimant was acting contrary to a condition of his employment.

The facts of this case clearly show that the physical roughhousing or horseplay which resulted in claimant's injury was not a condition of his employment. In my opinion, the majority finds the claim compensable simply because it occurred on the employer's premises. Thus, the majority completely ignores the statutes and case law which require proof of "some causal connection" in order for an injury to be compensable. ORS 656.005(7)(a); Norpac Foods, Inc. v. Gilmore, supra, 318 Or at 369.

In the Matter of the Compensation of
CINDEE A. KIRKMAN, Claimant
WCB Case No. 94-06148
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig , Turner-Christian and Gunn.

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

FINDINGS OF FACT

Claimant has worked for the employer as a truck driver since December 1988. Her duties included truck maintenance, pick up and delivery of motors, loading her truck, and wrapping, taping and tarping her load. The motors she delivered weigh from 30 pounds to 30 tons. Claimant loaded the motors by hand, forklift or crane.

Claimant first sought treatment in August 1993 for stomach pain and back pain. After an extensive workup, including examinations by a gastroenterologist, an urologist and a neurologist, Dr. Yates eventually diagnosed anxiety/depression and chronic lumbosacral strain. Dr. Yates took claimant off work on January 24, 1994.

In the interim, claimant injured her right shoulder in October 1993. Claimant treated with Dr. Jones, who restricted her to light duty from October 28, 1993 to November 3, 1993. Claimant did not mention back pain until December 1993. At that time, Dr. Jones noted a slightly sore spinous process and advised claimant to recontact him if it was a problem. Claimant did not return to Dr. Jones.

On March 15, 1994, claimant filed a Form 801 claiming stomach pain and nausea causing back pain and leg numbness. Claimant gave a January 24, 1994 date of injury. The insurer denied the claim on May 12, 1994.

Claimant began treating with Dr. Peters, a chiropractor, who diagnosed facet syndrome at L3-SI with chronic lumbosacral sprain. He referred claimant to Dr. Steinhauer for evaluation and reconditioning exercises. Dr. Steinhauer first saw claimant on May 20, 1994. Dr. Steinhauer related claimant's back condition to her small physical stature, the nature of her work, and to deconditioning from being off work for five months.

CONCLUSIONS OF LAW AND OPINION

Claimant did not sustain a specific injury. The parties agree that to establish compensability, claimant must prove that her work activities were the major contributing cause of her back condition. ORS 656.802.[1] "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to causation than all other causative agents combined. McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

The ALJ found that, based on the physical findings[2] reported by Dr. Yates and the analysis of Dr. Steinhauer, claimant's work activities caused her to develop a low back strain. We disagree.

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[1] Subsequent to the ALJ's order, the legislature enacted, effective June 7, 1995, Senate Bill 369 amending ORS 656.802(2). Or laws 1995, ch 332, §56 (SB 369, § 56). Our ultimate conclusion of compensability would be unaffected regardless of whether the former or current version of ORS 656.802 applied.

[2] The objective findings requirements were also amended by SB 369 and now require verifiable indications of injury or disease. SB 369, § 1. Because we find that claimant failed to satisfy the major contributing cause standard, we need not address the insurer's argument that there were not objective findings to support claimant's subjective complaints.

Based on claimant's history and a review of her medical records, Dr. Steinhauer opined that since Dr. Yates' examinations and workup did not indicate that claimant had an internal medical problem, that claimant's condition was musculoskeletal and related to her work. Dr. Steinhauer concluded that, given claimant's small physical stature and her heavy work, claimant sustained chronic, repetitive microtrauma to the low back which was the cause of her condition. Dr. Steinhauer reasoned that claimant's small stature and her heavy work predisposed her to develop a thoraco-lumbar condition. He further explained that since she had been off work for five months, claimant was deconditioned, which also led to her back pain. (Exs. 14A, 22, 23 pp. 15-16, 24).

Dr. Steinhauer's opinion establishes causation by assuming that other possible causes have been disproven. Such an opinion is insufficient to establish compensability. ORS 656.266; see McIntyre v. Standard Utility Contractors, Inc., 135 Or App 298 (1995). In addition, Dr. Steinhauer's explanation that claimant's deconditioning was a causal factor does not address claimant's condition at the time she filed her claim. Thus, although claimant's deconditioning may be relevant to the cause of her current condition, given the other infirmities of Dr. Steinhauer's opinion, that factor is insufficient to establish causation. Accordingly, we conclude that claimant failed to establish compensability of her low back condition.

ORDER

The ALJ's order dated January 6, 1995 is reversed in part. That portion of the order which set aside the insurer's denial of the low back claim is reversed. The insurer's May 12, 1994 denial is reinstated and upheld in its entirety. The ALJ's award of a $1,600 assessed attorney fee is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Gunn dissenting.

The definition of occupational disease includes "[a]ny series of traumatic events or occurrences which requires medical services or results in physical disability or death." ORS 656.802(1)(C).[1] That is exactly what occurred in this case.

As I understand the majority's holding, claimant's small physical stature (5 foot 2 inches tall and 130 pounds) cannot be considered a factor in determining causation. However, as the medical evidence establishes, claimant's small stature along with the heavy work she was required to perform caused repetitive microtraumas (i.e., series of traumatic injuries) resulting in overuse of the low back thereby causing her condition. This "mechanism of injury" is consistent with causing a low back condition regardless of whether claimant was 5 foot 2 or 6 foot 2.

Because the majority takes a "Randy Newman" approach to this case (for those who don't remember, he sang "Short people got no reason ..."), I respectfully dissent.

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[1] This definition was not changed by SB 369.

In the Matter of the Compensation of
KARREN S. MALDONADO, Claimant
WCB Case No. 94-14116
ORDER ON REVIEW
Max Rae, Claimant Attorney
James Moller (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Howell's order that set aside an Order on Reconsideration classifying claimant's occupational disease claim for a right carpal tunnel syndrome as nondisabling. On review, the issue is claim classification. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on Brenda Guzman, 46 Van Natta 2161 (1994), and Sharman R. Crowell, 46 Van Natta 1728 (1994), the ALJ found that claimant's claim should be classified as disabling because she had been released for modified work. On review, SAIF asserts that the Board wrongly decided Brenda Guzman because it is inconsistent with former ORS 656.005(7)(c).

In Sharman R. Crowell, supra, we addressed the proper claim classification for a claimant who performed modified work at her regular wage and incurred no time loss. We first discussed OAR 436-30-045(5)(a) and (d) providing that a claim is "disabling" if temporary disability is "due and payable" or if the worker is released to and doing a modified job at reduced wages from the job at injury. Finding the rules to be inconsistent with the holding in Stone v. Whittier Wood Products, 124 Or App 117 (1993), because they considered only the worker's post-injury wages, we gave the rules no effect. 46 Van Natta at 1728.

However, we further noted that Stone was not entirely on point because it involved the calculation of temporary partial disability rather than entitlement to such benefits. Rather, we held that "the mere fact that claimant was required by the compensable injury to work at modified employment means that she was temporarily and partially disabled under the rationale of cases such as [Kenneth W.] Metzker, [45 Van Natta 1631, 1632 (1993),] and [Valorie L.] Leslie, [45 Van Natta 929 (1993), rev'd on other grounds Leslie v. U.S. Bancorp, 129 Or App 1 (1994)]." 46 Van Natta at 1729. Thus, we found that the claim properly was disabling.

As discussed by the ALJ, we applied the holding in Crowell to Brenda Guzman, supra, finding that the claim was disabling because the claimant was released to modified work, notwithstanding the fact that she could receive temporary partial disability at the rate of zero. 46 Van Natta at 2161.

Subsequent to the ALJ's order, effective June 7, 1995, the legislature enacted Senate Bill 369, amending ORS 656.005(7)(c).[1] Or Laws 1995, ch 332, § 1 (SB 369, § 1). The statute now defines a "disabling compensable injury" as an "injury which entitles the worker to compensation for disability or death" and 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."

We find that the unambiguous language of the statute effectively overrules our holdings in Crowell and Guzman. In particular, because the statute now provides that an injury is not "disabling" if no temporary benefits are due and payable, we conclude that it is not enough that a claimant be limited

[1] Since there are no relevant exceptions, Section 1 of Senate Bill 369 retroactively applies to this case. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995); Walter L. Keeney, 47 Van Natta 1387 (1995).

to modified work; there also must be entitlement to temporary benefits or a reasonable expectation of permanent disability.[2]

Here, claimant was released to, and worked, modified employment. However, she was not entitled to temporary disability. Because no temporary benefits were due and payable, her claim is not disabling unless there is proof of a reasonable expectation of permanent disability. Amended ORS 656.005(7)(c). Based on a functional capacities report, treating physician Dr. Olson indicated that claimant was limited to lifting 20 pounds, as opposed to her previous ability to lift 50 pounds. (Ex. 12B). However, Dr. Olson also concurred with a report from examining physician Dr. Nolan stating that claimant had "no measurable impairment from the [accepted condition]." (Exs. 12-4, 22). In view of the lack of evidence that claimant's reduced lifting capacity was due to her injury and Dr. Olson's concurrence with Dr. Nolan's report, we find insufficient proof of a reasonable expectation of permanent disability resulting from the compensable injury. Therefore, we conclude that the claim cannot be classified as disabling.

ORDER

The ALJ's order dated February 24, 1995, as amended February 24, 1995, is reversed. The Order on Reconsideration is affirmed. The ALJ's attorney fee award is reversed.

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[2] We further note that Senate Bill 369 also amended ORS 656.212, the statute addressed by Stone v. Whittier Wood Products, supra. SB 369, § 16. As discussed above, we found Stone to not be directly on point with regard to the classification issue. Thus, in this case, we do not address the effect of amended ORS 656.212. Rather, we rely only on amended ORS 656.005(7)(c) in determining the proper claim classification.

Members Hall and Gunn dissenting in part and concurring in part.

As discussed in our dissenting opinions in Walter L. Keeney, 47 Van Natta 1387, 1392 (1995), we believe we should first consider supplemental briefs and arguments from the parties before issuing this order. Like Keeney, this case was litigated, appealed and briefed before the Board under pre-SB 369 law. Allowing the parties to first discuss the impact of the new law not only promotes fairness in processing this case but could only result in a better decision from this forum.

We concur with the majority's application and construction of amended ORS 656.005(7)(c). Because we would allow the parties an opportunity for supplemental briefing, we dissent.

In the Matter of the Compensation of
HAROLD E. SMITH, Claimant
WCB Case Nos. 94-01874 & 94-01873
ORDER ON REVIEW
Olson Law Firm, Claimant Attorney
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's denial of claimant's C5-6 condition. In its brief, the employer renews its contention that claimant's request for review was untimely filed. On review, the issues are timeliness of the claim, and, if timely, compensability.

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

Noting that claimant's request for review was filed with the Board on January 23, 1995 (32 days after the ALJ's December 22, 1994 order), the employer moved the Board for an order dismissing claimant's request for review. On February 22, 1995, we issued an Order Denying Motion to Dismiss. In our prior order, we explained that because the 30th day after the ALJ's December 22, 1994 order was January 21, 1995, a Saturday, the final day to perfect a timely appeal was Monday, January 23, 1995. We found, therefore, that claimant's request for review was timely filed. On review, we continue to adhere to our February 22, 1995 order.

ORDER

The ALJ's order dated December 22, 1994 is affirmed.

August 24, 1995 Cite as 47 Van Natta 1537 (1995)

In the Matter of the Compensation of
KENNETH R. FREE, Claimant
WCB Case No. C5-02147
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Pozzi, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On August 4, 1995, 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, except medical services, for the compensable injury. We disapprove the proposed disposition.

The CDA states that the insurer's partial denial of a neck condition was "rescinded pursuant to a Stipulation and Order of September 23, 1993" and that claimant requested "closure of the claim in light of the voluntary acceptance." The CDA further provides that, in exchange for payment of $10, 296.78, "claimant waives his right to request another closure of his claim due to the Stipulation and Order of September 23, 1993." The summary page of the agreement indicates a "partial release" of temporary and permanent disability in that "claimant waives the right to request reclosure or seek any benefits as a result of the September 23, 1993 Stipulation and Order."

We have held that it is impermissible for a CDA to accomplish claim processing functions, including claim closure, since it is not one of the objectives to be resolved with such an agreement. E.g., Debbie K. Ziebert, 44 Van Natta 51 (1992); James A. McCanna, 43 Van Natta 2276 (1991). In reaching this conclusion, we have reasoned that, by acting to close the claim, the CDA can affect the claimant's medically stationary status. In other words, by determining that the claimant is medically stationary, the claimant's entitlement to medical services is substantially limited under ORS 656.245(1)(c). Id.

Here, because claimant is waiving any right to request closure of his claim, we find that the CDA is effectively closing the claim. Commensurate with this claim closure action is the establishment of claimant's "medically stationary" date (regardless of whether formally or informally implemented). As explained above, the effect of such an action is to impinge on claimant's entitlement to medical services. Thus, because a CDA may not dispose of any matter regarding a claim for medical services, ORS 656.236(1), and we interpret this CDA as attempting to impact on claimant's right to medical services, we disapprove the proposed disposition on the ground that it is unreasonable as a matter of law. ORS 656.236; James A. McCanna, supra.[1]

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or partial disability that was stayed by the submission of the CDA. OAR 436-60-150(4)(i), (6)(e). The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1).

IT IS SO ORDERED.

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[1] We note that the parties may settle any temporary and/or permanent disability disputes following claim closure by stipulation. Former OAR 436-30-050(26). The stipulation, along with a request to affirm the reconsideration order, is submitted to the Hearings Division for approval. Former OAR 436-30-050(26)(b).

In the Matter of the Compensation of
JENICE L. PALMER, Claimant
WCB Case No. 94-06433
ORDER OF ABATEMENT
Black, Chapman, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer requests abatement and reconsideration of our July 26, 1995 Order on Review. Specifically, the insurer contends that, in light of Senate Bill 369, we erred in affirming Administrative Law Judge Menashe's order which found claimant's right knee degenerative joint disease to be compensable.

In order to consider this matter, we withdraw our July 26, 1995 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 shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL L. PETERSON, Claimant
WCB Case No. C5-02079
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On July 26, 1995 the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

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

Here, the disposition was submitted to us on July 26, 1995. The statutory 30th day following the submission is August 25, 1995. Claimant filed his request for disapproval of the disposition on August 23, 1995. The SAIF Corporation also filed its request for disapproval on August 23, 1995. Accordingly, we disapprove the disposition. Id.

Additionally, SAIF has submitted a letter requesting that the CDA be withdrawn as new information has come into the file that was unavailable when the original agreement was negotiated.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT R. BAGLEY, Claimant
WCB Case No. 94-00386
ORDER OF ABATEMENT
Emmons, Kropp, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On July 27, 1995, we affirmed an Administrative Law Judge's (ALJ's) order that had upheld the self-insured employer's denial of claimant's occupational disease claim for a psychological condition. Contending that we misinterpreted the relevant facts and law, claimant seeks reconsideration of our decision and a reversal of the ALJ's order.

In order to further consider claimant's motion, we withdraw our July 27, 1995 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROSS M. ENYART, Claimant
WCB Case No. 94-07546
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by the Board en banc.[1]

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order which modified a Director's order directing the insurer to provide vocational assistance. On review, the issues are jurisdiction and vocational assistance. We vacate the ALJ's order and dismiss claimant's hearing request from the Director's order.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable injury to his left lower leg on January 4, 1993. At the time of his injury, claimant was working on a temporary construction job out of his union hall, which paid $16.02 per hour. On March 16, 1994, the insurer found claimant ineligible for vocational assistance on the grounds that he did not have a substantial handicap to employment. Claimant requested Director review. The Director issued an order on May 10, 1994, finding claimant ineligible for vocational assistance. On June 23, 1994, the Board received claimant's request for hearing from the Director's vocational assistance order.

The ALJ concluded that claimant was eligible for vocational assistance because he had a substantial handicap to employment. Accordingly, the ALJ modified the Director's order, finding claimant eligible for vocational assistance. The insurer requested Board review.

Subsequent to the ALJ's order in this case, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.283(2), which now provides only for Director review of vocational assistance disputes.[2] Or Laws 1995, ch 332, § 34(2) (SB 369, § 34(2)).

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[1] Because of a personal conflict of interest, Board Member Hall has voluntarily recused himself from participation in the review of this case. OAR 438-11-023.

[2] Amended ORS 656.283(2) provides:

"(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires a high degree of cooperation between all of the participants in the vocational assistance process. Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and extent of vocational assistance services should be resolved through nonadversarial procedures to the greatest extent possible consistent with constitutional principles. The director is hereby charged with the duty of creating a procedure for resolving vocational assistance disputes in the manner provided in this subsection.

"(b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must apply to the director for administrative review of the matter. Such application must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time. If the worker's dissatisfaction is resolved by agreement of the parties, the agreement shall be reduced to writing, and the director and the parties shall review the agreement and either approve or disapprove it. If the worker's dissatisfaction is not resolved by agreement of the parties, the director shall resolve the matter in a written order containing findings of fact and conclusions of law. The order shall be based on a record sufficient to permit review under paragraph (c) of this subsection. For purposes of this subsection, the term 'parties' does not include a noncomplying employer.

Section 66 of Senate Bill 369 sets forth in subsection 1 the general principle regarding applicability of the amendments:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

Subsections (2) through (13) list specific exceptions to subsection (1), none of which specifically addresses the applicability of ORS 656.283(2).

In Volk v. America West Airlines, 135 Or App 565 (1995), the court held that, generally, the amendments to the Workers' Compensation law made by Senate Bill 369 apply to cases currently pending before the Board, absent a specific exception to the retroactive application of the law. See also Walter L. Keeney, 47 Van Natta 1328 (1995). No specific exception applies in this case. Compare Motel 6 v. McMasters 135 Or App 583 (1995) (retroactivity exception for procedural time limits applies to responsibility disclaimer/denial requirements of amended ORS 656.308(2); therefore, apply former law). Accordingly, we conclude that amended ORS 656.283(2) applies to the present case.

Our next task is to determine what the legislature intended by amending ORS 656.283(2). We begin with the text and context of that provision and resort to extrinsic aids only if those sources are unavailing. ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993); Porter v. Hill, 314 Or 86, 91 (1992).

Amended ORS 656.283(2) sets out the procedure for resolving vocational assistance disputes. A worker who is dissatisfied with the carrier's action regarding vocational assistance must first apply to the Director for administrative review. If the worker remains dissatisfied with the Director's decision, and the dispute cannot be resolved by agreement, the statute provides that the Director shall resolve the dispute in a written order. Amended ORS 656.283(2)(b). That "administrative review" order is subject to review only by the Director, who conducts a contested case hearing, which is subject to judicial review. Amended ORS 656.283(2)(c), (d).

There is no longer any reference to requesting a hearing before the Board's Hearings Division if a party is dissatisfied with the Director's action in a vocational assistance dispute. Compare former ORS 656.283(2). Furthermore, the statute now provides that when the Director issues an administrative order in a vocational assistance matter, "the order shall be subject to review only by the director." Amended ORS 656.283(2)(c) (emphasis supplied). The plain and mandatory language of the statute clearly reveals the legislature's intent that vocational assistance disputes be resolved exclusively by the Director, not by the Board or Hearings Division.

"(c) Director approval of an agreement resolving a vocational assistance matter shall be subject to reconsideration by the director under limitations prescribed by the director, but shall not be subject to review by any other forum. When the director issues an order after review under paragraph (b) of this subsection, the order shall be subject to review only by the director. At the contested case hearing, the decision of the director's administrative review shall be modified only if it:

"(A) Violates a statute or rule;

"(B) Exceeds the statutory authority of the agency;

"(C) Was made upon unlawful procedure; or

"(D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

"(d) An appeal of the director's administrative review under paragraph (b) of this subsection must be made within 60 days of the review issue date. Judicial review of the order shall be pursuant to ORS 183.310 to 183.550."

This conclusion is supported by amended ORS 656.283(1), which provides that any party or the Director may request a hearing on any matter concerning a claim, "except matters for which a procedure for resolving the dispute is provided in another statute, including ORS 656.245, 656.248, 656.260, 656.327 and subsection (2) of this section." SB 369, § 34(1) (emphasis supplied). In addition, amended ORS 656.704(3), which describes the respective authority of the Director and the Board to conduct hearings, investigations and other proceedings under chapter ORS 656, provides that "matters concerning a claim" do not include "disputes arising under ORS 656.245, 656.248, 656.260, 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under ORS 656.340 except as those provisions may otherwise provide." SB 369, § 50(3) (emphasis supplied). Amended ORS 656.340 governs the provision of vocational assistance and provides, inter alia, that if a carrier decides a worker is not eligible for vocational assistance, "the worker may apply to the director for review of the decision as provided in ORS 656.283(2)." SB 369, § 42(4) (emphasis supplied). Amended ORS 656.340 does not "otherwise provide" any other procedure for resolving vocational assistance disputes.

Accordingly, based on the text and context of amended ORS 656.283(2), read in conjunction with the retroactivity provisions of Senate Bill 369, we conclude that the Director now has exclusive jurisdiction over vocational assistance disputes, including those presently pending before the Board. We do not consider this to be an absurd or unjust result, but rather, precisely the result intended by the Legislature.

In reaching this conclusion, we are mindful that amended ORS 656.283(2)(d) provides that "[a]n appeal of the director's administrative review under paragraph (b) of this subsection must be made within 60 days of the review issue date." (Emphasis supplied). Here, the Director's administrative review order issued on May 10, 1994. The time for filing an appeal of the Director's administrative review order has long since expired. Here, however, on June 23, 1994 (within 60 days of that order), claimant filed a request for hearing from the Director's administrative order. Inasmuch as claimant sought a contested case hearing from the administrative review order, such a request may serve to preserve his appeal rights. (See Ex. 69-3). Alternatively, the request for Director review of the Director's administrative order may be rejected as untimely. Nevertheless, since the legislature has explicitly authorized the Director to address such disputes, the question of what actions the Director ultimately takes regarding any such request for review rests with him, not with this forum.

We share the parties' expected frustrations on being required to change forums after litigation has already occurred. However, it is not within our purview to ignore a clear legislative mandate. See Southwood Homeowners v. City Council of Philomath, 106 Or App 21, 24 (1991); Walter L. Keeney, supra.

ORDER

The ALJ's order dated October 31, 1994, as corrected November 9, 1994, is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

Board Member Gunn specially concurring.

Although I acknowledge that this holding is compelled by the holdings reached in Volk v. America West Airlines, 135 Or App 565 (1995), and Walter L. Keeney, 47 Van Natta 1387 (1995), I continue to adhere to the concerns expressed in my dissenting opinion in Keeney. In other words, I remain fearful that the retroactive application of the legislative amendments may well infringe on claimant's rights under Article I, section 10, of the Oregon Constitution and on his due process and equal protection rights under the state and federal constitutions. Therefore, I persist in my belief that parties in cases such as this should have the opportunity to address the retroactive application of Senate Bill 369's provisions and whether applying the amendments can withstand constitutional scrutiny.

The present case provides an excellent illustration regarding my concerns. Dissatisfied by the Director's decision finding that he was not entitled to vocational assistance, claimant properly requested a hearing under the then-applicable version of ORS 656.283(2). Following a hearing in which both parties fully presented their respective positions, the ALJ modified the Director's decision and directed the insurer to provide claimant with vocational assistance. Since the insurer objected to the ALJ's determination, it properly requested Board review again in accordance with then-existing law.

Notwithstanding the parties' timely and proper compliance with all procedural requirements and despite the fact that they have fully developed the evidenciary record and thoroughly analyzed the relevant substantive issues, the retroactive application of amended ORS 656.283(2) effectively requires the parties to return to the circumstances which existed when the Director issued his order over 15 months ago. Moreover, since claimant had prevailed before the ALJ, the Board's decision eliminates that compensation decision and exiles claimant to another adjudicative forum where it is far from clear that his appeal will even be considered as timely.

I find this situation to be a particularly egregious example of the workers' compensation system's failure to live up to two of its primary objectives, viz., to provide benefits to injured workers on a no-fault basis, ORS 656.012(2)(a), and to assure that those benefits are provided by a fair and just administrative system that, to the greatest extent practicable, reduces litigation. ORS 656.012(2)(b).

The administration of this case has been neither fair nor just: Despite his successful pursuit at hearing in securing his entitlement to vocational assistance benefits, claimant is now required to seek relief before still another forum. Although he appears to be entitled to such compensation, he may never obtain it for lack of a forum with jurisdiction to address the merits of this dispute. In other words, for the reasons expressed in my dissenting opinion in Keeney, I have serious concerns regarding the Director's authority to effectively modify any prior procedural limitations in order to effectuate a further review of this dispute. See Section 66(6) of Senate Bill 369.

In conclusion, neither fairness nor justice should allow this result. Nevertheless, in view of the recent amendments to the Workers' Compensation Act and the binding effect of Volk and Keeney, I have no jurisdiction to effect a fair or just result. Therefore, I regretfully concur with the decision to dismiss claimant's hearing request.

August 28, 1995 Cite as 47 Van Natta 1543 (1995)

In the Matter of the Compensation of
GAIL L. REYNOLDS, Claimant
WCB Case No. 94-05088
ORDER OF DISMISSAL
Lavis, Alvey, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requested review of Administrative Law Judge (ALJ) Thye's order that dismissed claimant's hearing request. The parties have submitted a proposed "Disputed Claim Settlement" and "Addendum," which are designed to resolve all issues raised or raisable in this case, in lieu of the ALJ's order.

Pursuant to the amended settlement, the parties agree that the self-insured employer's denial, as supplemented in the agreement, "shall remain in full force and effect." The amended settlement further provides that claimant's hearing request "shall be dismissed with prejudice" in "full settlement of all issues raised or raisable." Finally, claimant stipulates to the dismissal of her request for Board review.

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

IT IS SO ORDERED.

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[1] The agreement contains an "Addendum" which recites the "extraordinary amount of work on the part of claimant's counsel." Relying on that recitation of efforts, the supplemented settlement provides for an extraordinary attorney fee in an amount $187.50 greater than the $2,500 claimant's counsel would generally be allowed under OAR 438-15-050(1). Based on the circumstances represented in the "Addendum" and in the absence of an objection to these representations, we have approved the amended agreement which includes the "extraordinary attorney fee" provision. However, in doing so, the parties are reminded that they may seek reconsideration of our order if they disagree with any portion of our decision. Since our authority to reconsider expires within 30 days from the date of this order, any such motion for reconsideration must be filed as soon as possible.

In the Matter of the Compensation of
ROY D. WELTY, Claimant
WCB Case No. C502092
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Ackerman, et al, Claimant Attorneys
Bailey & Associates, Defense Attorneys

Reviewed by Board Member Neidig and Gunn.

On July 27, 1995, the Board acknowledged receipt of the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

Here, the CDA contains the following provision:

> "Pursuant to the Determination Order of August 12, 1994 and the Order on Reconsideration dated March 10, 1995, claimant was paid an overpayment of $6,720.00. In consideration of the release of all claims to the overpayment and the additional payment of $2,500.00 by the insurer/employer, claimant releases his right to the following workers' compensation benefits . . . ." (CDA Pg. 2, item 13) (emphasis supplied).

We have previously held that, where an overpayment apparently has been made pursuant to prior claims processing obligations, that overpayment cannot qualify as "proceeds" of the parties' CDA. See Ronald Smith, 47 Van Natta 38 (1995); Timothy W. Moore, 44 Van Natta 2060 (1992). Furthermore, a carrier's contractual forbearance of its right to pursue an offset cannot serve as consideration for claimant's release of certain rights. Id. Therefore, in this case, the carrier's release of all claims to the $6,720 overpayment cannot be consideration for the CDA[1].

Despite the above-quoted language, the summary page of the CDA provides for the amount of the disposition as follows: $1,875 due to claimant and $625 due to the attorney, which equals a total of $2,500. Thus, based on this information and the previous discussion concerning overpayment, we interpret the CDA as providing that the total amount of the consideration is $2,500 and no part of the stated overpayment is included in the total consideration for the CDA.

Accordingly, we conclude that the CDA in this case is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. See Oregon Laws 1995, ch 332, § 24(1)(a) (SB 369, § 24(1)(a)); OAR 438-09-020(1). Therefore, the parties' claim disposition agreement is approved. An attorney fee of $625, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

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[1] Nonetheless, the declaration unambiguously memorializes the parties' understanding that the insurer will not seek recovery of the over-payment from claimant.

In the Matter of the Compensation of
LARRY L. HINTON, JR., Claimant
Own Motion No. 95-0225M
OWN MOTION ORDER
Emmons, Kropp, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable right medial meniscus injury. Claimant's aggravation rights on that claim expired on June 2, 1982. SAIF opposes reopening on the ground that claimant was not in the work force when his compensable condition worsened requiring surgery.

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 a March 29, 1995 medical report, Dr. Steele, claimant's treating orthopedic surgeon, opined that, "[i]n spite of the [claimant's] young age at 38, I feel he has reached the point that he can no longer even do light walking and sedentary activity without having his surgery." In that report, Dr. Steele requested reopening of claimant's claim, and authorization to proceed with claimant's right knee joint replacement. Thus, we conclude that claimant's compensable injury worsened requiring surgery by at least March of 1995.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant has not returned to work since October of 1993. Claimant contends that he qualifies for temporary disability compensation because, although unemployed, he was seeking work and willing to work when his compensable condition worsened requiring surgery. Claimant has the burden of proof on this issue and must provide persuasive evidence to establish that he remained in the work force during the relevant time period.

Claimant submitted a copy of an application completed with SelectTemp on January 17, 1995. In that application, claimant listed his work history. From this work history, it appears that claimant has worked steadily from at least 1988 through August of 1994, when he was laid off from his employment. Furthermore, his application with SelectTemp persuades us that he was seeking work for which he qualified at the time his condition worsened

On this record, we conclude that claimant has established that he was willing to work, and seeking work when his compensable condition worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES H. JONES, Claimant
Own Motion No. 94-0166M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Coughlin, et al, Claimant Attorneys
Wausau Company, Insurance Carrier

Claimant requests review of the insurer's May 23, 1995 Notice of Closure which closed his claim with an award of temporary disability compensation from April 4, 1994 through May 7, 1995. The insurer declared claimant medically stationary as of May 7, 1995. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. In addition, claimant contends that his timeloss compensation was not properly calculated, that he is entitled to additional permanent partial disability, and that he is entitled to additional medical benefits, including physical therapy. We affirm the Notice of Closure.

FINDINGS OF FACT

Claimant sustained a compensable injury to his left knee in 1987. His aggravation rights expired September 20, 1993. In March 1994, Dr. Hessing, claimant's treating physician, requested authorization to perform a left knee arthroplasty. As a result of this request, the insurer recommended that the Board reopen claimant's claim under its "Own Motion" authority for payment of temporary disability benefits.

By order dated March 22, 1994, the Board authorized reopening of claimant's left knee injury claim. On April 22, 1994, claimant underwent the recommended surgery. On May 23, 1995, the insurer issued a Notice of Closure which found claimant medically stationary as of May 7, 1995 and awarded temporary disability benefits through that date. Thereafter, claimant requested review of the Notice of Closure.

In a July 24, 1995 letter, the Board requested that the insurer submit copies of materials considered in closing the claim. Upon submission of evidence by the insurer, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on July 28, 1995, however, no further response has been received from claimant.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

Claimant asserts that the May 23, 1995 Notice of Closure prematurely closed his claim. We disagree.

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-12-055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 23, 1995 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.

Claimant underwent left total knee arthroplasty on April 4, 1994. In a January 9, 1995 chart note, Dr. Hessing, claimant's treating orthopedic physician, opined that claimant's knee "appears to have excellent range of motion, with good quad strength." In addition, Dr. Hessing opined in that chart note that:

> "[d]espite [claimant's] complaints, I think the knee is serving him well and I have simply encouraged him to continue to exercise and strengthen his leg.
>
> "I do not see the need for continued physical therapy. I have suggested this be discontinued. He can certainly exercise on his own at home. I think through an individual exercise program, as well as a walking regimen, this knee should serve him just fine.

"I have asked him to return to see me in about three months. Hopefully at that time we can rate him as stable and finalize him."

In May 7, 1995 letter, Dr. Hessing, opined that "[c]ertainly at this time I do feel that he is stable..." Further, Dr. Hessing stated that "I last saw [claimant] in my office on January 9, 1995. He still complained of a fair amount of weakness and giving away of his knee, but overall I felt the knee was implanted well and I thought with time, he should continue to improve." Thus, it would appear that claimant did not return to see Dr. Hessing, but Dr. Hessing felt that his January 1995 assessment of claimant's knee was correct, and that he had no reason to believe claimant's knee was not medically stationary. Moreover, claimant has provided no medical evidence to rebut Dr. Hessing's opinion. Therefore, we find Dr. Hessing's opinion that claimant was medically "stable" by May 7, 1995 to be persuasive.

Based on the uncontroverted medical evidence, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper.

Calculation of Temporary Disability Benefits

Claimant contends that the insurer improperly calculated his temporary disability benefits. The insurer's response indicates that claimant's temporary disability benefits were calculated using the at-injury wage plus increases made up to the present time. Claimant offers no evidence or argument in support of his contention. Under these circumstances, claimant has not established that his temporary disability benefits were improperly calculated.

Permanent Disability

Claimant also contends that he is entitled to an award of permanent disability. We disagree. Because claimant's aggravation rights have expired, his claim is in own motion status. That means, although he is entitled to lifetime medical benefits related to his compensable injury, his only entitlement to future disability compensation is restricted to time loss benefits under limited circumstances. ORS 656.278(1)(a). Effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our own motion capacity. Independent Paper Stock v. Wincer, 100 Or App 625 (1990). Accordingly, we are not authorized to grant claimant's request.

Medical Services

Finally, claimant asserts that he is entitled to further medical benefits. As noted above, claimant is entitled to lifetime medical benefits related to his compensable injury. However, if there is a dispute between the parties concerning medical benefits, jurisdiction over such a dispute rests either with the Hearings Division or the Director, depending on the nature of the dispute. See ORS 656.245; 656.260; 656.327; 656.283. Consequently, the Board, under its own motion authority, lacks jurisdiction to resolve claimant's entitlement to further medical benefits.[1]

ORDER

The insurer's Notice of Closure, dated May 23, 1995, is affirmed.

IT IS SO ORDERED.

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[1] We note parenthetically, that the insurer's response indicates that it has not denied ongoing medical benefits and has paid for all such benefits that have been requested.

In the Matter of the Compensation of
SERAFIN MARTINEZ, Claimant
WCB Case Nos. 94-12183, 94-12184 & 94-04714
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order which set aside its denial of claimant's occupational disease claim for his right wrist Kienbock's disease. Claimant cross-requests review of that portion of the ALJ's order which upheld SAIF's denials of his injury claim for the same condition. On review, the issue is compensability.

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

The ALJ, relying on the opinion of a medical examiner, Dr. Weinam, found that claimant's Kienbock's disease was compensable as an occupational disease claim. In so doing, the ALJ disregarded the opinion of claimant's treating physician, Dr. Duncan.

On review, SAIF contends that the ALJ's conclusion is not supported by the record. Additionally, SAIF asserts that the opinion of Dr. Duncan is not persuasive because it was based on an inaccurate history. Specifically, SAIF alleges that claimant did not injure his wrist in the August 1992 work accident, as relied upon by Dr. Duncan.

Absent persuasive reasons to do otherwise, we generally give greater weight to the conclusions of the treating physician. Taylor v. SAIF, 75 Or App 583 (1985); Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to medical opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). However, considering the number of potential causative factors involving the onset of claimant's right wrist condition, we conclude that the issue of causation is a complex question requiring expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). We find no persuasive reasons to disregard the conclusions of claimant's treating physician, Dr. Duncan.

Here, the preponderance of the evidence shows that claimant injured his wrist in August 1992, when he fell off a scaffold at work. Claimant's wife testified that claimant complained of wrist problems and pain after the August 1992 work accident. (Tr. 27). Claimant attempted to participate in a bowling league after the August 1992 fall, but because of pain in his wrist, he had to quit. (Tr. 34). The employer testified that claimant wore a "bowling strap" because of wrist pain, but was unsure whether claimant began wearing the "strap" before or after the August 1992 industrial accident. (Tr. 16). Claimant testified that he began wearing the "strap" after the August 1992 work accident. (Tr. 33). Based on the testimony from claimant, as corroborated by his wife, we conclude that claimant's wrist was injured as a result of the August 1992 work accident.

Dr. Duncan opined that the cause of claimant's Kienbock's disease was claimant's August 1992 work accident, as well as the repetitive trauma he sustained while working in construction thereafter, including the November 1993 work accident. (Ex. 20, 35-2). Dr. Duncan's opinion was based on a complete and accurate history. Furthermore, Dr. Duncan has treated many patients for Kienbock's disease and opined that claimant's history is typical of many of his past patients. Specifically, Dr. Duncan stated that patients with Kienbock's disease typically do not seek immediate medical attention after a traumatic event initiates chronic pain in the wrist, because they believe that the injury will heal on its own. For this reason, according to Dr. Duncan, Kienbock's disease is often identified in its later stages, after the lunate bone has collapsed. Id.

Such is the history of claimant's Kienbock's condition. Claimant sustained a fall in August 1992. Although claimant experienced pain in his wrist, he did not seek immediate medical care for this condition. In November 1993, claimant slipped and fell at work, landing on his right wrist. Claimant's condition, at this time, was diagnosed as "end stage" Kienbock's disease and fracture of his lunate bone. (Exs. 10, 15, 16). Based on this history, Dr. Duncan opined that the cause of claimant's current Kienbock's condition was the result of the August 1992 accident, the November 1993 accident and his work activities. (Exs. 20, 35).

Therefore, we find Dr. Duncan's opinion persuasive because it was founded on his experience in working with patients who have Kienbock's disease, it was based on an accurate history, and was well reasoned. Consequently, we conclude that claimant's Kienbock's disease was caused by his work activities. Accordingly, claimant's condition is compensable as an occupational disease.[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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services regarding SAIF's request for review is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to SAIF's request for review (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee award for services devoted to his unsuccessful cross-request for review.

ORDER

The ALJ's order dated January 25, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by SAIF.

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[1] In reaching this conclusion, we reject claimant's contention that the ALJ erroneously neglected to set aside SAIF's injury claim. Based on Dr. Duncan's persuasive medical opinion, we find that the ALJ properly considered both of claimant's work injuries, as well as work exposures in determining whether they were the major contributing cause of his Kienbock's disease. See Stacy v. Corrections Division, 131 Or App 610, 614 (1994) (to establish that current condition was a new occupational disease, the ALJ properly required the claimant to prove that work activities after acceptance of mental stress claim were major contributing cause of current condition); Floyd D. Maugh, 45 Van Natta 442 (1993) (major contributing cause requires consideration of all possible causes of claimant's condition).

In the Matter of the Compensation of
CLARENCE R. PEYTON, Claimant
WCB Case Nos. 94-01143, 93-13187, 93-11578 & 93-10754
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant, pro se, requests review of those portions of Administrative Law Judge (ALJ) Livesley's order which: (1) upheld the SAIF Corporation's denial of claimant's consequential condition claim for a left shoulder condition; (2) and upheld Liberty Northwest's compensability and responsibility denials of claimant's "new injury/occupational disease" claim for the same condition. On review, claimant has submitted additional documents that were not admitted into evidence at the hearing. We treat such a request as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and compensability (potentially responsibility).

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

Claimant has submitted for our consideration on review a June 1, 1995 billing statement, an October 12, 1994 letter from Winton D. Miller and copies of some exhibits already admitted into evidence but with some hand-written comments on them. Since our review is limited to the record developed at hearing, we treat such a submission as a motion to remand. Judy A. Britton, supra.

We may remand a case to the ALJ for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). 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).

In this case, none of the proffered documents is likely to affect the outcome of the case. Moreover, we find no evidence that the letter that claimant has submitted was not obtainable prior to hearing with due diligence. For these reasons, we deny claimant's motion for remand.

On review, claimant contends that the ALJ erred in not finding that his left shoulder rotator cuff condition is related to his compensable 1984 crush injury to his chest, for which SAIF is responsible. The ALJ concluded that claimant had failed to prove that claimant's 1984 injury was the major contributing cause of his left rotator cuff tear, first diagnosed in 1993. See ORS 656.005(7)(a)(A).

In addition to the ALJ's reasoning, we find that claimant's current left rotator cuff condition is not compensable even if this condition was alleged to be a direct result of claimant's 1984 accident. In other words, even under a material causation standard, we find this claim not compensable. See Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992)

In his deposition, Dr. Versteeg, claimant's current attending physician, ruled out a causal relationship between claimant's 1984 injury and his current rotator cuff condition because claimant did not exhibit any rotator cuff symptoms in 1984 and 1985. (Ex. 140-22). In support of his claim, claimant cites a November 15, 1994 medical report from Dr. Grant, who treated claimant in 1989. Dr. Grant, however, stated that he could not render an opinion regarding the causation of claimant's left rotator cuff tear since he did not diagnose this condition. (Ex. 142).

Finally, claimant cites a May 10, 1989 medical report from another attending physician, Dr. Hall, who opined that all of claimant's "major symptoms" were "chiefly related" to the 1984 injury. However, we do not find this opinion persuasive with regard to establishing the compensability of claimant's current left rotator cuff tear, inasmuch as this condition was not diagnosed until 1993.

In conclusion, we agree with the ALJ that claimant failed to sustain his burden of proving the compensability of his left rotator cuff condition in relation to the compensable 1984 injury. Accordingly, we find that the ALJ properly upheld SAIF's denial of claimant's current left shoulder condition.

ORDER

The ALJ's order dated February 9, 1995 is affirmed.

In the Matter of the Compensation of
RICK A. WEBB, Claimant
WCB Case No. 94-14212
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order which set aside its denial of claimant's 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.

Inasmuch as we agree with the ALJ's reasoning and conclusion that claimant's compensable injury is the major contributing cause of his worsened condition, we need not address the question of whether the "material contributing cause standard" set forth in Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), is applicable under the 1995 statutory amendments. Accordingly, we conclude that claimant has proved a compensable aggravation claim.

The insurer notes that Senate Bill 369 amended ORS 656.273(3) to require that a claimant provide written notice of an aggravation claim in a form and format prescribed by the Director. Or Laws 1995, ch. 332, § 31 (SB 369, § 31). It contends that claimant's aggravation claim fails for lack of compliance with amended ORS 656.273(3).

We agree with the insurer that, pursuant to Section 66(1) of Senate Bill 369, the legislature intended that the amendments to ORS 656.273(3) be applied retroactively to cases already in litigation. Volk v. America West Airlines, 135 Or App 565 (1995) (retroactively applying amended ORS 656.386(2) pursuant to SB 369, § 66(1)). We, nevertheless, decline the insurer's request that we find claimant's aggravation claim not compensable for failure to comply with newly enacted procedural requirements that were not even in existence at the time of his aggravation claim.

In Ida M. Walker, 43 Van Natta 1402 (1991), we examined the issue of the retroactive application of 1990 amendments to workers' compensation law contained in Senate Bill 1197. In particular, we discussed the impact of Section 54 of Senate Bill 1197, which pertained to the effective date of that Act. We concluded that, examined as a whole, Section 54 expressed a strong statement by the legislature that it primarily intended the 1990 Act to apply retroactively to existing claims, with the exception of those "saved" by litigation or provided for in other sections.

In giving effect to that general legislative intent, however, we wrote in Walker that we must consider the nature of the statutory framework to which it is directed. We noted that the workers' compensation law creates a vast array of statutory rights and obligations that govern the conduct of injured workers, insurers, self-insured employers, medical and vocational providers and others. We emphasized that those governed by its provisions must conform their conduct to the law in effect at the time they act. We considered the unfairness of retroactively altering the rights and obligations of those who acted properly in reliance on the law in effect at the time of their actions to be obvious.

Accordingly, we held in Walker that a departure from the literal construction of Section 54 was justified when such construction would produce an "absurd or unjust" result and would clearly be inconsistent with the purposes and policies of the workers' compensation law.

As was the case with Section 54 of Senate Bill 1197, Section 66 of Senate Bill 369 also expresses a strong statement by the legislature that most of the 1995 amendments apply retroactively to existing claims, including those already in litigation and for which there is no final order or decision on or before the effective date of the Act. However, the same considerations that prompted us to depart from the literal construction of Section 54 of Senate Bill 1197 are equally applicable to Section 66 of Senate Bill 369. Accordingly, we will not apply the 1995 legislative amendments retroactively, even in the face of a clear expression of legislative intent, where such application will lead to an "unjust or absurd" result. Ida M. Walker, supra.

In this case, the insurer urges us to find this aggravation claim not compensable because claimant did not provide written notice of his aggravation claim in a form and format prescribed by the Director. However, such a holding would clearly be "absurd and unjust" when a Director's aggravation form was not even in existence at the time of claimant's aggravation claim. Moreover, the insurer has consistently litigated the merits of claimant's aggravation claim and has not heretofore raised an issue regarding notice of an aggravation claim. Under these circumstances, not only do we find retroactive application of amended ORS 656.273(3) to be absurd and unjust, but we also conclude that the interests of substantial justice would not be served by remanding this claim for compliance with the procedural requirements of that statute.

We recognize that we recently applied amendments to ORS 656.327(1) retroactively in concluding that the Director has exclusive jurisdiction over medical services disputes. Walter L. Keeney, 47 Van Natta 1328 (1995). In Keeney, we specifically concluded that retroactive application of ORS 656.327(1) would not bring about an absurd or unjust result because the parties could present their dispute to the Director, who was now unquestionably authorized to consider such matters. However, we explicitly recognized that, while it is fundamental that the clear unambiguous language of a statute controls, the courts will not apply a statutory provision if an application of the literal meaning would produce an unintended, absurd result or if the literal import of the words is so at variance with the apparent policy of the legislation as a whole as to bring about an unreasonable result. Walter L. Keeney, supra (citing Satterfield v. Satterfield, 292 Or 780 (1982), and Ida M. Walker, supra).

Here, in contrast to Keeney, the applicable statute is not jurisdictional. Review authority over this dispute remains with this forum. Moreover, unlike Keeney, retroactive application of amended ORS 656.273(3) to this case would clearly produce an absurd and unreasonable result by requiring claimant to have complied with notice procedures not even in existence at the time he filed his aggravation claim. Finally, consideration of this procedural challenge to claimant's aggravation claim would be particularly unwarranted since the insurer has consistently disputed the merits of the claim.

Under the circumstances of this case, we find a reasonable basis for departing from a literal reading of Section 66 of Senate Bill 369. Therefore, we decline to retroactively apply the procedural requirements of ORS 656.273(3) in the manner that the insurer suggests.[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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the aggravation issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 14, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, payable by the insurer.

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[1] In reaching this conclusion, we are mindful of Volk v. America West Airlines, supra. There, the court retroactively applied amendments to ORS 656.386(2) in holding that it is impermissible to require that "out-of-compensation" attorney fees be paid from any other source than the claimant's compensation. However, we do not construe the court's holding in that case as requiring retroactive application of amendments contained in Senate Bill 369 where, as in this case, such application would produce obviously absurd and unjust results.

In the Matter of the Compensation of
CARL E. AUSTIN, Claimant
WCB Case No. 93-13406
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's injury claim for a lumbar herniated disk. On review, the issue is compensability.

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

The ALJ found that claimant and his co-worker were credible witnesses based on their appearance and demeanor. Since claimant has a preexisting low back condition, the ALJ found that he must prove that the work incident was the major contributing cause of the disk herniation. See ORS 656.005(7)(a)(B).[1] The ALJ relied on Dr. Adams' opinion to conclude that claimant had established the compensability of his June 1, 1993 injury.

The insurer contends that claimant was not a credible witness and asserts that his testimony at hearing was evasive and inaccurate. The insurer argues that if claimant had injured himself on June 1, 1993, as he said, he would have reported the incident to Dr. Richardson when he saw him two days later.

Although not statutorily required, the Board generally defers to the ALJ's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Since the ALJ's credibility finding was based in part upon the observation of claimant's and the co-worker's appearance and demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990). However, 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).

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[1] We do not address the applicability of the 1995 amendments to ORS 656.005(7)(a)(B) in this case since it would not affect our decision.

At hearing, claimant testified that he injured his back at work on June 1, 1993, when he picked up some metal tubes with a co-worker. Claimant said that his "back started with like a sharp pain and then it quit real quick like -- like if somebody shot you in the back with Novocain and it just numbed it so I never thought anything about it." (Tr. 11). Claimant described the pain "like somebody stabbed you with an ice pick." (Tr. 22). He indicated that the pain after the June 1, 1993 incident was not only in his buttocks, but in his right leg, down to his toes. (Tr. 14, 15). However, since the pain went away, he thought that would be the end of it and he forgot to fill out an injury form. (Id.) Claimant did not really notice his back again until he was at the Hult Center on June 5, 1993 and he noticed that the pain started going down his buttocks and then down his leg. (Tr. 11).

Claimant's co-worker testified that he remembered the lifting incident, although he did not remember the date it occurred. (Tr. 26). The co-worker testified that claimant told him he had hurt his back and did not want to pick up the tube any more. (Tr. 28). They leaned the pipe against the shed and did not move it further. (Tr. 28, 31). Later that day, the co-worker asked claimant how his back was and claimant said that it was better. (Tr. 28). The co-worker recalled that claimant's back got worse during the summer. (Tr. 29).

In light of claimant's testimony that the back pain after the lifting incident went away and did not recur until June 5, 1993, we do not agree with the insurer that claimant's failure to report the incident to Dr. Richardson on June 3, 1993 indicates that he did not injure himself on June 1, 1993. Moreover, Dr. Adams testified that with a disk herniation, "it's not unusual sometimes that you will see them the first time, they will not have a positive neurological finding." (Ex. 12-20). He said that it was very common for a person with a herniated disk to have a normal neurologic exam during the first exam and then during subsequent visits they can have a neurologic finding. (Ex. 12-19).

Claimant acknowledged that he did not remember all of his visits to previous doctors at hearing. Although claimant did not recall many details of his medical treatment, we find that the history in the medical records is not inconsistent with his testimony. Inconsistent statements related to collateral matters are not sufficient to defeat claimant's claim where, as here, the record as a whole supports his testimony. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985). We agree with the ALJ that claimant and his co-worker were credible witnesses.

The insurer contends that claimant never reported the alleged work incident to Dr. Adams and it argues that the history provided to Dr. Adams proved to be inaccurate. According to the insurer, Dr. Adams based his causation opinion on the assumption that claimant's pains began on June 1, 1993 and progressed thereafter. The insurer argues that Dr. Adams did not base his causation opinion on a history of about 2 minutes of pain from the work incident, 4 days without pain, and then an onset of pain at the Hult Center.

Dr. Adams was provided with copies of claimant's prior medical records on September 12, 1994. (Ex. 11). In a concurrence letter from claimant's attorney, Dr. Adams agreed that the "herniated disc [was] caused by the lifting incident described by [claimant] on June 1, 1993." (Id.) In that letter, claimant's attorney provided the following history:

> "[F]or purposes of your opinion, we asked you to assume that [claimant's] history is true in that on June 1, 1993, when lifting and setting down an 84 lb. air tube (pipe) he felt a sharp pain and then numbness in his back, right buttocks and right leg. By Friday of that week, he had extreme pain in his right buttocks and right leg." (Id.)

After the hearing, the parties deposed Dr. Adams. Dr. Adams testified that his understanding was that claimant's pain had continued and progressed between the work incident and the time when he went to the Hult Center on June 5, 1993. (Ex. 12-7). However, Dr. Adams was asked whether he would change his opinion if claimant "had complained after the lifting incident about two minutes of pain that went away and then did not again recur until he was in the Hult Center." (Ex. 12-8). Dr. Adams replied:

> "Not necessarily. We do see people who have, they do something, they have a twinge or a pop or something and they don't attribute too much to it and few days later, it will start getting progressively more painful so that history doesn't bother me too much, no." (Id.)

Dr. Adams acknowledged that he did not have an accurate history of the work incident at his initial examination of claimant. (Ex. 12-8). However, since Dr. Adams was subsequently informed about the work incident and the later recurrence of claimant's back symptoms, we find that he had an accurate history. Moreover, Dr. Adams' opinion on causation did not change after he was informed that claimant had two minutes of pain after the lifting incident and the pain did not again recur until he was in the Hult Center.

The insurer also argues that the pre-incident findings of right hip pain is a possible cause of claimant's herniated disk. We disagree.

Claimant was treated for pain in his right buttock before the June 1, 1993 work incident. (Ex. 1). When asked about the prior treatment, Dr. Adams testified that the right back and right buttocks pain can be so nonspecific that it would not change his opinion about the work incident. (Ex. 12-10). Based on pain in the buttocks and back, Dr. Adams could not say that there was a disk rupture without more physical findings. (Ex. 12-16). Dr. Adams would expect claimant to have "more radicular component or more pain radiating down the leg rather than just in the buttocks." (Id.)

We are persuaded by Dr. Adams' opinion that the June 1, 1993 lifting injury was the major contributing cause of claimant's herniated disc. There are no contrary medical opinions. Accordingly, we agree with the ALJ that the claim is compensable.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). 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 $ 1,000, 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 9, 1995 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $1,000, payable by the insurer.

August 31, 1995 Cite as 47 Van Natta 1554 (1995)

In the Matter of the Compensation of
AUDREY F. CLARK, Claimant
WCB Case No. 93-12680
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a right upper extremity condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the employer since 1987. Claimant first worked primarily as a potato trimmer. In 1988, the employer began rotating its employees so that no one performed one task for more than two hours at a time. In 1989, claimant's primary job was in raw storage, and she performed only limited trimming. In 1990, she worked in housekeeping for one year. In 1991, claimant returned to rotating amongst the various departments, including potato trimming.

Claimant alleges that she began experiencing symptoms in her right neck, shoulder and arm in 1989. The ALJ found that claimant failed to prove that any right upper extremity conditions were caused by her work activities. Claimant asserts that there is sufficient medical evidence establishing that her work activities were the major contributing cause of her condition.

The record contains numerous medical opinions. Dr. Eisler, consulting neurologist, first diagnosed an overuse syndrome in the right neck and shoulder. (Ex. 42). He subsequently concurred with a "check-the-box" report drafted by the employer's attorney stating that there was evidence that a lifting incident involving claimant's mother precipitated her symptoms; that such an event was "significant"; and that, in light of such a history, he could not state that work activities were the major contributing cause of claimant's condition. (Ex. 55A).

Examining physicians Dr. Wilson, neurologist, and Dr. Burr, orthopedic surgeon, reported nonorganic pain findings that were unrelated to claimant's work. (Ex. 57-4).

Dr. Grimm, consulting neurologist, found "severe, chronic, repetitive motion or accumulative trauma disorder of the soft connective tissues of the right upper extremity," attributing the condition to claimant's work activities. (Ex. 61-4). Dr. Grimm relied on a history that claimant performed only potato trimming from 1987 through March 1993. (Id. at 2).

Treating physician Dr. Grewe, neurosurgeon, first diagnosed intermittent carpal tunnel syndrome secondary to industrial overuse, as well as degenerative joint disease in the right shoulder. (Ex. 56). He found that work activities were the major contributing cause. (Id.)

During a deposition, Dr. Grewe further explained that claimant's symptoms had several possible contributors, including cervical nerve root compression and carpal tunnel syndrome. (Ex. 61-27). Dr. Grewe also thought that claimant had a right frozen shoulder caused by disuse; he further stated that the disuse resulted from pain caused by cervical nerve root compression or carpal tunnel syndrome. (Id.) Although he stated that all three conditions were in major part caused by claimant's work, (id. at 38), Dr. Grewe also indicated that he did not know if claimant's work could cause the neck symptoms since such a condition was caused by lifting and carrying. (Id. at 43). Dr. Grewe also agreed that some of claimant's symptoms were nonatomical. (Id. at 22).

Finally, examining physician Dr. Peterson, neurologist, diagnosed a probable right carpal tunnel syndrome, right frozen shoulder, multilevel cervical degenerative disc disease, and strongly suspected somatoform disorder. (Ex. 65-12). With regard to causation, Dr. Peterson indicated that the cervical condition was preexisting and that work activities had not contributed to it. (Id. at 14). Dr. Peterson found the shoulder condition to be multifactorial, attributing it to possible trauma, work activities, and disuse. (Id. at 17). Dr. Peterson thought that further treatment and time was needed to determine the cause of the right arm condition; possible causes were the right shoulder condition and carpal tunnel syndrome. (Id. at 18). According to Dr. Peterson, if claimant had carpal tunnel syndrome, her work activities could be a material contributing cause, although Dr. Peterson expressed concern that claimant's symptoms had not abated while she was off work. (Id. at 19). Finally, Dr. Peterson attributed at least a portion of claimant's symptoms to somatoform disorder. (Id.)

We first note that, because claimant did not constantly perform potato trimming work from 1987, Dr. Grimm relied on an inaccurate history. Thus, we find his opinion unpersuasive. See Somers v. SAIF, 86 Or App 256 (1986).

Although Dr. Grewe at one point indicated that claimant's entire upper extremity condition was in major part caused by her work, a close examination of his opinion does not support such a statement. With regard to the neck, Dr. Grewe agreed that claimant's work was not consistent in causing such a condition; he also stated that claimant's frozen shoulder could be caused by carpal tunnel syndrome or cervical nerve root compression. Given this posture of Dr. Grewe's opinion, we understand him as stating that the neck condition was not caused by claimant's work and the frozen shoulder was only possibly a consequential condition of carpal tunnel syndrome.

Thus, even based on Dr. Grewe's opinion, we find insufficient proof that claimant's work activities were the major contributing cause of her neck and shoulder conditions. At best, Dr. Grewe's opinion showed only that her work caused a right carpal tunnel syndrome. For the following reasons, however, we do not find that opinion persuasive.

First, Dr. Grewe relied on a history that claimant's symptoms improved when she was not working, then increased with a return to work. (Ex. 64-13). As noted by the ALJ, claimant's symptoms did not improve while off work. Furthermore, like Dr. Grimm, Dr. Grewe apparently understood that claimant's work consisted of trimming potatoes all day with little rotation to other jobs. (Ex. 64-10). Thus, Dr. Grewe also relied on an inaccurate history, rendering his opinion less persuasive. Finally, Dr. Peterson provided persuasive reasoning concerning the multiple factors for claimant's right arm symptoms, including somatoform disorder.

Consequently, we conclude that claimant failed to prove that her work activities were the major contributing cause of her upper extremity condition. ORS 656.802(2)(a).

ORDER

The ALJ's order dated January 4, 1995 is affirmed.

In the Matter of the Compensation of
THEODORE A. COMBS, Claimant
WCB Case No. 94-13160
ORDER ON REVIEW
Heather Holt, Claimant Attorney
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Neidig, Turner-Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of claimant's right 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 modification and supplementation.

On September 6, 1994, claimant and several other employees and the employer's director were waiting for transportation to a recreational, employer-sponsored retreat. The employer's business was closed that day. Some of the employees were "shooting hoops" on a basketball court adjacent to the employer's premises.[1] No one was required to play basketball or to attend the retreat. The director eventually organized the players, including claimant and himself, into teams, and a game ensued. The director did not order anyone to play basketball. Claimant was playing basketball to "kill time" until transportation arrived; he was not paid for this activity. Claimant fell and injured his right hip shortly thereafter.

CONCLUSIONS OF LAW AND OPINION

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

The ALJ concluded that, because claimant's injury occurred while he was engaged in recreational activity primarily for personal pleasure, ORS 656.005(7)(b)(B), his claim is not compensable. We agree.

"'Compensable injury" does not include * * * [i]njury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure." ORS 656.005(7)(b)(B). On this record, we find that claimant's hip injury occurred while he was playing basketball primarily for his own personal pleasure.[2]

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[1] The ALJ found that the game occurred on the employer's premises. (Opinion and Order at 1). The employer's director testified that the game occurred on city property near the employer's entrance. (Tr. 20). Hence, we find that the game took place adjacent to the employer's premises. SAIF does not assert that claimant's injury is non-compensable because it occurred off the employer's premises; accordingly, we do not address that issue.

[2] The dissent asserts that the employer has the burden of proof in this case. Because we would conclude that claimant's claim is not compensable under ORS 656.005(7)(b)(B) regardless of which party has the burden of proof, we need not address that assertion.

Shortly before claimant was injured, several of his co-workers were "shooting hoops" while waiting for transportation to a recreational, employer-sponsored retreat; the employer's business was closed that day. The employer's director organized the players into teams, but no one was required to play.[3] Claimant was playing ball to "kill time"; he was not paid for that activity. There is no persuasive evidence that the employer derived any particular benefit from the basketball game. Cf. Ester E. Edwards, 45 Van Natta 1065 (1992) (injury incurred during an employer-sponsored volleyball game found compensable, because game's primary purpose was to enhance interoffice relationships). On these facts, we agree with the ALJ that claimant was playing basketball primarily for his own personal pleasure. See Elias Gonzalez, 46 Van Natta 439 (1994) (although employer initiated ball game, in light of fact that no one was required to play and claimant's testimony that he played because he enjoyed the game, claim not compensable).

Claimant asserts that, because the basketball game occurred while he was awaiting transportation to an employer-sponsored retreat, and because one of the purposes of the retreat was to give workers the opportunity to resolve any differences they had with each other, the game had a close work-connection and, therefore, did not occur primarily for the workers' personal pleasure. We disagree. The retreat was a voluntary, recreational event. Even if one of its purposes was to improve employee work relationships, there is insufficient evidence that the basketball game -- which was not, per se, part of the retreat -- was intended to have the same effect. See Ester E. Edwards, supra. Therefore, for the reasons stated above, we continue to find that claimant participated in the basketball game primarily for his own personal pleasure.

Last, claimant asserts that, under Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985), his claim is compensable. Because we have found this claim not compensable under ORS 656.005(7)(b)(B), we need not address that argument. As an aside, however, we note that the Court of Appeals' has counseled that, in view of Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), Mellis should no longer be used as an independent and dispositive work connection test. First Interstate Bank of Oregon v. Clark, 133 Or App 712, 717 (1995).

In sum, for the reasons stated in the ALJ's order, as supplemented here, we conclude that claimant's claim is not compensable. Accordingly, we affirm the ALJ's decision upholding SAIF's denial.

ORDER

The ALJ's order dated January 30, 1995 is affirmed.

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[3] Claimant testified that the director "ordered" him and the other employees to play. (Tr. 10). The director refuted that testimony, stating that he did not recall ever ordering anyone to play ball and that, at most, he organized the employees into teams. (See Tr. 18). We agree with the ALJ that the director's version is more persuasive.

Board Member Gunn dissenting.

The majority concludes that claimant's injury is barred by the statutory exclusion set forth at ORS 656.005(7)(b)(B). Because I disagree with the majority's reasoning and conclusion, I dissent.

The SAIF Corporation asserts that claimant's injury occurred during recreational activity primarily for his personal pleasure. As the proponent of that fact, SAIF has the burden of proof. Juan M. Zurita, 46 Van Natta 993, 994 (1994) (Member Gunn, dissenting); see Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1980) (burden of proof lies with "the party having the affirmative of any given issue").

Here, several workers were "shooting hoops" while waiting to attend an employer-sponsored retreat. The employer's director organized the workers into teams, and a game ensued. During the game, claimant fell and injured his right hip.

On those facts, I am unable to find that claimant played basketball primarily for his own pleasure. The employer, through its director, facilitated and encouraged the injurious activity. Further, gainsaying the majority's conclusion, I believe that the employer realized significant benefits from

claimant's basketball play: The workers played basketball while awaiting an employer-sponsored[1] retreat that was designed, in part, to enable the workers to improve their relationships with each other. Surely, pre-retreat recreational activities had the same purpose, and afforded the employer the benefits of improved relationships among its work force.[2]

Under these circumstances, SAIF has not carried its burden of proving that claimant played basketball primarily for personal pleasure. Accordingly, I would find that claimant's injury does not fall within the statutory exclusion set forth at ORS 656.005(7)(b)(B).

Having found no statutory bar to compensability, I would further conclude that the connection between the basketball game and claimant's work is sufficient to establish compensability under the work-connection test set forth in Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994). Under the Norpac test, claimant must show that his injury: (1) occurred "in the course of employment," which concerns the time, place and circumstances of the injury; and (2) "arose out of employment," which concerns the causal connection between the injury and the employment. Id. at 366.

Here, claimant's injury occurred on premises under the employer's control, and the injury was connected to claimant's employment, albeit by virtue of activities associated with a work-related retreat. That is sufficient to satisfy both prongs of the Norpac test.

For these reasons, I would reverse the ALJ's decision and set aside SAIF's denial of claimant's right hip injury. Because the majority concludes otherwise, I dissent.

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[1] The majority makes much of the recreational nature of the retreat, discounting the fact that it was an employer-sponsored event.

[2] It is also generally recognized that this type of physical exercise promotes productivity by alleviating worker tension and stress. Juan M. Zurita, supra, 46 Van Natta at 994 (Member Gunn, dissenting).

In the Matter of the Compensation of
JUDY A. DANIELSON, Claimant
WCB Case No. 95-00657
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
James D. Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that awarded claimant an insurer-paid attorney fee under former ORS 656.386(1) for causing the SAIF Corporation to amend its Notice of Acceptance to include her right knee condition. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

Claimant filed a claim for a mid-back and right knee injury which occurred on October 9, 1993. SAIF denied the claim on November 15, 1993, but, in an April 13, 1994 Opinion and Order, a prior ALJ found that claimant had injured her thoracic spine and right knee in the course and scope of her employment. The ALJ set aside SAIF's denial and ordered it to accept and process the thoracic and right knee claim.

On April 18, 1994, SAIF wrote claimant and advised her in part:

> "Your claim has been accepted for the following condition(s) resulting from your injury of October 9, 1993: thoracic strain. We accept responsibility only for the condition(s) specified above. If you feel that your claim should also cover other conditions, contact SAIF Corporation within 10 days of the date on this notice. Otherwise, we will assume the contents of this notice are correct." (Ex. 7, emphasis added).

On April 21, 1994, SAIF wrote claimant's attending physician, Dr. King, that it "has now accepted [claimant's] claim for thoracic and right knee strain/contusion." (Ex. 8, emphasis added). SAIF further requested that Dr. King perform a complete closing examination of the injured knee and report any objective permanent impairment resulting from the "accepted condition only."

SAIF closed the claim on May 6, 1994 by Notice of Closure which awarded temporary, but no permanent, disability. Claimant subsequently requested a hearing on January 12, 1995, alleging entitlement to penalties and attorney fees for a "de facto" denial.

On January 25, 1995, SAIF's claims adjuster wrote claimant advising him that SAIF was accepting a right knee strain in addition to the thoracic strain it had accepted on April 18, 1994. (Ex. 10). The letter also referenced the "April 14 [sic], 1994" Opinion and Order which had ordered SAIF to accept claimant's thoracic and right knee conditions. The adjuster asserted that the April 18, 1994 acceptance letter had omitted claimant's right knee strain by reason of a "clerical error." SAIF's letter stated that the "intent" had been to accept both conditions as ordered.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant contended that she was entitled to an assessed attorney fee for obtaining SAIF's formal acceptance of her right knee condition. The ALJ agreed, reasoning that an attorney fee was appropriate when claimant's hearing request had prompted SAIF's formal acceptance of claimant's right knee condition.

On review, SAIF contends that, as a result of amendments to ORS 656.262(6)(d) contained in Senate Bill 369, there was no "de facto" denial of claimant's right knee condition and, further, because of amendments to ORS 656.386(1), claimant is not entitled to an assessed attorney fee. SAIF also asserts that amended ORS 656.386(1) has effectively overruled our decision in Wesley R. Craddock, 46 Van Natta 713 (1994), and that Craddock is factually distinguishable.

We need not determine whether the amendments to ORS 656.262(6)(d) and 656.386(1) apply retroactively to this claim and, if so, whether they would change the result as SAIF contends. We agree with SAIF that Craddock is distinguishable and conclude for the following reasons that claimant's counsel is not entitled to an assessed attorney fee in this case even under the law in effect prior to Senate Bill 369.[1]

The facts of Craddock are similar to those in this case. There, the claimant sustained a compensable injury on July 27, 1992, involving multiple injuries to his head and body. Numerous diagnoses were subsequently made. The carrier wrote the claimant on October 22, 1992 and advised that the claim would be accepted for certain listed conditions. The Notice of Acceptance specifically stated that "we accept the responsibility only for the conditions specified above. If you feel that your claim should also cover other conditions, contact [the carrier] within 10 days of the date on this notice."

On April 15, 1993, the claimant requested a hearing, raising the issue of "de facto" denial and penalties for the carrier's failure to provide a notice of acceptance for all of the claimant's diagnosed conditions resulting from his industrial injury. On May 27, 1993, the carrier wrote the claimant's attorney that, although it was true that the carrier had not accepted all of the claimant's conditions in writing, all of them had been accepted. Further, the claimant was advised that all benefits had been paid. On the day before the hearing, the carrier formally amended its acceptance to include all of the claimant's conditions diagnosed as a result of his compensable injury.

We found, as a factual determination, that the carrier denied the compensability of the conditions for which the claimant's counsel was instrumental in obtaining acceptance. We reasoned that

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[1] Pursuant to amended ORS 656.386(1), a claimant is entitled to a carrier-paid attorney fee for prevailing over a "denied claim," which is defined as a claim for compensation for which a carrier refuses to pay on the express ground that the claimed injury or condition is not compensable or otherwise does not give rise to an entitlement to compensation. Moreover, the amended statute provides that a "denied claim" shall not be presumed or implied from a carrier's failure to pay compensation for a previously accepted injury or condition in timely fashion. In light of these provisions, this record would not support claimant's entitlement to a carrier-paid attorney fee award.

the best evidence of the carrier's intentions was contained in its initial acceptance letter. There, the carrier specifically limited its acceptance to the conditions listed in the letter. Although the carrier later contended that it initially accepted all conditions resulting from the claimant's injury, we were more persuaded by the express language of its initial acceptance letter than the carrier's subsequent assertions.

Therefore, we affirmed the ALJ's finding that the carrier had denied "de facto" the conditions that it formally accepted the day before the hearing. In addition, we concluded that, inasmuch as causation was at issue until the carrier "rescinded" its "de facto" denial and amended its acceptance the day before the hearing, the ALJ appropriately awarded an assessed attorney fee under former ORS 656.386(1).

Like Craddock, SAIF in this case issued an acceptance letter that specifically limited the accepted condition to that mentioned in the letter. Moreover, as was also true in Craddock, SAIF did not formally amend its acceptance in this case until after claimant had filed a request for hearing. However, we find that this case differs from Craddock in important respects.

First, in contrast to Craddock, an ALJ in this case ordered SAIF to accept and process both the thoracic and right knee conditions just prior to SAIF's "acceptance." SAIF, having once denied those conditions and having been ordered to accept them, could not deny them again. Knapp v. Weyerhaeuser, 93 Or App 670, 673 (1988), rev den 307 Or 326 (1989). Second, just a few days after issuing its "acceptance," SAIF stated in its letter to Dr. King that it had "accepted" the claim for both the thoracic and right knee conditions. In fact, SAIF specifically requested that Dr. King perform a closing evaluation and report permanent impairment regarding the "accepted" right knee condition. SAIF did not take similar action in Craddock.

While we agree with our observation in Craddock that the language of an acceptance letter is generally the best evidence of a carrier's intentions, the particular circumstances of this claim lend considerable credence to SAIF's claim that its omission of claimant's right knee condition in its initial acceptance letter was an inadvertent mistake owing to clerical error. Considering the totality of record in this case, we conclude that SAIF did not deny claimant's right knee condition "de facto." Therefore, we reverse the ALJ's decision that claimant's counsel was entitled to an assessed attorney fee under the law in effect prior to Senate Bill 369.

ORDER

The ALJ's order dated April 25, 1995 is reversed.

In the Matter of the Compensation of
DEAN V. HENNESSY, Claimant
WCB Case No. 93-13739
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys
Willner & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Dr. Belhumeur, claimant's medical services provider, requests review of Administrative Law Judge (ALJ) Hoguet's order that affirmed a Director's order finding that claimant's videofluoroscopy examinations were inappropriate. On review, the issues are jurisdiction and, alternatively, medical services. We vacate the ALJ's order and dismiss Dr. Belhumeur's hearing request.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We republish the relevant findings of fact from our previous order, Dean V. Hennessy, 46 Van Natta 2492 (1994), and supplement with additional facts.

Dr. Belhumeur sought reimbursment for videofluoroscopy (VF) examinations provided to claimant. On July 17, 1991, the insurer petitioned the Director for relief from paying for VF evaluations by Dr. Belhumeur on the basis that they were unnecessary. On October 21, 1993, the Director issued an order finding that the use of VF was not appropriate and ordering the insurer not to reimburse Dr. Belhumeur. Dr. Belhumeur appealed the order to the Hearings Division. The ALJ set aside the Director's order, permitting the parties to request the Director to reopen the case in order to consider the Oregon Board of Chiropractic Examiners protocol (Oregon Protocol) for the use of VF. Dr. Belhumeur requested Board review of the ALJ's order.

On previous review, we concluded that the ALJ was not limited to the record developed by the Director. Because the parties and the ALJ proceeded under the erroneous belief that the ALJ's review was limited to the record developed by the Director, we found there was a compelling reason to remand the matter to the ALJ. Dean V. Hennessy, supra.

On remand, the ALJ asked the parties how they wished to proceed and the parties agreed he should render a decision on the merits based on the record developed at hearing. The ALJ concluded that the Director's order was supported by substantial evidence and affirmed the Director's order. Dr. Belhumeur requested Board review.

On review, Dr. Belhumeur contends that the ALJ should have reviewed the case on the merits, rather than applying the "substantial evidence" rule. Alternatively, Dr. Belhumeur argues that the ALJ should have remanded this case to the Director for reconsideration on the basis of all the evidence, including that which was not considered the first time.

After the ALJ's order, the legislature enacted Senate Bill 369 and amended ORS 656.327 and ORS 656.245, effective June 7, 1995. The legislature amended ORS 656.327(1), which now provides that if an injured worker, a carrier, or the Director believes that an injured worker's medical services, not subject to ORS 656.260, are excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." (Emphasis added). Or Laws 1995, ch. 332, § 41(1) (SB 369, § 41(1)). The legislature also added ORS 656.245(6), which provides that, if a medical services claim is disapproved for any reason other than the formal denial of compensability of the underlying claim and the disapproval is disputed, the injured worker or carrier "shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327." (Emphasis added). Or Laws 1995, ch. 332, § 25(6) (SB 369, § 25(6)).

In Walter L. Keeney, 47 Van Natta 1387 (1995), we concluded that the amendments to ORS 656.327, as well as the new provision, ORS 656.245(6), apply to claims currently pending before the Board. We held that the language of ORS 656.327(1) and ORS 656.245(6) clearly revealed the legislature's intent that medical services disputes be resolved exclusively by the Director, not the Board or Hearings Division. Accordingly, based on the text and context of amended ORS 656.327(1), as read in conjunction with SB 369's retroactivity provisions, we concluded that the Director has exclusive jurisdiction over ORS 656.327(1) medical services disputes, including those presently pending before the Board.[1]

Here, the medical service dispute does not pertain to the compensability of claimant's underlying claim. Rather, the issue involves reimbursement for medical services. Because jurisdiction over this matter rests with the Director, rather than the Hearings Division, we vacate the ALJ's order.[2]

ORDER

The ALJ's order dated February 14, 1995 is vacated. Dr. Belhumeur's request for hearing is dismissed for lack of jurisdiction.

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[1] Member Hall is bound by the principles of stare decisis to apply the holding of Walter L. Keeney, supra, but directs the parties to his dissenting opinion in that case.

[2] We recognize that this matter was appealed by a medical service provider. Amended ORS 656.327(2) authorizes a worker, carrier or medical service provider dissatisfied by a Director's order to request a contested case hearing before the Director. Or Laws 1995, ch. 332, § 41(2) (SB 369, § 41(2)). We do not address the effect of that provision, because the precise issue before us concerns the ALJ's jurisdiction to address this matter in the first instance. Any issues regarding amended ORS 656.327(2) must be resolved by the Director.

In the Matter of the Compensation of
HEIDI M. IMFELD, Claimant
WCB Case Nos. 93-12054 & 93-12053
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Turner-Christian.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that upheld the insurer's denial of her occupational disease claim for lead poisoning and lead induced porphyria. On review, the issue is compensability.

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

The ALJ concluded that claimant failed to establish by a preponderance of evidence that she has a compensable occupational disease. Specifically, the ALJ determined that, even if claimant proved that she had enzyme deficiencies as a result of her lead exposure at work, she failed to establish that the deficiencies resulted in symptoms that required treatment or disability.

On review, claimant contends the ALJ erred in relying on the opinion of Dr. Loriaux, who examined claimant at the insurer's request, over that of claimant's treating physician, Dr. Morton. We disagree. Like the ALJ, we find Dr. Morton's opinion speculative and conclusory, and the contrary opinion of Dr. Loriaux thorough and well-reasoned.

For example, Dr. Morton's diagnosis of lead induced "mixed porphyria" for claimant's various symptoms after 1988 (primarily headaches, joint and muscle pain, cramping and alternating constipation and diarrhea) is based solely on the results of unproven blood porphyrin tests performed in 1993 which indicated that claimant was deficient in three enzymes. Dr. Morton opined that, although one of claimant's low enzyme levels was probably genetic (because her sister showed the same deficiency), her deficiency in the other two enzyme levels are attributable to lead exposure at work. However, we do not find Dr. Morton's opinion persuasive because it fails to meaningfully address (assuming the Mayo Clinic enzyme tests were completely accurate) how claimant's enzyme deficiency resulted in her various symptoms without causing any evident biochemical or metabolic effect on claimant's system.

Dr. Loriaux, who has been involved in the study of porphyria for more than 25 years, opined that even assuming the blood enzyme tests were accurate, claimant does not have any of the known porphyrias because she has not exhibited any clinically significant symptoms and has not shown any metabolic or biochemical evidence of the disease (i.e., her urine and fecal tests were normal). Dr. Loriaux explained that the clinical manifestations of porphyria are generally skin rashes and acute neurological disorders (such as paralysis, psychosis, and altered mentation) and the biochemical manifestations are elevated levels of the relevant porphyrin metabolites in the patient's feces and/or urine. Dr. Loriaux concluded that, in the absence of an altered pattern of metabolism (including elevated levels of porphobilinogen, amniolevulinic acid or coproporphyrin in her urine or feces), the various symptoms of which claimant is complaining could not be attributed to either a genetic or a lead-induced porphyria.

As to claimant's claim that her work exposure to lead between 1986 and 1988 caused lead poisoning which resulted in the symptoms for which she sought treatment, like the ALJ, we are more persuaded by the opinion of Dr. Burton, who reported that claimant's blood levels were not sufficiently high to cause toxicity that could explain her symptoms. Dr. Burton explained that claimant's complaints and symptoms during that time did not correlate with her blood level tests and were not compatible with lead poisoning.

Claimant also challenges the panel's assignment of "chronic depression" as the non-industrial explanation of claimant's symptoms in light of Dr. Pavaresh's diagnosis of a "somatoform disorder" not related to depression. However, we need not address the distinctions between these two psychological diagnoses in this case. Since we are persuaded by Dr. Loriaux and the rest of the panel's opinion that

claimant's symptoms are not the result of lead poisoning and lead induced mixed porphyria, we conclude that claimant has not proven that her employment activities were the major contributing cause of her condition. Amended ORS 656.802(2).[1]

ORDER

The ALJ's order dated January 4, 1995 is affirmed.

[1] Because claimant's occupational disease claim would fail under either version of the statute, we need not determine which statute is applicable.

August 31, 1995 Cite as 47 Van Natta 1563 (1995)

In the Matter of the Compensation of
JAMES M. KING, Claimant
WCB Case No. 92-12157
SECOND ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Carrol J. Smith (Saif)

On June 27, 1995, we abated our June 19, 1995 Order on Remand which set aside the SAIF Corporation's denial of claimant's coronary artery disease and remanded the claim to SAIF for processing according to law. We took this action to consider claimant's request for an assessed attorney fee. On June 29, 1995, we issued a Second Order of Abatement in order to consider SAIF's contention that its denial should be reinstated pursuant to certain statutory amendments contained in Senate Bill 369. Having received the parties' responses, and after further consideration of the matter, we issue the following order.

We begin with a brief summary of the relevant facts. In 1977, claimant suffered a heart attack which was found compensable by a prior Administrative Law Judge (ALJ). At that time, coronary artery disease was also diagnosed. In 1988, claimant suffered a second heart attack for which he filed a claim. SAIF denied claimant's claim as well as denying his preexisting coronary artery disease. SAIF's denial was set aside in its "entirety" by a prior ALJ whose order became final.

In 1992, SAIF issued a denial of claimant's coronary artery disease which is the subject of the present litigation. Finding that SAIF was precluded from denying claimant's coronary artery disease, the ALJ set aside SAIF's denial. On review, we concluded that SAIF was not precluded from issuing its denial and on the merits found that claimant's coronary artery disease was not compensable. James M. King, 46 Van Natta 1281 (1994). Thereafter, claimant requested judicial review.

Noting that SAIF had failed to appeal the prior ALJ's order relating to its denial of claimant's 1988 heart attack and coronary artery disease, the court concluded that SAIF was precluded from contesting the compensability of claimant's coronary artery condition. King v. Building Supply Discount, 133 Or App 179 (1995). Consequently, the court reversed and remanded. Thereafter, we issued our Order on Remand setting aside SAIF's denial.

On reconsideration of our Order on Remand, SAIF contends under amended ORS 656.005(7)(a)(B)and amended ORS 656.262(6)(c) it is not precluded from denying claimant's coronary artery disease and, on the merits, that condition is not compensable.

In order for either the former or current version of ORS 656.005(7)(a)(B)[1] to apply, a compensable injury must combine with the preexisting condition. Based on the following reasoning, we hold that the aforementioned statute has no application to this case.

[1] Subsequent to the court's decision, the Legislature amended ORS 656.005(7)(a)(B) which now provides that where a compensable injury combines with a preexisting condition, a worker must establish that the 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." OR Laws 1995, Ch 332, § 1 (SB 369, § 1). Assuming that the amendments to ORS 656.005(7)(a)(B) are applicable to this case, the result would remain the same as claimant's preexisting condition (coronary artery disease) has been found compensable by the court. Consequently, there is currently no "combined" condition under either version of the statute.

Here, claimant's coronary artery disease was found compensable by the court. Thus, there is no preexisting condition; only claimant's compensable coronary artery disease which the court found that SAIF previously accepted. Moreover, there is no evidence that the compensable coronary artery disease combined with any other preexisting condition. Consequently, neither the current nor former version of ORS 656.005(7)(a)(B) applies to this case. See Ronald L. Ledbetter, 47 Van Natta 1461 (1995) (neither former nor current ORS 656.005(7)(a)(B) are applicable where claimant's preexisting osteomyelitis condition was found compensable by the court); Joyce E. Soper, 46 Van Natta 740 (1994) (former ORS 656.005(7)(a)(B) not applicable where the claimant's preexisting degenerative arthritis condition was ordered accepted by a prior litigation order).

Amended ORS 656.262(6)(c) provides that a carrier is not precluded from later denying a "combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition." SB 369, § 28. Assuming *arguendo* that this provision applies retroactively to this case, we would continue to find claimant's coronary artery disease compensable. As with ORS 656.005(7)(a)(B), a "combined" condition is a prerequisite for application of the statutory provision. As noted above, claimant's coronary artery disease is the compensable condition and has not "combined" with any other preexisting disease or condition. Consequently, ORS 656.262(6)(c) is likewise not applicable to this case.

Under these circumstances, claimant's coronary artery disease is compensable. Accordingly, on reconsideration, we continue to affirm the ALJ's order dated February 3, 1993 which set aside SAIF's denial and remanded the claim to SAIF for further processing.

Finally, noting that the ALJ and the court granted attorney fee awards for his counsel's services before their respective forums, claimant asserts that his counsel is entitled to an assessed attorney fee for services previously rendered on Board review. We agree.

To begin, in cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or Board, then the ALJ, Board, or appellate court shall approve an attorney fee for services before every prior forum. ORS 656.388(1). Here, since claimant did not finally prevail until the issuance of our Order on Remand, statutory authority to award an attorney fee for services rendered at each level would appear to rest with this forum. Nonetheless, pursuant to its appellate judgment, the court has already granted a $3,525 carrier-paid attorney fee. Inasmuch as neither party challenges the statutory basis for such an award, we shall likewise not examine that question. See Mark L. Hadley, 47 Van Natta 725 (1995).

In any event, after considering the factors set forth in OAR 438-15-010(4), we would find that the court's award represents a reasonable fee for claimant's counsel's services performed before that forum. Likewise, based on a review of the aforementioned factors, we find that the ALJ's $2,000 attorney fee award constitutes a reasonable attorney fee for his counsel's services at the hearing level.

We now turn to a determination of a reasonable attorney fee for claimant's counsel's services previously provided on Board review of the ALJ's order, as well as on reconsideration of our remand order. After consideration of the factors recited in the aforementioned rule, we find that a reasonable attorney fee for claimant's counsel's services on Board review and reconsideration is $1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief and his response to SAIF's motion for reconsideration of our remand order), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our June 19, 1995 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
DONALD S. SHERIDAN, Claimant
WCB Case Nos. 94-02909, 94-02908, 93-14136 & 93-09281
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys
David Horne, Defense Attorney
Lundeen, et al, Defense Attorneys
Kevin Mannix, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation, on behalf of Taylor & Son Drywall, Inc. (Taylor/Liberty), requests review of Administrative Law Judge (ALJ) Baker's order that found it responsible for claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). Liberty Northwest Insurance Corporation, on behalf of R&H Drywall (R&H/Liberty), cross-requests review of that portion of the ALJ's order that awarded an assessed attorney fee of $3,000 against it. In its brief, R&H/Liberty contends that, even if the attorney fee is appropriate, it is excessive. Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to increase the rate of interim compensation paid by R&H/Liberty; and (2) awarded a $3,000 attorney fee to be paid by Taylor/Liberty and a $3,000 attorney fee to be paid by R&H/Liberty, contending that both fees are inadequate. On review, the issues are responsibility, rate of temporary disability and penalty and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that R&H/Liberty has requested dismissal of claimant's cross-request for review as untimely. Although claimant's cross-request was untimely, we have previously held that, as part of our de novo review, we have authority to consider issues that are raised other than by a timely cross-request for review and may make any disposition of the case we deem appropriate. ORS 656.295(6); Destael v. Nicolai, 80 Or App 600-601 (1986); Jimmie Parkerson, 35 Van Natta 1247 (1983) (There is no requirement that a party cross-request Board review in order to have particular issues considered on de novo review). Accordingly, because the ALJ decided the rate of temporary disability compensation and penalty and attorney fee issues, we proceed to consider those issues on review.

R&H/Liberty also requests that we reject claimant's cross-respondent's brief as untimely. Whether characterized as a cross-appellant's or cross-respondent's brief, as suggested by R&H/Liberty, claimant's brief was received untimely.[1] Since claimant's brief was not timely filed, it has not been considered. See, e.g., Brenda G. Chaney, 46 Van Natta 2340 (1994). Moreover, had we considered the brief, it would not change our ultimate disposition of this case.

Responsibility

We adopt and affirm the ALJ's conclusions regarding responsibility.

Rate of Interim Compensation

We affirm the ALJ's conclusions regarding the rate of temporary disability, but for different reasons.

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[1] An appellant's brief was due from Taylor/Liberty on December 7, 1994. OAR 438-11-020(2). No brief was filed. Respondent/cross-appellant briefs were due December 28, 1994, 21 days after appellant's December 7, 1994 deadline. Id. Respondent/cross-appellant R&H/Liberty filed its brief on December 27, 1994. Respondent Liberty/Avery filed its brief on December 27, 1994. Claimant submitted no respondent/cross-appellant brief by the December 28, 1994 deadline. A reply/cross-respondent's brief from appellant Taylor/Liberty was due by January 11, 1995. Id. Claimant's cross-respondent brief was due on January 11, 1995, 14 days from the date of mailing of R&H/Liberty's respondent brief. Id. Claimant's brief was received untimely on January 12, 1995.

Temporary disability benefits (including interim compensation) for a worker who incurs an occupational disease shall be based on the wage of the worker at the time there is medical verification that the worker in unable to work because of the disability caused by the occupational disease. ORS 656.210(2)(b)(B); OAR 436-60-025(1). Claimant was taken off work due to his occupational disease, CTS, on July 9, 1993, when he was working for Taylor/Liberty, not R&H/Liberty. Consequently, the rate of claimant's interim compensation payments is based on his wage at Taylor/Liberty, not R&H Liberty. Thus, the tool rental payments claimant received in conjunction with his employment at R&H Liberty (or Willamette Wallboard) are not considered in the computation of the rate of temporary disability.

Penalty and Attorney Fees

Finding, in effect, that claimant had prevailed in the matter of compensability without a hearing, and that R&H/Liberty's denial was unreasonable, the ALJ awarded claimant a $3,000 attorney fee against R&H/Liberty pursuant to both ORS 656.386(1) and ORS 656.382. The ALJ did not specify the dollar amount awarded under each statute. The ALJ also awarded claimant a $3,000 attorney fee against Taylor/Liberty for claimant's attorney's "active and meaningful participation" in the responsibility proceedings. R&H/Liberty contends that the combined fee of $3,000 is excessive. Claimant, in contrast, contends that both attorney fees are inadequate. We will address each attorney fee and the penalty issue separately.

Assessed Attorney Fee - ORS 656.386(1)

Claimant's counsel is entitled to a carrier-paid attorney fee pursuant to ORS 656.386(1)[2] for services in obtaining R&H/ Liberty's rescission of the compensability portion of its denial prior to a hearing regarding responsibility for the claim. Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 1994); see Dale A. Karstetter, 46 Van Natta 147 (1994).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's attorney's pre-hearing services concerning the rescission of the compensability denial is $2,500, payable by R&H/Liberty. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Penalty and Related Attorney Fee

ORS 656.382(1) authorizes the assessment of an attorney fee if an insurer unreasonably resists the payment of compensation, provided that there are no amounts of compensation then due upon which to base a penalty. See Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992). Here, although there is no compensation then due from R&H/Liberty, claimant is entitled to a penalty and related attorney fee pursuant to ORS 656.262(10) (formerly ORS 656.262(9), which may be based on the "amounts then due" from the responsible carrier for R&H/Liberty's unreasonable denial of compensability. SAIF v. Whitney, 130 Or App 429 (1994); SAIF v. Moyer, 63 Or App 498, rev den 295 Or 541 (1983); Michael P. Yauger, 45 Van Natta 419 (1993) (A penalty, which may be based on the "amounts then due" from the responsible carrier, may be assessed against a nonresponsible carrier when its unreasonable denial of compensability delays payment of compensation by preventing the designation of a paying agent).

R&H/Liberty denied both compensability and responsibility for claimant's CTS. R&H/Liberty contends that its denials were not unreasonable, in that the amended denials of April 21, 1994, and May 6, 1994, did not continue to deny compensability of claimant's bilateral carpal tunnel syndrome. We disagree.

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[2] ORS 656.386(1) was amended by the 1995 Legislature. Or Laws 1995, § 332, § ___ (SB 369, §§ 43, 66). Amended ORS 656.386(1) provides in part: "In [all] 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."

The reasonableness of a carrier's denial of compensability must be gauged based upon the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988). Further, the insurer must continually reevaluate its denial and rescind a denial which is or becomes unreasonable prior to the issuance of an order setting the denial aside. Id. at 592. The record establishes that R&H/Liberty had no legitimate basis to doubt compensability as to some employer at the time of its denial of compensability. Moreover, all of the medical reports, both before and after R&H/Liberty's denial, relate claimant's CTS to his work activities as a drywall taper. In addition, R&H/Liberty did not clearly rescind its denial of claimant's CTS condition or request a paying agent prior to its August 9, 1994 rescission. (See Exs. 42, 52, 57, 75 and 77). Thus, R&H/Liberty's denial of compensability was unreasonable.

R&H/Liberty's unreasonable denial of compensability, which it sustained up until one day before hearing, precluded the possibility of the designation of a paying agent pursuant to ORS 656.307 and constituted an unreasonable delay in the payment of compensation. Accordingly, claimant is entitled to a penalty pursuant to ORS 656.262(10), to be based on 25 percent of the "amounts then due" from the responsible carrier, one-half the additional amount to be paid to claimant and one-half to his attorney. SAIF v. Moyer, supra; Michael P. Yauger, supra. The penalty shall be based on the "amounts then due (as a result of the ALJ's order as affirmed by this order)" at the time of the rescission of R&H/Liberty's unreasonable compensability denial.

Assessed Attorney Fee - ORS 656.307(5)

The ALJ awarded claimant an attorney fee for services at hearing pursuant to former ORS 656.307(5). Former ORS 656.307(5), however, allowed an award when a claimant was represented in an arbitration proceeding to determine responsibility issues. This proceeding was not an arbitration. Thus, there was no basis for an attorney fee award under that statute.[3] Howard v. Willamette Poultry, 101 Or App 584 (1990). We consequently reverse the ALJ's attorney fee assessed against Taylor/Liberty. Because no attorney fee is appropriate under ORS 656.307(5), we need not address the reasonableness of the amount awarded by the ALJ.

Inasmuch as claimant's brief on review was untimely, no attorney fee is awarded for services on review. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The ALJ's order dated September 21, 1994, is modified in part, reversed in part, and affirmed in part. In lieu of the ALJ's assessed attorney fee award of $3,000, to be paid by R&H Drywall/Liberty Northwest Insurance Corporation, claimant is awarded $2,500, to be paid by R&H/Liberty. Claimant is also awarded 25 percent of the "amounts then due" (as a result of the ALJ's order, as affirmed by this order) at the time of the rescission of R&H/Liberty's unreasonable compensbility denial, one-half to be paid to claimant and one-half to claimant's attorney, by R&H Drywall/Liberty Northwest Insurance Corporation. The ALJ's attorney fee award of $3,000 assessed against Taylor Drywall/ Liberty Northwest Insurance Corporation is reversed. The remainder of the ALJ's order is affirmed.

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[3] ORS 656.307 was amended by the 1995 Legislature. Or Laws 1995, § 332, § ___ (SB 369, §§ 36, 66). A condition precedent to an attorney fee award under amended ORS 656.307(5) remains a request by the Director for the appointment of an ALJ to determine the responsible paying party. Here, there was no request by the Director to the Board regarding the responsibility matter. Accordingly, there is no basis for an attorney fee under amended ORS 656.307(5).

In the Matter of the Compensation of
GLENN C. SMITH, Claimant
WCB Case No. 94-14161
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Thomas J. Dzieman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its alleged "de facto" denial of claimant's left forearm condition and surgery; and (2) awarded an assessed attorney fee. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following brief summary and supplementation:

Claimant sustained a compensable injury to his right foot in September 1988, which necessitated a skin graft in June 1992. In May 1993, claimant underwent surgery to repair the skin graft donor site on his left forearm. On May 5, 1994, claimant again underwent surgery on his arm to repair the scar resulting from the original skin graft surgery.

On October 4, 1994, SAIF issued a Notice of Closure declaring claimant medically stationary as of May 4, 1994. Claimant did not request reconsideration of the Notice of Closure to correct the medically stationary date or time loss award.

SAIF paid all medical bills in connection with claimant's May 5, 1994 surgery, as well as temporary disability benefits through May 4, 1994.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, because SAIF's October 4, 1994 Notice of Closure erroneously declared claimant medically stationary as of May 4, 1994 (the day before his second forearm skin graft surgery), SAIF had denied the compensability of claimant's consequential left forearm condition. Although SAIF had paid the medical billings related to the May 5, 1994 surgery, the ALJ concluded that its failure to pay time loss in conjunction with the surgery constituted a "de facto" denial of that surgery and the consequential condition which warranted an assessed attorney fee pursuant to ORS 656.386(1). We disagree.

Entitlement to attorney fees in worker's compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). Where a dispute concerns the amount or extent of compensation, rather than a denial of compensability of a condition or related medical services, an attorney fee pursuant to ORS 656.386(1) is not authorized. See Short v. SAIF, 305 Or 541, 545 (1988).

Here, the dispute concerned SAIF's failure to pay temporary disability benefits. SAIF did not deny the compensability of claimant's condition or medical services and, in fact, all medical billings had been paid. Under these circumstances, the record does not support a conclusion that claimant's left forearm condition or surgery was denied. Moreover, inasmuch as the dispute concerned the amount or extent of compensation, claimant is not entitled to an attorney fee pursuant to ORS 656.386(1). Short v. SAIF, supra.

In reaching this conclusion, we note that claimant's claim was closed by an October 4, 1994 Notice of Closure which found claimant medically stationary on May 4, 1994, a day prior to his left arm surgery. Thus, to the extent that claimant is asserting entitlement to temporary disability benefits prior to the date of the Notice of Closure, he must challenge the Notice of Closure through the reconsideration process set forth in ORS 656.268. See Trevor E. Shaw, 47 Van Natta 1383 (1995). However, as noted above, claimant did not request reconsideration of SAIF's Notice of Closure. Consequently, we are not authorized to consider claimant's challenge which effectively pertains to the Notice of Closure's temporary disability award.

ORDER

The ALJ's order dated February 16, 1995 is reversed.

In the Matter of the Compensation of
JOHNNY C. TINKER, Claimant
WCB Case Nos. 92-10036 & 92-03014
ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

On June 15, 1995, we abated our May 18, 1995 order that: (1) set aside Maryland Casualty's (on behalf of Giesy, Gree & Gunn) denial of claimant's medical services claim for his current low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition. We took this action to consider Maryland Casualty's contention that it is not responsible for claimant's L3-4 and L5-S1 conditions. Having received claimant's response, we proceed with our reconsideration.

We begin with a brief summary of the relevant facts. In 1978, claimant sustained a noncompensable injury to his low back. As a result of this injury, he underwent a three-level laminectomy and excision of herniated nucleus pulposus at L3-4, L4-5, and L5-S1. In August 1982, claimant sustained another injury to his low back while working for Maryland Casualty's insured. Claimant sought treatment for this injury from Dr. Kaeshe, who diagnosed a herniated nucleus pulposus at L4-5 with right-sided L-5 nerve root impingement. (Ex.5B). In October 1982, Dr. Kaeshe performed a laminectomy and discectomy at L4-5. (Ex. 8). Claimant filed a claim for this injury, which was accepted by Maryland Casualty. (Ex. 9).

In our prior order, we concluded that Maryland Casualty accepted claimant's L4-5 condition (herniated nuclues pulposus with right-sided L-5 nerve root impingement) and remains responsible for that condition. Maryland Casualty does not dispute this conclusion. Rather, Maryland Casualty asserts that its denial should be upheld to the extent it denies claimant's L3-4 and L5-S1 conditions. After further consideration, we agree.

As noted above, claimant's 1982 compensable injury involved only the L4-5 level (with L5, right-sided nerve root impingement). There is no persuasive evidence which establishes that claimant sustained further injury to the L3-4 or L5-S1 levels at that time. Moreover, the record does not establish that Maryland Casualty accepted either of those two disc levels. Finally, the medical evidence does not support a causal relationship between claimant's current L3-4 and L5-S1 conditions and his 1982 compensable injury (herniated nucleus pulposus with right-sided L5 nerve root impingement). Accordingly, we modify our prior order to set aside Maryland Casualty's denial only to the extent that it denies claimant's L4-5 condition. To the extent that it denies claimant's L3-4 and L5-S1 conditions, the denial is upheld.[1]

Finally, claimant asserts that his counsel is entitled to an assessed attorney fee for services on reconsideration. Inasmuch as we have modified our prior order to uphold a portion of Maryland Casualty's denial, we find no basis for awarding claimant's counsel a further assessed attorney fee.

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[1] We note that Maryland Casualty asserts that amended ORS 656.262(6)(d) applies to this case. That statute provides, inter alia, that a worker who believes a condition has been incorrectly omitted from a notice of acceptance first must communicate in writing to the carrier the worker's objections to the notice. Or Laws 1995, ch 332 § 28 (SB 369, § 28). ORS 656.262(6)(d), as amended, also provides that a worker may initiate objection to the notice of acceptance at any time.

Here, considering Maryland Casualty's consistent opposition to the claim that its 1982 acceptance included claimant's L3-4 and L5-S1 condition, we conclude that it would not achieve substantial justice to remand this case for compliance with the aforementioned procedural rules (assuming, without deciding, that the amended version of the statute applies). See Renee M. Willshire, 47 Van Natta 1339 (1995).

Accordingly, as modified and supplemented herein, we adhere to and republish our May 18, 1995 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
DALE A. WECKESSER, Claimant
WCB Case No. 93-10648
SECOND ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

On June 14, 1995, we withdrew our June 1, 1995 Order on Remand which: (1) increased claimant's scheduled permanent disability award for the loss of use or function of the left ankle from 3 percent (4.05 degrees) to 8 percent (10.8 degrees); and (2) awarded a $3,000 carrier-paid attorney fee under former ORS 656.388(1). We took this action to consider SAIF's contention that claimant's attorney fee award is limited to 25 percent of the increased compensation granted by our order. Having received claimant's response, we proceed with our reconsideration.

Here, claimant finally prevailed on remand from the Court of Appeals when we awarded increased scheduled permanent disability for a chronic condition limiting repetitive use (our previous order had affirmed an Administrative Law Judge's order that affirmed an Order on Reconsideration award of 3 percent scheduled permanent disability for the left ankle). Relying on Cleo I. Beswick, 43 Van Natta 876, on recon 43 Van Natta 1314 (1991), we awarded an assessed attorney fee pursuant to former ORS 656.388(1), in addition to an "out-of-compensation" fee payable from claimant's increased permanent disability award. On reconsideration, SAIF contends that claimant is not entitled to an assessed fee, whether under the former or amended version of ORS 656.388(1).

Claimant argues that the amendments to ORS 656.388(1) (SB 369, §44) do not apply to this case because the claim did not "exist" or "arise" on or before the effective date of SB 369 or, alternatively, that amended ORS 656.388(1) should not apply in this case because claimant detrimentally relied on former ORS 656.388(1) when litigating his claim to the Court of Appeals. We need not address claimant's arguments because he is not entitled to a carrier-paid attorney fee under the former version of ORS 656.388(1).

Subsequent to our June 1, 1995 Order on Remand, the Court of Appeals issued its opinion in Liberty Northwest Insurance Corp. v. Koitzsch, 135 Or App 524 (1995). In Koitzsch, the court reversed that portion of our order on remand which had awarded a carrier-paid attorney fee in addition to an out-of-compensation attorney fee when claimant finally prevailed in obtaining an increase of her permanent partial disability award on remand from the court. Relying on Greenslitt v. City of Lake Oswego, 88 Or App 94 (1987), aff'd 305 Or 530 (1988), the court held that under prior versions of ORS 656.388(1), attorney fees could be paid only from a claimant's compensation award. Under such circumstances, the court considered it unnecessary to determine whether the recent statutory amendments applied in Koitzsch because, even before the 1995 amendments, the statute did not allow an award of carrier-paid fees.

In light of the court's decision in Koitzsch, we need not apply amended ORS 656.388(1) in this case. Likewise, pursuant to the court's opinion, claimant is only entitled to an out-of-compensation attorney fee for his counsel's services in this particular case. Therefore, we withdraw that portion of our prior order which granted claimant a $3,000 carrier-paid attorney fee award.

Accordingly, as supplemented and modified herein, we adhere to and republish our June 1, 1995 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 L. ABEL, Claimant
WCB Case No. 94-11455
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board en banc.[1]

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) denied its motion to dismiss claimant's hearing request for lack of jurisdiction; (2) set aside its "de facto" denial of home health care services beyond $1,300 per month and ordered it to pay $3,500 per month for such services; (3) assessed a penalty for the allegedly unreasonable denial; and (4) awarded attorney fees pursuant to ORS 656.386(1). On review, the issues are jurisdiction and, alternatively, medical services, penalties and attorney fees. We vacate the ALJ's order and dismiss claimant's hearing request.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the Hearings Division had jurisdiction over this matter and set aside SAIF's "de facto" denial of claimant's home health care services beyond $1,300 per month. SAIF asserts that this is an ORS 656.248 medical fee dispute over which the Director of the Department of Consumer and Business Services (DCBS) has exclusive jurisdiction. Claimant asserts that this case arises under either ORS 656.245 or 656.327 and, hence, that the Hearings Division and this Board have jurisdiction over this dispute. We need not resolve that controversy, because we conclude that none of those statutes vests us with jurisdiction over this matter.

ORS 656.327(1), 656.245(6) and 656.248 were amended by the 1995 legislature. Or Laws 1995, ch 332, §§ 25, 26, 41 (SB 369, §§ 25, 26, 41). Our first task is to determine whether those amendments apply to this case.

Except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565, 573 (1995) (interpreting SB 369, § 66(1) and (5)(a)[2]); see Walter L. Keeney, 47 Van Natta 1387 (1995) (amended ORS 656.327 and 656.245(6) apply to actions currently pending before the Board). Amended ORS 656.327(1) and 656.245(6) are not among the exceptions to this general rule.

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[1] Because of a personal conflict of interest, Board Member Hall has voluntarily recused himself from participation in the review of this case. OAR 438-11-023.

[2] Section 66(1) provides:

"Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

Section 66(5)(a) provides: "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which an order or decision has become final on or before the effective date of this Act."

SB 369 went into effect on June 7, 1995, the day the Governor signed the bill into law. See SB 369, § 69 (declaring emergency); Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) (effective date of act containing emergency clause is day Governor signs it).

See SB 369, § 66 (listing exceptions to general retroactivity provision). Consequently, they govern this matter.[3]

We reach the opposite conclusion regarding amended ORS 656.248. That statute does not go into effect until January 1, 1996. SB 369, § 66(3). Therefore, former ORS 656.248 and relevant case law govern this case. We now address the effect of each statute separately.

Amended ORS 656.327(1) provides that, if an injured worker, a carrier or the Director believes that an injured worker's medical services, not subject to ORS 656.260,[4] are excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." SB 369, § 41 (emphasis added). The Director now has exclusive jurisdiction over all ORS 656.327(1) medical services disputes, including those currently pending before the Board. Walter L. Keeney, supra, 47 Van Natta at 1389.

Consequently, assuming that this is a "327" medical services dispute, exclusive jurisdiction over this case now rests with the Director. Id. In that case, neither we nor the Hearings Division has jurisdiction over it.

We reach the same conclusion under amended ORS 656.245. That statute provides:

> "If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550." SB 369, § 25 (emphasis added).

Our next task is to determine what the legislature intended by amending ORS 656.245(6). We begin with the text and context of that provision, and resort to extrinsic aids only if those sources are unavailing. ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993); Porter v. Hill, 314 Or 86, 91 (1992).

The plain, mandatory text of amended ORS 656.245(6) reveals the legislature's intent that, unless a formal denial of a worker's underlying claim is disputed, ORS 656.245 medical services disputes "shall" be resolved exclusively by the Director, not the Board or the Hearings Division. See Walter L. Keeney, supra, 47 Van Natta at 1389.

That conclusion finds support in several related amendments: Amended ORS 656.327(1) provides that, to challenge the alleged excessiveness, propriety, effectiveness or legality of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." SB 369, § 41 (emphasis added). Amended ORS 656.704(3) provides that "matters concerning a claim," over which the Board has jurisdiction, "do not include any disputes arising under ORS 656.245* * *." SB 369, § 50 (Emphasis added). Amended ORS 656.283(1) provides that, "[s]ubject to ORS 656.319[5], any party or the Director of [DCBS] may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, including ORS 656.245 * * *." SB 369, § 34 (emphasis added).[6]

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[3] Under section 66(6) of SB 369, amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively. Cigna Insurance Co. v. McMasters, 135 Or App 583, 587 (1995). Because amended ORS 656.327(1) and 656.245(6) do not alter procedural time limitations, section 66(6) does not apply to them.

[4] ORS 656.260 concerns managed care organizations, which are not at issue here.

[5] ORS 656.319 pertains to timeliness of hearing requests.

[6] Because amended ORS 656.704(3) and 656.283(1) are not among the exceptions to SB 369's general retroactivity provision, SB 369, § 66(1), and because they do not alter procedural time limitations, we conclude that the legislature intended them to apply retroactively. See Volk v. America West Airlines, supra; Cigna Insurance Co. v. McMasters, supra; Walter L. Keeney, supra. Therefore, we rely on them as contextual evidence of the legislature's intent regarding amended ORS 656.245(6).

Those amendments are additional evidence that the legislature intended that the Director have exclusive jurisdiction over medical services disputes arising under ORS 656.245, so long as the compensability of a worker's underlying claim is not contested. Because the text and context of amended ORS 656.245(6) reveal the legislature's intent, we do not resort to legislative history or other extrinsic tools. Rather, we conclude that, if this is characterized as a "245" case, because no one has contested the compensability of claimant's underlying claim (but rather are contesting the amount of reimbursement for the compensable medical services claim), we lack jurisdiction over this matter.

Last, we consider SAIF's ORS 656.248 argument. As stated earlier, we apply the former version of that statute. See SB 369, § 66(3). The Director has exclusive jurisdiction over medical fee disputes arising under former ORS 656.248(13) involving workers' compensation carriers and medical service providers. E.g., Panek v. Oregon Health Sciences Univ., 123 Or App 623, 624 (1993), rev den 320 Or 453 (1994). Since this case involves a dispute regarding claimant and a workers' compensation carrier, former ORS 656.248(13) has no application. Alternatively, assuming that claimant could be considered as a medical service provider, under former ORS 656.248(13), jurisdiction would rest with the Director.

In sum, regardless of whether this claim arises under ORS 656.327, 656.245, or 656.248(13), neither we nor the Hearings Division has jurisdiction over this dispute. Accordingly, we vacate the ALJ's decision regarding the jurisdiction and medical services issues. Moreover, because we are without authority to award penalties or attorney fees for matters arising under the Director's jurisdiction, SB 369, § 42d(5),[7] we vacate the ALJ's penalty and attorney fee awards.

ORDER

The ALJ's order dated January 17, 1995 is vacated. Claimant's hearing request is dismissed.

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[7] Because section 42d(5) is not among the exceptions to the general retroactivity provision of SB 369, see SB 369, § 66, and because it does not alter a procedural time limitation, we apply it retroactively to this case. See Volk v. America West Airlines, supra; Cigna Insurance Co. v. McMasters, supra; Walter L. Keeney, supra.

Board Member Gunn specially concurring.

I continue to disagree with Walter L. Keeney, 47 Van Natta 1387 (1995), for the reasons set forth in my dissenting opinion. Particularly, I fear that the retroactive application of amended ORS 656.245, 656.248 or 656.327 may infringe on claimant's rights under Article I, section 10, of the Oregon Constitution and on his due process and equal protection rights under the state and federal constitutions. Therefore, I persist in my belief that parties in cases such as this should have the opportunity to address the retroactive application of Senate Bill 369's provisions and whether applying the amendments can withstand constitutional scrutiny. In view of the precedential value of Keeney, however, I reluctantly agree that we lack jurisdiction over this case.

Notwithstanding that agreement, I feel compelled to comment on how especially unfair the workers' compensation system has been to this claimant.

Claimant is a former logger who, over 20 years ago, sustained a work-related injury that resulted in the loss of his left eye and a severe, disabling seizure condition. Claimant requires 24-hour health care. In 1994, claimant's wife began to provide home health care services for him. Claimant submitted claims for reimbursement for those services to SAIF, which either ignored the claims or sent them back to claimant.[1] To date, SAIF has neither reimbursed claimant for any of the services that his wife has provided, nor formally accepted or denied those services. SAIF's inaction forced claimant to litigate his wife's status as a home health care provider, as well as the rate of compensation for her services.

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[1] SAIF responded by letter to claimant's attorney, stating that the services were not authorized or under the direct control and supervision of an attending physician, but offered to pay a fraction of the amount that claimant had requested for a family member to provide him the care that he required. SAIF subsequently reaffirmed its denial of services rendered while claimant was not under the direct control and supervision of an attending physician.

Now, over a year later, and after prevailing before the ALJ, the Legislature has effectively pulled the rug out from under claimant by retroactively changing the forum in which these types of cases may be litigated; presently, only the Director has jurisdiction over this matter. In view of the Director's current 180-day time limit for requesting review of medical services cases, OAR 436-10-046(4), (5), and the apparent expiration of that time limit in this case, however, claimant now may have no forum in which to air his grievances.

This is a particularly egregious example of the workers' compensation system's failure to live up to two of its primary objectives, viz., to provide benefits to injured workers on a no-fault basis, ORS 656.012(2)(a), and to assure that those benefits are provided by a fair and just administrative system that, to the greatest extent practicable, reduces litigation. ORS 656.012(2)(b).

The administration of this case has been neither fair nor just: SAIF has forced claimant to litigate his entitlement to obviously necessary and expensive medical services. Although claimant appears to be entitled to reimbursement for those services, he may never obtain it for lack of a forum with jurisdiction to address the merits of this dispute. In other words, for the reasons expressed in my dissenting opinion in Keeney, I have serious concerns regarding the Director's authority to effectively modify procedural time limitations in order to conduct a further review of this dispute. See Section 66(6) of Senate Bill 369. Thus, in actuality, SAIF eventually may be rewarded for its dilatory tactics and for promoting, rather than attempting to reduce, litigation.

Neither fairness nor justice should allow this result; however, in view of the recent amendments to the Workers' Compensation Act and the binding effect of Keeney, I have no jurisdiction to effect a fair or just result. Therefore, I regretfully concur with the decision to dismiss claimant's hearing request.

September 5, 1995 Cite as 47 Van Natta 1574 (1995)

In the Matter of the Compensation of
LARRY R. COMER, Claimant
Own Motion No. 93-0751M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Michael M. Bruce, Claimant Attorney

Claimant requests review of the self-insured employer's May 26, 1995 Notice of Closure which closed his claim with an award of temporary disability compensation from November 10, 1993 through April 11, 1995. The employer declared claimant medically stationary as of April 11, 1995. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 26, 1995 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.

The employer contends that claimant was medically stationary on April 11, 1995 and that claimant's claim was not prematurely closed.[1] While we agree that claimant was medically stationary on April 11, 1995, claimant's status on that date is not the relevant inquiry for purposes of premature closure. Rather, the issue is whether claimant was medically stationary as of May 26, 1995, the date his claim was closed.

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[1] The employer also contends that in order to be entitled to further temporary disability benefits, claimant must have been hospitalized or in need of additional surgery. Because claimant's claim was in "open" status, there is no requirement that claimant meet the requirements for reopening his claim under ORS 656.278(1). Consequently, we find no merit in the employer's contention.

In a May 1, 1995 chart note, Dr. Laubengayer, claimant's treating physician, noted that:

> "The [claimant] has been having pain and swelling in his left knee for about 2 weeks. Two weeks ago his knee had been bothering him some when he simply stepped up a small step and he felt something pop in his left knee. He had a sharp pain and the knee gave way."

In a May 1, 1995 letter, Dr. Laubengayer offered further explanation concerning claimant's left knee condition. He stated:

> "[Claimant] has had a sudden event in his left knee that represents a material worsening of his left knee condition. He is no longer medically stationary. Enclosed is a copy of the recent chart note which details the findings associated with a torn tendon in the left knee. At this time, he is totally disabled. I would anticipate that it will be about 3 months before his condition is again medically stationary."

Although claimant was medically stationary on April 11, 1995, Dr. Laugenbayer's uncontroverted opinion establishes that claimant's compensable condition was no longer considered stationary after that date. Moreover, claimant's left knee condition remained unstationary through May 26, 1995, the date of closure.

Therefore, based on the uncontroverted medical evidence, we find that claimant's compensable left knee condition was not medically stationary on May 26, 1995, the date of claim closure. Accordingly, we set aside the Notice of Closure as premature, and order the employer to recommence the payment of temporary disability compensation. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-12-055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN L. DESMOND, Claimant
WCB Case No. 94-12390
ORDER ON REVIEW
Schneider, Hooten, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Schultz's order that awarded claimant temporary total disability (TTD) from September 18, 1992 through October 4, 1992 and from October 13, 1992 through January 3, 1993, as awarded by a Determination Order, but withdrawn in a corrected Determination Order. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

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

Claimant is neither substantively nor statutorily entitled to TTD from September 18, 1992 through October 4, 1992 and from October 13, 1992 through January 3, 1993.

CONCLUSIONS OF LAW AND OPINION

The ALJ reasoned that, because SAIF failed to pay claimant temporary disability within 14 days of a January 20, 1994 Determination Order, see OAR 436-60-150(4)(e),[1] SAIF is obligated to pay that award now, notwithstanding that a corrected Determination Order withdrew the award of the contested TTD. SAIF asserts that, under Eliecer Vega, 46 Van Natta 2173 (1994), it is not obligated to pay the TTD.[2] We agree.

Before we address SAIF's argument under Vega, however, we note that, when the February 1994 corrected Determination Order issued, the January 1994 Determination Order had yet to become final. Former ORS 656.268(4)(b), (e) (since amended by Or Laws 1995, ch 332, § 30 (SB 369, § 30)) (claimant had 180 days to appeal determination order). The Department has authority to correct inadvertent errors or omissions that affect a Determination Order within 180 days after the order is mailed and if no one requests reconsideration before the corrected order issues. OAR 436-30-008(1).[3] Here, no one requested reconsideration of the original order, and the corrected order issued within the 180-day time frame. Therefore, the corrected order controls. Since that order does not award any TTD, SAIF cannot be ordered to pay such benefits.

We reach the same conclusion under SAIF's Vega argument. Neither we nor the Hearings Division has authority to impose an "administrative" overpayment of temporary disability benefits when a claimant is not substantively or statutorily entitled to such benefits. See Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992) (no authority to direct carrier to pay TTD beyond claimant's medically stationary date, when the substantive entitlement to such benefits ends); see also Anodizing, Inc. v. Heath, 129 Or App 352, 357 (1994) (no overpayment created by order requiring carrier to pay claimant statutorily authorized TTD during carrier's appeal of reconsideration order). A claimant is not substantively or statutorily entitled to disability benefits that are awarded in an unappealed order, but subsequently withdrawn in an amended or corrected order. See Eliecer Vega, supra, 46 Van Natta at 2174-75 (claimant neither substantively nor statutorily entitled to permanent disability benefits awarded in untimely appealed Order on Reconsideration, but subsequently withdrawn in corrected Order on Reconsideration). Therefore, when an amended or corrected order withdraws a prior, unappealed award of benefits, both we and the Hearings Division lack the authority to impose an "administrative" overpayment by ordering the carrier to pay the withdrawn benefits. See id.

Here, a January 20, 1994 Determination Order awarded claimant TTD from September 18, 1992 through October 4, 1992 and from October 13, 1992 through January 3, 1993. No one appealed that order. A February 24, 1994 corrected Determination Order withdrew TTD benefits for those periods. Under the circumstances, claimant is neither substantively nor statutorily entitled to TTD for those periods. See Seiber, supra; Vega, supra. An award of TTD in this case would create an "administrative" overpayment of temporary disability benefits. Because neither we nor the Hearings Division has authority to create such an overpayment, we reverse the ALJ's TTD award.

ORDER

The ALJ's order dated January 20, 1995 is reversed. The ALJ's attorney fee award is also reversed.

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[1] OAR 436-60-150(4)(e) provides, in part, that timely payment of temporary disability benefits means payment no later that the 14th day after the date of any department order that mandates such payment.

[2] SAIF concedes that it is liable for a penalty for its failure to pay the TTD awarded in the original Determination Order.

[3] Under amended ORS 656.268(4)(b) and (e), an aggrieved worker has 60 days to request reconsideration of a Determination Order. SB 369, § 30. Under §66(4) of SB 369, the amendments to ORS 656.268(4) apply only to claims that become medically stationary on or after the effective date of the Act. Inasmuch as claimant became medically stationary prior to the effective date of the Act, amended ORS 656.268(4)(b) and (e) do not apply to claimant's claim. In addition, § 66(6) also prevents ORS 656.268(4)(b) and (e) from applying retroactively to this case. See Motel 6 v. McMasters, 135 Or App 583, 587 (1995) (amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively). In any event, the Director amended the Determination Order in this case less than 60 days after the original order issued.

In the Matter of the Compensation of
RONALD R. STREIT, SR., Claimant
WCB Case No. 94-11452
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorneys

Reviewed by the Board en banc.[1]

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that dismissed claimant's hearing request on the ground that the Hearings Division lacked jurisdiction over this dispute, which involved a managed care organization's (MCO's) disapproval of a proposed surgery. On review, the issue is jurisdiction and, alternatively, medical services. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on Job G. Lopez, 47 Van Natta 193 (1995), claimant asserts that, because the Hearings Division had jurisdiction to address the reasonableness and necessity of proposed medical services, the ALJ erred by dismissing his hearing request regarding a proposed surgery. We disagree.

In Job G. Lopez, supra, we rejected the carrier's assertion that, under former ORS 656.260, the MCO statute, and former ORS 656.704(3), the Director had exclusive jurisdiction over an MCO proposed medical services dispute. 47 Van Natta at 194-200. Rather, we concluded that, in the MCO context, where jurisdiction lies depends on the type of medical services in dispute. Id. at 200. Citing Martin v. City of Albany, 320 Or 175 (1994), and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), rev den 320 Or 453 (1994), we held that, because the dispute in Lopez involved a proposed surgery, the Hearings Division had exclusive jurisdiction to review the matter. 47 Van Natta at 201-02.

The Legislature subsequently amended ORS Chapter 656. Or Laws 1995, ch 332 (SB 369). Amended ORS 656.260(6) provides, in part, that "[a]ny issue concerning the provision of medical services to injured workers subject to a managed care contract * * * shall be subject solely to review by the director [of the Department of Consumer and Business Services (DCBS)] or the director's designated representatives, or as otherwise provided in this section." SB 369, § 27 (emphasis added).

Our first task is to determine whether amended ORS 656.260(6) applies to MCO medical service disputes currently pending before the Board. The answer is "yes."

Except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565, 573 (1995) (interpreting SB 369, § 66(1) and (5)(a)[2]); see Walter L. Keeney, 47

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[1] Because of a personal conflict of interest, Board Member Hall has voluntarily recused himself from participation in the review of this case. OAR 438-11-023.

[2] Section 66(1) provides:

"Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

Section 66(5)(a) provides: "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which an order or decision has become final on or before the effective date of this Act."

SB 369 went into effect on June 7, 1995, the day the Governor signed the bill into law. See SB 369, § 69 (declaring emergency); Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) (effective date of act containing emergency clause is day Governor signs it).

Van Natta 1387 (1995) (amended ORS 656.327 and 656.245(6) apply to actions currently pending before the Board). Because amended ORS 656.260(6) is not among the exceptions to this general rule, see SB 369, § 66 (listing exceptions to general retroactivity provision), the amended version of the statute governs this matter.[3]

Our next task is to determine what the legislature intended by amending ORS 656.260(6). We begin with the text and context of that provision, and resort to extrinsic aids only if those sources are unavailing. ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993); Porter v. Hill, 314 Or 86, 91 (1992).

Amended ORS 656.260(6) provides that "[a]ny issue concerning the provision of medical services to injured workers subject to a managed care contract * * * shall be subject solely to review by the director, or the director's designated representatives," or as otherwise provided in that section. (Emphasis added). The unambiguous mandatory language of that provision reveals the legislature's intent that, unless otherwise provided in ORS 656.260, all MCO medical services disputes be resolved by the Director, not the Board or the Hearings Division. It also reveals the legislature's intent to overrule our decision in Job G. Lopez, supra. Having found no provision in amended ORS 656.260 requiring otherwise, we conclude that, under amended ORS 656.260(6), the Director has exclusive jurisdiction over all MCO medical services disputes, including those currently pending before the Board.

Three related amendments support this conclusion. Amended ORS 656.704(3) provides that "matters concerning a claim," over which the Board has jurisdiction, "do not include any disputes arising under ORS 656.245, 656.248, 656.260, 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under ORS 656.340 except as those provisions may otherwise provide." SB 369, § 50 (emphasis added). Amended ORS 656.245(6) provides:

> "If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550." SB 369, § 25 (emphasis added).

Amended ORS 656.283(1) provides that, "[s]ubject to ORS 656.319[4], any party or the Director of [DCBS] may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, including ORS 656.245, 656.248, 656.260, 656.327 and subsection (2) of this section." SB 369, § 34 (emphasis added).[5]

Those amendments are further evidence that the legislature intended that the Director of DCBS have exclusive jurisdiction over all MCO medical services disputes, and that Job G. Lopez be overruled.

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[3] Under section 66(6) of SB 369, amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively. Cigna Insurance Co. v. McMasters, 135 Or App 583, 587 (1995). Because amended ORS 656.260(6) does not alter a procedural time limitation, section 66(6) does not apply to that statute.

[4] ORS 656.319 pertains to timeliness of hearing requests.

[5] Amended ORS 656.327(1) specifically does not apply to cases governed by ORS 656.260. See SB 369, § 41.

Because amended ORS 656.704(3), 656.245(6) and 656.283(1) are not among the exceptions to section 66(1)'s general retroactivity provision, we conclude that the legislature intended them to apply retroactively to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. See Volk v. America West Airlines, supra; Cigna Insurance Co. v. McMasters, supra; Walter L. Keeney, supra. Therefore, we may rely on them as contextual evidence of the legislature's intent regarding amended ORS 656.260(6).

Because the text and context of amended ORS 656.260(6) reveal the legislature's intent, we do not resort to legislative history or other extrinsic tools.[6]

This matter involves a dispute regarding an MCO's denial of a proposed surgery. Under amended ORS 656.260(6), exclusive jurisdiction over this matter now rests with the Director of DCBS. Because neither the Hearings Division nor the Board has jurisdiction over this matter, the ALJ properly dismissed claimant's hearing request. In light of this conclusion, we do not address the medical services issue.

ORDER

The ALJ's order dated January 17, 1995 is affirmed.

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[6] Applying the clear language of the 1995 amendments to this case will result in this matter being decided by the Director rather than the Board and the Hearings Division. Because the parties will still have a forum in which to air their grievances about this claim, we do not consider that to be an unintended, absurd or unreasonable result. See Satterfield v. Satterfield, 292 Or 780, 782-83 (1982) (court declines to apply statute literally when to do so will produce unintended, absurd or unreasonable result). Consequently, we find no basis for departing from a literal reading of the amendments. See Walter L. Keeney, supra, 47 Van Natta at 1389 (legislative determination that ORS 656.327 medical services cases be decided by Director rather than Hearings Division and Board not an absurd or unintended result).

Board Member Gunn specially concurring.

I continue to disagree with Walter L. Keeney, 47 Van Natta 1387 (1995), for the reasons set forth in my dissenting opinion. Particularly, I fear that the retroactive application of amended ORS 656.260 may infringe on claimant's rights under Article I, section 10, of the Oregon Constitution and on his due process and equal protection rights under the state and federal constitutions. Therefore, I persist in my belief that parties in cases such as this should have the opportunity to address the retroactive application of Senate Bill 369's provisions and whether applying the amendments can withstand constitutional scrutiny. In view of the precedential value of Keeney, however, I reluctantly agree that we lack jurisdiction over this case.

Notwithstanding that agreement, I feel compelled to comment on how especially unfair the workers' compensation system has been to this claimant. It has now been 15 months since claimant's attending physician recommended surgery for claimant's compensable low back condition. As a result of the majority's retroactive application of amended ORS 656.260(6), claimant is exiled to another adjudicative forum where it is far from clear that his appeal will even be considered. In other words, in light of OAR 436-15-110(5), any subsequent request for review may be rejected by the Director as untimely. Moreover, as I noted in my dissenting opinion in Keeney, even if the Director attempted to modify prior procedural limitations in order to conduct a review of a dispute such as this, I have serious concerns regarding the validity of such an action. See Section 66(6) of Senate Bill 369.

This is a particularly egregious example of the workers' compensation system's failure to live up to two of its primary objectives, viz., to provide benefits to injured workers on a no-fault basis, ORS 656.012(2)(a), and to assure that those benefits are provided by a fair and just administrative system that, to the greatest extent practicable, reduces litigation. ORS 656.012(2)(b). I respectfully submit that the administration of this case has been neither fair nor just.

Neither fairness nor justice should allow this result; however, in view of the recent amendments to the Workers' Compensation Act and the binding effect of Keeney, I have no jurisdiction to effect a fair or just result. Therefore, I regretfully concur with the decision to dismiss claimant's hearing request.

In the Matter of the Compensation of
RONALD E. NORTON, Claimant
WCB Case No. 94-13246
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.[1]

The insurer requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) held that the Hearings Division retained jurisdiction to adjudicate whether proposed medical services are curative or palliative; (2) set aside the insurer's "de facto" denial of claimant's claim for the proposed medical services; (3) assessed a penalty for allegedly unreasonable claims processing; and (4) awarded a $3,200 carrier-paid attorney fee. On review, the issue are jurisdiction, medical services, penalties and attorney fees. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and briefly summarize the pertinent facts as follows:

Claimant sustained a compensable low back strain on March 8, 1989. During the course of treatment, it was discovered that he was suffering from mild degenerative disc disease at L4-5 with mild central bulging of the disc at that level. The claim was closed in February 1990, and claimant was awarded 15 percent unscheduled permanent disability for the low back.

In 1991, claimant was referred to Dr. Hacker, a neurosurgeon. A discography and CT scan administered on August 30, 1991 revealed a central and right L4-5 disc herniation. Claimant continued to experience recalcitrant leg pain, but was declared medically stationary by January 1992.

On July 13, 1994, claimant returned to Dr. Hacker with complaints of persistent right leg pain. Dr. Hacker recommended selective nerve block treatments to accurately diagnose and perhaps eliminate claimant's pain. The insurer refused to pre-authorize the treatments. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction and Medical Services

Subsequent to the ALJ's order, the legislature enacted Senate Bill 369 and amended ORS 656.327(1) to provide that if an injured worker, a carrier, or the director believes that the medical service the injured worker has received, is receiving or is proposed to receive is excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." Or Laws 1995, ch 332 § 41(1) (SB 369 § 41(1) (emphasis added). The legislature also added amended ORS 656.245(6), which provides that if a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim, and the claim is disputed, the injured worker or carrier "shall request administrative review by the director pursuant to this section [.]" Or Laws 1995, ch 332, § 25(6) (SB 369, § 25(6)).

We recently determined that these provisions apply retroactively to all pending cases, including those disputes that arose under former ORS 656.245. Walter L. Keeney, 47 Van Natta 1387 (1995).[2] The

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[1] Although constrained to follow the Board's holding in Walter L. Keeney, 47 Van Natta 1387 (1995), Member Gunn refers the parties to his dissenting opinion in that case.

[2] In Keeney, we recognized a potential problem in the retroactive application of amended ORS 656.245(6) concerning the timeliness of a claimant or insurer's request for director review under the Oregon Administrative Rules. We further held, however, that since the legislature explicitly authorized the Director to address medical services disputes, the question of whether the Director will dismiss a request for review as untimely under this rule rests with the Director and not the Board.

Court of Appeals also recently held that the provisions of Senate Bill 369 apply retroactively to all pending cases, unless specifically excepted from retroactive application by Section 66. Volk v. America West Airlines, 135 Or App 565 (1995). In the absence of any relevant exceptions, we apply the new law.

Here, the medical services dispute does not pertain to the compensability of claimant's underlying claim. Rather, the issue involves the effectiveness and appropriateness of the proposed selective nerve root injections for claimant's compensable condition, i.e., whether they constitute curative or palliative treatment. Because jurisdiction over this matter rests with the Director rather than the Hearings Division, we vacate the ALJ's decision concerning the medical services issue.

Penalties and Attorney Fees

Because we are without authority to award penalties or attorney fees for matters arising under the Director's jurisdiction, we vacate the ALJ's penalty and attorney fee awards. See SB 369, § 42d(5).

ORDER

The ALJ's order dated April 18, 1995 is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

September 6, 1995 Cite as 47 Van Natta 1581 (1995)

In the Matter of the Compensation of
LYNDA J. ZELLER, Claimant
WCB Case No. 93-13381
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's neuroma and reflex sympathetic dystrophy conditions and her proposed surgery request; and (2) assessed a penalty for the insurer's allegedly untimely and unreasonable denial. On review, the issues are compensability, jurisdiction, proposed surgery and penalties. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the ultimate findings of facts.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant compensably injured her upper back and right arm on August 4, 1990. Dr. Layman diagnosed a right carpal tunnel syndrome and right trigger thumb condition as well as an "early deQuervain's syndrome." (Ex. 4). The insurer accepted a claim for right carpal tunnel syndrome. (Ex. 5).

Claimant has had three compensable surgeries as a result of her compensable injury. On November 15, 1990, Dr. Layman performed a right carpal tunnel release and a bilateral trigger thumb release. (Ex. 6). Claimant had surgical treatment for the right de Quervain's syndrome on March 11, 1991, when Dr. Layman operated to release the first dorsal compartment in her right wrist. (Ex. 9). After surgery, Dr. Layman reported that claimant remained symptomatic in her right forearm.

Dr. Nathan examined claimant on behalf of the insurer on August 27, 1991 and reported that the de Quervain's surgery did not provide the anticipated relief of her symptoms. (Ex. 19). He noted that claimant continued to have symptoms in the right first dorsal compartment and he recommended a course of iontophoresis, followed by a work hardening program. He said that if that treatment failed, it might be worthwhile to consider re-release of the right first dorsal compartment, due to the possibility of the presence of a deeper compartment which was not found during the initial surgery. (Id.) However, Dr. Nathan believed that surgery should be the treatment of last resort. (Ex. 22).

On September 25, 1991, Dr. Layman reported that he had initiated the treatment suggested by Dr. Nathan and reported that claimant's findings were consistent with "entrapment of the superficial radial nerve in scar." (Ex. 23). Dr. Layman subsequently performed surgery on January 6, 1992. (Ex. 26). The operation was "excision of tendon sheath, first dorsal compartment right wrist, and neurolysis of superficial radial nerve, right forearm." (Id.) Dr. Layman found no evidence of neuroma in the area.

Approximately one month later, Dr. Layman reported that claimant had had no relief of her discomfort since surgery. (Ex. 10-3). He noted that claimant had been working with a therapist who had noticed, as did Dr. Layman, that she had "some color change, right versus left, and seems to have pain out of proportion to the surgical procedure consistent with an RSD [reflex sympathetic dystrophy]." (Id).

On October 15, 1992, Dr. Nye examined claimant and reported that her complaints were different than they were originally. Claimant no longer had numbness and tingling of median nerve compression at the wrist, trigger thumbs or complaints of deQuervain's tenosynovitis. (Ex. 40). However, claimant did have symptoms of superficial branch of the radial nerve irritation. Dr. Nye blocked the superficial branch of the radial nerve with complete relief of her discomfort. He reported that the "only satisfactory treatment" is to "divide the superficial branch of the radial nerve and translocate the stump proximally and bury it in muscle." (Id).

Dr. Layman requested authorization to perform surgery. The insurer sent the request to its managed care organization (MCO) for review and the request was denied. The insurer subsequently denied compensability of claimant's neuroma and reflex sympathetic dystrophy conditions and any surgery for those conditions. At hearing, the ALJ found those conditions compensable and concluded that surgery was reasonable and necessary.

Claimant agrees with the ALJ that her neuroma and reflex sympathetic dystrophy conditions are compensable because the compensable injury and the treatment for the compensable injury are the major contributing cause of these consequential conditions. Where a claimant suffers a new injury as the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A). Barrett Business Services v. Hames, 130 Or App 190, rev den 320 Or 492 (1994).

Claimant relies on the opinions of Drs. Layman and Nye to establish causation. Dr. Layman reported that claimant's grip strength findings and inability to perform rapid repetitive wrist or hand motion were due to "the conditions of reflex sympathetic dystrophy and/or neuroma which are consequences of the treatment that she had for her De Quervain's syndrome, the accepted condition." (Ex. 63). In a subsequent letter, Dr. Layman clarified that claimant had been diagnosed as having a "reflex sympathetic dystrophy due to injury/neuroma of the superficial radial nerve" that occurred "as a result of surgical treatment for her DeQuervain's syndrome." (Ex. 66). Dr. Layman's opinion is supported by Dr. Nye, who reported that claimant "did have evidence of a neuroma of the superficial branch of the radial nerve which is directly related to the deQuervain's surgery." (Ex. 65).

The insurer contends that the preponderance of medical evidence establishes that claimant does not have neuroma or reflex sympathetic dystrophy. The insurer relies on reports suggesting that claimant's subjective complaints are unreliable. Dr. Ochoa, neurologist, believed that claimant was suffering from "chronic idiopathic painful syndrome," although he noted that sympathetically maintained pain and partial neuroma must be ruled out. (Ex. 29-30). Dr. Ochoa also recommended a psychiatric evaluation because he believed claimant had somatoform disorders. (Ex. 29-31).

Dr. Parvaresh, a psychiatrist, performed an insurer-arranged medical examination on September 3, 1992 and found that claimant did not have a diagnosable psychiatric disorder. (Ex. 37-6). Dr. Parvaresh did not find evidence of a somatoform pain disorder. He noted, however, that there was a "lot of hysterical pattern of behaving and coping involved." (Id). Dr. Parvaresh reported that claimant did not need psychiatric treatment.

Dr. Ochoa disagreed with Dr. Parvaresh. According to Dr. Ochoa, the fact that claimant's condition did not fit the diagnostic criteria did not mean that her psychiatric profile had no diagnosis or treatment. (Ex. 39). Dr. Ochoa believed that claimant would benefit from a psychological perspective. (Id.) Dr. Seres, neurosurgeon, agreed with Dr. Ochoa that claimant had a somatoform pain disorder. (Ex. 53). Dr. Button, surgeon, performed a records review and found the "entire sequence of events very implausible" regarding claimant's right upper extremity symptoms. (Ex. 41).

In light of Dr. Parvaresh's specialized expertise as a psychiatrist, we defer to his opinion that claimant did not have a somatoform pain disorder or any other diagnosable psychiatric condition and that she did not need psychiatric treatment. See Abbott v. SAIF, 45 Or App 657, 661 (1980). Consequently, we are not persuaded by the opinions of other physicians that discredited claimant's symptoms on the basis of a somatoform pain disorder and we reject the insurer's argument that claimant's subjective complaints are unreliable.

The insurer contends that it is impossible for the March 1991 deQuervain's surgery to be the cause of claimant's current symptoms. The insurer asserts that claimant had been complaining of those symptoms since a year and a half before that surgery. We disagree.

Although the insurer focuses only on the second surgery on March 11, 1991, the medical evidence indicates that both the second and third surgeries were required to treat claimant's deQuervain's syndrome. Furthermore, as we discussed above, Dr. Nye reported after the third surgery that claimant's complaints were different than they were originally and that she no longer had numbness and tingling of median nerve compression at the wrist, trigger thumbs or complaints of deQuervain's tenosynovitis, but she did have symptoms of superficial branch of the radial nerve irritation. (Ex. 40).

When the medical evidence is divided, we tend to give greater weight to claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). As the physician who performed three surgeries on claimant, Dr. Layman had a better opportunity to evaluate claimant's condition than the other physicians. We are persuaded by Dr. Layman's reports, as supported by those of Dr. Nye, that the major contributing cause of the consequential neuroma and reflex sympathetic dystrophy conditions was the previous reasonable and necessary treatment for the compensable injury. Accordingly, we conclude that claimant has established the compensability of the consequential neuroma and reflex sympathetic dystrophy conditions. See Barrett Business Services v. Hames, supra.

Jurisdiction over Proposed Surgery

The insurer denied compensability of claimant's neuroma and reflex sympathetic dystrophy and proposed surgery on the basis that the preponderance of medical evidence indicated that there was no neuroma or reflex sympathetic dystrophy and also that the conditions, if they existed, were not a consequence of the compensable injury. (Ex. 61). The ALJ concluded that claimant was entitled to have the surgery proposed by Dr. Layman. The insurer argues that the Director has exclusive jurisdiction of the dispute concerning the reasonableness and necessity of surgery.

After issuance of the ALJ's order, the legislature enacted Senate Bill 369 and amended ORS 656.245, ORS 656.260 and ORS 656.327, effective June 7, 1995. The legislature added ORS 656.245(6), which provides that, if a medical services claim is disapproved for any reason other than the formal denial of compensability of the underlying claim and the disapproval is disputed, the injured worker or carrier "shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327." (Emphasis added). Or Laws 1995, ch 332, § 25(6) (SB 369, § 25). Amended ORS 656.327(1) provides that if an injured worker, a carrier, or the Director believes that an injured worker's medical services, not subject to ORS 656.260, are excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." (Emphasis added). SB 369, § 41(1). In addition, amended ORS 656.260(6) provides that issues concerning the "provision of medical services to injured workers subject to a managed care contract" shall be subject to the Director's exclusive review authority. SB 369, § 27(6).

Generally, the changes made to the Workers' Compensation law made by SB 369 apply to cases in which the Board has not issued a final order or for which the time to appeal the Board's order has not expired on the effective date of the Act. Volk v. America West Airlines, 135 Or App 565, 569 (1995).

In Walter L. Keeney, 47 Van Natta 1387 (1995), we concluded that the amendments to ORS 656.327, as well as the new provision, ORS 656.245(6), apply to claims currently pending before the Board. We held that the language of ORS 656.327(1) and ORS 656.245(6) clearly revealed the legislature's intent that medical services disputes be resolved exclusively by the Director, not the Board or

Hearings Division. Accordingly, based on the text and context of amended ORS 656.327(1), as read in conjunction with SB 369's retroactivity provisions, we concluded that the Director has exclusive jurisdiction over ORS 656.327(1) medical services disputes, including those presently pending before the Board.

Here, although the claim for surgery was initially denied on the basis that the underlying consequential claim was not compensable, we have concluded that claimant's neuroma and reflex sympathetic dystrophy conditions are compensable. Therefore, the medical service dispute regarding proposed surgery no longer pertains to the compensability of claimant's underlying claim. Rather, the issue to be decided is whether the proposed surgery requested by Dr. Layman is reasonable and necessary. Because jurisdiction over this matter rests with the Director, rather than the Hearings Division, we vacate the portion of the ALJ's order that purported to decide the issue of proposed surgery.

Penalty for Unreasonable Denial

Finding the "MCO" referral process for claimant's proposed surgery to be insufficient to comply with the insurer's obligation to timely accept or deny the claim, the ALJ awarded a penalty for an unreasonable delay in processing the surgery claim. The ALJ's penalty assessment was not based on an unreasonable denial, i.e., the ALJ did not find that the insurer had unreasonably contested the causal relationship between the proposed surgery and claimant's compensable condition.

The insurer argues that the ALJ erred in finding an unreasonable delay in the denial of surgery. According to the insurer, the ALJ's ruling regarding the insurer's delay in accepting or denying the surgery is not supported by evidence in the record and is based on an erroneous construction of the statutes.

Section 42d(5) of Senate Bill 369 provides: "Notwithstanding any other provision in ORS 656.382 or 656.386, an Administrative Law Judge or the Workers' Compensation Board may not award penalties or attorney fees for matters arising under the review jurisdiction of the director." SB 369, § 42d(5).

Inasmuch as we have concluded that the Director has jurisdiction of the proposed surgery request, the Director also has jurisdiction over penalties related to the alleged delay in the denial of surgery pursuant to section 42d(5) of Senate Bill 369. Therefore, we vacate the portion of the ALJ's order that purported to award a penalty for the delay in the denial of the proposed surgery request.

We retain jurisdiction over the penalty issue to the extent that claimant's request for a penalty assessment pertains to the insurer's unreasonable denial of a causal relationship between the proposed surgery and claimant's accepted condition.

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." Amended ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and " legitimate doubt" are to be considered in the light of all the evidence available. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

In its denial, the insurer asserted that the medical evidence indicated that there was no neuroma or reflex sympathetic dystrophy and, if those conditions did exist, the evidence did not establish that they were a consequence of claimant's industrial injury. At the time the insurer issued its denial, it had reports from Dr. Seres and Dr. Ochoa that claimant had a somatoform pain disorder. In addition, Dr. Button found the sequence of events "very implausible" regarding claimant's right upper extremity symptoms. In light of those medical reports, we conclude that the insurer had legitimate doubt as to its liability. Consequently, its denial was not unreasonable.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). 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 concerning the compensability issue is $2,000, 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 and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved. Finally, claimant is not entitled to an attorney fee for services on review regarding the proposed surgery issue.

ORDER

The ALJ's order dated November 23, 1994 is vacated in part and affirmed in part. Those portions of the order which pertained to the issues of proposed surgery and the award of a penalty for the alleged delay in the denial of the proposed surgery request are vacated and claimant's request for hearing on those issues is dismissed for lack of jurisdiction. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by the insurer.

Board Member Gunn specially concurring.

In regard to the proposed surgery issue, I refer the parties to my concurring/dissenting opinion in Walter L. Keeney, 47 Van Natta 1387 (1995). This case illustrates the concerns I expressed in Keeney. Here, claimant has been attempting to get surgical treatment for her right arm condition for over two years. Now, because of the retroactivity clause of Senate Bill 369, she has to relitigate the proposed surgery issue and start all over again with the Director.

As I pointed out in Keeney, application of the statutory amendments to this pending case is inconsistent with the purposes and policies of the workers' compensation law. Creation of another forum actually increases litigation and delays the provision of medical services.

Relitigating the proposed surgery issue with the Director does not provide "prompt and complete medical treatment for injured workers" under ORS 656.012(2)(a) and it is contrary to the objective stated in ORS 656.012(2)(c), which is "[t]o restore the injured worker physically and economically to a self-sufficient status in an expeditious manner." (Emphasis added). Furthermore, the new procedure creates more litigation, which frustrates the legislature's objective in ORS 656.012(2)(b) to reduce litigation to the greatest extent practicable. In my view, applying the amendments retroactively in this case does not serve a legitimate legislative purpose.

September 7, 1995 Cite as 47 Van Natta 1585 (1995)

In the Matter of the Compensation of
JOSEPH M. CHAMP, Claimant
WCB Case No. 94-07788
ORDER ON REVIEW
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Poland's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for low back, buttock and lower extremity condition. On review, the issue is compensability.

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

The ALJ concluded that the medical evidence failed to establish that the major contributing cause of claimant's low back condition was his work activities. In so doing, the ALJ found that the opinion of Dr. Karasek, which supports the compensability of claimant's claim, is unpersuasive.

On review, claimant contends that the physicians' reports and testimony support the compensability of his occupational disease claim. We disagree.

In order to establish an occupational disease claim, claimant must prove that his work activities were the major contributing cause of his low back condition or its worsening. ORS 656.802(1)(c)[1]; Roseburg Forest Products v. McSperitt, 108 Or App 288 (1991). Claimant has the burden of proof to present medical evidence affirmatively attributing his condition to his work activities, on the basis of medical probability, rather than possibility. See Miller v. SAIF, 60 Or App 557 (1982).

Dr. Hacker, on referral from Dr. Lundsgaard (treating physician), found that claimant had a mid-level compression fracture. Dr. Hacker initially diagnosed claimant's condition as chronic low back pain, likely the result of a displaced intervertebral disc. (Ex. 13-2). To confirm his diagnosis, Dr. Hacker ordered a lumbar discography. The discography revealed degenerative disc disease without concordant pain production. Based on these results, Dr. Hacker changed his diagnosis, stating that claimant's low back pain was not caused by a displaced intervertebral disc. (Ex. 18-1). Dr. Hacker was unable to offer an opinion as to the cause of claimant's condition. (Ex. 18-2).

Dr. Hunt, on behalf of SAIF, examined claimant and diagnosed chronic low back pain and stiffness in low back and hips. (Ex. 14-7). Dr. Hunt opined that claimant's condition was possibly the result of overuse syndrome. Id. at 8.

Dr. Karasek, on referral from Dr. Hacker, believed that claimant's pain was probably due to L5-S1 disc. Dr. Karasek ordered a discography to confirm his diagnosis, which was not performed. Dr. Karasek opined that the major contributing cause of claimant's low back condition was due to his work activities.

Here, we find, as did the ALJ, that there is no persuasive medical opinion which supports the compensability of claimant's low back condition. Dr. Hacker was unable to state an opinion in regard to the cause of claimant's condition. Dr. Hunt's opinion that claimant's condition was due to "overuse syndrome" is couched in terms of possibility rather that probability and is therefore unpersuasive. See Miller v. SAIF, supra. (medical opinions based on possibility rather that probability are not persuasive).

Although Dr. Karasek's opinion supports the compensability of claimant's claim, it is unpersuasive for two reasons. First, Dr. Karasek's diagnosis of L5-S1 disc pain was made without the support of a discogram which he believed would help to confirm his diagnosis. And secondly, Dr. Karasek's opinion is conclusory in that it is limited to a one sentence statement, without explanation as to how he arrived at his opinion. See Somers v. SAIF, 77 Or App 259, 263 (1986) (opinions that are conclusory and not well-reasoned are not given much weight). Therefore, we conclude that there is no medical opinion in the record, which affirmatively and persuasively establishes that the major contributing cause of his low back condition was due to his work activities. Consequently, claimant's occupational disease claim is not compensable.

ORDER

The ALJ's order dated February 2, 1995 is affirmed.

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[1] After the ALJ's order, the legislature enacted Senate Bill 369 which amended ORS 656.802. Or Laws 1995, ch 332 § 56 (SB 369 § 56). However, under either the former or amended versions of ORS 656.802, the outcome of this case remains the same. Therefore, we need not resolve the question of which version is applicable.

In the Matter of the Compensation of
MICHAEL G. EVEY, Claimant
WCB Case No. 94-11693
ORDER ON REVIEW
Susak, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the insurer's denials of claimant's claustrophobia. On review, the issue is compensability.

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

Claimant seeks compensation for claustrophobia that he contends was rendered symptomatic by work exposure. To establish the compensability of that condition as an occupational disease, claimant must prove, inter alia, that his work activities were the major contributing cause of that condition. ORS 656.802(2).[1] "Major contributing cause" is the primary cause of a condition; the precipitating cause may or may not be the primary cause of that condition. Dietz v. Ramuda, 130 Or App 397, 401, (1994); see Shanti M. Uri, 47 Van Natta 289, 292 (1995) (applying Dietz to psychological condition claim).

Claimant relies on the report of Dr. Ushman, treating occupational health physician, which states, "I do not feel that the claustrophobia was actually caused by his employment with [the employer] but I certainly do feel that it became symptomatic and required treatment as a result of a workplace exposure * * *." (Ex. 14A). That report does not meet claimant's burden of proof. Ushman did not address the relative contribution of the work exposure to claimant's symptoms. Therefore, we find that, at most, Ushman's report establishes that claimant's work exposure was the precipitating cause of his current symptoms of claustrophobia. Because a precipitating cause may or may not be the major contributing cause of a worker's condition, we conclude that Dr. Ushman's report is insufficient to establish the compensability of claimant's claustrophobia claim.

Accordingly, for the reasons stated in the ALJ's order, as supplemented here, we affirm the ALJ's decision upholding the insurer's denial.

ORDER

The ALJ's order dated January 3, 1995 is affirmed.

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[1] Claimant's claustrophobia is preexisting; therefore, he must also establish that his work exposure worsened that condition. ORS 656.802(2). We do not address that issue, because we conclude that claimant's claim fails under the "major contributing cause" analysis. For the same reason, we also do not address whether the former or amended version of ORS 656.802 applies. See Or Laws 1995, ch 332, § 56 (SB 369 § 56) (amending ORS 656.802).

In the Matter of the Compensation of
BENITO Z. GONZALEZ, Claimant
WCB Case No. 94-07722
ORDER ON RECONSIDERATION
Steven M. Schoenfeld, Claimant Attorneys
Carrol Smith (Saif), Defense Attorney

On August 10, 1995, we affirmed the Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's partial denial of claimant's claim for degenerative disc disease. Contending that the ALJ failed to decide a relevant issue (whether claimant's accepted lumbar strain was the major contributing cause of his current low back symptoms), claimant seeks reconsideration. Based on the following reasoning, we adhere to our prior decision.

At hearing, claimant agreed that the issues of compensability were those conditions denied by SAIF's June 22, 1994 denial letter. (Tr. 13). SAIF's denial letter stated that it had accepted claimant's lumbar strain, but was denying responsibility for his degenerative arthritis in L4-5, L5-S1, left upper shoulder, anterior chest wall and thoracic spine conditions. At the reconvened hearing, claimant again agreed that the issues were those conditions denied by SAIF's denial letter. (Tr. 60-61). Because the issue of the compensability of claimant's current low back symptoms (other than those attributable to the expressly denied conditions in the June 22, 1994 letter), we decline to address that issue on review.

SAIF accepted a condition at the same time it issued its denial. Therefore, we interpret SAIF's denial to be a "partial denial." See Johnson v. Spectra Physics, 303 Or 49, 58 (1987) (the insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies). As previously noted, SAIF's denial letter accepted claimant's "lumbar strain," but specifically denied responsibility for claimant's degenerative arthritis, left shoulder, anterior chest wall and thoracic spine conditions. (Ex. 12). See Tattoo v. Barrett Business Service, 118 Or App 348 (1993) (the express language of the denial controls the scope of the conditions denied); Weyerhaeuser Co. v. Warrilow, 96 Or App 34, 38 (1989) (partial denial of the claimant's condition needs to be specific). As such, the issues at hearing were the compensability of those conditions denied by SAIF, not the compensability of claimant's current low back condition or symptoms other than any attributable to the denied conditions.

Further, claimant contends that he clearly raised, in closing argument, the issue that his lumbar strain was the major contributing cause of his current low back symptoms. We reject such a contention since we do not address issues raised for the first time in closing argument. See Larry L. Schutte, 45 Van Natta 2085 (1993) (Board will not consider an issue raised for the first time during closing argument); Edward R. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2133 (1989).

In reaching this conclusion, we wish to emphasize that our decision does not expressly pertain to the compensability of claimant's current low back condition or symptoms. To be sure, to the extent that any of claimant's symptoms are attributable to a degenerative disc disease, those symptoms have been found not causally related to claimant's accepted low back strain. Nevertheless, insofar as claimant's symptoms are alleged to be related to claimant's accepted low back strain, this decision will have no effect on such an allegation.

Accordingly, we withdraw our August 10, 1995 order. On reconsideration, as supplemented herein, we adhere to and republish our August 10, 1995 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
JOEL C. GUZEK, Claimant
WCB Case Nos. 93-15107 & 93-11893
ORDER ON REVIEW (REMANDING)
Stoel, Rives, et al, Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of Presiding Administrative Law Judge (ALJ) Tenenbaum's order that: (1) found that claimant had unreasonably delayed the hearing for more than 60 days; and (2) dismissed claimant's hearing request pursuant to OAR 438-06-071. On review, the issue is dismissal. We reverse and remand.

FINDINGS OF FACT

The following procedural history appears from the parties' allegations and briefs on review.

Claimant is currently incarcerated at the Oregon State Correctional Institution. There are two claims at issue in this case. On October 5, 1993, claimant requested a hearing of the September 22, 1993 denial from Liberty Northwest Insurance Corporation (Liberty) of claimant's low back condition. Claimant had alleged that he had injured his lower back in 1986, while working for Liberty's insured.

In the second claim, claimant has requested benefits for a low back condition allegedly related to a July 25, 1980 compensable injury claim with Peter Kiewit & Sons (Kiewit). The original claim for an electrical burn to claimant's left arm was accepted as nondisabling. Claimant subsequently asserted that he was having severe lower back pain and requested benefits.

Claimant wrote to the Hearings Division on October 12, 1993 and November 15, 1993, stating, among other things, that he had never received a response to an August 29, 1993 letter he sent to Kiewit concerning his low back condition. ALJ Quillinan wrote to claimant on December 3, 1993, notifying him that there was no record of a current claim against Kiewit. She suggested that claimant write to Kiewit and its present insurer, Aetna Casualty Co. (Aetna).

In response to ALJ Quillinan's letter, claimant notified Aetna of his claim on December 7, 1993. On December 13, 1993, Aetna issued a denial on the basis that Aetna did not carry worker's compensation insurance for Kiewit at the time of the injury. Aetna notified claimant that he might have a claim with another carrier. On December 14, 1993, claimant notified the other carrier of the claim and sent a copy to the Workers' Compensation Board. ALJ Tenenbaum subsequently interpreted that letter as a request for hearing on Aetna's denial.

On January 4, 1994, Kiewit notified the Hearings Division that it received notice of claimant's apparent aggravation claim on December 9, 1993 and it noted that it was still within the statutory period to accept or deny the claim. There is no indication in the record that Kiewit has formally accepted or denied the claim.

A hearing was convened on January 5, 1994, but was postponed by ALJ Emerson. The hearing was rescheduled, but was subsequently postponed on April 21, 1994.

Claimant submitted a 59 page "affidavit" that described all the events and his history regarding his lower back. On June 30, 1994, claimant wrote to ALJ Emerson and requested that the hearing not be scheduled until all discovery had been completed. He enclosed a copy of a June 13, 1994 letter sent to Kiewit, which was a 19 page request for discovery. On July 11, 1994, Kiewit wrote to ALJ Tenenbaum requesting relief from complying with claimant's discovery request. Kiewit advised that the claim was in "Own Motion" status. (Claimant's "five year" aggravation rights running from the date of first closure of his 1980 claim had expired). On July 28, 1994, Kiewit requested a protective order to disallow claimant's discovery request and relieve the parties of any duty to respond.

Claimant wrote to ALJ Tenenbaum on July 29, 1994, notifying her that he had been in an accident and would not be able to immediately respond to the discovery issues. On August 19, 1994, claimant requested a hearing to resolve all issues related to discovery. Claimant wrote to ALJ Tenenbaum on September 26, 1994 and asked that a hearing not be scheduled until late December 1994 because he was involved in a pending case in Marion County Circuit Court.

On October 11, 1994, Aetna filed a motion to dismiss, arguing that claimant had not filed a request for hearing on Aetna's December 13, 1993 denial. Claimant objected to Aetna's motion on October 13, 1994.

On October 14, 1994, ALJ Tenenbaum advised the parties that she would not rule on the "discovery" issues until she was clear on claimant's issues and each defendant's legal defenses. In regard to claimant's 1986 claim against Liberty's insured, the ALJ asked claimant to advise "what conditions you have that you believe are Liberty's responsibility." In regard to claimant's 1980 "Kiewit" claim, the ALJ stated, in part:

> "At this point, the five year time period for filing a claim of aggravation on the 1980 injury has also passed. That places the claim in 'own motion' status, governed by ORS 656.278. The Board's 'own motion' authority is limited to awarding time loss if claimant has surgery or is hospitalized. However, claimant is incarcerated, and in 1990 the legislature passed a new law, ORS 656.160, that says that regardless of other provisions of the workers' compensation statutes, an injured worker is not eligible to receive temporary disability benefits while incarcerated for the commission of a crime. You should also be aware that the Board does not have the power to award permanent partial or permanent total disability benefits to a worker with respect to a claim that is in 'own motion' status.
>
> "All this being the case, I am unclear about what relief you seek from the Hearings Division with respect to the 1980 claim, Mr. Guzek, and I need you to say clearly what relief you seek on the 1980 claim before I will go any further on it. At some point, it may be appropriate for me to refer the matter to the Board itself if "own motion" relief is requested."

On December 5, 1994, Aetna again moved for an order of dismissal. Liberty and Kiewit did not object. Claimant did not respond to Aetna's December 5, 1994 motion. On January 11, 1995, ALJ Tenenbaum issued an Interim Order of Dismissal as to Aetna and stated that the dismissal would be incorporated into a final order resolving all claimant's requests for hearing.

On January 13, 1995, ALJ Tenenbaum issued claimant an Order to Show Cause. The ALJ referred to the October 14, 1994 letter and noted that claimant had not responded to the letter in any fashion. Citing OAR 438-06-071(1), the ALJ allowed claimant 20 days to show good cause why his requests for hearing should not be dismissed with prejudice.

Claimant responded to the Order to Show Cause by document dated January 23, 1995, which was received by the Hearings Division on January 31, 1995. Claimant referred to previous letters in which he had asked the ALJ not to schedule any hearings until about December 1994 or until further notified because of a pending circuit court case. Claimant advised the ALJ that he was about 20 to 25 percent finished with his circuit court case. He stated that he was overwhelmed with trying to work on his workers' compensation cases and the circuit court case at the same time. Due to medical problems, claimant said that he could only work on the cases for a limited time each day. Claimant requested a postponement, stating that he said he would notify the ALJ as soon as the circuit court case was complete. He also discussed the merits of his discovery requests.

On March 6, 1995, the ALJ issued a dismissal order. Finding that claimant had offered no valid justification for the extremely broad discovery requests, the ALJ denied his motion for a hearing on the discovery requests. The ALJ found that none of the documents claimant had filed adequately stated a justiciable controversy over which the Hearings Division had jurisdiction and that claimant had failed to state what issues he raised with respect to the claim against Liberty. The ALJ concluded that claimant had had ample time to attend to these matters and that he had, without good cause, been responsible for unjustified delays of more than 60 days. The ALJ dismissed claimant's hearing requests with prejudice.

CONCLUSIONS OF LAW AND OPINION

The ALJ is authorized to dismiss a proceeding under OAR 438-06-071(1) only if "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." Here, there is no evidence that claimant has abandoned his request for hearing. Therefore, the issue is whether claimant's conduct resulted in an unjustified delay in the hearing.

In the Order to Show Cause, the ALJ found that it was in the interest of substantial justice to not unduly expend the resources of the Hearings Division or the parties on "frivolous litigation." In her October 14, 1994 letter to claimant, the ALJ advised claimant that she was unclear about what relief he sought on the 1980 claim and she requested that he "say clearly what relief you seek on the 1980 claim before I will go any further on it." The ALJ also directed claimant to advise her of what conditions he believed were Liberty's responsibility with respect to the 1986 claim. In the dismissal order, the ALJ found that claimant had failed to "adequately state a justiciable controversy over which the Hearings Division has jurisdiction" in connection with his 1980 "Kiewit" claim. In regard to the 1986 "Liberty" claim, the ALJ found that claimant had failed to state what issues he raises with respect to the claim against Liberty.

Kiewit argues that claimant has been "unable to articulate a basis for relief" against Kiewit. In other forms of civil litigation under Oregon law, the parties may file motions pursuant to ORCP 21 that require the adversary party to clarify and specify the claims, i.e., motions to dismiss for failure to state ultimate facts sufficient to constitute a claim, ORCP 21(A)(8), motions to make more definite and certain, ORCP 21D, etc. In addition, summary judgment is available pursuant to ORCP 47 if a party can show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. At the time of the ALJ's order, the workers' compensation statutes and rules did not provide a similar procedure. The ALJ had no statutory or administrative authority to dismiss claimant's hearing requests because he could not adequately state a "justiciable controversy," particularly since claimant is proceeding pro se.

Claimant argues that his post-conviction case is still pending and that it is medically impossible for him to pursue his post-conviction case and the workers' compensation cases at the same time. Claimant asserts that he spends 18 to 20 hours per day in his hospital bed, due to extreme pain in his lower back and legs. Claimant also states that he has limited access to the law library and a typewriter. Claimant contends that he has done his best to comply with the ALJ's requests for more precise information and that he cannot offer any other relevant information until there is a hearing.

Under these circumstances, we are not persuaded that claimant "unjustifiably" delayed the hearing. OAR 438-06-071(1) does not authorize the dismissal of a claimant's request for hearing unless the delay was unjustified. See Nick Shevchynski, 46 Van Natta 1297 (1994) (no basis for the ALJ's finding that the claimant's lack of cooperation caused an unjustified delay); Shirley A. McCoy, 46 Van Natta 19 (1994) (insurer's motion to dismiss on the ground that the claimant had offered no medical evidence proving causation was not authorized under OAR 438-06-071). Consequently, we vacate the ALJ's dismissal and reinstate claimant's hearing requests.

Our decision should not be interpreted as a ruling on the merits of the parties' arguments (particularly Aetna's and Kiewit's requests to be dismissed as parties to this proceeding). Furthermore, on remand, the parties may wish to consider the impact amended ORS 656.308(2)(c) may have on this case. On remand, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice to all parties.

ORDER

The ALJ's order dated March 6, 1995, as amended March 10, 1995, is vacated. Claimant's requests for hearing are reinstated. This matter is remanded to the Presiding ALJ for further proceedings consistent with this order.

In the Matter of the Compensation of
TIMOTHY O. LOGSDON, Claimant
WCB Case No. 95-01016
ORDER ON REVIEW
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Nichols' order that dismissed his request for hearing on an Order on Reconsideration/Notice of Closure as untimely. On review, the issue is the propriety of the dismissal order.

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

ORDER

The ALJ's order dated April 17, 1995 is affirmed.

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[1] Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.268, changing the time limitations within which a request for reconsideration and a request for hearing on an order on reconsideration must be made. Or Laws 1995, ch 332, § 30 (SB 369, § 30). However, amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively. SB 369, § 66(6); Motel 6 v. McMasters, 135 Or App 583, 587 (1995). Because this case involves a procedural time limit, the amended version of ORS 656.268 does not apply here.

In the Matter of the Compensation of
JAMES H. McKEANE, JR., Claimant
WCB Case No. 94-01350
ORDER ON REVIEW
Parks & Ratliff, Claimant Attorneys
Thomas J. Dzieman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

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

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

Claimant injured his low back in early January 1993, while working as a volunteer emergency medical technician (EMT). (Tr. 22). Self Insured Management Services, Inc. (SIMS) initially accepted the claim, then issued a "back-up" denial. Subsequently, SIMS and claimant entered into a Disputed Claim Settlement (DCS).

Claimant was employed by SAIF's insured at the time he sustained the injury as a volunteer EMT. After he entered into the DCS with SIMS, claimant filed an injury claim and an occupational disease claim for a low back condition with SAIF.

Claimant contends that his work activity with SAIF's insured could have worsened his low back condition which initially herniated in January 1993 while working as a volunteer for the ambulance service. Therefore, relying on Bennett v. Liberty Northwest Insurance Corp., 128 Or App 71 (1994), claimant argues that SAIF is responsible for his low back condition under the last injurious exposure rule. The ALJ concluded that the last injurious exposure rule was not applicable in this case. We agree.

In Bennett, the claimant contended that his hearing loss was caused by exposure to noise at two separate employments. The claimant entered into a disputed claim settlement with the first employer, but continued to pursue his hearing loss claim against the second employer. The court held that if the claimant could show that employment conditions at both employers were the major contributing cause of his hearing loss, the claimant could rely on the last injurious exposure rule to prove the compensability of the claim against the second employer by showing that employment conditions there could have caused the condition. Id at 78.

Here, unlike Bennett, claimant initially filed an injury claim with SIMS for a discrete injury that occurred on January 1, 1993. The medical evidence shows that claimant's disc herniation occurred on January 1, 1993, when he was lifting a heavy patient on a stretcher while volunteering as an EMT. (See Exs. 33, 38, 47, 58-6). Subsequently, claimant entered into a DCS with SIMS in regard to his low back condition. Based on Bennett, we must examine the language in the DCS to determine whether claimant agreed that his work for the employer did not contribute in any way to his condition. See Kristin Montgomery, 47 Van Natta 961 (1995).

In the DCS, claimant agreed that the employer's denial of the low back/disc herniation condition/symptoms, as supplemented by its contentions in the agreement, would "stand affirmed and claimant shall have no further claim against the employer/administrator * * *." The DCS further provided that claimant's work activities at the employer were not a material, or the major, cause of claimant's low back/disc herniation symptoms/condition, or an aggravation thereof.

Based on Bennett, supra, we find that claimant's DCS with SIMS evidenced an agreement by claimant that his work with the employer did not contribute in any way to his current low back condition. See Lola K. Springer, 46 Van Natta 2213 (1994). In other words, the aforementioned provisions establish that claimant elected to prove actual causation against SAIF's insured. Kristin Montgomery, supra. Therefore, claimant cannot rely on her employment exposure with the employer to establish compensability of her condition.

Here, in light of the medical evidence, we are not persuaded that claimant sustained an injury at SAIF's insured. Accordingly, we agree with SAIF's contention that claimant must prove that his work activities while working for SAIF's insured following his January 1, 1993 low back injury were the major contributing cause of a worsening of his low back condition. We further agree that claimant has failed to sustain his burden of proof.

ORDER

The ALJ's order dated October 26, 1994 is affirmed.

September 7, 1995 Cite as 47 Van Natta 1593 (1995)

In the Matter of the Compensation of
RAM NARAYAN, Claimant
WCB Case No. 91-12335
ORDER ON REVIEW
Ackerman, et al, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) McCullough's order that increased claimant's unscheduled permanent disability award for a left shoulder injury from 22 percent (70.4 degrees) as awarded by an Order on Reconsideration, to 29 percent (92.8 degrees). On review, the issue is extent of unscheduled permanent disability.

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

At hearing and on review, claimant argues that he is entitled to an adaptability factor of 6 based on his residual physical capacity of light work with restrictions, pursuant to former OAR 436-35-310(4) and (5). We agree with the ALJ that the preponderance of the medical evidence establishes that claimant has a residual physical capacity of light work, not light work with restrictions.

Under the relevant portion of former OAR 436-35-310(5), a worker is "considered to be restricted where the preponderance of medical opinion establishes that the worker is permanently precluded from frequently performing at least three of the following activities: stooping, crouching, kneeling, twisting, climbing, pushing or pulling." (Emphasis added). We agree with the ALJ that there is no medical evidence that claimant is precluded from frequently performing at least three of those activities.

Claimant argues that the limitations placed on him by various physicians necessarily preclude him from performing at least three of these activities. However, the Board is without the expertise to make such a medical inference. Furthermore, former OAR 436-35-310(5) requires that a preponderance of medical opinion establish these restrictions.

Claimant also argues that, on July 25, 1990, Dr. Butters, treating physician, restricted claimant from climbing, pushing, and pulling. (Ex. 6). However, we agree the ALJ that, because this report was issued months before claimant became medically stationary, it is not persuasive evidence of claimant's condition after he became medically stationary or at the date of reconsideration, the relevant date for evaluating claimant's disability. ORS 656.283(7). In this regard, claimant relies on Dr. Butters' notation that the July 25, 1990 restrictions were "permanent." (Ex. 6-2). However, in a September 4, 1990 report, Dr. Butters noted that claimant had made "significant progress" in his shoulder over the "last several months." (Ex. 7-1). These comments place in doubt the permanency of Dr. Butters' pre-medically stationary restrictions.

More importantly, no physician restricts claimant from at least three of the above listed activities after claimant became medically stationary. By his pre-medically stationary report, Dr. Butters showed that he was aware of how to indicate restrictions on these types of activities. However, he did not repeat these restrictions after claimant became medically stationary.

Consequently, we agree with the ALJ that the preponderance of the medical evidence establishes that claimant is capable of light work, which entitles him to an adaptability value of 4. Accordingly, we affirm the ALJ's award of 29 percent unscheduled permanent disability.

ORDER

The ALJ's order dated January 25, 1995 is affirmed.

September 7, 1995 Cite as 47 Van Natta 1594 (1995)

In the Matter of the Compensation of
JANELL TACKET, Claimant
WCB Case No. 94-09533
ORDER ON REVIEW (REMANDING)
Francesconi & Associates, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that dismissed her request for hearing with prejudice. Claimant filed no brief.[1] On review, the issue is the propriety of the ALJ's dismissal order. We vacate the ALJ's order and remand.

FINDINGS OF FACT

Claimant requested a hearing on August 3, 1994. The issues raised were the compensability of a consequential stress condition, penalty and attorney fees. The insurer did not file a cross-request for hearing. Hearing was scheduled for November 2, 1994.

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[1] The insurer provided a copy of a July 10, 1995 letter in which claimant's present attorney resigned as claimant's counsel in a case different from this one (WCB 94-15255). The insurer contends that this letter, in combination with claimant's failure to provide a brief in this case, indicates that the appeal has been abandoned. Claimant has provided no indication that her counsel is no longer representing her in this case or that she has abandoned her appeal. Moreover, failure to file a brief is not jurisdictional. OAR 438-11-020(1). Consequently, we have proceeded with our review.

On October 18, 1994, claimant withdrew her request for hearing and asked that the matter be dismissed without prejudice. On October 27, 1994, the insurer moved for an order of dismissal with prejudice. No hearing was held.

The ALJ's Order of Dismissal issued on December 14, 1994. The order indicated that claimant's request for hearing was dismissed with prejudice. The ALJ's order did not provide any reason(s) for the decision. Claimant requested review.

CONCLUSIONS OF LAW AND OPINION

When the party requesting a hearing moves for dismissal, and there is no cross-request for hearing, the ALJ has discretion to set the terms and conditions of an order of dismissal as he or she deems proper. We will not disturb the terms and conditions imposed by the ALJ except under a showing of an abuse of discretion. See Julie Mayfield, 42 Van Natta 971 (1990). However, in the absence of reasons for such a dismissal, we have found it appropriate to remand to the ALJ for the inclusion of such reasons. Ronald D. Robinson, 44 Van Natta 1232 (1992).

Here, no hearing was held and the ALJ's order of dismissal provided no reasoning regarding the ALJ's decision to issue the order of dismissal with prejudice.

We have previously concluded that, without a record containing the ALJ's reasoning on an issue involving an exercise of the ALJ's discretion, we are unable to review for an alleged abuse of discretion. Ronald D. Robinson, supra. Since the ALJ's order provides no reason for dismissing the request for hearing with prejudice, we find this record "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5); Ronald D. Robinson, supra.

Consequently, we vacate the ALJ's December 14, 1994 order. This matter is remanded to ALJ Podnar with the following instructions. ALJ Podnar shall issue a final, appealable order on remand explaining his reasons for issuing the dismissal order with prejudice. Thereafter, should claimant wish to again request Board review of the ALJ's order, she may do so. At that point, we would then be able to conduct our review for "abuse of discretion."

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID E. THOMPSON, Claimant
WCB Case No. 94-11505
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that upheld the SAIF Corporation's denial of claimant's low back injury claim. On review, the issues are timeliness of the claim and compensability.

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

On review, claimant argues that SAIF was not prejudiced by his untimely filing of his low back injury claim because he reported the injury soon after he first sought treatment for low back pain following his attempt to play basketball with his children. Claimant asserts that SAIF cannot argue prejudice based on its inability to obtain medical evidence prior to the time that claimant first required medical treatment, contending that no physician could have examined claimant before he sought medical treatment.

However, as the ALJ found, claimant's untimely filing of his low back injury claim prevented SAIF from obtaining medical evidence between the date of the alleged work injury and the date of the basketball incident. Furthermore, as the ALJ found, this prejudice is supported by medical evidence and is not merely speculation. The relevant factor is that SAIF was prevented from obtaining medical evidence during this relevant period, not that claimant did not seek medical treatment.

Claimant also relies on statutory definitions of "compensable injury," "claim," and "compensation" in support of his argument that he had no basis to make an injury claim before he sought medical services following the basketball incident. ORS 656.005(6); 656.005(7)(a); 656.005(8). Therefore, he contends, the employer received timely notice of the "claim" when he reported it within 30 days of first receiving medical treatment. We find no merit in this argument.

ORS 656.265[1] provides the requirements for the timely filing of an injury claim. The various definitional statutes cited by claimant do not control the timeliness issue. ORS 656.265(1) provides that notice of an accident resulting in an injury shall be given "not later than 30 days after the accident." [Emphasis added]. Thus, timely reporting is not tied to the date of first medical treatment.

ORDER

The ALJ's order dated January 17, 1995 is affirmed.

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[1] ORS 656.265 was amended by the 1995 legislature. SB 369, 68th Leg., Reg. Sess., § 29 (June 7, 1995). However, those amendments apply only to injuries occurring on or after June 7, 1995, the effective date of the Act. SB 369, 68th Leg., Reg. Sess., § 66 (2) (June 7, 1995). Because claimant's alleged injury occurred prior to June 7, 1995, the amendments to ORS 656.265 do not apply to this claim.

In the Matter of the Compensation of
ALDA S. CARBAJAL, Claimant
WCB Case No. 94-05806
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) awarded temporary disability compensation from August 10, 1993, less time worked; and (2) awarded a penalty and attorney fee for the employer's allegedly unreasonable failure to pay temporary disability compensation. In addition, claimant requests review of the ALJ's awards of out-of-compensation attorney fees. On review, the issues are temporary disability compensation, penalties, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, correction, and supplementation. We do not adopt the last sentence of the fourth paragraph of the findings of fact. Claimant was injured on May 15, 1992 while working as a mushroom packer, a job that required lifting and weighing boxes of mushrooms weighing 10 to 15 pounds. (Ex. 7, Tr. 29-30).

Claimant continued to work at the mushroom packer job until about October 5, 1992. (Tr. 30, Ex. 2). Thereafter, claimant worked on the belt line position. (Tr. 30). The belt line position did not require lifting and weighing boxes of mushrooms. Id.

On October 28, 1992, Dr. Bolin, treating chiropractor, released claimant to light duty work effective October 29, 1992. (Ex. 4).

In May 1993, claimant experienced increased right shoulder pain caused by the fast pace of work on the belt line position. (Ex. 14-1). Claimant accepted the employer's offer of modified work as a janitor's assistant. (Exs. 12-1, 13, 14-1). Claimant worked at this modified job from May 10, 1993 until August 10, 1993, when the employer withdrew this modified job. (Tr. 6, 11-12, 15). The employer offered no other modified work at that time.

On November 16, 1993, the employer offered claimant a "packer" job, the same job she had at injury. (Ex. 22A). This job included "sorting, dumping, weighing, and filling of mushrooms." Id. On November 23, 1993, claimant returned to work for the employer and worked at the belt line position for about an hour before leaving work. (Tr. 32-34, 41-45). Claimant did not return to her regular "packer" job. Claimant left work because she was not able to perform the job due to her shoulder injury. (Ex. 24-1, -2).

On December 6, 1994, Dr. Stringham, M.D., performed a record review on behalf of the employer. (Ex. 24). On January 6, 1994, Dr. Stringham became claimant's attending physician. (Ex. 28). As of January 6, 1994, and throughout his treatment of claimant, Dr. Stringham restricted claimant's ability to work due to the right shoulder injury. (Exs. 27-2, 27-5, 27-6, 36). Specifically, he limited claimant to no overhead reaching or work above mid-chest to shoulder height and limited repetitive use and movement of the right arm. Id.

On February 9, 1994, Dr. Stringham referred claimant to Dr. Zirschky, orthopedist, for an orthopedic consultation. (Ex. 27-4). Thereafter, claimant received treatment from both Drs. Stringham and Zirschky.

On February 23, 1994, Dr. Zirschky examined claimant. (Ex. 33). On March 7, 1994, claimant changed her attending physician to Dr. Zirschky. (Ex. 34). On March 9, 1994, and throughout his treatment of claimant, Dr. Zirschky restricted claimant's ability to work due to the right shoulder injury. (Exs. 35-1, -2, 39-2, 45). Specifically, he restricted claimant to work below shoulder level and within 18 inches of her body, with no repetitive pushing or pulling, and no reaching to the side with her right arm. Id. On July 21, 1994, Dr. Zirschky released claimant to light work. (Ex. 45).

On April 26, 1994, the parties entered a stipulation, which in pertinent part: (1) rescinded the August 24, 1993 Determination Order and the December 3, 1993 Order on Reconsideration; (2) reopened claimant's right shoulder claim; and (3) awarded an approved attorney fee to claimant's former attorney equal to 25 percent of any additional temporary disability compensation that may be awarded to claimant. Claimant's former attorney subsequently requested the hearing on the present matter, raising the issues of temporary partial and temporary total disability benefits and penalties for unreasonable failure to pay those benefits.

In July 1994, claimant terminated the services of her former attorney and retained her current attorney. By letter dated July 12, 1994, claimant's former attorney notified the ALJ of his lien for the attorney fees awarded by the April 26, 1994 stipulation. In enumerating the issues raised at hearing, the ALJ noted that claimant's former attorney asserted this lien for attorney fees.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Compensation

Subsequent to the ALJ's order and the parties' briefing on review, the legislature passed Senate Bill 369, which became effective June 7, 1995.[1] Or Laws 1995, ch 332 (SB 369). The bill, which is

[1] Because SB 369 contains an emergency clause (section 69), its effective date is June 7, 1995, the date the Governor signed the bill into law. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) ("effective date" of act containing emergency clause is day Governor signs it).

applicable in this case,[2] amended, *inter alia,* ORS 656.005(12)(b)(B), 656.212, and 656.262(4)(g). See Volk v. America West Airlines, supra (generally, changes made by SB 369 apply to cases in which the Board has not issued a final order or the time to appeal the Board's order has not expired on the effective date of the Act, unless a specific exception applies).

The issue regarding temporary disability is limited to claimant's entitlement to temporary disability compensation after August 10, 1993, the date the employer withdrew the modified janitor's assistant job. On October 28, 1992, Dr. Bolin, claimant's treating chiropractor, released claimant to "light duty" work as of October 29, 1992. Relying on that release to modified work and the lack of any subsequent release to regular work by an attending physician, the ALJ awarded claimant temporary disability compensation after August 10, 1993, less time worked. For the reasons discussed below, we modify this award.

The employer argues that claimant is not entitled to temporary disability because her condition is medically stationary and she was earning wages at a "substantially similar" job with another employer. Yet, as a result of the parties' stipulation, claimant's claim remained open. The claim had not been closed as of the date of hearing. Therefore, the issue is procedural entitlement to temporary disability, not substantive entitlement. A claimant's procedural entitlement for all periods of time during an open claim is contingent upon authorization of temporary disability by the attending physician. Former ORS 656.245(3)(b)(B) (since renumbered as ORS 656.245(2)(b)(B), SB 369, § 25); OAR 436-30-036(1).

The employer also argues that claimant is not entitled to temporary disability benefits because no attending physician has authorized such benefits. We disagree.

An "attending physician" is a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury. Amended ORS 656.005(12)(b). Only an attending physician may authorize payment of temporary disability compensation. Amended ORS 656.245(2)(b)(B); Manuel Altamirano, 47 Van Natta 1499 (1995). A chiropractor may serve as an attending physician for a "period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever first occurs[.]" Amended ORS 656.005(12)(b)(B). However, a chiropractor may only authorize payment of temporary disability compensation for the period permitted by amended ORS 656.005(12)(b)(B). Amended ORS 656.262(4)(g).[3] In other words, a chiropractor may only authorize payment of temporary disability for 30 days from the first visit on the initial claim or for 12 visits, whichever first occurs.

Here, claimant first sought medical treatment with Dr. Cummings, chiropractor, on September 28, 1992. (Ex. 1). Dr. Cummings treated claimant twice before he referred her to Dr. Bolin, chiropractor. (Ex. 6-1). On October 28, 1992, Dr. Bolin released claimant to light duty as of October 29, 1992. (Ex. 4). As of October 28, 1992, Dr. Bolin had treated claimant four times. (Ex. 3-1).

As specified above, the issue here is claimant's entitlement to temporary disability after August 10, 1993. Therefore, it does not matter whether Dr. Bolin was in the 30 day/12 visit statutory period, wherein he was authorized to serve as an attending physician, when he released claimant to light duty in October 1992, because his authority to authorize temporary disability expired long before August 10, 1993. Amended ORS 656.005(12)(b)(B); 656.262(4)(g). Accordingly, claimant may not rely on Dr. Bolin's light duty work restriction to establish entitlement to temporary disability for the period in question.

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[2] Section 66 of SB 369 provides, with few exceptions not relevant here, that it is intended to be retroactive, and applies to all claims or causes of action existing or arising after the effective date, regardless of the date of injury or date of the claim. Volk v. America West Airlines, 135 Or App 565 (1995). Moreover, we find that in this case, retroactive application of the new law would not lead to an absurd or unjust result. See Ida M. Walker, 43 Van Natta 1402 (1991). Finally, the Court of Appeals has held that, pursuant to subsection (6) of section 66 of SB 369, the changes made by SB 369 are not applicable when a case involves a procedural time limit. Motel 6 v. McMasters, 135 Or App 583 (1995). However, the present case does not involve a procedural time limit. Having found no relevant exceptions to the retroactive application of SB 369, we determine that it is applicable to this case.

[3] Amended ORS 656.262(4)(g) provides:

"The worker's disability may be authorized only by a person described in ORS 656.005(12)(b)(B) or 656.245(5) for the period of time permitted by those sections. The insurer or self-insured employer may unilaterally suspend payment of temporary disability benefits to the worker at the expiration of the period until temporary disability is reauthorized by an attending physician."

Claimant did not have an attending physician again until she began treating with Dr. Stringham, M.D., on January 6, 1994.[4] (Exs. 27-1, 28). As of January 6, 1994, and throughout his treatment of claimant, Dr. Stringham restricted claimant's ability to work due to the right shoulder injury. (Exs. 27-2, 27-5, 27-6, 36). Specifically, he limited claimant to no overhead reaching or work above mid-chest to shoulder height and limited repetitive use and movement of the right arm. Id.

On February 9, 1994, Dr. Stringham referred claimant to Dr. Zirschky, orthopedist, for an orthopedic consultation. (Ex. 27-4). Thereafter, claimant received treatment from both Drs. Stringham and Zirschky.

On March 7, 1994, claimant changed her attending physician to Dr. Zirschky. (Ex. 34). On March 9, 1994, and throughout his treatment of claimant, Dr. Zirschky restricted claimant's ability to work due to the right shoulder injury. (Exs. 35-1, -2, 39-2, 45). Specifically, he restricted claimant to work below shoulder level and within 18 inches of her body, with no repetitive pushing or pulling, and no reaching to the side with her right arm. Id. On July 21, 1994, Dr. Zirschky released claimant to light work. (Ex. 45).

On this record, we find that claimant was released to modified work by Dr. Stringham, her attending physician, as of January 6, 1994, and she remained released to modified work by her attending physicians (Dr. Stringham and, subsequently, Dr. Zirschky) thereafter. Therefore, we find that claimant's attending physicians authorized temporary disability as of January 6, 1994. OAR 436-30-036(1); Salome Orenday, 47 Van Natta 403 (1995).

Claimant did not return to her regular job as a mushroom packer after about October 5, 1992. Instead, she worked on the belt line position, which did not require lifting and weighing boxes of mushrooms. The belt line position caused increased pain in claimant's right shoulder due to the fast pace of the work. (Ex. 14-1). As a result, claimant accepted the employer's offer of a modified job of a janitor's assistant, which paid claimant's regular wage. Claimant worked at this modified job from May 10, 1993 until August 10, 1993, at which time the employer withdrew the job offer. (Tr. 6, 11-12).

From August 10, 1993 through December 4, 1993, and from July 18, 1994 through July 27, 1994, claimant worked for another employer as a line helper. This line helper job paid a higher wage than claimant's at-injury job.

We have found that claimant's attending physicians authorized temporary disability as of January 6, 1994. Therefore, our inquiry focuses on claimant's entitlement to temporary disability for the period beginning on that date. In regard to that period, the employer contends that claimant is not entitled to temporary disability because she returned to her regular work. We note that ORS 656.268(3)(a) provides for the termination of temporary total disability when a worker returns to regular or modified work. The employer makes two arguments in support of its contention that claimant returned to regular work.

First, the employer argues that claimant returned to her regular work on November 23, 1993 and "left of her own volition" after working about an hour. We disagree with this characterization of the facts.

Although the employer gave claimant a written offer to return to her at-injury job as a packer, claimant actually returned to the modified belt line position on November 23, 1993. (Ex. 22A, Tr. 33-34, 44). In addition, Dr. Stringham opined that claimant left this belt line position due to her injury in that the rapid repetitive use of her right arm caused her problems. (Ex. 24-2). Based on Dr. Stringham's unrebutted opinion, we conclude that claimant left the modified position in November 1993 due to the work injury. In any event, this attempted return to work with the at-injury employer occurred before the relevant period when claimant was authorized temporary disability by her attending physicians.

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[4] On December 6, 1994, Dr. Stringham performed a record review on behalf of the employer. (Ex. 24). However, he did not begin treating claimant or become her attending physician until January 6, 1994. (Exs. 27-1, 28).

Second, the employer argues that claimant is not entitled to temporary partial disability for the period from July 18, 1994 through July 27, 1994, while she worked at the line helper job, because that job was substantially the same as claimant's at-injury job. In effect, the employer is arguing that claimant is not entitled to temporary partial disability because she returned to her regular work. We disagree with the employer's argument that the line helper job represents a return to regular work. However, for the reasons discussed below, we find that claimant's temporary partial disability rate was zero while she worked at the line helper job.

In Thomas W. Lundy, 43 Van Natta 2307 (1991), we held that temporary partial disability was not payable because the claimant had been released to full duty work activities by his attending physician. We reasoned that, although former ORS 656.268(3) does not expressly authorize the unilateral termination of temporary partial disability, as distinct from temporary total disability, a carrier may terminate temporary partial disability when a claimant has been released for regular work. Id. at 2309. However, the Lundy holding is not applicable here because claimant has not been released to regular work by an attending physician. In addition, the line helper job was not substantially the same as claimant's regular packer job in that the line helper job did not involve lifting weights of from 10 to 15 pounds, as did the packer job. Therefore, claimant did not return to her "regular" work by performing the line helper job. Furthermore, claimant remained released to modified work by her attending physicians while she performed the line helper job.

Nevertheless, while claimant worked as a line helper she was entitled to temporary partial disability calculated pursuant to amended ORS 656.212(2), which provides that temporary partial disability is calculated based on the at-injury wage. Because claimant earned more than her at-injury wage at the line helper job, her temporary partial disability rate is zero during the period she worked at that job.

In summary, claimant's attending physicians authorized temporary disability when they restricted claimant's ability to work as of January 6, 1994. Therefore, we find claimant entitled to temporary disability as of January 6, 1994. Furthermore, the employer was not entitled to unilaterally terminate payment of temporary disability under amended ORS 656.268(3). In this regard, since January 6, 1994, claimant has not been released to regular work, has not returned to regular work, remains released only to modified work, and has not been offered modified work within her restrictions by the employer. Id.

Accordingly, we conclude that claimant is entitled to temporary disability benefits from January 6, 1994 until termination is authorized by law, including temporary total disability benefits during any periods claimant was not earning wages. Gray v. SAIF, 70 Or App 313 (1984); Marcheta M. West, 46 Van Natta 402 (1994). As discussed above, payment of temporary partial disability during the period from July 18, 1994 through July 27, 1994, when claimant worked as a line helper for another employer, shall be at a rate of zero.

Penalty

The ALJ found that the employer's refusal to pay temporary disability benefits was unreasonable and awarded a penalty equal to 25 percent of the awarded temporary disability. Based on the following reasoning, we modify the ALJ's penalty award.

The employer argues that it was not unreasonable in failing to pay temporary disability because, after the modified janitor's assistant job was terminated on August 10, 1993, claimant immediately began work at another employer at "substantially the same job" as her at-injury job. We have found that the line helper work with the other employer was not "substantially the same job" or the equivalent of claimant's regular work. However, we have also found that claimant was not released to modified work by her attending physicians until January 6, 1994. Therefore, the employer's failure to pay temporary disability before that date was not unreasonable. In any event, prior to her attending physicians' release to modified work, there were no amounts "then due" upon which to assess a penalty and no unreasonable resistance to the payment of compensation upon which to assess an attorney fee pursuant to ORS 656.382(1).

In addition, until approval of the April 26, 1994 stipulation, claimant had a closed claim. Therefore, until that date, the employer had no duty to calculate or pay any procedural temporary disability.

However, the employer has a continuing duty to process a claim. See OAR 436-60-010(1) (carrier shall process claim in accordance with Chapter 656, WCD administrative orders and bulletins); Dennis R. Lewis, 46 Van Natta 2408, on recon 46 Van Natta 2501 (1994); Salome Orenday, supra. Thus, following the April 26, 1994 stipulation, the employer had a duty to process claimant's open claim, which includes the payment of procedural temporary disability.

The record does not establish that, after April 26, 1994, the employer paid any temporary disability. Prior to the passage of SB 369, the employer's duty to process claimant's claim would have included calculation of temporary partial disability in reference to claimant's "earning power at any kind of work" pursuant to former ORS 656.212, temporary OAR 436-60-030, and Stone v. Whittier Wood Products, 116 Or App 427 (1992), on recon 124 Or App 117 (1993). However, SB 369 amended ORS 656.212 to require calculation of temporary partial disability based on a worker's at-injury wage. Therefore, because claimant's wage at the line helper job with another employer was greater than her at-injury wage, there were no amounts "then due" from the employer while claimant worked at that job. However, there is no reasonable justification for the employer's failure to pay temporary total disability for the periods that claimant was released to only modified work and the employer did not offer her modified work within her restrictions.

Under these circumstances, we find the employer's conduct unreasonable. Consequently, claimant is entitled to recover a penalty for the employer's unreasonable failure to pay temporary disability after April 26, 1994. Accordingly, we assess a 25 percent penalty based on any temporary disability due from April 26, 1994 through the date of the August 10, 1994 hearing. Former ORS 656.262(10) (since renumbered as ORS 656.262(11), SB 369 § 28); Dennis R. Lewis, supra. One-half of this penalty shall be paid to claimant's attorney in lieu of an attorney fee on this issue. Former ORS 656.262(10)

Attorney Fees

The April 26, 1994 stipulation awarded to claimant's former attorney an approved attorney fee equal to 25 percent of any additional temporary disability compensation that may be awarded to claimant as a result of the stipulation's agreement to reopen claimant's claim. The ALJ approved claimant's former attorney's lien for these attorney fees. In addition, the ALJ awarded claimant's current attorney an approved attorney fee equal to 25 percent of the additional awarded temporary disability compensation. The ALJ also awarded claimant's current attorney one-half of the penalty assessment for the employer's unreasonable failure to pay temporary disability. Claimant requests review of the attorney fee awards.

Through claimant's former attorney's efforts in having the prior Determination Order and Order on Reconsideration rescinded, claimant was entitled to any additional compensation awarded as a result of the reopened claim. However, the employer paid no additional compensation. Through claimant's former attorney's efforts in requesting a hearing and claimant's current attorney's efforts in pursuing the issue of temporary disability at hearing, claimant secured her entitlement to temporary disability benefits from January 6, 1994, as clarified above. Thus, at the date of hearing, through the efforts of both of claimant's attorneys, claimant has secured a single benefit of these temporary disability benefits. On this single benefit, claimant's attorneys are awarded an approved fee of 25 percent of any additional temporary disability compensation created by the ALJ's order, as modified by this order, not to exceed $1,050. OAR 438-15-045.

We decline to apportion this fee between the two attorneys. See Gabriel Zapata, 46 Van Natta 403, 405 n. 1 (1994) (manner in which the fee is shared by claimant's current and former counsel is a matter to be decided between the two of them, not by this forum). In other words, one attorney fee is awarded payable to claimant's current attorney of record (the attorney who represented claimant at hearing and on review). The particular manner in which that fee will be subsequently distributed between claimant's current and former attorney is a matter between them to decide. Darron A. Arnold, 46 Van Natta 2467 (1994); Fred L. Snider, 43 Van Natta 577 (1991).

To the extent that the ALJ's directive regarding these attorney fee matters is inconsistent with our order, the ALJ's order is modified.

We find that the penalty was secured solely through the efforts of claimant's current attorney. Therefore, the portion of the penalty payable to claimant's current attorney is not subject to claimant's former attorney's lien.

Finally, inasmuch as the compensation awarded to claimant by the ALJ has been reduced and penalties are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an assessed fee for services on review. ORS 656.382(2); Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated September 26, 1994 is modified in part and affirmed in part. In lieu of the ALJ's directive concerning temporary disability benefits, the self-insured employer is directed to pay temporary disability benefits from January 6, 1994, until termination is authorized by law. In lieu of the ALJ's directive concerning claimant's former attorney's lien, the self-insured employer is directed to pay claimant's "out-of-compensation" attorney fee directly to claimant's current attorney of record. That fee shall be equal to 25 percent of the increased temporary disability resulting from the ALJ's order, as modified by this order, not to exceed $1,050. The penalty award is modified to award claimant a penalty equal to 25 percent of the temporary disability compensation due from April 26, 1994 through the August 10, 1994 hearing. That penalty shall be shared equally by claimant and her current attorney of record. The remainder of the order is affirmed.

In the Matter of the Compensation of
WILLIAM R. ENGLESTADTER, Claimant
WCB Case No. 94-14109
ORDER ON REVIEW
Brothers, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) increased claimant's unscheduled permanent disability for a skin disorder from 3 percent (9.6 degrees), as awarded by an Order on Reconsideration, to 54 percent (172.8 degrees); and (2) increased claimant's scheduled permanent disability for a skin disorder of the left forearm from 3 percent (4.5 degrees), as awarded by an Order on Reconsideration, to 38 percent (57 degrees). On review, the issues are extent of unscheduled and scheduled disability.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 22, 1995 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the insurer.

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[1] Subsequent to the ALJ's order, the Legislature significantly amended the Workers' Compensation Law, including ORS 656.214(5) and ORS 656.726(3)(f), which establish the criteria for rating unscheduled permanent disability. Or Laws 1995, Ch 332 § § 17, 55 (SB 369, § § 17, 55). As amended, ORS 656.214(5) continues to provide that earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f). Under Section 66(1) of SB 369, amended ORS 656.214(5) applies retroactively to all claims existing on or after the effective date of the Act (June 7, 1995), regardless of the date of injury or date of claim presentation. However, under Section 66(4), amended ORS 656.726(3)(f) applies only to claims that become medically stationary on or after the effective date of the Act. Claimant became medically stationary prior to June 7, 1995. Thus, amended ORS 656.726(3)(f) does not apply in this case.

In the Matter of the Compensation of
REX D. HALLER, Claimant
WCB Case No. 94-13814
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral hand condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In December 1992, claimant sought treatment for bilateral wrist pain and was diagnosed with tendonitis. In March 1993, SAIF denied a claim; the denial was not appealed. In August 1994, claimant again experienced bilateral wrist pain and sought further treatment.

Finding that claimant failed to prove that his work was the major contributing cause of his need for treatment, the ALJ upheld the denial. Claimant challenges this conclusion, asserting that his claim is compensable because he showed that work activities were the major contributing cause of a worsening of his disease.

Because there is an uncontested denial of his disease, claimant can prevail only with evidence of a pathological worsening of his condition since the date of the denial and that such worsening was in major part caused by work activities. E.g., Mary L. Miller, 46 Van Natta 369 (1994).[1] According to examining orthopedic surgeon Dr. Scheinberg, there was no evidence that claimant's disease pathologically worsened. (Exs. 4-10, 11-31). Claimant's treating physician, Dr. Klass, indicated only that claimant's condition became "aggravated" over a period of time. (Ex. 9-4). We find such evidence insufficient proof that claimant's disease pathologically worsened following the March 1993 denial. Thus, we agree with the ALJ that claimant failed to establish compensability.

ORDER

The ALJ's order dated April 20, 1995 is affirmed.

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[1] Although SAIF makes contentions regarding SB 369, Or Laws 1992, ch 332, § 56, because we find that this case is not affected by the new law, we do not address its application.

In the Matter of the Compensation of
JAMES G. HILL, Claimant
WCB Case No. 94-14791
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of claimant's right hydrocele condition. On review, the issue is compensability.

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

We change the findings of fact to reflect that claimant was examined on November 20, 1992 by Dr. Eickhoff, rather than Dr. Ekloff. We further note that Dr. Konowalchuk is a urologist, rather than a family physician. In addition, we delete the second paragraph of the findings of fact and replace it with the following paragraph:

> On May 17, 1993, Dr. Eickhoff reported that claimant called, wondering if his original problem on November 20, 1992 was job related. (Ex. 3). Claimant reported that the problem had continued off and on and he "feels like he is swollen up." (Id.) Dr. Eickhoff told claimant that he did not think that the original problem was job-related, but he urged him to seek follow-up care. (Id.)

Claimant asserts that the injury suffered in November 1992 resulted in his need for treatment for a right hydrocele condition in 1994. The ALJ found that Dr. Konowalchuk, claimant's treating physician, was given an inaccurate history regarding the onset of claimant's symptoms. Dr. Konowalchuk was told that claimant had experienced right groin pain at the time of the 1992 accident, but none of the contemporary medical records revealed anything in the way of groin pain. The ALJ did not find Dr. Konowalchuk's opinion on causation persuasive.

Claimant testified that when he was injured on November 20, 1992, he had sharp pains in his lower right groin area. (Tr. 11). He testified that the pain sometimes went down the side of his leg and "just about to the bottom of my ribs." (Tr. 12). Claimant was taken to the emergency room by ambulance and was given a prescription. He returned to work the next day. (Tr. 13).

Claimant contends that the contemporaneous medical records give circumstantial evidence of groin pain in 1992. We disagree. The histories contained in the medical records are inconsistent with claimant's testimony and do not mention pain or other symptoms in the groin. The November 20, 1992 ambulance report reflects that the reason for dispatch was "chest pain." (Ex. 1). Another report states "chest pn, possible cardiac, possible abd." (Ex. 2). That report noted that claimant was "clutching chest." Dr. Eickhoff examined claimant in the emergency room and reported "sudden onset, severe epigastric pain that doubled him up, causing him to have to stop work and sit down." (Ex. 2A). Dr. Eickhoff reported that the pain had occurred off and on over the past week but was never severe. He also stated that the symptoms were "not related to exertion or eating." (Id.)

Based on the inconsistencies between claimant's testimony of the November 20, 1992 injury and the contemporaneous medical records, we find that claimant is not a reliable historian with regard to the onset of symptoms for his right hydrocele condition. Moreover, in view of the passage of time between claimant's November 20, 1992 injury and the right hydrocele condition in 1994, we find that the issue of causation is a complex medical question. Thus, resolution of the issue turns on an analysis of the medical evidence. See Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

We give greater weight to the conclusions of a treating physician unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we are persuaded to do otherwise. Dr. Konowalchuk reported that claimant's history "dated back into November of 92, at which time he was lifting something, had pain and discomfort for approximately three days, and his right testicle hurt." (Ex. 6). Dr. Konowalchuk opined that claimant's work-related injury was the major contributing cause of his right hydrocele. (Ex. 14). Based on claimant's history, Dr. Konowalchuk

believed that claimant had traumatized the cord structures on the right side and had developed a low grade infection. Dr. Konowalchuk believed that claimant had a reactive hydrocele to the infection and that his infection was stimulated by the trauma that he received several years ago. (Id.)

Dr. Konowalchuk's opinion on causation was based on his understanding that claimant suffered groin pain and trauma in November 1992. Inasmuch as claimant's history regarding the onset of his groin pain in November 1992 is unreliable, we are not persuaded by Dr. Konowalchuk's opinion since it is based on this unreliable history. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Claimant argues that the ALJ erred by discounting Dr. Konowalchuk's report based on an inadequate history because Dr. Konowalchuk was familiar with claimant's earlier medical records, at least after he reviewed Dr. Edward's report. Claimant asserts that Dr. Konowalchuk 's opinion did not change when he read Dr. Edwards report.

Dr. Edwards performed a records review and reported that the medical records did not support claimant's claim of right groin pain at the time of the November 1992 lifting injury. (Ex. 13). Dr. Edwards opined that, even if there was documentation of right groin pain, Dr. Edwards did not see "how this could conceivably be related to a hydrocele several years later." (Id.) In addition, Dr. Edwards did not believe that claimant's treatment on November 20, 1992 was related to his diagnosis of right hydrocele. He reported that "[n]one of the possible problems that are described in his initial treatment on that date are due in material or major part to his work activities." (Id.)

Dr. Konowalchuk did not agree with Dr. Edwards. Dr. Konowalchuk referred to the "marked paragraph" on Dr. Edwards' letter, and stated:

> "The groin pain noted here was due to epididymitis of trauma. This became chronic and eventually flared resulting in the hydrocele. This patient may continue to have flare ups of the epidiymitis in the future. I agree with the rest." (Ex. 15).

Dr. Konowalchuk did not explain what "trauma" he was referring to when he said that the groin pain was "due to epididymitis of trauma." If he is referring to the trauma of the November 20, 1992 injury, none of the contemporary medical records suggest that claimant suffered any trauma in the groin area. Moreover, Dr. Eickhoff's reports concerning the November 20, 1992 injury suggested that claimant's symptoms were not related to exertion and were not job-related. (Exs. 2A, 3). Since Dr. Konowalchuk failed to adequately explain the causal connection between claimant's November 20, 1992 injury and the 1994 right hydrocele condition, we do not find his opinion persuasive. Consequently, we are not persuaded that claimant's injury on November 20, 1992 was related in material or major part to his right hydrocele condition.

ORDER

The ALJ's order dated March 28, 1995 is affirmed.

September 8, 1995 Cite as 47 Van Natta 1605 (1995)

In the Matter of the Compensation of
CAROLYN L. JONES, Claimant
WCB Case No. 93-01452
ORDER ON REVIEW
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's denial of her occupational disease claim for a mental disorder. Claimant also contests several evidentiary rulings made by the ALJ and has submitted additional evidence which we treat as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand, evidence, and compensability.

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

The Board may remand a case for receipt of additional evidence if it determines 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 clearly be shown that the material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, the new evidence consists of seven additional documents (five letters and photocopies of two envelopes). All of the letters were generated in 1993, at least a year prior to the hearing. Consequently, we are not persuaded that those documents were unobtainable prior to the hearing. Moreover, we do not find that the photocopied envelopes are material to this dispute. In any event, even if we were to consider the proferred evidence, it would not change the result in this case. Consequently, we deny claimant's motion to remand and proceed to review the merits without considering any new information not already in the record. ORS 656.295(5).

Claimant also asserts, inter alia, that: (1) her case was improperly consolidated with WCB Case No. 93-00874 (Reginald Lie-A-Tjam); (2) she was prevented from subpoenaing records and witnesses; (3) the ALJ erred in not excluding the testimony of certain witnesses; and (4) the ALJ did not fully consider all the evidence submitted. We review the ALJ's rulings for abuse of discretion. James D. Brusseau, II, 43 Van Natta 541 (1991).

To begin, both claimant's claim and Mr. Lie-A-Tjam's claim involved lengthy testimony from a number of the same witnesses. Moreover, both claims were based on allegations of similar harassment stemming from the same operative facts, i.e., concerns regarding the difference between the employer's listed inventory and its actual inventory. Finally, although the hearings were consolidated for purpose of taking testimony, the ALJ made a separate evidentiary record for each claim and issued separate orders. In light of this, we do not find that it was an abuse of discretion for the ALJ to have consolidated the aforementioned cases.

With regard to claimant's assertion that she was prevented from subpoenaing witnesses and documents, we note that the record does not indicate that claimant ever attempted to subpoena such information nor does it establish that she was prevented from doing so. Moreover, to the extent that Presiding ALJ Tenenbaum's interim ruling indicated that some of the information claimant sought would not be admitted, that decision was based on relevance grounds and claimant has not established that such information would be relevant to this proceeding. Finally, while the ALJ's order does not discuss each specific exhibit or every witness' testimony, that does not mean that the ALJ, or the Board, has not fully considered the entire record. Under these circumstances, we are not persuaded that the ALJ's evidentiary rulings were an abuse of discretion.[1]

While we do not find claimant's assertions persuasive, assuming arguendo that we accepted claimant's contentions, the result would not change. In other words, even if we agreed with claimant's assertions and declined to consider all of the evidence and testimony that claimant objects to, we would still conclude that she has not established that her mental disorder is compensable. We base such a conclusion on the following reasoning.

Claimant has the burden to prove, by clear and convincing evidence, that her mental disorder arose out of and was in the course of her employment. ORS 656.802(3)(d). Here, based on the credible testimony of the other witnesses, the ALJ found that the events claimant alleged to have happened did not "exist in a real and objective sense, " as required by ORS 656.802(2). Although not statutorily required, the Board generally defers to the ALJ's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). After our review of the testimony, we agree with the ALJ's determination regarding the relative credibility of the witnesses. Moreover, as noted by the ALJ, the medical evidence from Dr. Freed which would tend to support claimant's claim is not persuasive as Dr. Freed did not have an accurate history on which to base her conclusions. Without such evidence, claimant has not sustained her burden of proof.

ORDER

The ALJ's order dated January 4, 1995 is affirmed.

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[1] Claimant also appears to take exception to statements made by the employer's counsel. We note, however, that statements by counsel are not evidence and were not considered as such by either the ALJ or the Board.

In the Matter of the Compensation of
HERBERT C. KALER, Claimant
WCB Case No. 94-12101
ORDER ON REVIEW
Johnson, Cram & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Livesley's order which increased claimant's unscheduled permanent disability award for a back injury from 5 percent (16 degrees), as awarded by an Order on Reconsideration, to 28 percent (89.6 degrees). On review, the issue is unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of his "Findings of Ultimate Fact." We also find that claimant withdrew his request for hearing appealing the September 21, 1994 Order on Reconsideration. (Tr. 2).

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable back injury on November 1, 1993, which was accepted as a lumbar muscle strain. The claim was closed without an award of permanent disability by Notice of Closure of July 12, 1994. An Order on Reconsideration was issued on September 21, 1994, which awarded 5 percent unscheduled permanent disability.

On October 3, 1994, claimant requested a hearing on extent of unscheduled permanent disability. On October 11, 1994, SAIF cross-requested a hearing on unscheduled permanent disability. At hearing, claimant requested that the 5 percent award in the reconsideration order be affirmed. (Tr. 2). SAIF contended that claimant's permanent disability should be reduced to zero pursuant to its cross-request for hearing. Id.

Despite claimant's request that the unscheduled permanent disability award in the reconsideration order be affirmed, the ALJ increased claimant's unscheduled permanent disability award to 28 percent. On review, SAIF contends that the ALJ was without authority to increase claimant's unscheduled permanent disability award in the absence of a request that claimant's permanent disability be increased. It asserts that the award of permanent disability in the Order on Reconsideration should be reinstated. We agree.

The ALJ described the issues at hearing as follows:

> "Now, what we're really here on today--we've narrowed the issues down to we're here on what started out to be a cross-request from SAIF regarding the unscheduled permanent partial disability but since claimant has elected to just go on the award of five percent that was awarded under the 9/24/94 [sic] Order on Reconsideration, what we really have is a Request for Hearing on the part of SAIF to reduce the 9/21/94 five percent award to the zero award of the 7/12/94 Notice of Closure. Of course, if SAIF is unable to do that, then the claimant would be entitled to an attorney fee." (Tr.2).

Both parties agreed that the ALJ's description of the issues was accurate. Id.

Based on the ALJ's summary of the issues, we agree with SAIF that claimant withdrew his hearing request[1] and that the only issues before the ALJ were: (1) whether, pursuant to SAIF's hearing request, claimant's 5 percent unscheduled permanent disability award should be reduced or eliminated; and (2) whether an attorney fee award under ORS 656.382(2) should be granted. SAIF failed in its attempt to reduce claimant's award. Contrary to these recited issues, the ALJ found that claimant was entitled to increased permanent disability and awarded claimant 28 percent unscheduled permanent disability. We reverse and reinstate claimant's 5 percent award.

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[1] Claimant does not contend otherwise on review.

It is well-settled that we will not increase or reduce an award of permanent disability in the absence of a request to do so by one of the parties. E.g., Carlos S. Cobian, 45 Van Natta 1582, 1583 (1993); Jesus Mejia, 44 Van Natta 32, 33 (1992); Daniel L. Banta, 42 Van Natta 1158 (1990); Daniel M. Alire, 41 Van Natta 752 (1989). Inasmuch as the only issue before the ALJ was whether claimant's 5 percent award should be reduced, we reverse the ALJ's award of increased unscheduled permanent disability. Carlos S. Cobian, supra. Consequently, we reinstate and affirm the 5 percent unscheduled permanent disability award granted in the Order on Reconsideration.[2]

ORDER

The ALJ's order dated March 10, 1995 is reversed in part and affirmed in part. That portion which increased claimant's unscheduled permanent disability from 5 percent (16 degrees) to 28 percent (89.6 degrees) is reversed. The September 21, 1994 Order on Reconsideration award of 5 percent (16 degrees) is reinstated and affirmed. The ALJ's out-of-compensation attorney fee award is also reversed. The remainder of the order is affirmed.

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[2] In light of our decision, we need not address SAIF's other contentions regarding the ALJ's calculation of claimant's unscheduled permanent disability.

In the Matter of the Compensation of
REGINALD LIE-A-TJAM, Claimant
WCB Case No. 93-00874
ORDER ON REVIEW
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's denial of his occupational disease claim for a mental disorder. Claimant also contests several evidentiary rulings made by the ALJ and has submitted additional evidence which we treat as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand, evidence, and compensability.

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

The Board may remand a case for receipt of additional evidence if it determines 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 clearly be shown that the material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, the new evidence consists of a February 16, 1995 performance appraisal from claimant's current employer; a February 7, 1994 letter from claimant's current employer; and, a May 4, 1995 letter from claimant's current employer. We have evaluated this new evidence and do not find that it is material to the dispute inasmuch as it relates to claimant's work with a subsequent employer and not the employer involved in this matter. Moreover, we note that the second letter is dated some 10 months prior to the December 5, 1994 hearing and was clearly obtainable with due diligence prior to the hearing. In any event, even if we were to consider the proferred evidence, it would not change the result in this case. Consequently, we deny claimant's motion to remand and proceed to review the merits without considering any new information not already in the record. ORS 656.295(5).

Claimant also asserts, inter alia, that: (1) his case was improperly consolidated with WCB Case No. 93-01452 (Carolyn L. Jones, 47 Van Natta 1605); (2) he was prevented from subpoenaing records and witnesses; (3) the ALJ erred in not excluding the testimony of certain witnesses; and (4) the ALJ did not fully consider all the evidence submitted. We review the ALJ's rulings for abuse of discretion. James D. Brusseau, II, 43 Van Natta 541 (1991).

To begin, both claimant's claim and Ms. Jones' claim involved lengthy testimony from a number of the same witnesses. Moreover, both claims were based on allegations of similar harassment stemming from the same operative facts, i.e., concerns regarding a difference between the employer's listed inventory and its actual inventory. Finally, although the hearings were consolidated for the purpose of taking testimony, the ALJ made a separate evidentiary record for each claim and issued separate orders. In light of this, we do not find that it was an abuse of discretion for the ALJ to consolidate the aforementioned cases.

With regard to claimant's assertion that he was prevented from subpoenaing witnesses and documents, we note that the record does not indicate that claimant ever attempted to subpoena such information nor does it establish that he was prevented from obtaining such information. Moreover, to the extent that Presiding ALJ Tenenbaum's interim ruling indicated that some of the information claimant sought would not be admitted, that decision was based on relevance grounds and claimant has not established that such information would be relevant to this proceeding. Finally, while the ALJ's order does not discuss each specific exhibit or every witness' testimony, that does not mean that the ALJ, or the Board, has not fully considered the entire record. Under these circumstances, we are not persuaded that the ALJ's evidentiary rulings were an abuse of discretion.[1]

While we do not find claimant's assertions persuasive, assuming arguendo that we accepted claimant's contentions, the result would not change. In other words, even if we agreed with claimant's assertions and declined to consider all of the evidence and testimony that claimant objects to, we would still conclude that he has not established that his mental disorder is compensable. We base such a conclusion on the following reasoning.

Claimant has the burden to prove, by clear and convincing evidence, that his mental disorder arose out of and was in the course of his employment. ORS 656.802(3)(d). Here, based on claimant's demeanor and the substance of his testimony, the ALJ found that claimant was not credible. Although not statutorily required, the Board generally defers to the ALJ's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Since the ALJ's credibility finding was based in part upon the observation of claimant's demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990). Moreover, as noted by the ALJ, the medical evidence which would tend to support claimant's claim is rendered unpersuasive as it is based on a history from claimant which is not reliable. Without such credible or reliable evidence, claimant has not sustained his burden of proof.

ORDER

The ALJ's order dated January 4, 1995 is affirmed.

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[1] Claimant also appears to take exception to statements made by the employer's counsel. We note, however, that statements by counsel are not evidence and were not considered as such by either the ALJ or the Board.

September 8, 1995 Cite as 47 Van Natta 1609 (1995)

In the Matter of the Compensation of
JO W. ORMAN, Claimant
Own Motion No. 91-0707M
OWN MOTION ORDER OF ABATEMENT
Darris K. Rowell, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our August 11, 1995 Own Motion Order, in which we assessed penalties and attorney fees regarding the processing of temporary disability compensation under our November 25, 1992 Own Motion Order.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. Claimant is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
VELMA L. PEIRCE, Claimant
WCB Case Nos. 93-14716 & 93-14715
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Gunn, Christian and Haynes.

The noncomplying employer (NCE), A Touch of Fashion, requests review of that portion of Administrative Law Judge (ALJ) Spangler's order which set aside the denial by the SAIF Corporation, as the NCE's statutory claims processor, of claimant's claim for head, jaw and shoulder injuries. Claimant cross-requests review of those portions of the ALJ's order which: (1) admitted exhibits A through E; and (2) awarded an attorney fee of $3,000 for prevailing against SAIF's denial. On review, the issue are compensability, evidence and attorney fees.

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

Evidence

On review, claimant contends that the ALJ erred in admitting photographs of the NCE's van (exhibits A through F) because no foundation was laid showing the accuracy of the pictures. Inasmuch as we agree with, and adopt the ALJ's decision to set aside SAIF's denial on the merits (even without consideration of the photographs), it is unnecessary to address the evidentiary issue.

Attorney Fee

Claimant submitted a Motion for Specific Assessed Attorney Fee which seeks to increase her attorney fee award for services at hearing to $5,000. In determining a reasonable attorney fee award, we consider the factors contained in OAR 438-15-010(4). In determining a reasonable attorney fee, in this case we particularly considered the time devoted to the case (as represented by the hearing record), the value of the interest involved, the complexity of the issue, and the risk that claimant's counsel might go uncompensated. Based on our review of the record and after consideration of the factors listed in OAR 438-15-010(4), we conclude that the ALJ's attorney fee award of $3,000 was reasonable.

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 438-15-010(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 $1,500, payable by SAIF on behalf of the NCE. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 11, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, payable by SAIF on behalf of the NCE.

Board Member Haynes dissenting:

Because the preponderance of the evidence supports a conclusion that claimant could not have been injured while working for the employer, I find little support for the majority's conclusion that claimant sustained a compensable injury. Accordingly, I dissent.

The employer hired claimant to sell clothing at a merchandise show. In order to get to the show, the employer packed two vans with boxes of clothing. On top of these boxes, the employer placed unsecured metal racks, which were used to display the clothing. The employer would drive one of the vans and claimant would drive the other van. While driving over to pick up another employee, claimant was allegedly injured when the metal racks slid forward and hit her in the back of the head.

I recognize that the ALJ found that claimant was credible based on her demeanor. However, the ALJ made similar findings for all of the witnesses, including those that contradicted claimant's recollections of relevant events surrounding her alleged injury. In light of the ALJ's credibility findings, and because the alleged accident was unwitnessed, I look to the physical evidence to determine whether claimant's injury occurred as she has claimed. As such, I find dispositive, the findings of the accident reconstruction expert, Mr. Stearns.

Mr. Stearns' findings are as follows. The van claimant was driving was loaded with garment boxes placed behind the driver and passenger's seats. These boxes were 47 inches tall, 24 inches wide and 20 inches deep. (Ex. 48-3). They were made of stiff, corrugated cardboard sufficiently strong to withstand significant vertical weight compression without collapsing. Id. The maximum vertical height inside the van, from the floor to the roof was 53 inches. (Ex. 48-4). Thus, when the garment boxes were placed inside the van, there was approximately 6 inches from the top of the boxes, to the roof of the van.

On top of the garment boxes were laid the metal "display" racks. These racks came in two sizes, 7 feet by 24 inches and 8 feet by 24 inches. (Ex. 48-3). Each rack was constructed in grid shape with interconnecting metal bars spaced every three inches. Id.

The driver's seat was 42.5 inches from the top of the headrest to the van floor. As such, when the garment boxes (height 47 inches) were placed in the van they would be 4 1/2 inches above the top of the driver's seat headrest. Based on this detailed "reconstruction" of the loaded van, claimant could have been struck by the metal racks in two different ways, neither of which occurred in this case.

First, if claimant were tall enough, so that while she was sitting in the driver's seat her head could extend above the top of the seat's headrest, then the racks may have hit her when they slid forward. However, Mr. Stearns, the accident reconstruction expert, persuasively explained that a person would have to be over 6 feet tall, in order for their head to be above the head rest while sitting in the van's driver's seat. Since claimant is 5 feet 4 1/2 inches tall her head would have been below the top of the headrest and well below the path of the sliding metal racks.

The second possibility of how the racks could have hit claimant, is if they tipped or bent downward when they slid forward. However, the racks were at least 7 feet long, so when they slid forward they would have to follow the contour of the garment boxes (47 inches high) upon which they were placed. The racks would be sliding at a height of 47 inches above the van's floor, and thus 4 1/2 inches above the driver seat's headrest (which was 42.5 inches above the van's floor). Therefore, according to Mr. Stearns, the only way for the racks to drop down to a height which would put them in a collision course with claimant's head would be for someone to grab hold of them and deliberately force/bend them downwards.

Further, John Simpson, the employer's husband, who is 6 1/2 inches taller than claimant, credibly testified that when he sat in the van's driver's seat, he tried to deliberately grab the metal racks and bend them down enough to touch his head. Mr. Simpson but was unable to do so. (Tr. 131). Therefore, it is unexplainable how claimant was struck by the sliding racks, when Mr. Simpson who is 6 1/2 inches taller than her, deliberately forcing the racks down with his arms, could not bend or tip the racks sufficiently downward to touch his head.

Additionally, because there was only 6 inches from the top of the garment boxes to the top of the van's roof, there was insufficient vertical clearance for the racks to have "tipped" down and hit claimant as they were sliding forward. This conclusion is supported by Mr. Simpson's physical inability to tip (or bend) the racks, a sufficient distance, to even touch the top of his head. (Tr. 131). Therefore, the physical and demonstrative evidence (Mr. Simpson's inability to force the racks downward) proves that the racks could not have struck claimant when they slid forward.

Such a conclusion is further confirmed by the physical damage to the van as a result of the metal racks sliding forward. First, the metal above the van's windshield was damaged, as was the sun visor on the driver's side. (Ex. 48-4). The scratches in the metal above the windshield when compared with the end prongs of the metal racks confirms the finding, that indeed the racks caused the damage above the windshield. Id. As such, the racks would have been well above the height of the headrest and thus well above claimant's head when they slid forward. (Ex. 48-3). Second, claimant's testimony that the rear view mirror was knocked off the windshield when the racks slid forward, provides further support for the conclusion that the racks were well above claimant's head when they slid forward. (Tr. 13).

Finally, I find claimant's changing history about how the injury occurred suspect. For instance, claimant testified that the racks slid forward, hit her in the back of the head and came to rest on her shoulders "pinning" her down. (Tr. 10). However, Maxie Burns, co-worker, credibly testified that claimant told her that she was able to "duck" the sliding racks and that they just "brushed" the top of her head. (Tr. 71).

Rosemarie Simpson, the employer, testified that claimant described being "hit" or "grazed" by the sliding racks with no mention of being pinned down. (Tr. 99). As such, the inconsistencies in the record in regard to how the racks allegedly hit claimant in the head, make the physical findings all the more dispositive since it is well documented that it was physically impossible for the racks to have hit claimant when they slid forward.

Accordingly, I am convinced that the preponderance of the evidence supports a conclusion that the racks could not have struck claimant in the back of her head when they slid forward. Consequently, I find that claimant's injuries were not sustained while working for the employer. Therefore, I must respectfully dissent.

In the Matter of the Compensation of
THERESA G. PETERSON, Claimant
WCB Case Nos. 94-05706, 94-04684 & 94-07987
ORDER ON REVIEW
Schneider & Hooten, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Bethlahmy's order that found that claimant was required to treat with a physician under the managed care organization (MCO). On review, the issues are jurisdiction and medical services. We conclude that the Hearings Division lacks jurisdiction over this issue and we vacate the ALJ's order.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The only issue at hearing was whether Dr. Baldwin could continue to be claimant's treating physician or whether claimant must treat with an MCO physician. The ALJ rejected the employer's argument that the Hearings Division did not have jurisdiction over this matter. On review, the employer contends that the Hearings Division does not have jurisdiction over this matter because OAR 436-15-110(1) requires that claimant must first pursue her dispute through the dispute resolution process of the MCO. Claimant responds that she is not subject to the MCO requirements because she did not receive proper notice of the employer's MCO contract.[1]

After the ALJ's order, the legislature enacted Senate Bill 369 and amended ORS 656.245, ORS 656.260 and ORS 656.327, effective June 7, 1995. The legislature added ORS 656.245(6), which provides that, if a medical services claim is disapproved for any reason other than the formal denial of compensability of the underlying claim and the disapproval is disputed, the injured worker or carrier "shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327." (Emphasis added). Or Laws 1995, ch 332, § 25(6) (SB 369, § 25(6)). Amended ORS 656.327(1) provides that if an injured worker, a carrier, or the Director believes that an injured worker's medical services,

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[1] We note that, to the extent that claimant's argument involves a "change" of attending physician, our previous cases held that those disputes are not a "matter concerning a claim" over which the Hearings Division has jurisdiction. See Robin L. Smith, 47 Van Natta 423, on recon 47 Van Natta 886 (1995); Tracy Johnson, 43 Van Natta 2546 (1991); Ronald D. Robinson, 44 Van Natta 1657 (1992).

not subject to ORS 656.260, are excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." (Emphasis added). SB 369, § 41(1). In addition, amended ORS 656.260(6) provides that issues concerning the "provision of medical services to injured workers subject to a managed care contract" shall be subject to the Director's exclusive review authority. SB 369, § 27(6).

In Walter L. Keeney, 47 Van Natta 1387 (1995), we concluded that the amendments to ORS 656.327, as well as the new provision, ORS 656.245(6), apply to claims currently pending before the Board. We held that the language of ORS 656.327(1) and ORS 656.245(6) clearly revealed the legislature's intent that medical services disputes be resolved exclusively by the Director, not the Board or Hearings Division. Accordingly, based on the text and context of amended ORS 656.327(1), as read in conjunction with SB 369's retroactivity provisions (§ 66), we concluded that the Director has exclusive jurisdiction over ORS 656.327(1) medical services disputes, including those presently pending before the Board.

Here, the medical service dispute does not pertain to the compensability of claimant's underlying claim. Rather, the issue primarily involves Dr. Baldwin's status as claimant's physician and his request for authorization to perform surgery. Because jurisdiction over this matter rests with the Director, rather than the Hearings Division, we vacate the ALJ's order.

In reaching this conclusion, we acknowledge the possibility that a request for Director review might be potentially challenged as untimely. See, e.g., OAR 436-15-008(3); OAR 436-15-110; OAR 436-10-008(6); OAR 436-10-046; But see Temp. OAR 436-01-015 (Effective August 18, 1995, WCD Admin. Order 95-061). Nevertheless, the question of whether the Director will dismiss any such request for review rests with him. As we stated in Walter L. Keeney, supra, it is not within our purview to ignore a clear legislative mandate, despite a potentially harsh result.

ORDER

The ALJ's order dated October 19, 1994, as corrected November 2, 1994, is vacated. Claimant's request for hearing on the issue of attending physician is dismissed for lack of jurisdiction.

Board Members Gunn and Hall specially concurring.

We acknowledge that, in accordance with the doctrine of stare decisis, we are compelled to follow the Board's decision in Walter L. Keeney, 47 Van Natta 1387 (1995). However, we write separately to express our continued disagreement with the Keeney decision, as set forth in our concurring and dissenting opinions in that case.

Applying the amendments retroactively in this case may deprive the parties of a remedy if the time period for requesting Director review has expired. Under those circumstances, retroactive application of Senate Bill 369 would produce an unintended, absurd and unreasonable result. We also believe the parties should have the opportunity to address the retroactivity clause and whether application of the amendments to this case can withstand constitutional scrutiny.

In the Matter of the Compensation of
DAVID C. THOMPSON, Claimant
WCB Case Nos. 94-02048, 93-12133, 93-09055 & 92-15937
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Bostwick, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys
R. Thomas Gooding (Saif), Defense Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

CNA Insurance Co. (CNA) requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's claim for a left shoulder condition; and (2) assessed a penalty against CNA for an allegedly unreasonable denial. Liberty Northwest Insurance Co. on behalf of Landa, Inc. (Landa/Liberty) cross-requests review of those portions of the order that: (1) set aside Landa/Liberty's denial of claimant's claim for a right shoulder condition; (2) upheld the denials of the SAIF Corporation and Liberty Northwest (on behalf of KOEI America); and (3) upheld CNA's denial as to the same condition. On review, the issues are compensability, responsibility and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of Fact No. 16, and briefly summarize the pertinent facts as follows:

Claimant was employed by CNA's insured from November 1985 to February 1989. On December 12, 1986, following a November 4, 1986 industrial incident involving the lifting of a heavy bundle, claimant sought treatment for shoulder pain, with significantly greater pain in the left shoulder.[1] CNA accepted a claim for left shoulder tendinitis in March 1987. Claimant received treatment for his shoulder, both oral medications and injections, through December 1987.

Claimant sought treatment for a painful left shoulder in early 1990. In June 1991, claimant sought treatment for bilateral shoulder pain, the left worse than the right. He underwent arthroscopic surgery on the left shoulder in August 1991, and returned to work in September although his symptoms had not fully resolved. On April 13, 1992, claimant's left shoulder claim with CNA was closed with an award of 5 percent unscheduled permanent partial disability. As of the date of closure, claimant continued to have left shoulder problems with activity.

Four months later, in August 1992, claimant again sought treatment for bilateral shoulder pain while working for SAIF's insured. He continued to have, and seek treatment for, bilateral shoulder problems through April 1994, at which time he was employed by Landa.

CONCLUSIONS OF LAW AND OPINION

Compensability

On review, CNA contends that claimant has failed to establish that his current shoulder condition is compensable as to CNA's insured.[2] This contention is premised on CNA's position that claimant is not credible and therefore any medical opinions based on the history he has provided should be rejected.

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[1] The emergency room record mentions both left and right shoulder pain, although the treatment focused on the left shoulder. (Ex. 14.)

[2] CNA also argues that claimant's occupational disease claim is untimely under ORS 656.807(1). We disagree. This section provides, in pertinent part, that an occupational disease claim shall be void unless a claim is filed 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 claimant becomes disabled or is informed by a physician that

Although not statutorily required, the Board generally defers to the ALJ's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). In this case, the ALJ specifically found that claimant's demeanor while testifying was truthful and that claimant offered reasonable explanations for the discrepancies in the statements he made regarding his condition over the years. Since the ALJ's credibility finding was based in part upon the observation of claimant's demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990). Moreover, based on our de novo review of the substance of claimant's testimony, we agree that claimant is a credible witness. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Because we uphold the ALJ's credibility finding, we are not inclined to discount the medical opinions based on the history provided by claimant. We therefore adopt and affirm the ALJ's reasoning and conclusion that claimant's bilateral shoulder condition is compensable.

Responsibility - Left Shoulder Condition

The ALJ found that under ORS 656.308(1),[3] CNA remained responsible for claimant's left shoulder condition because that condition involves the same condition CNA accepted in 1987 and claimant's work activities since his employment with CNA's insured were not the major cause of his current condition and need for treatment. SAIF v. Drews, 318 Or 1 (1993). We adopt the and affirm the ALJ's reasoning and conclusion on this issue, and in so doing find that claimant's employment with CNA's insured (Steiner) remains the major contributing cause of claimant's current left shoulder condition.

Responsibility - Right Shoulder Condition

In assigning responsibility for claimant's current right shoulder condition, the ALJ applied the "last injurious exposure rule" because there was no prior accepted claim for this condition. The ALJ found that regardless of which insurer was presumptively responsible under the rule for claimant's right shoulder, liability shifted to Landa/Liberty because claimant's work for Landa contributed to the worsening of his condition.

Citing Runft v. SAIF 303 Or 493 (1978) and Eva R. Billings, 45 Van Natta 2142 (1993), Landa/Liberty argues that it is unnecessary to apply the last injurious exposure rule because the medical evidence establishes that claimant's employment with CNA's insured was the actual cause of his right shoulder condition as well. We agree.

Dr. Rusch, claimant's treating physician since 1990, reported in January 1993 that the major cause of his current bilateral shoulder condition and need for treatment was his work activity and injury with CNA's insured. (Ex. 51.) This report clarified his earlier letter of October 2, 1992, where Dr. Rusch indicated that claimant's current symptoms related to his then-current work. (Exs. 45 & 46). Given claimant's history that both shoulders had been symptomatic since his employment with CNA's insured, Drs. Bald and Logan also opined that the major contributing cause to claimant's condition was his employment with CNA's insured and the 1986 work-related injury to his shoulders, even though claimant's employment with Landa may have contributed to his symptoms. (Ex. 79-5). Similarly, Dr. Stewart opined that the primary cause of the onset of claimant's condition was his 1986 work injury with CNA's insured. (Ex. 73, 80-32.) Dr. Stewart reported that claimant's subsequent work with SAIF's

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claimant is suffering from an occupational disease. Here, it appears that claimant's visits to Dr. Rusch in August and September 1992 constituted a claim for his bilateral shoulder condition. CNA's October 27, 1992 denial mentions this treatment and denies claimant's "current condition and need for treatment for both shoulders." Since there is no evidence that claimant had been disabled by this condition or informed by a physician that he had an occupational disease prior to September 1992, we conclude this claim is not barred by ORS 656.807(1). Furthermore, in the alternative, in order for the insurer to prevail on a "timeliness defense," it must prove prejudice due to the late filing. See Joanne C. Rockwell, 44 Van Natta 2290 (1990). Here, CNA has not contended that it has been prejudiced by claimant's alleged failure to timely file his occupational disease claim.

[3] Subsequent to the ALJ's order, ORS 656.308(1) was amended by Senate Bill 369. Or Laws 1995, ch 332 § 37 (SB 369, § 37). The amendments to this section are not pertinent to the outcome in this case, however.

insured and Landa/Liberty increased claimant's symptoms, although it is not clear from his report or his testimony whether he believed that this subsequent employment caused a pathological worsening of claimant's bilateral shoulder condition. (See, e.g., Ex. 80-17, 80-30.)

Like the ALJ, we see no persuasive reason not to defer to the opinion of claimant's attending physician, Dr. Rusch. See Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, we conclude that claimant has established that his employment with CNA's insured was the major contributing cause of his bilateral shoulder condition. There is, therefore, no need to rely on the last injurious exposure rule of proof to assign responsibility.[4]

Penalty

CNA challenges the ALJ's award of a penalty for its allegedly unreasonable denial of claimant's current left shoulder condition. In support of its contention that its compensability denial was reasonable when issued, CNA points to Dr. Rusch's letter indicating that claimant's condition related to his then-current work with SAIF's insured. (Ex. 46.)

We find, especially in light of Dr. Rusch's letter, that CNA's compensability denial was unreasonable. At the time CNA issued the denial, it had no legitimate reason to believe that claimant's current condition and need for treatment arose from a non-work related activity. See Michael P. Yauger, 45 Van Natta 419 (1993); Harold R. Borron, 44 Van Natta 1579 (1992) (nonresponsible carrier's compensability denial unreasonable where there was no evidence the condition was not work-related). We therefore uphold the ALJ's penalty assessment.

Attorney Fee/Hearing

Landa/Liberty, the carrier found responsible by the ALJ, had only denied responsibility for claimant's right shoulder condition. Since CNA and SAIF had also contested compensability for the condition, the ALJ ordered those carriers to each pay one-half of claimant's $2,000 attorney fee award. Since we have now found CNA responsible for claimant's right shoulder condition, it follows that CNA is likewise entirely responsible for claimant's $2,000 attorney fee award for services at the Hearings level regarding that issue. Consequently, we modify that portion of the ALJ's order.

Attorney Fees On Review

Claimant is entitled to an assessed attorney fee for prevailing over CNA's request for review. ORS 656.382(2). 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 regarding the left shoulder issue is $1,000, payable by CNA. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee award for his counsel's services on review devoted to the penalty issue and his counsel's unsuccessful efforts to have Landa/Liberty held responsible for his right shoulder condition. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated January 9, 1995 is affirmed in part and reversed in part. That portion of the order that set aside Landa/Liberty's denial as to claimant's current right shoulder condition is reversed, and Landa/Liberty's denial is reinstated and upheld. That portion of the order that upheld CNA's denial as to claimant's right shoulder condition is reversed. CNA's denial of claimant's right shoulder condition is set aside and the claim is remanded to CNA for processing according to law. The ALJ's $2,000 attorney fee award regarding the right shoulder condition to be equally shared by CNA and SAIF, shall be entirely the responsibility of CNA. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by CNA.

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[4] Given this determination, we do not address Landa/Liberty's alternative arguments on review.

In the Matter of the Compensation of
MARSHA BROWN, Claimant
Own Motion No. 94-0137M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Hedges & Mitchell, Claimant Attorneys
EBI Companies, Insurance Carrier

The insurer requests reconsideration of our August 4, 1995 Own Motion Order Reviewing Carrier Closure, in which we set aside the insurer's June 16, 1995 Notice of Closure as premature. In its June 16, 1995 Notice of Closure, the insurer declared claimant medically stationary as of June 16, 1995. With its request for reconsideration, the insurer contends that: (1) claimant did not seek medical treatment for her compensable injury; (2) claimant did not treat with a physician who was a member of the managed cared organization (MCO), Vantage Onsite; (3) under OAR 436-30-035, claimant is presumed to be medically stationary if she fails to seek medical treatment; and (4) there was no medical evidence available to it prior to closure. Claimant contends that: (1) she sought medical treatment up to the time of claim closure; (2) her treating physician, although not a member of the MCO, opined that she was "medically unstable" at the time of closure; and (3) she further sought treatment from Dr. Radakovich, a member of the MCO, who opined that she needed further surgery. On August 18, 1995, we abated our prior order, and allowed the parties additional time to respond to the motion.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the June 16, 1995 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.

In our prior order, we found that claimant had carried her burden of proving she was not medically stationary when her claim was closed. We reached this conclusion based on unrebutted medical evidence in the record supplied by Dr. Yanney, claimant's non-MCO treating physician, that claimant's temporomandibular joint (TMJ) disorder required further surgery, and that there was a reasonable expectation of further material improvement in claimant's condition.

In addition, although the insurer contended that claimant did not seek medical treatment with Dr. Yanney after April 6, 1995, Dr. Yanney prescribed physical therapy for claimant. Therefore, although claimant might not have "seen" Dr. Yanney between April 6, 1995 and May 18, 1995 (substantiated by April 6 and May 18, 1995 chart notes), he prescribed her treatment and her continued use of the mandibular splint, and continued to follow her progress through reports sent to him by the physical therapist. Further, on May 4, 1995, Dr. Yanney prescribed treatment by "referral to Dr. Mary McCarthy for stress management and counseling for chronic depression due to chronic traumatic pain." Therefore, we find that she continued to "treat" under the auspices of her treating physician, irrespective of the physician's membership in the MCO.

Although the insurer contends that there was no medical evidence available to it prior to closure, we find that, by letter dated May 3, 1995, which enclosed his chart notes, Dr. Yanney advised the insurer of claimant's status by opining that "[m]oving [claimant's] case ahead towards a resolution for medical stability is of utmost importance..."

In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. See Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

On May 23, 1995, the insurer notified claimant that she needed to seek medical treatment from a physician who was a member of the MCO. That letter advised claimant that:

> "if we do not hear from you or an appropriate physician within two weeks from the date of this letter confirming that you are again under active treatment with an appropriate physician, we will assume that you have recovered to the point where your physical

condition is the same as it was before you were injured, and will proceed to close your claim."

In a June 1, 1995 letter, claimant notified the insurer that she had an appointment with Dr. Radakovich, a member of the MCO, on July 11, 1995. However, the insurer closed her claim on June 16, 1995. Claimant submitted a July 13, 1995 medical report from Dr. Radakovich, who opined that "[i]t appears to me that the proposed bilateral TMJ arthroplasty with auricular cartilage graft would be her best option at this time."

Here, the medical record conclusively supports claimant's contention that she was not medically stationary on June 16, 1995, when the insurer closed her claim. Claimant was actively treating with her physician (although he was not a MCO-member), and she complied with the insurer's request to treat with and obtain a second opinion from a MCO-member physician. Moreover, medical reports from Dr. Yanney prior to closure indicated that, because she requires further surgery to improve her TMJ condition, she was not medically stationary. Therefore, we continue to find that the insurer's June 16, 1995 Notice of Closure was premature.

Accordingly, on reconsideration, and as supplemented herein, we adhere to and republish our August 4, 1995 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

September 12, 1995 Cite as 47 Van Natta 1618 (1995)

In the Matter of the Compensation of
JEFFERY D. KUHN, Claimant
WCB Case No. 93-14636
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed By Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a cervical and left arm condition. On review, the issue is compensability.

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

The record contains four medical opinions regarding claimant's cervical spondylosis condition since the 1992 unappealed denial. Dr. Mason, claimant's attending physician, opined that claimant had preexisting cervical spondylosis that became symptomatic as a result of his work activity as a lineman. He explained that cervical spondylosis is a condition that takes years to develop and, in its early phases, is not particularly symptomatic. He further explained that, as the degree of arthritic changes increases, the likelihood of nerve irritability increases as well. He opined that claimant's work activity during the summer and fall of 1992 resulted in the onset of neck and arm symptoms, which in turn required medical services. (Exs. 30 and 32). Dr. Mason's opinion does not establish that claimant's work activities were the major contributing cause of claimant's worsened cervical condition.

Dr. Fuller, in contrast, explained that the bone spurs (i.e., degenerative condition) causing the narrowing of claimant's disc space as seen in the June 1992 x-rays and MRI, probably began over five years earlier and did not change structurally by the time of the October 1993 study. He concluded that the major cause of claimant's cervical condition were the bone spurs, not his work activities. (Tr. 72, 73, 82).

Dr. Wilson also concluded that claimant's symptoms, which initially came on during a period in which he was not working, and then increased while putting on his boots at home, were not related to claimant's work activities. (Ex. 29).

Dr. Domby, osteopath, who rendered an opinion in support of compensability on March 8, 1994, had not seen claimant since January 2, 1992, when he had treated him for a stiff neck.

Since we consider their opinions to be more thorough and well reasoned, we are more persuaded by the opinions of Drs. Fuller and Wilson than by those of Drs. Mason and Domby. Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810 (1983). Consequently, we conclude that claimant has failed to prove the compensability of his occupational disease claim for his cervical and left arm condition.[1]

Moreover, the medical record as a whole, without limiting it to the period following the 1992 denial, also fails to establish that claimant's claim is compensable. Consequently, we decline to address the parties' arguments regarding the 1992 denial.

ORDER

The ALJ's order dated January 24, 1995 is affirmed.

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[1] Since briefing in this case was completed, the legislature amended ORS 656.802, the occupational disease statute. SB 369, 68th Leg., Reg. Sess. § 56 (June 7, 1995). We need not address the retroactive applicability of the statute here, because, we conclude that, under either version of the statute, claimant has failed to prove the compensability of his claim.

In the Matter of the Compensation of
ROBERT D. LAWRENCE, Claimant
WCB Case No. 93-14953
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that upheld the SAIF Corporation's denial of claimant's claim for an L5-S1 disc herniation. In his brief, claimant moves to remand the case to the ALJ. On review, the issues are remand and compensability.

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

In upholding SAIF's denial, the ALJ found that claimant failed to prove the compensability of a herniated disc. Asserting that the record is improperly, incompletely or insufficiently developed, claimant seeks remand for further development of the record concerning a "separate claim" for low back strain "that was discussed for the first time during closing arguments." For the following reasons, we deny the motion.

At the beginning of the hearing, both parties agreed with the ALJ's statement that "the only issue today is compensability of an L5-S1 herniated disc." (Tr. 2). Claimant concedes that he first raised compensability of a separate claim for a low back strain in closing arguments. SAIF argues that this issue was not properly raised at hearing. We agree.

We have consistently held that we will not consider an issue raised for the first time during closing argument. Larry L. Schutte, 45 Van Natta 2085 (1993); Leslie Thomas, 44 Van Natta 200 (1992); John C. Schilthuis, 43 Van Natta 1396 (1991). In accordance with the aforementioned holdings, we conclude that claimant did not properly raise the compensability of a strain injury at hearing. Accordingly, we decline to address this issue on review.

Because the issue of compensability of an injury claim for a low back strain is not properly before us, we deny the motion for remand. In denying claimant's motion for remand, we note that claimant does not assert that he has any evidence which was not obtainable with due diligence at the time of hearing. See ORS 656.295(5); Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Under such circumstances, we find no basis to remand to the ALJ. Accordingly, the motion for remand is denied.

As a final matter, we offer the following additional observations. The ALJ noted that SAIF did not contest the facts from which a finding of compensability of a lumbar strain condition could be made. The ALJ further noted that SAIF conceded that there was an incident at work, claimant reported an injury to his employer, claimant sought medical treatment, the doctor diagnosed lumbar strain, and claimant was treated.

On review, SAIF does not challenge these conclusions. Such circumstances do not support a conclusion that a dispute regarding the compensability of a lumbar strain existed at the time of the hearing. Consequently, it would be inappropriate for us to entertain such an "issue" at this late date.

ORDER

The ALJ's order dated January 27, 1995 is affirmed.

September 12, 1995 Cite as 47 Van Natta 1620 (1995)

In the Matter of the Compensation of
ROBERT J. WESTFALL, Claimant
WCB Case No. 94-05629
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Brown's order that: (1) upheld the SAIF Corporation's denial of claimant's mental disorder claim; and (2) declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except that we substitute all references to "Granny accident" with "December 11, 1993 accident."

CONCLUSIONS OF LAW AND OPINION

Compensability

On December 11, 1993, claimant was driving a sander truck and had parked along the side of the road. A car containing four children slid into the back of claimant's truck; claimant examined the driver, who appeared injured and unconscious or dead, and helped the children exit the car and get to safety. In view of claimant and the children, another car slid into the first car. No one was seriously injured.

On December 21, 1993, claimant drove a truck under a tree, bending a sign mounted on the top of the truck. Claimant initially falsely reported that the accident occurred while performing work activities; claimant subsequently admitted that the sign was damaged while he was conducting personal business during work hours. In March 1994, claimant was terminated from his job for "dishonest reporting of the event," "conducting personal business during working hours," and because the December 21, 1993 incident constituted the third preventable accident in a three-year period. (Ex. 5A-3).

On April 1, 1994, claimant sought treatment from his family physician, Dr. Gilmour, for extreme anxiety. (Ex. 6A). Dr. Gilmour referred claimant to Dr. Legner, E.A.D., who treated claimant for six one-hour sessions beginning April 12, 1994.

Claimant asserts that his need for psychological treatment is in major part caused by the December 11, 1993 event, when he witnessed and assisted in a multiple-car accident involving a grandmother and her four young grandchildren. Claimant relies on the opinions of Dr. Legner and Dr. Gilmour.

In order to prove a compensable claim for a mental disorder, claimant in part must provide clear and convincing evidence that the mental condition arose out of and in the course of employment. ORS 656.802(3)(d). In order to be clear and convincing, the truth of the facts asserted must be highly probable. E.g., Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987). The only dispute in this case is whether claimant's psychological condition was in major part caused by the December 11, 1993 accident and, therefore, compensable.

Dr. Parvaresh, psychiatrist, and Dr. Klecan, psychiatrist, both examined claimant on behalf of SAIF. Dr. Parvaresh understood claimant to be experiencing nightmares and flashbacks of his experience during the Vietnam war. (Ex. 13-8). He diagnosed a preexisting and chronic post traumatic stress disorder (PTSD) related to his Vietnam history; although Dr. Parvaresh thought that claimant's condition worsened after being terminated, he noted that, if claimant had experienced PTSD from the December 11, 1993 accident, onset of symptoms would have been immediate and claimant had not sought treatment until months later. (Id. at 7-8).

Dr. Klecan found no diagnosable mental disorder. (Ex. 14-8). Dr. Klecan based this opinion on claimant's failure during the interview to mention any PTSD symptoms relating to Vietnam or the December 11, 1993 accident. (Id.) Like Dr. Parvaresh, Dr. Klecan felt that onset of true PTSD symptoms would have been immediate and, since claimant did not provide such a history, such a condition was not likely. (Id.) Rather, based on claimant's focus of believing he was unfairly terminated, Dr. Klecan found that the "primary and only significant stressor from the history is and has been termination from employment." (Id. at 8, 9).

During a deposition, Dr. Legner explained that he diagnosed PTSD based on claimant's symptoms of flashbacks, nightmares, exaggerated startle response, and depression. (Ex. 15-12). Although Dr. Legner acknowledged some contribution to claimant's condition from numerous sources, including his termination, Vietnam experience, and marital discord, he stated that the major contributing cause was the December 11, 1993 accident. (Id. at 26). Dr. Legner was not surprised that claimant had either failed to mention, or described the accident only in passing, to the examining physicians since he found claimant to be a private person who does not easily discuss his feelings. (Id. at 44). Although Dr. Legner did not discuss with claimant his reason for not seeking treatment until April 1994, Dr. Legner explained that termination "triggered" his condition, thus delaying the need for treatment. (Id. at 17, 26).

Finally, Dr. Gilmour stated that claimant related to him that his flashbacks and nightmares related principally to Vietnam and that such symptoms were triggered by the accident. (Ex. 16-6).

Dr. Legner is in the best position to provide an opinion because he had the most extensive contact with claimant; he also persuasively explains his reasons for attributing claimant's condition in major part to the December 11, 1993 accident. We do not find, however, that his opinion rises to the level of clear and convincing evidence. Claimant did not consistently report his symptoms. According to Dr. Gilmour and Dr. Parvaresh, claimant's PTSD symptoms principally related to Vietnam; claimant failed to discuss any such symptoms to Dr. Klecan, instead talking about his feelings regarding the termination. We are not convinced that such inconsistency is simply due to claimant being a private person, as explained by Dr. Legner, since he discussed his symptoms with his family physician, with whom he had previously treated.

Because Dr. Legner relied only on claimant's statements regarding his condition, and because claimant exhibited inconsistency in reporting his symptoms, we conclude that Dr. Legner's opinion is not sufficiently reliable to be clear and convincing proof that any mental disorder in major part arose out of and in the course of employment. Thus, we agree with the ALJ that claimant failed to prove compensability.

Penalties

Inasmuch as claimant did not prove compensability, he is not entitled to a penalty. ORS 656.262(11)(a).

ORDER

The ALJ's order dated February 9, 1995 is affirmed.

In the Matter of the Compensation of
DENNIS YOUNGSTROM, Claimant
WCB Case No. TP-95005
THIRD PARTY DISTRIBUTION ORDER
Powers, McCulloch, et al, Claimant Attorneys

GAB Business Services, Inc., (GAB), as paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to the amount of GAB's share of the settlement proceeds. We conclude that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

In December 1994, claimant sustained a compensable pelvic injury when he was involved in a motor vehicle accident while performing his employment duties as a truck driver. GAB accepted the claim and has provided compensation. To date, it has incurred actual claim costs totaling $5,125.11.[1] These costs are composed of temporary disability ($3,034.65) and medical expenses ($2,090.46)

Claimant retained legal counsel to pursue a third party lawsuit against the party responsible for the motor vehicle accident. Claimant and the third party reached a $21,670.86 settlement. GAB approved the settlement on the condition that its entire $5,125.11 lien be paid in full.

Thereafter, GAB received a check from claimant's attorney in the amount of $3,843.83. Noting that one-fourth of GAB's $5,125.11 lien had been deducted for an attorney fee, claimant's attorney asserted that the check represented "full and final settlement of this matter."

GAB advised claimant's counsel that it was holding the reimbursement check pending receipt of the amount claimant's counsel withheld for his attorney fee. Contending that claimant's attorney was not entitled to reduce its lien by an attorney fee, GAB requested full payment of its lien. When no payment was forthcoming, GAB petitioned the Board for resolution of the dispute.

Following its receipt of GAB's petition, the Board granted claimant's counsel an opportunity to respond to GAB's petition. Specifically, claimant's counsel was given 21 days to file his response, including any supporting evidence. The 21-day period having expired without claimant's counsel's response, the Board has proceeded with its review.

A distribution of the third party settlement in accordance with ORS 656.593(1) is "just and proper." Such a distribution would permit GAB to receive $5,125.11 as full reimbursement for its lien.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury as a result of the negligence or wrong of a third person. The claim was accepted by GAB, which has provided compensation. Inasmuch as GAB has paid benefits to claimant as a result of a compensable injury, it is a paying agency. ORS 656.576.

When claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable. Thus, the third party settlement became subject to GAB's lien for its "just and proper" share. See ORS 656.593(3). We now proceed to a determination of a "just and proper" distribution.

We are required to exercise our discretion in arriving at a "just and proper" distribution of settlement proceeds under ORS 656.593(3). Urness v. Liberty Northwest Insurance Corporation, 130 Or App 454, 458 (1994). Since "ad hoc" distributions are contemplated by ORS 656.593(3), it is improper for us to automatically apply the distribution scheme for third party judgments under ORS 656.593(1)

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[1] GAB alleges a total of $5,125.10 in claim costs. Our calculation, however, differs from GAB's by one cent, based on GAB's summary of claim costs.

when resolving disputes regarding third party settlements. Id. Despite the impropriety of such an automatic method, a distribution which mirrors the third party judgment scheme may, in fact, be "just and proper" provided that such a determination was based on the merits of the case. Id.

In resolving this particular dispute, we are, therefore, mindful of the court's admonishment that we must refrain from automatically applying the third party judgment scheme when determining a "just and proper" distribution for third party settlement proceeds. Urness v. Liberty Northwest, supra. Thus, in reaching our determination regarding a "just and proper" distribution, we judge this case based on its own merits and not on an inapplicable statutory distribution scheme. In other words, in exercising our statutory authority under ORS 656.593(3), we do not arbitrarily adhere to the specific distribution scheme set forth in ORS 656.593(1).

Here, GAB contends that it is entitled to full reimbursement of its $5,125.11 in claim costs from the third-party settlement proceeds. We agree with GAB's contention.

Claimant has not contested GAB's assertion that it has incurred $5,125.11 in actual claim costs. In fact, claimant does not dispute GAB's assertion that it is entitled to full satisfaction of its statutory lien.

Pursuant to ORS 656.593(1)(c), the paying agency shall be paid and retain the balance of a third party recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service. "Compensation" includes 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 ORS Chapter 656. ORS 656.005(8).

Where a paying agency has incurred expenditures for compensation attributable to an accepted injury claim and the claimant has not challenged the payment of those benefits, we have found it "just and proper" for a paying agency to receive reimbursement for such claim costs. Jack S. Vogel, 47 Van Natta 406 (1995). Inasmuch as the expenditures in this case constitute "compensation" which has previously been provided to claimant, we find it "just and proper," under the circumstances of this case, for GAB to receive full reimbursement for these expenses from claimant's third party settlement. See ORS 656.593(3); Norman H. Perkins, 47 Van Natta 488, 490 (1995). Accordingly, we conclude that GAB's "just and proper" share of the third party settlement is $5,125.11.

Rather than distributing $5,125.11 to GAB in full satisfaction of its lien, claimant's counsel unilaterally deducted one-fourth of the lien for an attorney fee. Yet, there is no statutory provision that would permit claimant's attorney to reduce the recovery of GAB's lien by an additional attorney fee. See Sheri L. Cody, 44 Van Natta 2254 (1992); Clifford S. Brush, 44 Van Natta 954, 955 (1992). (Claimant's attorney not entitled to reduce a paying agency's share of a third party recovery for an additional attorney fee.) Instead, the statutory distribution scheme, which we have determined to be applicable to this case, is precise.

Specifically, pursuant to ORS 656.593(1)(a), a claimant's attorney fees in a third party recovery are initially deducted from the recovery and distributed to the attorney. Following this attorney fee distribution and litigation costs, the remaining balance of the third party recovery is distributed amongst claimant (1/3 share) and the paying agency (to the extent of its lien). Thus, the third party statutes do not provide authorization for an additional attorney fee award other than that disbursed from a third party recovery. See Sheri L. Cody, supra.

In conclusion, claimant's counsel's unilateral and unauthorized action was clearly contrary to the statutory distribution scheme as set forth in ORS 656.593 (1) and (3). As a result of claimant's counsel's impermissible distribution, GAB's recovery has been improperly reduced. Under such circumstances, we have previously held that the paying agency may recover its unpaid lien from claimant's attorney. Steven B. Lubitz, 40 Van Natta 450, 452 (1988).

In accordance with the reasoning discussed above, we conclude that claimant's attorney is jointly and severally responsible for remedying this situation. Accordingly, claimant and/or claimant's attorney are directed to pay GAB the additional $1,281.28 in order to fully satisfy GAB's lien of $5,125.11.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMOND P. BALES, Claimant
WCB Case Nos. 94-03251 & 94-03252
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order which: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition; and (2) upheld SAIF's denial of claimant's occupational disease claim for the same condition. On review, the issues are compensability and aggravation.

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

The ALJ found that claimant failed to establish the compensability of his current low back condition, as either an aggravation of his compensable injury or as an occupational disease. In reaching his conclusion, the ALJ disregarded the medical opinions, regarding the cause of claimant's low back condition because they were premised on inaccurate histories. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977). Additionally, the ALJ found claimant's testimony, that he reported hip and low back problems to every examining physician, inaccurate and misleading.

On review, claimant contends that compensability turns on credibility. Specifically, claimant asserts that his "credible" testimony at hearing, is sufficient to overcome the "inconsistent interpretation of medical" histories as reported by his examining physicians. (App. Br. 12). Noting that the ALJ made no express credibility finding, claimant asks the Board to make the necessary credibility finding based on the substance of his testimony at hearing, not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Under ORS 656.273(1), a claimant has a compensable aggravation if he proves that his compensable injury materially contributed to his worsened condition, unless it is proven that an off-the-job injury is the major cause of his worsened condition. Fernandez v. M & M Reforestation, 124 Or App 38, 42 (1993). To establish an occupational disease claim, claimant must prove that his work activity subsequent to his January 1989 compensable injury is the major contributing cause of his current low back condition. See Stacy v. Corrections Division, 131 Or App 610, 614 (1994) (to establish that current condition was a new occupational disease, the ALJ properly required the claimant to prove that work activities after acceptance of mental stress claim were major contributing cause of current condition).

Because of the various possible causes of claimant's current low back condition, including a prior non-work related accident in 1983 and his continued work activities, we find that the causation issue is a complex medical question requiring expert medical opinion to resolve. See Rick C. Wertman, 47 Van Natta 340, 341 (1995) (citing Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986) and Uris v. Compensation Department, 247 Or 420 (1967). In conducting our review, we do not discard claimant's credible testimony. Nevertheless, due to the complexity of this casual relationship issue, we tend to rely on expert medical opinions which are based on complete histories and thoroughly analyze the relationship between a claimant's claimed condition and his work activities.

After reviewing the record, we, like the ALJ, are unable to conclude that the medical opinions were based on an accurate history. In rendering this conclusion, we are unable to reconcile claimant's contemporaneous description of his industrial accident (rotating, slipped, over reaching, pulled muscles) with the various histories reported by Drs. Belza, Woolpert, Stewart and Altrocchi. (Exs. 11-5, 35-1, 45-1, 53-1). For instance, Dr. Belza reported that claimant fell 20 feet from a fuel pile onto a conveyer belt, when his pitchfork got stuck. (Ex. 53-1). The history Dr. Stewart noted was that claimant was injured when the fuel pile he was standing on gave way causing him to fall onto a conveyor belt. (Ex. 35-1). Further, we find it unlikely that the various physicians who initially examined claimant would neglect to mention or treat his low back problems, particularly in light of his testimony that he "told every physician about [his] low back condition" after the 1989 work related accident. (Tr. 39).

As such, we find no persuasive medical opinion, based on an accurate and complete history, which supports the compensability of claimant's low back condition. See Somers v. SAIF, 77 Or App 259 (1986) (persuasiveness of medical opinion depends on accurate and complete history); Miller v. Granite Construction Co., supra. Accordingly, regardless of whether the applicable legal standard is material or major contributing cause, we find that claimant's aggravation/occupational disease claim for his low back condition must fail.

ORDER

The ALJ's order dated March 2, 1995 is affirmed.

September 13, 1995 Cite as 47 Van Natta 1625 (1995)

In the Matter of the Compensation of
VICTORIA A. BROKENSHIRE, Claimant
WCB Case No. 94-10853
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Howell's order that: (1) held that the Hearings Division retained jurisdiction to consider claimant's request for surgery; (2) set aside SAIF's "de facto" denial of claimant's medical services claim; and (3) awarded a $2,400 assessed attorney fee. On review, the issue is jurisdiction and, alternatively, medical services and attorney fees. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In examining the text and context of former ORS 656.260(6), the ALJ determined that the Hearings Division had jurisdiction to resolve the disputed medical services claim and denied SAIF's motion to dismiss. Relying on the opinion of Dr. Mawk, claimant's treating surgeon, the ALJ concluded that the May 31, 1994 surgery was reasonable and necessary medical services and, therefore, compensable. We conclude that the Hearings Division does not have jurisdiction over this dispute and vacate the ALJ's order.

Relying on Job G. Lopez, 47 Van Natta 193 (1995), claimant asserts that the ALJ had jurisdiction to review the reasonableness and necessity of the surgery she received. We disagree.

We have recently held that the unambiguous mandatory language of amended ORS 656.260(6)[1] indicated the legislature's intent to overrule Job G. Lopez, supra and that, pursuant to that statute, the Director has exclusive jurisdiction over all MCO medical services disputes. Ronald R. Streit, Sr., 47 Van Natta 1577 (1995). In reaching this conclusion, we looked to the text and context[2] of amended ORS 656.260(6).

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[1] Amended ORS 656.260(6) now provides, in part, that "[a]ny issue concerning the provision of medical services to injured workers subject to a managed care contract *** shall be subject solely to review by the director as the director's designated representatives, or as otherwise provided in this section." Or Law 1995, ch 332 §27 (SB 369, §27).

[2] In particular, we found that amended ORS 656.704(3), 656.245(6) and 656.283(1) were further evidence that the legislature intended the Director to have exclusive jurisdiction over MCO medical services disputes. Ronald R. Streit, Sr., supra, slip op at 7.

Because neither the Hearings Division nor the Board[3] has jurisdiction over the MCO's denial of claimant's surgery, claimant's request for hearing is dismissed.[4] Accordingly, we do not address the medical services issue. Likewise, because the remaining issues are contingent upon the resolution of the medical services issue, we are without authority to address the accompanying attorney fee issue. See SB 369, §42b(5).

ORDER

The ALJ's order dated January 19, 1995 is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

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[3] In Ronald R. Streit, Sr., supra, we also held that because amended ORS 656.260(6) did not fall within any of the exceptions to SB 369, §66 nor altered a procedural time limitations, it applied retroactively. See Volk v. America West Airlines, 135 Or App 565 (1995); Cigna Insurance Co. v. McMasters, 135 Or App 583 (1995).

[4] Applying the clear language of the 1995 amendments to this case will result in this matter being decided by the Director rather than the Board and the Hearings Division. Because the parties will still have a forum in which to air their grievances about this claim, we do not consider that to be an unintended, absurd or unreasonable result. See Satterfield v. Satterfield, 292 Or 780, 782-83 (1982) (court declines to apply statute literally when to do so will produce unintended, absurd or unreasonable result). Consequently, we find no basis for departing from a literal reading of the amendments. See Walter L. Keeney, 47 Van Natta at 1387 (1995) (legislative determination that ORS 656.327 medical services cases be decided by Director rather than Hearings Division and Board not an absurd or unintended result).

In the Matter of the Compensation of
HELEN M. CALLANDER, Claimant
WCB Case No. 94-10978
ORDER ON REVIEW (REMANDING)
Emmons, Kropp, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by the Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) Garaventa's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that, because claimant established a worsened low back condition that resulted in diminished earning capacity, she had proved the compensability of her aggravation claim. In reaching that conclusion, the ALJ found that the Determination Order closing claimant's original low back claim did not contemplate that claimant would experience waxing and waning of symptoms of that condition. On review, the parties dispute both the ALJ's reasoning and conclusions. For the following reasons, we vacate the ALJ's decision.

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.273(1) to read, in part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by evidence of an actual worsening of the compensable condition supported by objective findings." Or Laws 1995, ch 332, § 31 (SB 369, § 31; emphasis added). The 1995 amendments do not define the term "actual worsening." Under former ORS 656.273(1), a symptomatic or pathologic worsening was sufficient to establish an aggravation. E.g., Caroline F. Wood, 46 Van Natta 2278 (1994).

Except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565, 572-73 (1995). Because amended ORS 656.273(1) is not among the exceptions to this general rule, see SB 369, § 66 (listing exceptions to general retroactivity provision), and because this matter has not been finally resolved on appeal, the amended version of the statute applies here.[1] See Bill's Kwik Mart v. Wood, 135 Or App 692, 693 (1995) (in light of parties' agreement that 1995 revisions to workers' compensation act applied to aggravation claim, court agreed that remand of case to Board was proper disposition of case).

We may remand a case for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986). A compelling basis for remand exists when the record is devoid of evidence regarding a legal standard that goes into effect while Board review of a case is pending. See, e.g., Troy Shoopman, 46 Van Natta 21, 22 (1994) (case remanded to ALJ because record devoid of evidence regarding legal standard recently announced by Supreme Court); see also Betty S. Tee, 45 Van Natta 289 (1993) (Board remanded matter to ALJ in light of Supreme Court's intervening definition of relevant statutory term); cf. Rosalie S. Drews, 46 Van Natta 408, recon den 46 Van Natta 708 (1994) (Board declined to remand case to ALJ for additional evidence under Supreme Court's recent interpretation of statute, when record was sufficiently developed to analyze issue under that interpretation).

Here, Board review of this case was pending when amended ORS 656.273(1)'s "actual worsening" standard went into effect. Other than evidence that claimant experienced worsened pain or range of motion (e.g., Exs. 21, 41-8, -40), or a "worsening of her situation" (Ex. 22; see Ex. 41-34, -56), the record is devoid of either documentary or testimonial evidence regarding whether her low back condition "actually" worsened. Under the circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant sustained a compensable aggravation. Moreover, we find that there is a compelling reason to remand this matter for the submission of additional evidence regarding whether claimant sustained an "actual worsening" of her compensable low back condition.

In reaching this conclusion, we note the insurer's argument that claimant has failed to establish that her alleged aggravation was more than a waxing and waning of symptoms of her compensable low back condition. The insurer refers us to ORS 656.214(7), which is a new provision that the 1995 Legislature added to the Act. That subsection provides, in part, that "[a]ll permanent disability contemplates future waxing and waning of symptoms." SB 369, § 17. The insurer asserts that, as a matter of law, the Determination Order closing claimant's low back claim contemplated future waxing and waning of symptoms. The insurer then contends that, because claimant has not established a worsening that is more than a waxing and waning of symptoms of her compensable condition, ORS 656.273(8), her aggravation claim fails.

We do not address those issues. Rather, because we are remanding this matter for further development regarding the worsening issue, we consider it appropriate to allow the parties an opportunity on remand to present additional evidence and argument regarding the effect, if any, of ORS 656.214(7), on this case.

In view of these conclusions, we do not address the diminished earning capacity issue. On remand, the parties shall remain free to contest that issue.[2]

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[1] Under section 66(6) of SB 369, amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively. Cigna Insurance Co. v. McMasters, 135 Or App 583, 587 (1995). Because ORS 656.273(1) does not alter a procedural time limitation, section 66(6) does not apply to this case.

[2] The parties also dispute whether claimant's medical treatment was curative or palliative. In view of our decision to remand this matter for further development regarding the aggravation issue, we do not address that issue. On remand, however, the parties may wish to address the effect, if any, of the relevant provisions of SB 369. See SB 369, § 25, amended ORS 656.245(1), (6).

Accordingly, we vacate the ALJ's order and remand this case to ALJ Garaventa for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

September 13, 1995 Cite as 47 Van Natta 1628 (1995)

In the Matter of the Compensation of
RAYMOND T. COX, JR., Claimant
WCB Case No. 93-04847
ORDER ON REVIEW
Paul King, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Neidig and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Podnar's order which granted claimant permanent total disability, whereas an Order on Reconsideration awarded claimant 28 percent (43 degrees) scheduled permanent disability for loss of use or function of the right leg and 59 percent (188.8 degrees) unscheduled permanent disability. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the last two findings. We also provide the following supplementation.

In August 1990, following his June 29, 1990 compensable lumbar laminectomy and prior to his noncompensable September 29, 1990 motorcycle accident, claimant was able to sit, stand, walk on his toes and heels and get on and off his physician's examining table without assistance. (Ex. 27B). Claimant engaged in physical therapy two times a week between August 14, 1990 and September 18, 1990. The physical therapist's records indicate that despite persistent pain, claimant's gait appeared fairly relaxed and he was able to tolerate the treadmill and exercises. (Ex. 27C). On September 25, 1990, claimant's surgeon, Dr. Wright, determined that no further neurosurgical intervention or follow-up was indicated. (Ex. 28).

CONCLUSIONS OF LAW AND OPINION

Appellee's Surreply Brief

As a preliminary matter, the insurer moves to strike claimant's "Appellee's Surreply" brief on the grounds that claimant (as the respondent) has no basis for submitting such a brief. We agree. The rules make no provision for a surreply brief of the respondent and we have not otherwise authorized the filing of such a brief in this case. See OAR 438-11-020(2). We therefore grant the insurer's motion to strike and do not consider claimant's surreply brief.

Permanent Total Disability

In order to establish permanent total disability, claimant must prove either that: (1) he is completely physically disabled and therefore precluded from gainful employment; or (2) his physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd lot" doctrine. Amended ORS 206(1)(a); Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). In determining whether claimant is permanently and totally disabled, we consider only disability that preexisted or was caused by his compensable injury. Subsequent, noncompensable conditions are not considered. Elder v. Rosboro Lumber Co., 106 Or App 16 (1991); Emmons v. SAIF, 34 Or App 603 (1978).

Here, the ALJ concluded that claimant was permanently disabled as a result of his industrial injury based on physical incapacity. The ALJ also determined that claimant's physical condition and limited vocational capabilities (as described by Dr. Fisher) effectively prohibited any gainful and suitable employment and that it would be futile for claimant to seek work in the labor market. We disagree.

First, we conclude that the record does not establish that claimant was completely physically incapacitated as a result of his May 19, 1987 industrial accident. Rather, the record shows that following his compensable hospitalization, claimant returned to modified work with the same employer. He ultimately terminated his employment for reasons unrelated to his injuries in late 1987. The medical evidence indicates that in 1990, prior to his noncompensable motorcycle accident, claimant underwent lumbar surgery and was having an unremarkable recovery. In the early fall of 1990, claimant was undergoing physical therapy and able to sit, stand and walk without assistance. Although claimant continued to have low back pain and edema associated with the thrombophlebitis in his right leg, all of the other injuries he sustained in the work accident had essentially resolved by the time he was involved in the first noncompensable accident, where he was injured while riding a motorcycle.[1]

Even claimant's treating physician, Dr. Wescott, opined in January 1992 that, but for claimant's noncompensable motorcycle accident, claimant would have been capable of sedentary work. (Ex. 36D-2). Dr. Fisher, who examined claimant at his request, also indicated that claimant might be physically capable of some sort of sedentary work on an occasional part time basis. (Ex. 37-7). All of the other examining physicians, including Dr. Hallin, the medical arbiter who assessed claimant's vascular condition, reported that claimant was capable of sedentary work. Without separating the compensable injuries from the noncompensable injuries, Dr. Hallin found claimant only partially disabled and capable of sedentary work, with restrictions. (Ex. 80).

Dr. Gambee, who examined claimant at the insurer's request, opined that the injuries claimant sustained in his noncompensable motorcycle accident were "far more severe" than the residuals from his 1987 compensable accident. Dr. Gambee was convinced that, but for his subsequent noncompensable accidents, claimant would be capable of employment, and that even considering all of his injuries, claimant could do sedentary work. (Ex. 100-18, -26). Further, Dr. Gardner, a neurologist who reviewed claimant's medical records, found no objective evidence of neurologic impairment as a result of the compensable accident that would prevent claimant from returning to work. (Ex. 62). On this record, we conclude that claimant has not established that he is totally physically incapacitated as a result of the 1987 industrial accident.[2]

Because we have found claimant is not totally incapacitated on a medical basis alone, he may prevail only by proving that he falls under the "odd-lot" doctrine. Under that doctrine, a disabled person with some residual physical capacity may still be permanently and totally disabled due to a combination of his physical condition and certain nonmedical factors such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Co., 72 Or App 397 (1985); James S. Daly, 45 Van Natta 2409 (1993). However, since application of the "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all probability, would be futile. SAIF v. Simpson, 88 Or App 638, 641 (1987). Even if a work search would be futile, claimant must nevertheless prove that, but for the compensable injury, he is willing to work. SAIF v. Stephen, 308 Or 41 (1989).

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[1] As the insurer notes, by law of the case, we must find that claimant's cervical condition resulted from the September 1990 motorcycle accident and not the 1987 work accident. In a March 3, 1993 Opinion and Order (from which review was not requested), ALJ Bethlahmy found that claimant had recovered from any cervical injury caused by the 1987 accident as of January 1989, and therefore claimant's claim for an ongoing cervical condition was not compensable. (Ex. 85-7).

[2] To the extent the reports Dr. Wescott, and consulting doctors, Fisher and Rao, can be read to suggest that claimant is permanently and totally disabled on a medical basis alone, these reports do not persuade us that claimant's 1987 industrial accident is the reason for this incapacity. First, although we generally give great weight to the opinion of the treating doctor (Weiland v. SAIF, 64 Or App 810 (1983)), here there are persuasive reasons not to do so. Specifically, Dr. Wescott, like Drs. Fisher and Rao, is considering a body part that cannot be used in rating claimant's permanent total disability. These physicians erroneously assume that claimant's cervical condition is related to the industrial accident rather than the noncompensable motorcycle accident (see Exs. 36D, 37-6, 63), when the law of the case establishes otherwise. Because these opinions are inconsistent with the law of the case, they must be discounted. See Kuhn v. SAIF, 73 Or App 768, 772 (1985). In addition, we find these doctors' opinions conclusory and not well reasoned. For example, Dr. Fisher states that it is "difficult to segregate out each injury" because "there are now so many areas involved in making him totally incapacitated," then summarily concludes that claimant is permanently precluded from gainful employment as a result of the industrial accident. (Ex. 37-7).

Claimant was 44 years old at the time of hearing. He has a high school education. He also has a certificate to appraise diamonds, and has had experience selling and appraising jewelry. The record does not establish that claimant's age, education, prior work experience, mental capacity[3] or emotional conditions preclude him from gainful employment. The only evidence claimant offered (which goes primarily to his adaptability to nonphysical labor) is the opinion of Dr. Fisher, who summarily stated that claimant's "background and training do not permit him" to find and be employed in a sedentary capacity.

Unlike the ALJ, we are not persuaded by Dr. Fisher's assessment of claimant's capabilities. Although as a physician Dr. Fisher is qualified to render an opinion regarding claimant's medical and physical incapacities, he is not necessarily qualified to render an opinion regarding claimant's vocational abilities. We therefore do not afford his "vocational" conclusion much weight. See William H. Long, 43 Van Natta 1451 (1991) (On vocational issues, Board affords greater weight to the opinions of vocational experts rather than medical experts).

The insurer, on the other hand, offered the opinion of vocational rehabilitation counselor Byron McNaught who, based on claimant's reported history and physical capabilities, concluded that claimant is employable even in his current condition. Mr. McNaught indicated that within the sedentary category, claimant could work as a cashier, ticket seller, license clerk, telephone operator, telephone solicitor or security monitor. (Ex. 101-9, 10). McNaught further indicated that these types of jobs were available in the hypothetical labor market, and that claimant would need little or no retraining to qualify for such employment.

The ALJ gave no weight to Mr. McNaught's opinion because he had not tested claimant to determine whether claimant was qualified for the identified jobs based upon his temperament, skills or adaptability, and also because McNaught did not perform a market survey to determine whether such positions were actually available. Considering that Mr. McNaught was present during claimant's testimony and offered a thorough opinion which was subject to a full examination from both parties, we do not disregard his opinion. In any event, since claimant has the burden of proof under ORS 656.266, even if we were to totally discount the expert opinion of Mr. McNaught, the vocational evidence is in equipoise.[4] Claimant has not established that he is incapable of sedentary employment, that there are no appropriate jobs available or that it would be futile for him to look for work.

Accordingly, on this record, we find that claimant has failed to prove that he is permanently and totally disabled as a result of his May 19, 1987 industrial accident. We therefore reverse the ALJ's decision.

ORDER

The ALJ's order dated February 3, 1995, as amended February 17, 1992, is reversed. The November 10, 1992 Order on Reconsideration, as amended December 23, 1992, is reinstated and affirmed.

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[3] There is some evidence in the record that as a result of the closed head injury sustained in the noncompensable motorcycle accident, claimant has some slurring of speech and loss of memory. However, since these are subsequent, noncompensable conditions, they are not to be considered in our assessment of permanent disability. Elder v. Rosboro Lumber Co., supra.

[4] As noted above, we give no probative value to Dr. Fisher's assertion that claimant lacks the background and training to perform sedentary work since Dr. Fisher is not a vocational expert.

In the Matter of the Compensation of
KENNETH W. MADDEN, Claimant
WCB Case No. 94-04528
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Brown's order that upheld the self-insured employer's denial of claimant's claim for a right rib muscle strain. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On Wednesday afternoon, February 2, 1994, claimant felt a "cringe" in his back after deflecting a log while working on the porkie at the employer. He did not report this incident as an injury. For the next two days, claimant worked on the planer grading lumber, a more physical job than work on the porkie. Although claimant felt stiffer after work, he still reported no incident. On Saturday evening, claimant attended a basketball game. At the start of the second half of the game, claimant stood up to cheer, turned suddenly, coughed or sneezed, and experienced a severe muscle spasm in the right mid back for which he sought treatment at an emergency room. On Sunday, claimant's wife notified the employer that claimant would not be at work the next day. On Monday, claimant's wife notified the employer that claimant's condition might have been caused by work. Claimant filed a Form 801 on February 12, 1994. The employer denied the claim on February 18, 1994 with an amended denial dated February 22, 1994.

It is claimant's burden to prove that his injury is compensable. ORS 656.266. A compensable injury is an accidental injury arising out of and in the course of employment requiring medical services or disability. ORS 656.005(7)(a).[1] Here, the issue is whether claimant's muscle spasm was due to an injury at work or whether it arose as a result of claimant's activity at the basketball game.

The record indicates that claimant did not report the "cringe" incident at work prior to the basketball incident. Moreover, the record also indicates that it was not until two days after the basketball incident that claimant reported a possible work connection to the employer. Thus, we must rely on the medical record to establish the cause of claimant's condition.

There are two medical opinions regarding causation. Dr. Knudsen, claimant's treating chiropractor, opines that, based on the history provided by claimant, claimant was in a weakened state when his condition worsened at the basketball game. (Ex. 13). In contrast, Dr. McKaskill, who treated claimant at the emergency room, opined that claimant's actions while jumping up and cheering at the basketball game were sufficient in themselves to bring on claimant's muscle spasm.[2] (Ex. 12).

Due to the number of potential causes and claimant's failure to report a work injury to the employer until after the basketball game incident, as well as his failure to mention a work connection at the emergency room, resolution of the issue requires expert medical evidence. Uris v. Compensation

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[1] Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.005(7)(a). Or Laws 1995, ch 332, § 1 (Senate Bill 369, § 1). The provisions of Senate Bill 369 apply retroactively to all pending cases, unless specifically excepted from retroactive application by Section 66. Volk v. America West Airlines, 135 Or App 565 (July 26, 1995). Here, there is no exception to retroactive application of the law. However, because none of the limitations or exclusions under amended ORS 656.005(7) apply in this case, claimant's burden of proof remains the same as it was prior to the SB 369 amendments.

[2] Although Dr. McKaskill initially reported that claimant's muscle strain arose as a result of playing basketball (Ex. 1-2), his opinion on causation was provided after he had been informed that claimant was merely at the game, when he experienced the pain for which he sought emergency room treatment.

Department, 247 Or 420, 424 (1967). We ordinarily give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons otherwise. Because Dr. Knudsen relies solely on claimant's history to hypothesize that claimant was in a "weakened condition" without having examined claimant prior to the game incident and does not address the effect of claimant's activities at the game, we do not find his opinion sufficient to carry claimant's burden to prove that his work was a material cause of his muscle spasm. Consequently, claimant has failed to prove that his muscle spasm is compensable.

ORDER

The ALJ's order dated March 17, 1995 is affirmed.

September 14, 1995 Cite as 47 Van Natta 1632 (1995)

In the Matter of the Compensation of
PATRICIA D. LEE, Claimant
Own Motion No. 95-0157M
OWN MOTION ORDER ON RECONSIDERATION
Huffman, Zenger & Rich, Claimant Attorneys
EBI Companies, Insurance Carrier

Claimant requests reconsideration of our July 28, 1995 Own Motion Order in which we authorized the reopening of her 1977 industrial injury claim for the payment of temporary disability compensation beginning the date she entered the hospital for her proposed surgery. With her request for reconsideration, claimant contends that she went to the hospital for the proposed surgery on August 14, 1995, but was "ordered home by her doctor to appear for the rescheduled surgery when her hypertension has been reduced." Claimant requests that we treat the August 14, 1995 episode "as though she were hospitalized and commence her temporary disability as of August 14, 1995."

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

Here, claimant was hospitalized on August 14, 1995 in order to undergo proposed surgery. In an August 16, 1995 letter, Dr. Eilers, claimant's treating physician, opined that:

> "When I examined her in the office her blood pressure was up some and on follow-up checks at the hospital on four occasions her pressures continued to be up to 200/100 which is too high. Since this was an elective procedure it was felt it would be better to try to get this under control and she was seen by Dr. O'Neill and we will see if we can get her blood pressure down prior to doing surgery.
>
> "At this time she cannot return to any kind of employment and I concur that she should be on temporary disability because of her problems."

Dr. Eilers opined that the proposed surgery is an elective procedure, and thus, he felt that it would be best to "get [the hypertension] under control" prior to performing the surgery. Although Dr. Eilers opined that claimant cannot return to employment and that she should be on temporary disability "because of her problems," he does not opine that her left knee is a problem to which he referred, nor does he opine that the compensable condition is the reason she cannot return to work. Rather, since the authorized surgery is elective, Dr. Eilers postponed the proposed surgery to bring claimant's noncompensable blood pressure within safe limits to undergo the procedure. Thus, the proposed surgery, for which we authorized the payment of temporary disability compensation, did not take place and claimant was sent home.

Moreover, claimant submitted no evidence that she remained hospitalized because of the compensable condition. Thus, although the parties agree that claimant's compensable left knee condition has worsened requiring surgery, she did not remain hospitalized nor did she undergo that surgery for that condition on August 14, 1995. Therefore, the record fails to demonstrate that claimant's compensable condition required surgery or hospitalization on August 14, 1995, as specifically required by

ORS 656.278. As a result, we are unable to authorize temporary disability compensation beginning August 14, 1995, as claimant has not met the criteria for own motion reopening on that date. However, we continue to authorize the payment of temporary disabilility compensation beginning the date she enters the hospital to undergo the proposed surgery for her compensable knee condition.

Accordingly, our July 28, 1995 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 28, 1995 order in its entirety. The parties rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

September 14, 1995 Cite as 47 Van Natta 1633 (1995)

In the Matter of the Compensation of
EDWARD T. ROTHAUGE, Claimant
Own Motion No. 66-0410M
OWN MOTION ORDER REFERRING FOR FACT FINDING HEARING
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for medical services for his November 21, 1950 low back injury. SAIF has recommended that the Board deny the provision of the requested medical services, contending that claimant's low back condition "is not a continuation of his industrial injury."

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. William A. Newell, 35 Van Natta 629 (1983). However, the Board may exercise its own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. ORS 656.278(1)(b). No worsening of the pre-1966 injury is required to qualify for such authorization. Gerald S. Gaage, 42 Van Natta 2722 (1990); Donald B. Karstetter, 42 Van Natta 156 (1990). In this regard, the Board applies the same standard clarified in Beck v. James River Corp., 124 Or App 484, 487 (1993), regarding the compensability of medical services under ORS 656.245. That is, medical services for conditions resulting from a work injury are compensable if the need for treatment bears a material relationship to the compensable condition. Id.

Here, however, the medical evidence is inadequate to determine whether the requested medical services meet that standard.

On December 27, 1950, claimant underwent surgery for his compensable low back injury. That surgery consisted of a laminectomy and extraction of a herniated nucleus pulposus at L4-5 on the right. On November 8, 1994, Dr. Karasek examined claimant and related a history of a subsequent surgery in 1985 for removal of a disc fragment at L4-5. Dr. Karasek stated that claimant thought that this surgery "was part of his work claim, although that is not clear form the records." (November 8, 1994 chart note, page 1). Dr. Karasek noted that claimant suffered from increasing low back pain over the last three to six months. He stated that he needed to "[r]ule out progressive stenosis at L4-5 due to old disc deterioration there. This is possibly related to the progressive changes at the 4-5 level operated on in 1985. As such, it might be related to his industrial injury and will pursue with MRI." (November 8, 1994 chart note, page 2).

On November 17, 1994, an MRI was performed. In a December 9, 1994 chart note, Dr. Karasek noted that the MRI showed dramatic disc space deterioration at all levels of the lumbar spine, foraminal stenosis and spur formation on the right at L4-5 and L5-S1. He recommended anti-inflammatory medication.

In a March 31, 1995 letter, Dr. Karasek stated that claimant

> "received an MRI to evaluate whether his work injury had in fact been aggravated or recurred or if he had progressive stenosis at the 4-5 space.
>
> "This did not turn out to be the case and I saw [claimant] for a single follow up visit to inform him of that in December of 1994.

"My view is that evaluation and MRI were for the purpose of determining whether he had suffered a worsening of his work injury. That did not turn out to be the case."

On May 18, 1995, the Board reopened claimant's claim for diagnostic evaluation to determine the compensability of claimant's current need for medical treatment. By the same order, the Board closed the claim.

On July 24, 1995, SAIF submitted claimant's request for medical services for his November 21, 1950 low back injury. SAIF recommended that the Board deny the provision of the requested medical services. Because the record was insufficient to determine whether we should authorize payment of the requested medical services, we requested the parties to submit their positions and any supporting medical evidence regarding the compensability of the requested medical services. SAIF responded by sending copies of several reports from the early 1950's. No response was received from claimant.

After considering SAIF's submittals, we remain unable to determine whether we should authorize payment of the requested medical services based on the current record. In particular, Dr. Karasek initially noted that progressive stenosis might be related to the work injury, stating that the issue would be pursued with an MRI. However, after the MRI was obtained showing stenosis, Dr. Karasek failed to explain its relationship, if any, to the work injury. Instead, he redefined the purpose of the MRI, stating, in part, that its purpose was to determine whether there was a worsening of the work injury. In addition, he indicated there was no worsening of the work injury. However, as discussed above, a worsening is not necessary to establish the compensability of medical services.

Under these circumstances, we conclude that this is an appropriate matter for referral to the Hearings Division for an evidentiary hearing. OAR 438-12-040.

Accordingly, this matter is referred to the Hearings Division with instructions to assign an Administrative Law Judge (ALJ) to perform the fact finding hearing. At the hearing, the assigned ALJ shall take evidence on the issue of whether the work injury is a material cause of claimant's need for the requested medical treatment.

This hearing may be conducted in any manner that the ALJ determines will achieve substantial justice. ORS 656.283(7). Following the hearing, the ALJ shall issue a recommendation to the Board within 30 days. In that recommendation, the ALJ shall make findings of fact on whether the work injury is a material cause of claimant's need for the requested medical treatment. Based on those findings of fact, the ALJ shall recommend to the Board whether it should order the claim reopened under own motion jurisdiction for payment of medical services. Following the hearing and closure of the record, we shall implement a briefing schedule, and, upon its completion, proceed with our review.

IT IS SO ORDERED.

In the Matter of the Compensation of
EVERETT G. WELLS, Claimant
Own Motion No. 95-0013M
OWN MOTION ORDER
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights expired on July 25, 1990. In its recommendation to the Board, SAIF opposed reopening of the claim on the ground that claimant was not in the work force at the time of the current disability. However, in its April 18, 1995 cover letter sent with that recommendation, SAIF contends that "[t]here has been no worsening of the condition since last claims [sic] closure. Surgery is not recommended." Furthermore, by subsequent letter dated May 1, 1995, SAIF contends that no surgery or hospitalization is requested. Claimant contends that he is entitled to temporary disability compensation beginning February 22, 1995, when he was hospitalized for evaluation.

In a July 10, 1995 letter, the Board requested the parties' positions regarding the surgery and work force issues. Claimant has replied to our request. SAIF has not responded. Since the time to respond has expired, we will proceed with our review of the record.

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 February 22, 1995, claimant was hospitalized by his treating neurosurgeon, Dr. Freeman, for evaluation of his current back condition, including the administration of a myelogram and other tests. Claimant was discharged on February 23, 1995.

As cited above, we may authorize the reopening of a claim under our own motion authority when there is a worsening of a compensable injury which requires inpatient hospitalization or outpatient surgery. See id. However, we have previously held that hospitalization for a diagnostic procedure, even if that procedure requires an overnight stay in a hospital or similar facility, may not constitute a "worsening of a compensable injury" particularly where the treatment is not likely to result in temporary disability. See Fred E. Smith, 42 Van Natta 1538 (1991); Roger D. Jobe, 41 Van Natta 1506 (1989). Thus, although claimant was hospitalized overnight in February 1995, the record does not establish that his compensable condition had worsened or that the testing would temporarily disable him. Therefore, we are not persuaded that those diagnostic tests satisfy a "worsening of the compensable injury requiring inpatient hospitalization..." as required by ORS 656.278(1)(a).

This conclusion, however, does not end our inquiry. In response to SAIF's contention that Dr. Freeman is not requesting surgery or hospitalization at this time, claimant advised the Board that Dr. Freeman performed the surgery on June 19, 1995 (no post-operative report submitted). This is not contested by SAIF. Moreover, the reasonableness and necessity of that surgery is currently in dispute before the Director. Since the surgery is in dispute, we would normally postpone action on this matter. However, it is not necessary to postpone action given our conclusion below that claimant was not in the work force at the time of the June 19, 1995 surgery.

In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant is not in the work force. Claimant contends that he qualifies for temporary disability compensation beginning with his hospitalization in February of 1995, because he was self-employed and continued working until his compensable condition worsened. However, as noted above, claimant has not established that his condition worsened in February 1995. Rather, the relevant time period is in June of 1995, when claimant underwent surgery.

Claimant also contends that, because of his worsened condition, his family physician advised him to "shut down his business on February 9, 1995." Claimant has the burden of proof on this issue and must provide persuasive medical evidence, such as a letter from a physician stating that he was unable to work because of the compensable condition for the remainder of the period in question.

Claimant has submitted copies of his 1994 tax returns, which verify that he was self-employed and earning wages during 1994. Although these tax forms might establish that claimant was in the work force through December 1994, there is no persuasive evidence in the record which establishes that he continued working after December 1994, and there is no medical opinion concerning whether claimant was able to work until the time of his June 1995 surgery. Without evidence of claimant's work force status at the relevant time, we are not persuaded that claimant has established that he remained in the work force until his compensable condition worsened requiring surgery.

Hence, based on the record submitted to us, we conclude that claimant has not carried his burden of proving that he was working until the time of his disability, nor has he established that he was willing to work, but unable to work because of the compensable condition when that condition worsened requiring surgery. Therefore, we find that claimant was not in the work force at the time of his current disability.

Accordingly, claimant's request for temporary disability compensation is denied. We will reconsider this order if the required evidence is forthcoming within 30 days from the date of this order.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

September 14, 1995 Cite as 47 Van Natta 1636 (1995)

In the Matter of the Compensation of
CARL E. WORLEY, Claimant
WCB Case No. C4-02946
ORDER DENYING RECONSIDERATION
Coons, et al, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

On December 20, 1994, the Board approved the parties' Claim Disposition Agreement (CDA). Pursuant to that agreement, in consideration of the payment of a stated sum, claimant released his rights to future workers' compensation benefits, except medical services, for his compensable injury.

On August 10, 1995, we received the parties' August 7, 1995 letter seeking amendment of the previously approved CDA. Inasmuch as the CDA has been approved in a final order, the Board regards this letter as a motion for reconsideration of the previously approved CDA. The motion for reconsideration is denied, based on the following reasoning.

In requesting reconsideration, the parties stipulate that one line of the original CDA was inadvertently dropped during the editing process. Board rules provide that reconsideration of a final order issued under ORS 656.236 shall be limited to the record before the Board at the time of its final order, unless the Board finds good cause for the additional submission. OAR 438-09-035(3). We have previously held that an inadvertent error in the original CDA can constitute good cause for considering additional information. Robert S. Robinson, 43 Van Natta 1893, 1894 (1991) (inadvertent typographical error constitutes "good cause" for considering revised consideration amount).

However, the request for reconsideration must be timely filed with the Board in order to be considered. OAR 438-09-035(1), (2) (motion for reconsideration must be filed within 10 days of date of mailing of final order); Leonard J. Lamb, 43 Van Natta 1226 (1991) (Board considered motion for reconsideration filed within 10 days).

Here, the CDA was approved in a final order on December 20, 1994. The parties' letter requesting reconsideration was received by the Board on August 10, 1995, more than 7 months after the time for requesting reconsideration expired. Accordingly, we find that the parties' motion for reconsideration was not timely filed. Therefore, the Board cannot consider the parties' motion for reconsideration[1].

IT IS SO ORDERED.

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[1] We recognize the predicament in which claimant has been placed with respect to the implications of Social Security offsets. We have no objection to provisions regarding Social Security offsets, as long as the disposition itself satisfies the terms and conditions prescribed by the Director (now Board) and is not unreasonable as a matter of law. See ORS 656.236(1)(a). Here, it is unfortunate if the approved CDA did not fully and accurately memorialize the parties' intentions. However, such a submission does not establish that the previously approved CDA was unreasonable as a matter of law. In any event, inasmuch as the request for reconsideration of the approved CDA was not timely filed, we are unable to consider the parties' request to amend the CDA approved in our December 20, 1994 order.

In the Matter of the Compensation of
LILLIAN M. AMAN, Claimant
WCB Case No. 93-12657
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the self-insured employer's denials of claimant's current condition; and (2) declined to assess penalties for allegedly unreasonable denials. On review, the issues are compensability and penalties.

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

On September 22, 1993, the employer issued the following denial:

> "Your claim was originally accepted on 2-19-93 for a temporary worsening of a pre-existing condition-low back strain. At this time we must respectfully deny this claim as continued treatment is not related to your on the job injury of 9-22-92[,] treatment is not for an on the job injury[,] and is for personal health problems. Therefore, this is a denial of this claim."

On December 23, 1993, the employer issued a second document entitled "Supplemental Denial" which provided:

> "Your claim was accepted on February 19, 1993 for a temporary worsening of a pre-existing condition/low back strain. We issued a partial denial on September 22, 1993 and now need to amend that partial denial. At this time, we must respectfully deny your current condition as the accepted claim no longer is the major cause of your current need for treatment and disability. Rather, your current need for treatment and disability is related to your low back condition which pre-existed your injuries with [employer]."

Claimant first asserts that the documents should be separately analyzed. Specifically, claimant contends that, because the first denial is limited to medical services, she prevails over the denial with proof that her accepted condition is a material contributing cause of her need for treatment. See Beck v. James River Corp., 124 Or App 44 (1993). We disagree.

The "Supplemental Denial" specifies that the employer "now need[s] to a amend" the September 22, 1993 denial. (Emphasis added). The letter further denies claimant's "current condition as the accepted claim no longer is the major contributing cause of your current need for treatment and disability." Based on such language, we find that the letters properly are read together. In particular, the second letter intended to revise the denial by expressly amending it to include the need for treatment and disability. Thus, we find that the second letter is best understood as effectively subsuming the first and that the scope of the denial includes the current need for treatment and disability.[1]

Claimant further asserts that both letters constitute "back-up" denials under ORS 656.262(6) because the condition being denied is the same as that previously accepted by the employer. We have held that a carrier's denial of a current condition is a "back-up" denial unless the denied condition is different from the accepted condition. E.g., Melvin E. Schneider, Jr., 47 Van Natta 1024 (1995). We are not convinced, however, that the accepted condition of "temporary worsening of pre-existing condition/low back strain" is the same for which claimant sought treatment.

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[1] We also note that, under claimant's construction of the denials, the second letter would duplicate the first in the sense that both would relate to medical services. The illogic of this result is further support that the scope of the denial should be determined by viewing the second letter in conjunction with, and as a progression of, the first correspondence.

Moreover, because we do not find that any portion of the claim should be analyzed as one for only medical services, we do not discuss the effect, if any, of amended ORS 656.245. Or Laws 1995, ch 332, § 25 (SB 369, § 25).

In September 1992 and October 1992, claimant sustained injuries while working. In February 1993, after claimant's treating neurosurgeon, Dr. Jutzy, found claimant medically stationary and the employer issued its acceptance, claimant fell at work and experienced another increase of symptoms. The record contains no specific diagnosis of claimant's condition after February 1993. Dr. Rudd, consulting physician, stated that claimant had completely recovered from her previous September and October 1992 injuries and made references to spondylosis and degenerative disc disease. (Exs. 18, 28). Dr. Jutzy reiterated that claimant was medically stationary in February 1993 from her September and October 1992 injuries and that the cause of her current symptoms were, in equal proportion, her work injuries and preexisting condition. (Exs. 34, 35-17).

In light of such evidence, we construe the physicians as indicating that claimant's degenerative disc disease was being treated, rather than a musculoligamentous condition such as a strain. Because degenerative disc disease is not the same as "temporary worsening of pre-existing condition/low back strain," we find that the employer's denial related to a different condition than the one accepted. Thus, we reject claimant's assertion that the employer issued "back-up" denials.[2]

Having agreed with the ALJ that the employer properly denied claimant's current condition and, based on evidence that a preexisting condition combined and contributed to the need for treatment and disability, we also agree with the ALJ's application of ORS 656.005(7)(a)(B).[3] In the absence of evidence that claimant's work injuries were the major contributing cause of the need for treatment of the combined condition, claimant failed to prove compensability.

ORDER

The ALJ's order dated February 24, 1995 is affirmed.

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[2] Thus, we need not discuss the effect, if any, of amended ORS 656.262(6). SB 369, § 28.

[3] The ALJ applied the former version of ORS 656.005(7)(a)(B), which was amended subsequent to his order. SB 369, § 1. Inasmuch as our decision would be the same under either version of the statute, we need not decide which version is applicable.

In the Matter of the Compensation of
MARY J. FITZER, Claimant
WCB Case No. 94-10320
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that reduced claimant's scheduled permanent partial disability (PPD) award for the loss of use or function of the right arm from 3 percent (4.5 degrees), as granted by an Order on Reconsideration, to zero. In her brief, claimant contends that the ALJ erred in admitting Exhibit 40 into evidence. On review, the issues are evidence and extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's findings of ultimate facts.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Matter

The self-insured employer issued a January 28, 1994 Notice of Closure. Claimant requested reconsideration and appointment of a medical arbiter. An arbiter report issued on June 30, 1994, and an Order on Reconsideration issued on August 11, 1994. At hearing, over claimant's objection, the ALJ admitted Exhibit 40, a November 2, 1994 "post reconsideration" report from Dr. Karty (claimant's attending physician at the time of claim closure) which addresses the causal relationship between claimant's compensable injury, preexisting scaphoid cyst and permanent impairment.

On review, claimant contends that the ALJ should have excluded Exhibit 40, because it was generated after the Order on Reconsideration. Citing Frank H. Knott, 46 Van Natta 364 (1994), the employer contends that the ALJ properly admitted Exhibit 40 into evidence, on the ground that it addresses the cause of claimant's wrist impairment as related to the injury of 1992. We agree with claimant.

Subsequent to the briefing in this case, we issued David B. Weirich, 47 Van Natta 478 (1995), in which we disavowed our opinion in Knott. In Knott, we held that medical evidence concerning the causal relationship between a compensable injury and the permanent impairment necessary to determine the extent of a worker's permanent impairment under ORS 656.214(5) was not excluded by ORS 656.268(7)[1]. Instead, in light of our decision in Daniel L. Bourgo, 46 Van Natta 2505 (1994), we concluded in Weirich that, other than certain incomplete arbiter report exceptions (as represented by the arbiter or the Department), ORS 656.268(7) precludes the admission at hearing of "post- reconsideration" medical evidence, whether it concerns impairment or causation of impairment.

Accordingly, we reverse the ALJ's evidentiary ruling and conclude that Exhibit 40 is not admissible. We therefore do not consider Exhibit 40 on review.

Extent of Scheduled Permanent Disability

Relying on attending physician Karty's post-reconsideration medical opinion, the ALJ concluded that claimant had failed to prove that her right wrist impairment results from the compensable injury. The ALJ thus reduced claimant's permanent disability award to zero. The employer seeks affirmance of the ALJ's order. Claimant seeks affirmance of the Order on Reconsideration which awarded 3 percent scheduled PPD. We agree with claimant.

Generally, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). As we have found above, the post-reconsideration report from Dr. Karty is not admissible. Consequently, in assessing the extent of claimant's permanent disability arising out of the May 1993 injury, the record on review properly includes the reports of Dr. Karty issued before the Order on Reconsideration, the medical arbiter's report, and any report related to claimant's impairment that was ratified by Dr. Karty before the Order on Reconsideration. See Tektronix, Inc. v. Watson, 132 Or App 483 (1995).

Dr. Karty did not (before the Order on Reconsideration issued) rate claimant's impairment or address the causal relationship between claimant's compensable injury and permanent impairment. Neither did he concur in any report related to claimant's impairment or the cause thereof. Therefore, the medical evidence concerning claimant's impairment comes from Dr. Martens, the medical arbiter.

Dr. Martens noted the following reduced ranges of motion in claimant's right wrist: 45 degrees dorsiflexion and 18 degrees radial deviation. More importantly, in response to specific instructions from the Appellate Unit that he apportion claimant's impairment findings between the compensable injury and the nonwork- related scaphoid cyst, medical arbiter Martens stated that claimant's impairment findings are not related to the scaphoid cyst. Pursuant to OAR 436-35-080(1), 436-35-080(5), 436-35-007(11), and 436-35-100(10) (WCD Administrative Order 6-1992), claimant is entitled to 2.5 percent impairment for loss of dorsiflexion and .4 percent for loss of radial deviation, for a total award of 2.9 percent, rounded to 3 percent.

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[1] ORS 656.268(7) was amended by the 1995 legislature. Amended ORS 656.268(7)(g) provides that: "[a]fter reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the department, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure." Or Laws 1995, ch 32, § 30 (SB 369, § 30). The only change is that the statute now prohibits subsequent medical evidence after the date of the Order on Reconsideration rather than after the date of the medical arbiter's report. Here, the exhibit in question was generated after the date of the Order on Reconsideration. We need not decide whether the amended statute is retroactively applicable because, under either version of the statute, this evidence is inadmissible. But see, Volk v. America West Airlines, 135 Or App 565 (1995) (slip op at 8) (except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, have not been finally resolved on appeal.)

Accordingly, we reverse the ALJ's order. We affirm and reinstate the Order on Reconsideration which awarded claimant 3 percent scheduled PPD for the loss of use or function of the right arm.

The employer requested a hearing, seeking elimination of the Order on Reconsideration award. By this order, we have found that claimant's 3 percent award (as granted by that Order on Reconsideration) should not be disallowed or reduced. Under such circumstances, claimant is entitled to an attorney fee award under amended ORS 656.382(2) for successfully defending her scheduled award at hearing. Claimant seeks a $2,500 assessed attorney fee. The employer responds that the amount sought is not reasonable.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this issue, we find that a reasonable fee for claimant's counsel's services at hearing is $1,500 to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Because we have reversed the ALJ's order which eliminated claimant's permanent disability award and have reinstated the scheduled award made by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is also entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by our order, not to exceed $3,800. See amended ORS 656.386(2); OAR 438-15-055(1).

ORDER

The ALJ's order dated December 22, 1994 is reversed. The Order on Reconsideration is affirmed and reinstated in its entirety. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. Claimant's attorney is also awarded a fee of $1,500 for services at hearing regarding the permanent disability issue, payable by the self-insured employer.

September 15, 1995 Cite as 47 Van Natta 1640 (1995)

In the Matter of the Compensation of
TAMERA A. FORCIER, Claimant
WCB Case No. 94-10815
ORDER ON RECONSIDERATION
Burt, Swanson, et al, Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

On July 6, 1995, we withdrew our June 8, 1995 order that affirmed an Administrative Law Judge's (ALJ's) order which found claimant, a partner in a business, to be a subject worker at the time of her left hand injury. We took this action to consider the SAIF Corporation's contention that, in light of the 1995 statutory amendments, partners are not subject workers unless personal coverage is purchased. Having received claimant's response, we proceed with our reconsideration.

After further reconsideration of the matter, we withdraw our prior order and issue the following order.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last paragraph, with the following supplementation.

On the date of injury, July 25, 1994, claimant was not a "worker" within the meaning of ORS Chapter 656 generally and ORS 656.005(30) specifically.

CONCLUSIONS OF LAW AND OPINION

Claimant, a partner in a woodshop business, suffered a hand injury while performing the duties of a woodshop worker. SAIF denied the claim, contending that claimant was a non-subject worker under ORS 656.027(8).

The ALJ found that claimant was a covered "subject worker" when she was injured. The ALJ reasoned that claimant was performing the duties of an ordinary employee rather than those of a partner at the time of her injury. In reaching this conclusion, the ALJ relied on the "dual capacity doctrine" as expressed in Erzen v. SAIF, 40 Or App 771, rev den 287 Or 507 (1979). On reconsideration, we are not persuaded that claimant was a worker and, even if she was, we would find that she was a "nonsubject worker."

In Martelli v. R.A. Chambers and Associates, 310 Or 529, 534 (1990), the Supreme Court observed: "From the inception of the first compensation act, [the] rights and immunities [provided therein] expressly depended upon who was a worker and who was his or her employer."

More recently, in S-W Floor Covering Shop v. National Council on Compensation Insurance, 318 Or 614 (1994), the Court was required to address how the statutory definition of "independent contractor" affects statutory provisions for determining when a person is subject to ORS chapter 656 and therefore covered by workers' compensation insurance. The Court reasoned that the "internal logic of workers' compensation law" is not altered by the definition of "independent contractor." 318 Or at 623. More broadly, the Court stated: "It is logical that a determination must be made under ORS 656.005(28) whether one is a 'worker' before it can be determined if the worker is 'nonsubject' under ORS 656.027." Id. at 622 (emphasis in original); see ORS 656.027 ("All workers are subject to this chapter. . . .").

The Court concluded that former ORS 656.005(28)[1], the threshold statute defining a "worker," and ORS 656.027, describing "nonsubject" workers, require the following approach:

"A determination first is made as to whether one is a 'worker' before a determination is made as to whether that 'worker' is a 'nonsubject' worker pursuant to one of the exemptions of ORS 656.027. The initial determination of whether one is a 'worker' under ORS 656.005(28) continues to incorporate the judicially created 'right to control' test. One who is not a 'worker' under that test is not subject to workers' compensation coverage, and the inquiry ends. The "nonsubject worker" provisions of ORS 656.027 never come into play." 318 Or at 630 (Emphasis added).

Thus, the first determination to be made in a subjectivity case such as this is whether claimant is a "worker" within the meaning of ORS Chapter 656. Id; see Lockard v. The Murphy Co., 49 Or App 101, 109 n.1 (1980) ("Because we conclude that the plaintiff is not a 'worker' within the meaning of Workers' Compensation Law, we are not required to decide if he is a 'sole proprietor' as that term is used in ORS 656.027(7).").; Michael L. Cole, 46 Van Natta 970 (1994); Charles J. Fields, 43 Van Natta 263, 264 (1991) ("Only if claimant is a 'worker' within the meaning of the statute do we proceed to a discussion of the nonsubject worker exceptions contained in ORS 656.027.").

Under ORS 656.005(30):[2] "'Worker' means any person * * * subject to the direction and control of an employer. . . ." See S-W Floor Covering Shop v. National Council on Compensation Insurance, supra at 630 ("The initial determination of whether one is a 'worker' * * *continues to incorporate the judicially created 'right to control' test.").

The factors to be considered under the traditional "right to control" test include: (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 at will without liability. Woody v. Waibel, 276 Or 189 (1976).

In this case, there is no "direct evidence" that claimant worked for an employer with the right to control her work or that the company exercised such control. On the contrary, it appears that claimant worked independently (at her own behest) performing her regular "duties," which included payroll, purchasing, accounts payable and receivable, and quarterly reports. It further appears that claimant was her own "boss" when she decided to enter the woodworking area and operate the saw which cut her fingers on the day she was injured. (Tr. 7). Thus, the record does not establish that claimant was subject to the direction and control of an employer generally or at the time of her injury.

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[1] Renumbered ORS 656.005(30). Or Laws 1995, ch 332, § 1.

[2] Formerly ORS 656.005(28).

Claimant "did the books" for the company, including payroll. (Tr. 23). She was not paid on a "pay period" basis, nor did she receive a regular salary. (Tr. 11, 21). If the company made money, she made money. (Tr. 21). As a partner, she could not be fired. (Id.) There is no evidence regarding ownership of the equipment claimant used.

Having considered these facts, we cannot say that claimant was a "worker" within the meaning of ORS 656.005(30). Consequently, she could not be a "subject worker" entitled to Workers' Compensation coverage. See Cortes v. Wyland, 107 Or App 218, 222 (1991) (Where a son's remuneration bore no relation to the amount of work he performed, the son and his mother were partners, and neither was a subject employee). Under these circumstances, the ALJ's order must be reversed.

Moreover, even if we had found claimant to be a "worker," we would not consider her to be a "subject worker." We base such a conclusion on the following reasons.

ORS 656.027(8) expressly provides that "partners" are "nonsubject workers" except those "who are not engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto." No argument is advanced that claimant's regular work activities or those at the time of injury satisfied the precise statutory requirements for exclusion of a partner from "nonsubject worker" status.

In addition, we acknowledge that claimant contended (and the ALJ so found, as we initially affirmed on review), that she qualified as a subject worker under the "dual capacity doctrine" because she was injured while performing employment activities as a wood worker. However, even assuming that the "dual capacity doctrine" would otherwise apply in a partnership case such as this, it does not apply here, because the required threshold "worker" status is not proven, as explained above.[3]

Finally, even assuming that claimant could have obtained coverage under ORS 656.039 or 656.128, by election,[4] we would find that she accomplished no such election. Although claimant sometimes deducted amounts from her own checks for "workers' compensation," and reported those

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[3] In Erzen v. SAIF, 40 Or App 771, 775 (1979), the court applied the "dual capacity doctrine" and concluded that the claimant, an officer of a corporation who had not elected coverage, could receive benefits as a covered worker because he was injured while performing the duties of an ordinary employee. In Erzen, the claimant was a "worker," carried on the employer's payroll as an office manager. Here, because claimant is neither a "worker" nor a corporate officer, the material facts are distinguishable and the "dual capacity doctrine" articulated in Erzen is inapposite. Under these circumstances, we decline to address SAIF's challenge to our "resurrection" of the "dual capacity doctrine" in Kenneth G. Mize, 45 Van Natta 477 (1993), dismissed SAIF v. Mize,129 Or App 636 (1994).

Were we to further examine the reasoning in Kenneth G. Mize, supra, in the present context, we would still conclude that the "dual capacity doctrine" has no application to this situation. As explained in Erzen v. SAIF, supra, the doctrine is premised on "the absence of contrary statute." In applying the doctrine in Mize, we essentially found no such "contrary statute" because the phrase "regardless of the work performed" had been removed from the subsection of ORS 656.027 that described those corporate officers who are "nonsubject workers."

Here, in contrast to Mize, the applicable statute (ORS 656.027(8)) explicitly describes those partners who are excluded from "nonsubject worker" status. In other words, a "contrary statute" exists to preclude application of the "dual capacity doctrine." See Erzen v. SAIF, supra. That statute specifically provides that, except for partners who are engaged in work performed in direct connection with improvements / appurtenances to real property, partners are "nonsubject workers." As noted above, because claimant was not engaged in such activities, it would follow that she is a "nonsubject worker" under ORS 656.027(8).

Moreover, since we would reach this conclusion under either the former or current version of ORS 656.027, we need not determine which version is applicable. Based on such reasoning, it is likewise unnecessary for us to address claimant's argument that retroactive application of the statutory amendments constitutes an unconstitutional violation of her right to due process of law.

[4] See e.g., Kenneth Cartwright, 34 Van Natta 1007, 1009 (1982) ("Therefore, since there was a partnership or sole proprietor arrangement at the time of the claimant's alleged injury, with no election for coverage in effect at that time, claimant is not a subject employee under ORS 656.027.").

deductions to the state (but not to SAIF), she never filed a written notice of election of coverage for herself with SAIF as required by the statutes. See SAIF v. D'Lyn, 74 Or App 64 (1985); Quadel Industries v. Luckman, 95 Or App 612 (1989); Ronald Sasse, 42 Van Natta 1828 (1990) (Payment of premiums, absent notice of election, does not transform an otherwise exempt person into a covered worker).

Accordingly, we reiterate our conclusion on reconsideration that claimant is not a covered "subject worker" for the fundamental reason that she is not a "worker" within the meaning of ORS Chapter 656.[5]

Accordingly, our June 8, 1995 order is withdrawn. On reconsideration, the ALJ's order dated January 11, 1995 is reversed. The ALJ's attorney fee award is reversed. The SAIF Corporation's denial is reinstated and upheld.

IT IS SO ORDERED.

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[5] In reaching this conclusion, we do not decide that a partner could never be a covered "subject worker." See Davis v. State Ind. Acc. Comm., 156 Or 393 (1937) (A partner in a sawmill business, who was killed while working for an "independent contractor" logging company, was a covered worker); Liberty Northwest Ins. Corp. v. Hegerberg, 118 Or 282 (1993) (The insurer for the subcontracting employer was responsible for the claimant's compensation, even though claimant was a partner, apparently in part because the partnership was not exempt as it was engaged in work performed in direct connection with construction); Richard F. Erzen, 36 Van Natta 218 (1989) (Where claimant, a partner, was also a subcontractor, he was a covered subject worker under former ORS 656.029); see also Maroon v. Great Western Construction, 107 Or App 510, 513-514 (1991) ("The Board's decision appears to have been based on the assumption that claimant could not be both a sole proprietor and an employee of the same business, in the absence of an election. That is a correct assumption.") (emphasis added).

In the Matter of the Compensation of
JOSE GARZA, Claimant
WCB Case No. 94-09845
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Neal's order which declined to award an overpayment of procedural temporary disability benefits. With his brief, claimant submits additional documents. On review, the issues are remand and temporary disability. We deny the motion for remand, affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction. The sixth sentence of the second paragraph should read: Dr. Hampson found claimant capable of gainful employment if he did not have to work looking up or work with his arms overhead. (Ex. 17).

CONCLUSIONS OF LAW AND OPINION

Remand

With his brief, claimant submitted a copy of his request for reconsideration of the November 22, 1994 Determination Order. Although contending that this submission is not a request for remand, claimant contends that the submission is "properly before the Board" because it is "offered only for purposes of clarification." (Claimant/Appellant's Reply Brief, page 1). However, we may only review the record presented at hearing. Therefore, contrary to claimant's contentions, we regard this submission as a motion for remand to the ALJ. Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand to the ALJ should we find 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); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

We conclude that claimant has not established a compelling reason for remand. The issue before us is claimant's entitlement to procedural temporary disability. Because claimant's request for reconsideration of the November 22, 1994 Determination Order does not pertain to that issue, it is not reasonably likely to affect the outcome of the case. Thus, we deny the motion for remand and do not consider claimant's submission on review.

Temporary Disability

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

On November 15, 1994, a hearing was held in this matter. At that time, the claim remained open. At hearing, claimant raised, among other issues, the issue of procedural entitlement to temporary disability from September 10, 1993 until claim closure. (Tr. 7-8). On November 29, 1994, the ALJ issued an order finding, among other things, claimant entitled to procedural temporary total disability from September 10, 1993 until claim closure. In reaching this decision, the ALJ found that the insurer improperly unilaterally terminated claimant's temporary disability benefits on September 10, 1993, having unilaterally terminated time loss without meeting any of the requirements of ORS 656.268(3) that would have allowed such a termination.

In the meantime, on November 22, 1994, the claim was closed by Determination Order, which awarded temporary total disability from August 12, 1992 through September 10, 1993, and from July 21, 1994 through July 21, 1994. The insurer requested reconsideration of the ALJ's order and admission of the Determination Order into the record. The ALJ abated her order and allowed claimant an opportunity to respond.

On January 4, 1995, following receipt of claimant's response, the ALJ issued a reconsideration order in which she admitted the Determination Order and found that, pursuant to Lebanon Plywood v. Seiber, 113 Or App 651 (1992), claimant was not entitled to a procedural overpayment of temporary disability. The ALJ also ordered that "claimant be paid time loss as directed by the November 22, 1994 Determination Order, less time worked."

On review, claimant argues that the ALJ improperly considered substantive entitlement to temporary disability when the only issue before her was procedural entitlement. Claimant also argues that we should reinstate the ALJ's November 29, 1994 order, contending that he is entitled to a procedural award of temporary disability from September 10, 1993 until claim closure.

To the extent that the ALJ addressed substantive entitlement to temporary disability by addressing the Determination Order in the order language quoted above, we agree that the ALJ was without authority to do so and do not adopt that portion of her order, as reconsidered. However, we disagree that the ALJ's initial order should be reinstated.

Under ORS 656.268(4)(e) and (5), the Hearings Division lacks original jurisdiction to address challenges regarding an injured worker's substantive entitlement to temporary disability. Because the Determination Order determines claimant's substantive entitlement to temporary disability benefits, and the Determination Order is not subject to our review in this case, we are without jurisdiction to review claimant's substantive entitlement to those benefits. See Galvin C. Yoakum, 44 Van Natta 2403, 2404, on recon 44 Van Natta 2492 (1992); John L. Desmond, 45 Van Natta 1455 (1993). Rather, the proper method of challenging the insurer's award of temporary disability is through a direct appeal of the Determination Order. Our jurisdiction in this case is limited to claimant's procedural entitlement to temporary disability benefits, i.e., temporary disability benefits payable prior to claim closure. See Galvin C. Yoakum, supra, Steven V. Bischof, 44 Van Natta 255, recon 44 Van Natta 433 (1992), aff'd mem Freightliner Corporation v. Bischof, 115 Or App 758 (1992).

Inasmuch as claimant's substantive entitlement has been determined by Determination Order to end as of September 10, 1993, with the exception of an additional substantive award for July 21, 1994, we are without authority to impose a procedural overpayment by awarding temporary disability benefits beyond that date. See Lebanon Plywood v. Seiber, supra. Therefore, although the ALJ simply stated that she was prohibited by Lebanon Plywood v. Seiber from awarding a procedural overpayment, the actual affect is no award of procedural temporary disability in this case. The reason is that, in this case, any procedural award beyond September 10, 1993 would create a procedural overpayment since, pursuant to the Determination Order, claimant's substantive entitlement ended that date, with the exception mentioned above. Rather, because claimant is seeking more temporary disability than that awarded by the Determination Order, his remedy is to directly appeal that Determination Order. John L. Desmond, supra.

Finally, we note that the ALJ determined that the insurer acted unreasonably in failing to pay temporary disability benefits on an open, accepted claim through the date of claim closure when none of the requirements under ORS 656.268(3) were met that would permit the insurer to unilaterally terminate payment of such benefits. As a result, the ALJ awarded a penalty of 25 percent of the "additional time loss compensation due . . . for the insurer's unreasonable unilateral termination of time loss and unreasonable delay in providing claims information," with the penalty to be shared equally by claimant and his attorney.[1]

We agree that claimant is entitled to a penalty award based on the unpaid compensation which was due and payable as of the date of the hearing (November 15, 1994). See Lebanon Plywood v. Seiber, supra; Pascual Zaragoza, 45 Van Natta 1221 (1993), aff'd mem Zaragoza v. Liberty Northwest Insurance Corp., 126 Or App 544 (1994). Therefore, we modify the ALJ's penalty assessment and clarify that the penalty is to be based on 25 percent of the temporary disability that was due from September 10, 1993 until the date of the November 15, 1994 hearing. ORS 656.262(10)(a).

ORDER

The ALJ's order dated November 29, 1994, as reconsidered January 4, 1995, is affirmed in part and modified in part. In lieu of the ALJ's penalty assessment, claimant is awarded a penalty equal to 25 percent of the temporary disability due as of the November 15, 1994 hearing (from September 10, 1993 until November 15, 1994 to be shared equally by claimant and his counsel. The remainder of the ALJ's order is affirmed.

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[1] Neither the penalty issue regarding the insurer's discovery violation, nor the penalty issue regarding the insurer's unreasonable failure to pay "procedural" time loss was raised on review. However, in light of our above clarification that no procedural temporary disability is due in this case, we felt that clarification of the penalty award was in order.

September 15, 1995 Cite as 47 Van Natta 1645 (1995)

In the Matter of the Compensation of
KATHERYNN L. JUDD, Claimant
WCB Case No. 94-13852
ORDER ON REVIEW
Max Rae, Claimant Attorney
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that upheld the SAIF Corporation's denial of claimant's head and neck injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not established that her working conditions were a material cause of her fainting spell or that her work environment placed her in a position to sustain her head and neck injuries. The ALJ accordingly concluded that claimant's injury claim was not compensable. Claimant argues that the hot conditions in which she had to work were a material cause of her fainting spell or, alternatively, that her work environment placed her in a position to sustain the injury.[1] We agree with the ALJ that claimant failed to prove that her injury is compensable, but for different reasons.

On August 26, 1994, at 10:30 am, claimant went to work at the employer, a hot food concession stand in an outdoor food court at the Oregon State Fair. The stand consisted of an open-air booth sitting on a cement surface. The stand contained a warming table, located about three feet from the cash register, food fryers and a grill. A water source was located at the back of the booth. The weather was sunny and hot and the customer lines long. Claimant had eaten nothing but a small Nutri-grain bar since the previous day. While filling hot food orders and cashiering, claimant became hot and dizzy. At about noon, claimant asked her supervisor for permission to leave her station to get a drink of water and sit down, which was granted. Claimant turned and fainted. In falling, she hit her head, neck and shoulders on the side of the booth and the concrete floor.

There is no dispute that claimant received her injuries at work and that they resulted from a fall, which in turn resulted from claimant's fainting spell.

A compensable injury is "an accidental injury * * * arising out of and in the course of employment." ORS 656.005(7)(a). An unexplained fall that occurs on the employer's premises, during working hours, while the employee is performing required duties is compensable if the employee eliminates idiopathic causes, i.e., the reason is known but is personal to claimant rather than work-related. However, if the fall is due to idiopathic causes, it is not compensable. Neither is one where it is equally possible that its cause was idiopathic or work-related. See Phil A. Livesley Co. v. Russ, 296 Or 25, 30 (1983); McAdams v. SAIF, 66 Or App 415 (1984) (Where it is equally possible that a claimant's fainting spell was idiopathic as that it was work related, claimant's burden of proof not satisfied).

Claimant's fall is not an unexplained fall. Claimant's fainting episode caused her fall and the fall caused her injuries. Thus, the question is not whether claimant's work was a material cause of her fainting spell, but whether the fainting spell was sufficiently work-connected to satisfy the burden of proof delineated above. We think it was not.

Claimant had no previous fainting episodes prior to the incident in question. Dr. Hare, who treated claimant at the emergency room, diagnosed her fainting episode as a result of heat exposure and hypoglycemia. He later evaluated his emergency room records and concluded that the outside temperature as well as the heat in the tent from cooking and low blood sugar contributed to claimant's fainting spell. He was unable to determine the relative causes of her fainting. (Ex. 10). Thus, it is equally possible that the cause of claimant's fainting episode was idiopathic as that it was work related. That is not enough to satisfy claimant's burden of proof. Phil A. Livesley Co. v. Russ, supra; McAdams v. SAIF, supra. See also Ruben G. Rothe, 45 Van Natta 369, 370-71 (1993) (Injury from fall not compensable where claimant failed to rule out two potential idiopathic causes of the fall).

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[1] We acknowledge receipt of claimant's supplementary brief dated July 25, 1995, in which she presents arguments arising under Senate Bill 369. See Or Laws 1995, ch 332. Claimant's arguments regarding the constitutionality of the major contributing cause standard and the new definition of "preexisting condition" need not be addressed here. First, the major contributing cause standard and preexisting condition language was in effect when the ALJ heard this case. Consequently, claimant's arguments regarding those provisions could have been raised at hearing. Because claimant did not raise those arguments until review, we do not consider them. Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991). Moreover, neither the major contributing cause standard nor the preexisting condition language is relevant to our review. There is nothing in the record to indicate that claimant has a preexisting condition. Thus, she is not required to prove that her work was the major contributing cause of her injuries. The issue here is whether claimant's fainting spell was sufficiently work-connected to find her injuries compensable.

Moreover, even if claimant's fall was the result of idiopathic causes, claimant's work environment presented no inherent risks different from those encountered by any person walking or standing on a concrete floor. Thus, her injury from striking the side of the booth and the concrete floor would not be compensable under the increased danger rule. Pat Jennings, 45 Van Natta 1191 (1993); Ruben G. Rothe, supra; see also Emery A. Reber, 45 Van Natta 2373, 2375 (1991) (To place the risk of loss on the employer due to an idiopathic fall requires a showing of substantial employment contribution to the risk or to the extent of harm).

ORDER

The ALJ's order dated February 24, 1995 is affirmed.

September 15, 1995 Cite as 47 Van Natta 1647 (1995)

In the Matter of the Compensation of
JOHN MAHON, Claimant
WCB Case No. 94-04672
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that: (1) set aside its denial of claimant's claim for a knee injury; and (2) awarded penalties for an allegedly unreasonable denial. On review, the issues are compensability, and penalties. We reverse.

FINDINGS OF FACT

In late 1993, claimant moved from Eagle Point to Bend for what he thought would be three to six month job with the employer. The employer terminated claimant on a Friday afternoon, after he had been employed approximately eight days.

The day of his termination, claimant discussed his termination with the employer's owner, Mr. Tyvand. He asked Mr. Tyvand to overrule the decision to let him go, but Mr. Tyvand refused to do so. Claimant did not indicate to Mr. Tyvand that he had been injured on the job a few days earlier.

Sometime between the end of work that Friday and the following Monday, claimant left two messages on the employer's answering machine. In the first message, claimant reiterated his belief that his termination was unjustified. He stated that he intended to pursue all legal remedies to recover his living expenses, and requested that the employer contact him. In the second message, claimant stated: "This is John Mahon again. On December 29, 1993 I reported to your shop foreman that I had twisted my knee on a 2 x 4 and he made no request of me to fill out an accident report or anything." He concluded this message by saying: "Thank you again for your time."

A few days after receiving the phone messages, Mr. Tyvand notified the insurer of claimant's claimed injury.

Claimant first sought treatment for a knee injury on March 18, 1994, two and a half months after the alleged work incident. Dr. James diagnosed a significant tear of the medial meniscus, and recommended arthroscopic surgery to relieve claimant's symptoms.

CONCLUSIONS OF LAW AND OPINION

A compensable injury is established by proof that claimant's work exposure was a material contributing cause of his disability or need for treatment, if the injury is established by medical evidence supported by objective findings. ORS 656.005(7)(a); see Mark N. Weidle, 43 Van Natta 855 (1991). Claimant bears the burden of proving compensability. ORS 656. 266.

In this case, because the claimed work injury was unwitnessed, claimant's credibility is of particular importance. Without making a specific demeanor-based credibility finding,[1] the ALJ found that the injury happened as claimant described it. The ALJ also found that claimant had established the compensability of a knee injury which allegedly occurred on December 29, 1993. We disagree.

Although we generally defer to the ALJ's determination of credibility when that finding is based on the ALJ's opportunity to observe claimant's demeanor, we are in as good a position as the ALJ to evaluate claimant's credibility based on an objective evaluation of the substance of claimant's testimony and other inconsistencies in the record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Even minor inconsistencies can be a sufficient basis to disagree with the ALJ's credibility determination, particularly where factual inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. David A. Peper, 46 Van Natta 1656 (1994), Angelo L. Radich, 45 Van Natta 45 (1993).

Like the ALJ, we are troubled by claimant's testimony regarding the timing and order of his two phone messages to the employer, since his story is belied by the audio tape itself. Claimant testified that he made the call reporting his injury on the Friday afternoon he was terminated and the call challenging his termination the following Sunday or Monday night. Yet, in the call reporting his injury, claimant identifies himself "again" and thanks the employer "again" for his time, indicating that this call followed the other call and not vice versa.

If that were the only inconsistency, we would not necessarily reject claimant's testimony.[2] After our review of the record in this case, however, we find other, more crucial portions of claimant's testimony (i.e., regarding his condition after the alleged work injury and his reporting of the incident to his supervisor) are also inconsistent with or unsupported by the testimony of other witnesses.

For example, claimant testified that a couple of days before he was terminated he injured his knee in the morning and it popped and swelled up. He stated that he continued to work, but was forced to limp. Claimant testified that his supervisor, Paul, noticed him limping, and asked what was wrong but did not do anything about it when claimant described his fall. (Tr. 4). Claimant indicated that it was painful for him to walk. (Tr. 9.) He also testified that the next day, he told another employee, Rudy Quintana, that he had injured his knee on the job. (Tr. 8.)

Claimant did not call his supervisor, Paul (who no longer works with the employer) as a witness at hearing to corroborate his testimony. Mr. Quintana, who testified on the employer's behalf, testified that claimant did not complain to him about hurting his knee. Mr. Quintana further stated that he worked with claimant on a daily basis and watched him do his work. Mr. Quintana did not observe any signs of an injury and did not see claimant limping. (Tr. 19, 22.)

Mr. Tyvand also testified that he observed claimant's work in the two or three days prior to claimant's termination and that he did not observe any sign of physical injury. (Tr. 30.) Mr. Tyvand testified that he saw claimant kneeling without difficulty, and that on the day claimant was terminated, he saw claimant come "bounding up the steps looking for me." (Tr. 35-36.)

Since claimant identified his supervisor, Paul, as a witness in his favor, but did not produce him or explain why he was not called at hearing, we construe the failure to call Paul against claimant. See e.g., Gloria A. Vaneekhoven, 47 Van Natta 670 (1995); Kirk Meyers, 42 Van Natta 2757 (1990) (where the claimant did not produce a witness at hearing who could allegedly verify that he was injured at this job, he failed to sustain his burden of proving that his injury occurred in the course and scope of employment).

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[1] Although the ALJ indicated that claimant's testimony was "straightforward," he also stated that claimant's rebuttal testimony (regarding the order of his two messages to the employer) was "simply not believable."

[2] We recognize that a claimant who lacks credibility in certain matters can still meet his burden of proof of the remainder of the record supports his version of how he was injured. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984); Anthony P. Thexton, 47 Van Natta 1000 (1995). In this case, however, the remainder of the record does not support the compensability of claimant's claim.

In summary, considering the aforementioned inconsistencies, contradictions and discrepancies, we are not persuaded that claimant was a truthful witness. See Erck v. Brown Oldsmobile, 311 Or App 519, 528 (1991). We, therefore, do not rely on his testimony. We also find that the remainder of the record does not support the compensability of claimant's condition.

The ALJ determined that Dr. James' report was sufficient to establish medical causation based on claimant's history. However, in light of the inconsistencies in claimant's testimony, we are not persuaded Dr. James had an accurate history of the events leading to claimant's knee injury. See Miller v. Granite Construction Co., 23 Or App 473 (1977). Under these circumstances, we conclude that claimant has not carried his burden of proving that his work activity was a material cause of his disability and need for treatment. Accordingly, claimant has failed to establish a compensable injury.

In light of our conclusion that the insurer's denial should be upheld, it follows that we do not consider the denial to be unreasonable. Consequently, we also reverse the ALJ's penalty assessment.

ORDER

The ALJ's order dated February 2, 1995 is reversed. The insurer's denial of April 8, 1994 is reinstated and upheld. The penalty and $2,800 attorney fee awards are also reversed.

September 15, 1995 Cite as 47 Van Natta 1649 (1995)

In the Matter of the Compensation of
RICKY MINER, Claimant
WCB Case No. 94-14306
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
James W. Moller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Howell's order that set aside an Order on Reconsideration classifying claimant's lumbar strain claim as nondisabling. On review, the issue is claim classification. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on Brenda Guzman, 46 Van Natta 2161 (1994), and Sharman R. Crowell, 46 Van Natta 1728 (1994), the ALJ found that claimant's claim should be classified as disabling because she had been released for modified work. We disagree.

In Sharman R. Crowell, supra, which was decided under former ORS 656.005(7)(c), we addressed the proper claim classification for a claimant who performed modified work at her regular wage and incurred no time loss. We held that the mere fact the claimant was required to do modified work meant that the claimant was temporarily and partially disabled. See also Brenda Guzman, 46 Van Natta 2161 (1994) (claim properly classified as disabling where the claimant was released to modified work, even though she missed no time and suffered no wage loss).

Subsequent to the ALJ's order, effective June 7, 1995, the legislature enacted Senate Bill 369, amending ORS 656.005(7)(c).[1] Or Laws 1995, ch 332, § 1 (SB 369, § 1). The statute now defines a "disabling compensable injury" as an "injury which entitles the worker to compensation for disability or death" and 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."

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[1] Absent any relevant exception, Section 1 of Senate Bill 369 retroactively applies to this case. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995) Walter L. Keeney, 47 Van Natta 1387 (1995).

In Karren S. Maldonado, 47 Van Natta 1535 (1995), we held that the unambiguous language of the amended statute effectively overrules our holdings in Crowell and Guzman.[2] We specifically found, in light of the statutory language providing that an injury is not "disabling" if no temporary disability benefits are due and payable, that it is not enough that a claimant be limited to modified work. To classify a claim as disabling, there must also be entitlement to temporary disability benefits or a reasonable expectation of permanent disability.

Here, claimant was released to, and worked, modified employment. However, he was not entitled to temporary disability. Claimant continued on modified work until he was released to regular work. Because no temporary disability benefits were due and payable, his claim is not disabling unless there is proof of a reasonable expectation of permanent disability. Amended ORS 656.005(7)(c).

Claimant's treating physician reported that claimant was medically stationary with no limit in range of motion, no loss of strength or limitation in his activities due to his compensable injury. (Ex. 13). When claimant was released to regular work, he did so without restrictions. (Ex. 2). Therefore, based on claimant's return to regular work without any impairment, we find insufficient proof of a reasonable expectation of permanent disability resulting from the compensable injury. Consequently, we conclude that the claim cannot be classified as disabling.

ORDER

The ALJ's order dated February 21, 1995 is reversed. The Order on Reconsideration is affirmed.

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[2] Although constrained to follow the Maldonado holding, Member Gunn refers the parties to his concurring and dissenting opinion in that case.

In the Matter of the Compensation of
BEVERLY K. SCOTT, Claimant
WCB Case No. 93-12602
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the insurer's partial denial of her claim for a headache condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.[1,2]

ORDER

The ALJ's order dated October 31, 1994 is affirmed.

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[1] Claimant submitted Exhibit 51 after the record was closed. The insurer objected to its submission. The ALJ admitted Exhibit 51 and allowed the insurer.the opportunity to submit rebuttal evidence. The insurer submitted Exhibit 52 as rebuttal evidence to claimant's Exhibit 51. On review, the insurer continues to object to the submission on the basis that claimant could have obtained the evidence therein with due diligence at the time of hearing. Because we conclude that claimant has failed in her burden to prove compensability even were we to consider that evidence, we decline to address the insurer's evidentiary argument.

[2] ORS 656.005(7)(a)(B) was amended by the 1995 Legislature. Or Laws 1995, ch 332, §§ 1, 66 (SB 369, §§ 1, 66). Amended 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 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." We need not address the retroactive applicability of the amended statute because, under either version of the statute, claimant fails to prove her current condition is compensable.

Board Member Hall specially concurring.

I agree that claimant's current headache condition is not compensable. I write to note, first, that the medical record supports compensability of claimant's "fibromyalgia" and "neck pain" conditions. Thus, our affirmance of the denial does not include those conditions. Moreover, to the extent that claimant has non-migraine headaches previously a part of her claim, those are still part of claimant's claim (i.e., even Dr. Petersen grants that claimant's headaches in 1992 and 1993 were compensable). The carrier's denial is a current condition denial only, not a back-up denial of previously accepted conditions.

September 19, 1995 Cite as 47 Van Natta 1651 (1995)

In the Matter of the Compensation of
ROBERT B. ENDERS, Claimant
WCB Case No. 93-12500
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order which: (1) affirmed a Director's order denying claimant eligibility for vocational assistance; (2) affirmed an Order on Reconsideration awarding claimant 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of claimant's left leg; and (3) affirmed an Order on Reconsideration that awarded claimant 7 percent (22.4 degrees) unscheduled permanent disability for his low back condition. On review, the issues are jurisdiction, vocational assistance, and extent of scheduled and unscheduled permanent disability. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Vocational Assistance/Jurisdiction

Claimant sustained a compensable low back injury in January 1992. In November 1992, the insurer determined that claimant was not eligible for vocational assistance due to his failure to participate in vocational evaluation. (Ex. 66). Claimant requested Director review. On October 12, 1993, the Director issued an order finding claimant ineligible for vocational assistance. Claimant requested a hearing from the Director's vocational assistance order. The ALJ upheld the Director's order. Claimant requested Board review.

Subsequent to the ALJ's order in this case, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.283(2), which now provides only for Director review of vocational assistance disputes. Or Laws 1995, ch 332 § 34(2) (SB 369, § 34(2)).

We recently addressed the question of jurisdiction over vocational assistance disputes in Ross M. Enyart, 47 Van Natta 1540 (1995). In that case, the claimant requested a hearing regarding a Director's order which found that the claimant was not entitled to vocational assistance. The ALJ found that the claimant was entitled to such assistance, and the carrier sought Board review. We held, relying on Volk v. America West Airlines, 135 Or App 565 (1995), that absent a specific exception, the amendments made by Senate Bill 369 are retroactively applicable to cases pending before the Board. We found no such exception pertaining to review of vocational assistance disputes. Accordingly, we concluded that amended ORS 656.283(2), which provides for Director review of vocational assistance disputes, is applicable. Consequently, based on amended ORS 656.283(2), we held that the exclusive jurisdiction over vocational assistance disputes rests with the Director. Therefore, we vacated the ALJ's order and dismissed claimant's hearing request for lack of jurisdiction.

Inasmuch as the vocational assistance portion of this case is before us on a request for hearing from a Director's vocational assistance order, and we have held that the Director now has exclusive jurisdiction to resolve vocational assistance disputes, we conclude, based on our decision in Enyart, supra, that we lack jurisdiction to consider the vocational assistance matter. Accordingly, we vacate that portion of the ALJ's order which upheld the Director's vocational assistance order, and we dismiss claimant's hearing request from the Director's order.

Extent of Permanent Disability

The ALJ affirmed the Order on Reconsideration awarding 7 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the loss of use cr function of claimant's left leg. We adopt and affirm that portion of the ALJ's order.

ORDER

The ALJ's order dated December 16, 1994 is affirmed in part and vacated in part. That portion of the ALJ's order which affirmed the Director's vocational assistance order is vacated, and claimant's hearing request from the Director's order is dismissed for lack of jurisdiction. The remainder of the ALJ's order is affirmed.

September 19, 1995 Cite as 47 Van Natta 1652 (1995)

In the Matter of the Compensation of
JOHN J. FREDERICK, Claimant
WCB Case No. 94-02113
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order which affirmed an Order on Reconsideration that declined to find claimant permanently and totally disabled. In his brief, claimant contends that the ALJ erred by not admitting post-hearing evidence. On review, the issues are evidence and permanent total disability.

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

In his brief, claimant contends that the ALJ erred by not admitting post-hearing evidence consisting of two newspaper articles relating to the closure of the employer's truck terminal. The ALJ concluded that the evidence was not relevant because the articles referred to a closure that would occur in April 1995, whereas the job of dispatcher was offered to claimant in mid-1993. (Tr. 31).

We may remand a case to the ALJ for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). 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).

Here, we agree with the ALJ that the evidence is not relevant. Furthermore, after considering the entire record, even if we were to admit the reports, we conclude that the evidence is not likely to affect the outcome of the case. Accordingly, we affirm the ALJ's decision concerning the admission of post-hearing evidence.

ORDER

The ALJ's order dated February 23, 1995 is affirmed.

In the Matter of the Compensation of
PAMELA McGEE, Claimant
WCB Case No. 94-01450
ORDER ON REVIEW
Susak, Dean & Powell, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Davis' orders that: (1) dismissed claimant's hearing request regarding an Order on Reconsideration; and (2) upheld the self-insured employer's denial of claimant's current condition and aggravation claims for a low back condition. On review, the issues are waiver, compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Waiver

We adopt the ALJ's conclusions regarding waiver.

Compensability

We adopt and affirm the ALJ's conclusions regarding the compensability of claimant's current low back condition, with the following supplementation.

Claimant argues that the Americans with Disabilities Act (ADA), 42 USCA § 12101 et seq., requires that the compensability of her current low back condition be evaluated without consideration of her preexisting degenerative spinal condition.[1] Claimant raised the ADA issue for the first time on review. Therefore, we will not address that issue. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991) (Board has discretion not to address issue raised for first time on review).

Aggravation

The ALJ concluded that, because claimant had failed to prove the compensability of her current low back condition under former ORS 656.005(7)(a)(B) (since amended by SB 369, § 1), and because there is no medical evidence that claimant's accepted low back strain has worsened, claimant's aggravation claim fails. We agree with the ALJ's worsening conclusion.

To establish a compensable aggravation, claimant must prove that her compensable condition worsened since the last award of compensation and that the worsening was causally related to the compensable condition. ORS 656.273(1). The worsening must be established by medical evidence supported by objective findings, ORS 656.273(3), and must have resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986).

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[1] Most of the provisions of SB 369 went into effect on June 7, 1995. Or Laws 1995, ch 332, §§ 66, 69 (SB 369, §§ 66, 69); see Volk v. America West Airlines, 135 Or App 565 (1995) (applying amended ORS 656.386(2) retroactively); Walter L. Keeney, 47 Van Natta 1387 (1995) (applying amended ORS 656.327(1) retroactively). Because the amendments do not directly bear on the issues on review in this case, we do not address the impact, if any, of those changes.

In light of our adoption of the ALJ's compensability decision, claimant's sole compensable condition is a lumbar strain. There is no evidence that that condition has worsened.[2] Consequently, we agree with the ALJ that claimant has failed to establish the compensability of her aggravation claim. Accordingly, we affirm the ALJ's decision upholding the employer's denial of that claim.

ORDER

The ALJ's orders dated January 29, 1994 and December 5, 1994 are affirmed.

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[2] The medical experts were either unable to determine whether a worsening had occurred (Exs. 44, 45-10), or concluded that, if claimant's "condition" had worsened, it was due to her preexisting spinal condition. (Ex. 43A-1).

ORS 656.273(1) and (3) were amended by SB 369, § 31. Both the former and amended versions of ORS 656.273(1) require proof of a worsened compensable condition to establish an aggravation, although amended ORS 656.273(1) requires proof of an "actual" worsening. Because we find that claimant's compensable condition did not worsen, we need not decide which of the versions of ORS 656.273(1) applies. Moreover, because the amendments to ORS 656.273(3) are not at issue here, we do not address them.

In the Matter of the Compensation of
FOREST STALNAKER, Claimant
WCB Case No. 94-06638
ORDER ON REVIEW
Greg Noble, Claimant Attorney
James D. Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Poland's order which: (1) declined to grant claimant permanent total disability; and (2) upheld the SAIF Corporation's denial of claimant's psychological condition. SAIF cross-requests review of those portions of the ALJ's order which: (1) set aside SAIF's denial of claimant's spasmodic condition; (2) increased claimant's unscheduled permanent disability from 74 percent (236.8 degrees), as awarded by the May 1994 Order on Reconsideration, to 75 percent (240 degrees); and (3) increased claimant's scheduled permanent disability for loss of use or function of his left arm from 14 percent (26.88 degrees), as awarded by the May 1994 Order on Reconsideration, to 18 percent (34.56 degrees). On review, the issues are compensability, permanent total disability and extent of unscheduled and scheduled permanent disability. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that claimant's spasmodic condition was compensable. In so doing, the ALJ relied on the opinion of Dr. Melgard, treating neurologist.

On review, SAIF contends that the March 1993 Stipulation Order precludes claimant from litigating the compensability of his spasmodic condition. Alternatively, SAIF asserts that the medical evidence fails to establish the compensability of claimant's spasmodic condition.

Since claimant's spasmodic condition was diagnosed prior to the time of the Stipulation (which contained settlement of all issues raised or raisable), it is likely that the compensability issue for this condition is precluded. However, even if the compensability issue was not precluded, we find that claimant's spasmodic condition is not compensable.

On November 5, 1989 claimant sustained a compensable cervical and low back injury while working for SAIF's insured. SAIF accepted a claim for "cervical/thoracic/lumbar strain/sprain." (Ex. 19). Prior to his November 1989 industrial accident, claimant sustained a compensable injury while working for a different employer. At that time, claimant's injury was diagnosed as chronic cervical and lumbar strain superimposed on degenerative disc disease. (Exs. 6, 7). Claimant was not experiencing any cervical or low back symptoms prior to his November 1989 injury.

Claimant asserts that his November 1989 industrial accident caused his spasmodic condition. Claimant's theory of compensability is not clear. If it is a direct causation theory, the material contributing cause standard applies. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). If it is a consequential or resultant condition theory, the major contributing cause standard applies. ORS 656.005(7)(a)(A), (B); see Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod on recon 120 Or App 590, rev den 318 Or 27 (1993); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We need not resolve that dilemma because even under the lower standard, claimant does not prevail. Inasmuch as claimant is alleging that his spasmodic condition developed as a consequence of his compensable injury, we find that the medical causation question is complex, requiring expert medical opinion for its resolution. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986); Uris v. Compensation Department, 247 Or 420 (1967).

Dr. Chester, disability conference examiner, noted that claimant's spasmodic movements were "unexplained." (Ex. 49-1). Dr. Melgard, treating neurologist, concurred with Dr. Chester's report, expressly noting that claimant's "extrapyramidal movements are not due to cervical pathology." (Ex. 54). Subsequent to his concurrence, Dr. Melgard changed his opinion stating:

> "It is hard for me to believe that the distress that [claimant] has, in regard to these unusual movements, is related to his cervical spine although curiously enough these symptoms have improved since his cervical spine surgery. I am sorry that I am unable to clarify this to any greater degree but I think that [claimant's spasmodic condition] may most likely [be] related to the injury and to the concussion and head injury..." (Ex. 64B).

In contrast, Drs. White and Burr, who examined claimant on behalf of SAIF, concluded that claimant's spasmodic torticollis condition was probably hysterical in origin. (Ex. 58-5). Drs. Seres and Newman, also on behalf of SAIF, described claimant's spasmodic condition as myoclonic jerks involving the head and upper extremities. In their opinion, the etiology of claimant's condition was undetermined. (Ex. 41-1).

We generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find persuasive reasons not to rely on the medical opinion of claimant's attending neurologist, Dr. Melgard.

Here, we find Dr. Melgard's causation opinion ("may most likely") unpersuasive because it suggests possibility rather than probability. See Gormley v. SAIF, 52 Or App 1055 (1981) (a possibility of a causal relationship is insufficient to meet claimant's burden of proof). Dr. Melgard's opinion is also unpersuasive because of its contradictory nature. For instance, Dr. Melgard's opinion initially states that he does not believe that claimant's spasmodic condition is related to his cervical spine injury. (Ex. 64B). Then he acknowledges that claimant's spasmodic symptoms improved after cervical surgery. Id. However, Dr. Melgard offers no explanation of why the surgery would improve claimant's condition. Lacking such an explanation, we find his opinion conclusory and thus unpersuasive. See Somers v. SAIF, 77 Or App 259 (1986); Kelso v. City of Salem, 87 Or App 630 (1987) (unexplained change in opinion renders physician's opinion unpersuasive). Further, the opinions of Drs. White, Chester, Burr, Seres and Newman support a conclusion that claimant's spasmodic condition was not related to his industrial accident/injury. This is evidenced in the fact that these physicians stated that they could not "explain" the etiology of claimant's spasmodic condition. Therefore, we find that the medical evidence does not persuasively support the compensability of claimant's spasmodic condition. Accordingly, regardless of whether the applicable legal standard is material or major contributing cause, we find that claimant's spasmodic condition is not compensable. Consequently, SAIF's denial of claimant's spasmodic condition will be reinstated and upheld.

Additionally, the ALJ found that claimant's depression was not compensable. In so doing, the ALJ found that no medical opinion related claimant's depression to his compensable injury.

On review, claimant contends that his depression is a result of his compensable injury. Claimant relies on the medical report of Dr. Pitchford to support the compensability of his depression.

Because claimant is alleging that his depression developed as a result of his compensable injury, he must prove that the major contributing cause of his depression was his compensable injury. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra. The medical causation question is complex, requiring expert medical opinion for its resolution. Kassahn v. Publishers Paper Co., supra; Uris v. Compensation Department, supra.

Dr. Pitchford, psychologist, diagnosed depression and recommended that claimant be evaluated for antidepressant medication. However, Dr. Pitchford did not advance an opinion as to the cause of claimant's depression. As such, no other expert medical opinion exists in the record which would support the compensability of claimant's claim for depression.

Further, claimant contends that the testimony of his family and friends supports the compensability of his depression claim. Inasmuch as the cause of claimant's depression is a complex medical question requiring expert medical opinion, we find claimant's proffered lay testimony unpersuasive. Kassahn v. Publishers Paper Co., supra; Uris v. Compensation Department, supra. Therefore, we find, as did the ALJ, that claimant has failed to establish the compensability of his depression. See ORS 656.266.

Permanent Total Disability

The ALJ found that claimant was not PTD. In so doing, the ALJ did not consider claimant's depression or somatoform pain disorder in determining claimant's PTD. On review, claimant contends that he is PTD under the "odd lot" doctrine. See Welch v. Banister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985).

Under the "odd lot" doctrine, a claimant is permanently totally disabled if he establishes that, due to a combination of his physical condition and nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions, as well as the condition of the labor market, he is permanently incapacitated from performing gainful and suitable employment. Clark v. Boise Cascade Co., 72 Or App 397 (1985). Finally, claimant's noncompensable conditions (i.e. depression and somatoform pain disorder) cannot be included in determining whether claimant is PTD because they were not disabilities which preexisted claimant's compensable injury. Searles v. Johnston Cement, 101 Or App 589, 592-3 (1990), rev den 310 Or 393 (1990) (disability resulting from noncompensable conditions are not considered in determining PTD).

Dr. Strum, medical arbiter, opined that claimant was limited to part-time sedentary work. Dr. Strum based his opinion on objective findings, which included reduced range of motion of the cervical and lumbar spines. (Ex. 63-5). Dr. Burr, on behalf of SAIF, opined that claimant was restricted to sedentary work. (Ex. 58). Dr. Tiley, treating orthopedist, concurred with Dr. Burr's report. (Ex. 60).

Rehabilitation counselor, Brian McNaught, testified that claimant would not be able to find work in the work force. Mr. McNaught based his opinion on claimant's functional limitations (part-time sedentary work) and the fact that claimant would not be a dependable employee. (Tr. 57). According to Mr. McNaught, claimant's "pain level" is the most important factor which prevents him from being a dependable employee. (Tr. 58).

Here, we agree with the ALJ, that claimant did not prove that he is PTD. The only evidence which supports such a finding is the testimony of Mr. McNaught. However, we find Mr. McNaught's opinion unpersuasive because it is primarily based on claimant's subjective pain complaints which are due, in part, to claimant's noncompensable somatoform pain disorder. Searles v. Johnston Cement, supra. Consequently, no other medical or vocational evidence persuasively supports a conclusion that claimant is PTD. Accordingly, we find that claimant is not permanently and totally disabled.

Extent of Scheduled and Unscheduled Disability

We adopt the ALJ's reasoning and conclusions as they pertain to these issues.

Inasmuch as we have found that claimant's spasmodic condition not compensable, we modify that portion of the ALJ's order which awarded claimant's attorney $965 for services at hearing concerning the spasmodic and low back conditions. 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 at hearing regarding the low back condition is $700, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on Board review regarding SAIF's challenge to the ALJ's permanent partial disability awards. ORS 656.382(2). 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 Board review regarding those issues is $500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's appellate briefs), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 16, 1994 is affirmed in part, modified in part, and reversed in part. The SAIF Corporation's denial of claimant's claim for spasmodic condition is reinstated and upheld. In lieu of the ALJ's $965 attorney fee award for the low back and spasmodic conditions, claimant's attorney is awarded $700 for the low back condition, to be paid by SAIF. For services on Board review defending SAIF's cross-request concerning the permanent partial disability awards, claimant's attorney is awarded $500, to be paid by SAIF. The remainder of the ALJ's order is affirmed.

September 20, 1995 Cite as 47 Van Natta 1657 (1995)

In the Matter of the Compensation of
RAYMOND D. HARRIS, Claimant
WCB Case No. 93-14069
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that upheld the SAIF Corporation's denial of his injury claim for aortic dissection. On review, the issue is compensability.

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

The ALJ concluded that claimant's work activities on July 27, 1993 (removing a stump) were not the major contributing cause of his need for treatment for an aortic dissection. On review, claimant contends that, because this is a claim for an accidental injury, he need only show that work activities were a material cause of the initial "injury which resulted; then, if that injury subsequently combines with a preexisting condition to 'cause or prolong disability or a need for treatment,' such disability or treatment is compensable if the major cause test is satisfied."

Since claimant's heart condition was allegedly caused by physical exertion, his aortic dissection is compensable if it meets the statutory requirement for accidental injuries. ORS 656.005(7)(a); See Mathel v. Josephine County, 319 Or 235 (1994).

According to the preponderance of the medical evidence, physical exertion during claimant's employment caused the aortic wall, weakened from preexisting hypertension, an aneurysm, and atherosclerotic plaque, to perforate, resulting in a tear to the aorta. We construe such evidence as showing that claimant has preexisting atherosclerotic heart disease that allegedly combined with work activity to produce the aortic dissection. Our threshold inquiry then is whether claimant's heart injury

claim is subject to the statutory limitations in subparagraph (B) of ORS 656.005(7)(a), which applies to "combined conditions."[1]

In SAIF v. Batchelor, 130 Or App 414 (1994), the court considered whether a heart attack claim was compensable. Applying the major contributing cause standard, the Board had determined that the decedent's claim was compensable under ORS 656.802. The court first noted that, under Mathel, supra, the claim should be analyzed as an injury claim, rather than as a disease claim. The court explained, however, that because the decedent's work activities were the major contributing cause of his death, the claim would be found compensable if analyzed under ORS 656.005(7)(a)(B) as involving a preexisting condition.[2]

We infer from the court's discussion in Batchelor that where a claimant has a preexisting heart condition, review of the claimant's heart injury claim should include consideration of all applicable standards for accidental injuries in ORS 656.005(7)(a), including those set forth in subparagraph (B). This inference is further supported by our obligation as a fact finder to apply the appropriate legal standard in determining the compensability of a worker's claim. See also Dibrito v. SAIF, 319 Or 244, 249 (1994); Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995); Michelle K. Dibrito, 47 Van Natta 970, on recon 47 Van Natta 1111 (1990).

Therefore, inasmuch as we have found that a work event/injury combined with a preexisting, noncompensable condition to cause or prolong disability or a need for treatment, in order to prove the compensability of his accidental injury claim, claimant must prove that work activity was the major contributing cause of his aortic dissection. See SAIF v. Batchelor, supra; Deitz v. Ramuda, 130 Or App 397, (1994); Tektronix, Inc. v. Nazari, 117 Or App 409, mod 120 Or App 590, rev den 318 Or 27 (1993) (rejecting the two-step analysis under ORS 656.005(7)(a)(B) proposed by claimant.)

Alternatively, claimant contends that if ORS 656.005(7)(a)(B) is applicable, because the "triggering mechanism" of increased blood pressure due to physical exertion and stress caused the onset of the aortic dissection, the medical evidence shows that the injury resulted "in a major sense" from work activity. We disagree.

ORS 656.005(7)(a)(B) requires an assessment of the "major contributing cause." Deitz v. Ramuda, supra. Determining the major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. See McGarrah v. SAIF, 296 Or 145 (1983); Dethlefs v. Hyster Co., 295 Or 298 (1983); Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991), rev den 313 Or 210 (1992). Although work activities that precipitate a claimant's injury or disease may be the major contributing cause, that is not necessarily always true. Under ORS 656.005(7)(a)(B), the relative contribution of each cause, including the precipitating cause, must be evaluated under the particular circumstances.

On this record, we agree with the ALJ that claimant has failed to sustain his burden of proving that his work activities were the major contributing cause of his need for treatment for the aortic dissection. Thus, his claim is not compensable.

ORDER

The ALJ's order dated September 30, 1994 is affirmed.

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[1] ORS 656.005(7)(a)(B) was amended by the 1995 legislature. The amended statute now provides that where a compensable injury combines with the preexisting condition, the injury is not compensable unless 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." Or Laws 1995, ch 332, § 1(7)(a)(B) (SB 369, § 1(7)(a)(B)). Since the result would be the same under either version of the statute, we need not resolve the question of which version is applicable.

[2] In construing former ORS 656.005(7)(a)(B), the court distinguished between preexisting and predisposing conditions. See Liberty Northwest Ins. Corp. v. Spurgeon, infra. That distinction is no longer viable under the June 7, 1995 legislative amendments. "Preexisting condition" now includes any injury, disease, or condition that "contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury[.]" SB 369, § 1(24). Nevertheless, once again, since the medical evidence establishes that claimant's current condition would not be compensable under either version of the statute, we need not determine the applicability of SB 369 to this case. But see, Volk v. America West Airlines, 135 Or App 565, 572-73 (July 26, 1995) (except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, have not been finally resolved on appeal).

In the Matter of the Compensation of
JEANETTE D. MARTIN, Claimant
WCB Case Nos. 93-15012 & 93-15011
ORDER ON REVIEW (REMANDING)
Jon C. Correll, Claimant Attorney
Robert Jackson (Saif), Defense Attorney
Steve Maher, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) denied its motion to reopen the record; (2) set aside Liberty's denial of claimant's aggravation claim for a September 1990 low back condition; (3) set aside Liberty's August 18, 1993 Notice of Closure regarding claimant's original 1989 low back injury claim; (4) remanded the original injury claim back to Liberty for reclassification and further processing; (5) set aside Liberty's denial of claimant's aggravation claim for a June 1993 low back condition; and (6) upheld the SAIF Corporation's disclaimer and denial of claimant's "new injury" claim for the June 1993 low back condition. On review, the issues are the propriety of the ALJ's procedural ruling and remand, and, alternatively, aggravation, reclassification, compensability and responsibility. We affirm in part, vacate in part and remand.

FINDINGS OF FACT

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

In December 1993, claimant requested a hearing regarding SAIF's December 7, 1993 denial of claimant's "new injury" claim for a June 1993 low back condition[1] and Liberty's November 8, 1993 denial of claimant's aggravation claim for the same condition. A hearing was held before former ALJ Emerson in March 1994. At hearing, claimant added an aggravation claim concerning a September 1990 low back condition with Liberty. ALJ Emerson closed the evidentiary record and heard closing arguments.

Prior to issuing an order in this matter, ALJ Emerson resigned. In a July 7, 1994 letter, Presiding ALJ Tenenbaum advised the parties of Emerson's resignation and asked how the parties wished to proceed. She proposed the following options: one, assigning the file to another ALJ, who would prepare an order based on the exhibits and transcript, and any recorded closing argument; in the absence of recorded closing argument, or at any parties' choice, the parties could re-argue the case before a new ALJ; and two, the parties could "start from scratch and re-try the case before a new [ALJ]."

In a July 19, 1994 letter to claimant's counsel and copied to Presiding ALJ Tenenbaum, Liberty's counsel expressed its desire to re-litigate the matter. In a July 21, 1994 letter, claimant's counsel advised Tenenbaum that neither claimant nor SAIF wished to re-try the case; rather they wanted a new ALJ to decide the case on the existing record, which included recorded closing arguments.

On August 8, 1994, the parties' attorneys held a teleconference with Presiding ALJ Tenenbaum. Tenenbaum's notes of the teleconference reveal that Liberty's counsel admitted that there was no good reason to re-try the case. Based on her review of the former ALJ's notes, Tenenbaum concluded that credibility was not at issue. In view of that conclusion, and Liberty's admission, Tenenbaum denied Liberty's request.

Thereafter, Presiding ALJ Tenenbaum assigned the matter to ALJ Kekauoha. After ALJ Kekauoha issued his order, Liberty requested reconsideration, seeking a ruling on its request for a new hearing. Because ALJ Kekauoha's tenure had ended, Presiding ALJ Tenenbaum decided the matter, and in a supplemental order that incorporated ALJ Kekauoha's original order, again denied Liberty's request. In the supplemental order, Presiding ALJ Tenenbaum noted that Liberty's counsel objected to a decision issued by a new ALJ without a new hearing, but acknowledged "that he had no reason specific to this case for requesting a retrial."

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[1] Claimant also requested a hearing regarding SAIF's denial of her claim for bilateral plantar fasciitis. ALJ Kekauoha set aside the denial. No one contests that portion of the order on review.

CONCLUSIONS OF LAW AND OPINION

Propriety of ALJ's Procedural Ruling/Remand

Liberty has requested that we remand this matter to the Hearings Division for a new hearing. For the following reasons, we deny Liberty's request.

We may remand this matter for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed or heard. ORS 656.295(5). Remand is appropriate on a showing of good cause or some other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986).

On review, Liberty argues that, because Presiding ALJ Tenenbaum gave it the option of re-trying the case, and because claimant's admissions and demeanor at hearing support its denial, Tenenbaum erred in declining to grant its request for a new hearing. We disagree.

We addressed a similar issue in Melinda K. Wilson, 47 Van Natta 1065 (1995). That case involved almost identical facts as that presented here, including the letter in which Presiding ALJ Tenenbaum offered the parties two options for proceeding in the wake of ALJ Emerson's departure. In that case, however, the employer's request for a new hearing was based on its assertion to the Hearings Division that credibility was at issue.

In Wilson, we first determined that, because the employer had, in effect, sought to reopen the record for a continuance of the hearing, the standard of review was for abuse of discretion. 47 Van Natta at 1066. We then concluded that Presiding ALJ Tenenbaum had the authority to rule on the employer's request for another hearing, and to offer the parties alternative methods of proceeding after ALJ Emerson's departure, including the option of "starting from scratch." Id. Because Tenenbaum's offer to allow the parties to "start[] from scratch" was unqualified, we found that the employer's request for another hearing before an ALJ who would issue the opinion and order was, by itself, sufficient to trigger the Hearings Division's obligation to schedule another hearing in the matter. Id.

Finally, because the evidence revealed a potential, if not actual, issue regarding claimant's credibility, we concluded that substantial justice required that the ALJ who issued the opinion and order in that matter have the opportunity to observe the claimant's demeanor. Id. Consequently, we held that it was an abuse of discretion for the ALJ to deny the employer's request for another hearing, and we remanded the matter for another hearing. Id.

This case is distinguishable from Wilson. Here, as in Wilson, we find that Presiding ALJ Tenenbaum's unqualified offer to allow the parties to re-try the case was sufficient to trigger the Hearings Division's obligation to schedule another hearing in this matter. However, in contrast to Wilson, we find that the Division was relieved of that obligation by Liberty's counsel's undisputed admission that there was no reason specific to this case for requesting a new hearing. Under the circumstances, we find no abuse of discretion in Presiding ALJ Tenenbaum's denial of Liberty's requests for another hearing. Consequently, we deny Liberty's remand request.

Notice of Closure/Claim Reclassification

The ALJ set aside as invalid Liberty's August 18, 1993 Notice of Closure of the 1989 nondisabling low back injury claim and remanded that claim to Liberty for reclassification and for further processing to closure. Because claimant had not been declared medically stationary with respect to the 1989 claim when the August 1993 Notice of Closure issued, we agree with the ALJ's decision to set aside that notice. See ORS 656.268(1).[2]

Next, Liberty asserts that the ALJ lacked jurisdiction to order the reclassification of the 1989 low back injury claim. We agree.

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[2] The 1995 Legislature recently amended ORS 656.268(1). Or Laws 1995, ch 332, § 30 (SB 369, § 30). Amended ORS 656.268(1) qualifies the requirement that a claim not be closed until the claimant is medically stationary. Those qualifications are not at issue here. Therefore, we need not decide which version of the statute applies.

Claimant's 1989 low back injury claim was classified as nondisabling. Under ORS 656.277(1), claimant had one year within which to request reclassification of that claim. That did not happen. Rather, more than a year after the 1989 work accident occurred, claimant's low back condition became disabling. Under the circumstances, claimant's recourse, which she exercised, was to pursue an aggravation claim. ORS 656.277(2).[3] Neither the Hearings Division nor this Board has jurisdiction to order the reclassification of the 1989 injury. Charles B. Tyler, 45 Van Natta 972, 974 (1993). Accordingly, we vacate that portion of the ALJ's order ordering the reclassification of that claim.

Compensability of September 1990 Aggravation/Compensability and Responsibility for Current Low Back Condition

The remainder of the ALJ's order concerns the compensability of claimant's September 1990 low back aggravation claim and the compensability of and responsibility for claimant's current low back condition as either an aggravation of her accepted low back condition with Liberty, or as a new injury with SAIF. For the following reasons, we vacate that portion of the ALJ's order.

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.273(1) to read, in part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by evidence of an actual worsening of the compensable condition supported by objective findings." SB 369, § 31 (emphasis added). The 1995 amendments do not define the term "actual worsening." Under former ORS 656.273(1), a symptomatic or pathologic worsening was sufficient to establish an aggravation. E.g., Caroline F. Wood, 46 Van Natta 2278 (1994).

Except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565, 572-73 (1995). Because amended ORS 656.273(1) is not among the exceptions to this general rule, see SB 369, § 66 (listing exceptions to general retroactivity provision), the amended version of the statute now governs this matter.[4]

As we stated earlier, we may remand a case for further evidence taking if we find that the case 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, supra, 79 Or App at 420. A compelling basis for remand exists when the record is devoid of evidence regarding a legal standard that goes into effect while Board review of a case is pending. See, e.g., Troy Shoopman, 46 Van Natta 21, 22 (1994) (case remanded to ALJ because record devoid of evidence regarding legal standard recently announced by Supreme Court); see also Betty S. Tee, 45 Van Natta 289 (1993) (Board remanded matter to ALJ in light of Supreme Court's intervening definition of relevant statutory term); cf. Rosalie S. Drews, 46 Van Natta 408, recon den 46 Van Natta 708 (1994) (Board declined to remand case to ALJ for additional evidence under Supreme Court's recent interpretation of statute, when record was sufficiently developed to analyze issue under that interpretation).

Here, while Board review of this matter was pending, amended ORS 656.273(1)'s "actual worsening" standard went into effect. Other than evidence that claimant's 1990 and 1993 conditions constituted worsenings of her compensable back conditions,[5] the record is devoid of either documentary

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[3] The 1995 Legislature also amended ORS 656.277(1) and (2). SB 369, § 32. Both the former and amended versions of the statute give a claimant one year in which to seek reclassification of a claim or to thereafter file an aggravation claim. Therefore, we do not address which version applies.

[4] Under section 66(6) of SB 369, amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively. Cigna Insurance Co. v. McMasters, 135 Or App 583, 587 (1995). Because ORS 656.273(1) does not alter a procedural time limitation, section 66(6) does not apply to this case.

[5] The evidence supporting claimant's 1990 aggravation claim suggests only that her low back condition had worsened. (E.g., Ex. 35-3, -8). The evidence supporting her 1993 back condition aggravation claim suggests alternatively that she sustained a temporary worsening (Ex. 72A-9, -10, 73-8, 74-2), a symptomatic worsening (Exs. 72B, 75-6), or an insignificant worsening. (Ex. 73-7). None of the evidence addresses whether claimant experienced, in either 1990 or 1993, an "actual worsening."

or testimonial evidence regarding whether claimant sustained an "actual worsening" in either 1990 or 1993. Under the circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant sustained a compensable aggravation in either of those years. Moreover, because amended ORS 656.273(1) went into effect after this record was developed and while Board review of this matter was pending, we find that there is a compelling reason to remand this matter for the submission of additional evidence regarding whether claimant sustained an "actual worsening" with respect to either her 1990 or 1993 low back claims. See Helen M. Callandar, 47 Van Natta 1626 (1995).

Accordingly, the ALJ's order dated October 31, 1994, as supplemented November 10, 1994, is affirmed in part and vacated in part. We vacate those portions of the ALJ's order that pertain to the reclassification of claimant's 1989 low back injury claim and to the compensability of claimant's 1990 and 1993[6] low back claims. This matter is remanded to the Presiding ALJ to assignthis case to an ALJ who shall conduct further proceedings regarding the compensability of claimant's 1990 and 1993 low aggravation back claims with Liberty and her "new injury" claim with SAIF. Those proceedings may be conducted in any manner that the assigned ALJ determines will achieve substantial justice. Thereafter, the assigned ALJ shall issue a final, appealable order. The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

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[6] We recognize that claimant's 1993 claims are based on both aggravation and new injury theories. Because resolution of this issue under either theory requires an inquiry into a worsening analysis, see Luella M. Best, 45 Van Natta 1638 (1993) (a mere symptomatic exacerbation of an accepted condition is not a "new injury"), we consider it appropriate to remand both 1993 claims to the Hearings Division. On remand, claimant shall be free to continue to press her new injury theory.

In the Matter of the Compensation of
DARLENE I. NARANJO, Claimant
WCB Case Nos. 94-04037 & 93-14613
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Wallace & Klor, Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order which: (1) upheld Liberty Northwest Insurance Corporation's denial of compensability and responsibility for claimant's right upper extremity condition; and (2) upheld the self-insured employer's (West Coast Grocery's) denial of compensability and responsibility for the same condition. Claimant seeks remand to the Hearings Division for admission of post-hearing evidence. Claimant also contends that the ALJ erred by denying claimant's request for a postponement of the hearing. West Coast requests that its previously rejected brief be accepted as timely. On review, the issues are remand, postponement, timeliness of respondent's brief, compensability and responsibility. We deny claimant's motion to remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant seeks remand to the Hearings Division for admission of a post-hearing operative report for carpal tunnel and ulnar nerve decompression surgery. Liberty Northwest contends that remand is not appropriate because the operative report does not contain evidence of causation of the conditions.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. 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). A compelling basis 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); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board). We consider the proffered evidence only to determine whether remand is appropriate.

Here, after our de novo review of all of the medical evidence, including the reports of at least eleven physicians, we do not find that this one operative report, which does not specifically address the focal issue, causation of claimant's right extremity condition, is reasonably likely to affect the outcome of the case, even if such evidence was admitted. Accordingly, we conclude that this record has not been improperly, incompletely, or otherwise insufficiently developed, and remand is not appropriate.

Postponement

At hearing, West Coast amended its denial to include the issue of compensability. Claimant contends that she was not prepared for a compensability denial from the West Coast, and that the ALJ erred by not granting a postponement to allow claimant to file an amended hearing request.

Here, the ALJ noted that the hearing had been reset two times, and that claimant had requested a third set-over, which was denied. (Tr. 2). Further, when given the opportunity to show prejudice by being denied the postponement, claimant asserted that she did not know whether or not there was prejudice. (Tr. 4) Finally, the ALJ noted that the issue of compensability had previously been raised by Liberty Northwest's denial in November 1993, and therefore compensability was already an issue at hearing. (Tr. 4; Ex. 38). Under these circumstances, we affirm the ALJ's decision to deny claimant's postponement request. See OAR 438-06-031 and 438-06-081.

Compensability

We adopt the ALJ's reasoning and conclusion with regard to this issue. Furthermore, because we have concluded that claimant's right extremity condition is not compensable, we do not address the responsibility issue. Finally, because consideration of West Coast's respondent's brief would not effect our decision regarding the merits of claimant's appeal, we decline to address West Coast's request for reconsideration of our previous rejection of its respondent's brief.

ORDER

The ALJ's order dated January 12, 1995 is affirmed.

September 20, 1995 Cite as 47 Van Natta 1663 (1995)

In the Matter of the Compensation of
RONALD E. OACHS, Claimant
WCB Case No. 94-02701
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Neidig and Christian.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order which: (1) upheld the self-insured employer's denial of claimant's injury claim for a low back condition; and (2) declined to award a penalty and attorney fee for an allegedly unreasonable denial. In his brief, claimant contends that the ALJ erred in admitting Exhibit OA into evidence, and erred in failing to require the employer to disclose other evidence allegedly withheld as "attorney work product." On review, the issues are compensability, evidence, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant advised his supervisor of his August 15, 1993 work injury within 30 days of the incident.

CONCLUSIONS OF LAW AND OPINION

On August 15, 1993, while performing his work activities, claimant injured his low back while riding in a jet boat through rapids on a river. He mentioned the incident to his supervisor, but the supervisor did not file an incident report. (Tr. 30-31, 38). In early November 1993, when the pain in claimant's back did not subside, claimant again mentioned the back injury to his supervisor. (Tr. 43, 44). On November 4, 1993, the supervisor prepared an incident report, and claimant and the supervisor signed an 801 form.

Claimant did not seek medical treatment for the August 1993 injury until November 8, 1993. Dr. Shonerd initially diagnosed a compression fracture at L5, but a subsequent bone scan ruled out the fracture. (Ex. 7). His subsequent diagnosis was lumbar strain with associated spondylolisthesis. (Ex. 9-2).

The employer denied claimant's low back claim as untimely, and further denied claimant's preexisting L5 spondylolysis with Grade 1 L5-S1 spondylolisthesis. (Ex. 16).

The ALJ did not address the timeliness of claimant's claim. Claimant argues that, if we find that his notice of his injury was timely, the denial of the contusion, on the timeliness basis alone, should be set aside. For the following reason, we disagree.

In clarifying the issues at hearing, claimant contended that he "did suffer a low back contusion, and that based on the medical records his current symptoms are caused in major part by the incident at work." (Tr. 5)(emphasis added). Claimant's statement of his theory of the case suggests that he was also proceeding under ORS 656.005(7)(a)(B). Accordingly, we conclude that the employer is not limited to defending the denial on the timeliness issue alone. See Pedro C. Rodriguez, 47 Van Natta 710, on recon 47 Van Natta 871 (1995) (ALJ properly addressed compensability of current condition under ORS 656.005(7)(a)(B) when claimant agreed with ALJ's statement of issues at beginning of hearing); compare Dolph M. Wiedenmann, 46 Van Natta 1584 (1994)(ALJ precluded from considering carrier's denial "amended" at hearing because claimant objected to carrier's attempt to orally amend denial). Therefore, we first address the timeliness issue.

Timeliness of Hearing Request

Former ORS 656.265[1] requires that written notice of an accident resulting in an injury be given to the employer within 30 days. Former ORS 656.265(4) provides:

> "Failure to give notice as required by this section bars a claim under [the workers' compensation act] unless:
>
> "(a) The employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice * * *."

On May 6, 1994, claimant's supervisor gave a statement to an investigator concerning the boating incident. At that time, the supervisor could not be specific as to how soon after the incident he and claimant had discussed it. (Ex. 18-3, 5).

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[1] The amendments to ORS 656.265 are not retroactively applicable. See SB 369, 68th Leg., Reg. Sess. Section 66(2) (June 7, 1995).

At hearing, claimant's supervisor testified that claimant had informed him of the boating incident about two weeks after it happened. (Tr. 30). The supervisor had noticed that claimant was moving as though his back was bothering him, so he inquired about it. Claimant briefly explained the boating incident at that time, but the supervisor did not make a record of the incident. Id. After considering the testimony of claimant's supervisor, we conclude that it is more likely than not that claimant gave notice of his injury to his supervisor within the required 30 day time period. See former ORS 656.265.

In any event, claimant's injury claim is not time barred if the employer was not prejudiced by the late filing. See former ORS 656.265(4)(a). The burden is on the employer to prove prejudice. Argonaut Ins. Co. v. Mock, 95 Or App 1, 4, rev den 308 Or 79 (1989). Here, the employer has not claimed that it was prejudiced by an allegedly untimely claim filing. Accordingly, we conclude that claimant's injury claim is not barred as untimely.

Compensability

Claimant contends that the employer's denial was "two-pronged" because it denied a low back contusion on the basis that the claim was not timely, and it denied preexisting L5 spondylolysis with Grade 1 L5-S1 spondylolisthesis. Claimant argues that, if notice was timely, the denial of the contusion should be set aside. Nevertheless, as we have previously stated, because of the way claimant framed the issues at hearing, the compensability issue extends beyond the low back contusion. Therefore, the employer is not limited to defending the denial on the timeliness issue alone.

Our "'first task is to determine which provisions of the Workers' Compensation Law are applicable.'" Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994)); see also Michelle K. Dibrito, 47 Van Natta 970 (1995). Each of those holdings support the proposition that it is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim.

Here, as previously determined, claimant's statement of his theory of the case at the outset of hearing suggested that he was proceeding under ORS 656.005(7)(a)(B)[2]. Furthermore, the medical evidence shows that, prior to his August 1993 work incident, claimant had preexisting lumbar spine conditions. (Exs. 2, 4-9). Additionally, Dr. Shonerd, treating physician, opined that the work incident combined with claimant's preexisting spondyloisthesis. Finally, the record does not establish that claimant had disability or required medical services for a low back "contusion" alone, inasmuch as when claimant first sought treatment, it was for persistent pain in his low back, subsequently determined to be caused by preexisting spondylolisthesis. (Exs. 9-1, 2; 11; 12); see ORS 656.005(7)(a). Accordingly, claimant has the burden of proving that his work incident was the major contributing cause of his current condition. ORS 656.005(7)(a)(B).

Having determined the applicable law, we adopt the ALJ's conclusion and reasoning which determined that claimant's work incident was not the major contributing cause of his low back disability and need for medical treatment.

Evidence

Claimant contends that the ALJ erred in admitting Exhibit OA, a "hearsay" 1989 employee memo concerning claimant's prior work-related back injury. We review the ALJ's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). Hearsay evidence is generally admissible in workers' compensation proceedings, although such evidence may be excluded when it is in the interest of substantial justice to do so. Armstrong v. SAIF, 67 Or App 498 (1984).

After our review of the evidence, we conclude that the evidence the ALJ admitted is not particularly relevant to, and not determinative of, the issue of compensability of claimant's low back condition. Furthermore, after considering the medical evidence, we conclude that, even if the admission of the evidence was error, consideration of the exhibit would not alter our conclusion. Accordingly, we decline to resolve the question of whether the ALJ abused her discretion in admitting Exhibit OA.

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[2] Our ultimate conclusion of compensability would be unaffected regardless of whether the former or current version of ORS 656.005(7)(a)(B) was applied.

Claimant next contends that the ALJ erred by not requiring the employer to disclose certain evidence that was withheld for impeachment purposes. Claimant argues that the evidence is relevant to the issues of penalties and attorney fees for unreasonable claim processing.

At the end of testimony, claimant's attorney requested that the employer provide any investigative reports, or other evidence, that the employer had withheld for impeachment purposes. The employer declined to furnish the evidence, responding that all evidence had been provided except that which was "attorney work product." After taking the issue under advisement, the ALJ ordered claimant to indicate whether he wished to present additional testimonial or documentary evidence in connection with his request. Not having received a response, the ALJ issued her Opinion and Order.

We need not address claimant's argument concerning the relevance of the withheld material with regard to unreasonable claim processing.[3] Rather, because we have concluded that claimant's low back claim is not compensable, even if the employer's claim processing conduct was unreasonable, there are no "amounts then due" upon which to base a penalty. See ORS 656.262(10)(a). Likewise, because there has been no unreasonable resistance to the payment of compensation, claimant is not entitled to an attorney fee pursuant to ORS 656.382(1).

ORDER

The ALJ's order dated October 26, 1994 is affirmed.

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[3] Although we need not address the merits of claimant's argument here, we believe there was a more appropriate method for addressing this issue. Specifically, the employer could have furnished copies of the "privileged" evidence to the ALJ. Pursuant to an in camera review, the ALJ could then determine whether the evidence claimant requested was, in fact, attorney work product and what, if any, further action should be taken. Such an independent review from the adjudicator would further the interests of substantial justice to all parties.

In the Matter of the Compensation of
ISABELLE ROBY, Claimant
WCB Case No. 94-01521
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Neidig and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order which upheld the self-insured employer's denial of her claim for injuries to multiple body parts. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

On October 28, 1993, claimant and several other employees were ascending a stairway to a break room at the employer's place of business. There were people in front of claimant as she climbed the stairs. At the top of the stairs is a landing with a door that opens outward, toward the stairway. When the door is open, there is a distance of over two feet between the open door and the edge of the top stair.

When claimant was within one step of the landing she fell, injuring her head and other parts of her body. Claimant does not remember anything that happened before she fell. (Tr. 39). The histories given to several physicians reflect conflicting reasons for claimant's fall. (Exs. 18, 19, 25, 26, 30).

Claimant has a history of high blood pressure, dizziness, vertigo, thyroid condition, and chronic anxiety. She takes medication for each of those conditions. In September 1992, claimant had a syncopal episode, where she passed out without explanation.

FINDING OF ULTIMATE FACT

Hitting her head on the open door did not render claimant unconscious, causing her to fall.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that she was at the top step of the stairway and her head struck the door as someone opened it, rendering her unconscious and causing her to fall. The employer contends that claimant experienced an ideopathic syncopal episode that was not related to claimant's work. We agree with the employer.

It is claimant's burden to prove, by a preponderance of the evidence, that her fall was caused by striking her head on the door, rather than by an ideopathic cause. Claimant does not remember hitting the door or falling. Claimant relies on the testimony of a coworker, climbing the stairs with claimant, who witnessed claimant's fall.

The ALJ found that the coworker's testimony, by demeanor, was credible. Nevertheless, considering the medical evidence and photographic evidence, the ALJ concluded that the coworker's testimony was not believable. We, likewise, do not rely on the coworker's testimony.

The coworker testified that claimant was holding the stair railing and, as claimant took a step up, someone opened the door from the inside, hitting claimant in the head. (Tr. 12, 13). The coworker also testified that the "platform" (landing) at the top of the steps was very small, and that the door opened to the very edge of the platform. (Tr. 20). However, photographs taken of the stairs, landing and door, show that the door, when fully opened, is over two feet from the edge of the top step. (Ex. 49). Furthermore, the photographs indicate that the landing is over five feet long. (Exs. 49-2, 3). In light of this evidence, we are not persuaded by the coworker's version of claimant's fall.

Claimant concedes that the medical evidence indicates that claimant's fall would be consistent with an idiopathic or syncopal episode, if one assumes claimant lost consciousness prior to striking the door. See Exs. 34, 37, 40, 45, 46-33, 34, 46A-25. Nevertheless, claimant continues to rely on the testimony of the coworker that she struck her head on the door, then lost consciousness and fell. Because we decline to rely on the coworker's testimony for the reasons stated above, we conclude that claimant has not met her burden of proving that she experienced a compensable fall in October 1993.

ORDER

The ALJ's order dated October 17, 1994 is affirmed.

September 20, 1995 Cite as 47 Van Natta 1667 (1995)

In the Matter of the Compensation of
ARNOLD D. SCHAFFER, Claimant
WCB Case No. 94-12430
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order which upheld the SAIF Corporation's denial of his injury claim for a cervical strain. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant had a series of compensable cervical injuries beginning in 1982 while working for SAIF's insured. He also sustained a noncompensable cervical injury as a result of a motor vehicle accident in January 1994. By May 24, 1994, claimant's neck and arm symptoms were about 65 percent improved according to claimant's treating chiropractor, Dr. Kelley. (Ex. 75-1).

On or about May 25, 1994, while performing his work activities, claimant was struck by a small tree or limb on the right side of his hard hat behind the right ear and on the right shoulder. Claimant returned to Dr. Kelley prior to his previously scheduled appointment complaining of cervical symptoms and right arm and hand tingling. Dr. Kelley diagnosed a cervico-thoracic strain and right head and ear lacerations. Claimant filed a claim that SAIF accepted as a scalp laceration. SAIF, however, denied claimant's treatment and disability related to claimant's cervical condition on the ground that the May 25, 1994 incident was not the major contributing cause of claimant's cervical condition.

Dr. Butler, an orthopedic surgeon, became claimant's attending physician on July 1, 1994. Dr. Butler would later opine that the May 25, 1994 incident was the major contributing cause of claimant's cervical strain. (Ex. 73). An examining orthopedic surgeon, Dr. Farris, concluded, however, that claimant's prior industrial injuries were the major contributing cause of his cervical condition. (Ex. 72-5). Dr. Kelley considered the May 25, 1994 incident to be "a" major contributing factor in claimant's need for treatment. (Ex. 75).

At hearing, claimant did not assert either a medical services claim under ORS 656.245 or an aggravation claim pursuant to ORS 656.273 in relationship to any of his prior compensable neck injuries. The ALJ stated that the parties had agreed that claimant's May 1994 accident had "combined" with his preexisting neck condition and, further, that claimant was contending that Dr. Kelley's opinion satisfied his burden of proving that his "resultant condition" was compensable under former ORS 656.005(7)(a)(B).[1]

Finding Dr. Farris' medical opinion to be more persuasive than Dr. Butler's, the ALJ concluded that claimant had failed to sustain his burden of proof under former ORS 656.005(7)(a)(B). Thus, the ALJ upheld SAIF's denial.

On review, claimant contends that the most persuasive medical evidence establishes that his cervical strain is compensable, noting that the ALJ failed to discuss Dr. Kelley's medical opinion. Claimant emphasizes that he has two distinct conditions: a preexisting degenerative cervical condition and a cervical strain. Claimant argues that he is seeking only a finding that his cervical strain is compensable. Claimant asserts that there is no "resultant condition" of which compensability must be determined under ORS 656.005(7)(a)(B).

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995) and Michele K. Dibrito, 47 Van Natta 970 (1995)). In determining whether ORS 656.005(7)(a)(B) applies, we find Dr. Kelley's opinion to be the most persuasive, inasmuch as he treated claimant both before and after the May 25, 1994 incident and supplied the most detailed explanation regarding the impact of this injury on claimant's preexisting cervical condition. Dr. Kelley reported that claimant's May 25, 1994 work injury aggravated and exacerbated his preexisting spinal and upper extremity condition, which was not yet medically stationary from his January 1994 motor vehicle accident. (Ex. 75). Based on that opinion, we find that claimant's May 25, 1994 injury "combined" with his preexisting cervical condition to cause a need for medical treatment. We, therefore, conclude that ORS 656.005(7)(a)(B) is applicable and decide the compensability issue pursuant to that statute.

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[1] There was no discussion of the applicability of ORS 656.005(7)(a)(B) on the record.

Initially, we note that, effective June 7, 1994, Senate Bill 369 amended ORS 656.005(7)(a)(B).[2] We need not decide whether the amendments to that statute are applicable because we would not find this claim to be compensable under either former or amended ORS 656.005(7)(a)(B).

The medical evidence concerning the causation issue is not uniform. As previously noted, Dr. Butler considered the May 1994 accident to have been the major contributing cause of claimant's cervical strain. (Ex. 73). Dr. Farris, on the other hand, opined that claimant's series of prior neck injuries were the major contributing cause of claimant's cervical condition. (Ex. 72-5). Noting that neither physician explained his opinion, the ALJ nevertheless found Dr. Farris' opinion more persuasive because it was more consistent with claimant's long history of prior injuries. Therefore, without discussion of Dr. Kelley's medical opinion, the ALJ determined that claimant's neck condition was not compensable under former ORS 656.005(7)(a)(B).

Inasmuch as both Dr. Farris' and Dr. Butler's opinion are conclusory, we find neither opinion helpful and assign them little weight in determining the causation issue. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Instead, we find that resolution of the medical causation issue depends on the persuasiveness of Dr. Kelley's opinion.

Dr. Kelley, who has treated claimant since 1984, confirmed that claimant was 65 percent improved from his January 1994 motor vehicle accident before his May 25, 1994 injury, but was still not medically stationary. Dr. Kelley further opined:

> "The May 25, 1994 work-related injury was a major contributing cause of [claimant] requiring continuing care after that date. The blow to the right side of his head caused an extremely rapid lateral flexion of his head to the right which increased the compression of the right side of the cervical and cervicothoracic spine which aggravated and exacerbated his pre-existing spinal and upper extremity radicular condition. Rather than waiting the week and a half planned before his next appointment, he was scheduled for a follow-up visit the same week and again the next week." (Ex. 75-2, emphasis supplied).

It is claimant's burden to prove under ORS 656.005(7)(a)(B) that the May 1994 industrial injury is the major contributing cause of his disability or need for treatment. Michele K. Dibrito, supra, 47 Van Natta at 971. SAIF argues that Dr. Kelley's opinion cannot satisfy claimant's burden of proof, correctly observing that Dr. Kelley used the word "a" rather than the word "the" as required by the statute. However, we recognize that a physician is not required to use "magic words" in a medical report. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986).

In James L. Curtis, 45 Van Natta 396 (1993), we addressed the issue of whether the opinion of a physician who used the word "a" rather than the word "the" satisfied the claimant's burden of proving that his injury was the "the" major contributing cause of his disability or medical treatment under ORS 656.005(7)(a)(B). After reviewing the medical evidence, we concluded that, given the context of the doctor's entire testimony, the requisite major causation standard had not been satisfied. We were particularly influenced by the physician's testimony that the distinction between "a" major cause and " the" major cause was too arbitrary to "deserve a response."

After examining the context of Dr. Kelley's opinion in this case, we reach a similar conclusion. Dr. Kelley, having treated claimant for many years, and having examined claimant both before and after the May 25, 1994 incident, was in a unique position to provide an opinion on causation. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). He explained the effects of the blow to claimant's head which aggravated and exacerbated claimant's preexisting spinal condition.

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[2] Amended ORS 656.005(7)(a))(B) now 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."

Dr. Kelley, however, confirmed that claimant was still under active treatment for his noncompensable January 1994 motor vehicle accident at the time of his May 1994 injury. Claimant was not medically stationary from the motor vehicle accident, had not returned to his pre-motor vehicle accident status and was scheduled for additional treatment prior to the May 25, 1994 incident. Although the latter incident caused claimant to seek treatment sooner than he had planned, it is clear that claimant's January 1994 accident was still a significant factor in claimant's current cervical condition prior to May 25, 1994.

After examining the entire context of Dr. Kelley's opinion, and in light of claimant's recent history of cervical injuries and complaints, we do not find that Dr. Kelley's conclusion satisfies claimant's burden of proving that the May 25, 1994 injury is the major contributing cause of his need for medical treatment after that incident. James L. Curtis, supra. Inasmuch as both former and amended ORS 656.005(7)(a)(B) require that an injury be the major contributing cause of a claimant's need for treatment, we conclude that claimant's current cervical condition is not compensable under either version of the statute. We, therefore, affirm the ALJ's decision.

ORDER

The ALJ's order dated January 20, 1995 is affirmed.

September 21, 1995 Cite as 47 Van Natta 1670 (1995)

In the Matter of the Compensation of
JENNIFER M. BADEAU, Claimant
WCB Case No. 94-08806
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order which: (1) declined to award temporary disability benefits after June 28, 1994; and (2) declined to assess penalties or attorney fees for the insurer's allegedly unreasonable termination of temporary disability benefits. We reverse.

FINDINGS OF FACT

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

In lieu of the ALJ's findings contained in the third paragraph from the bottom of page 2 of the Opinion and Order, we make the following findings:

Dr. Sedgewick examined claimant on June 27, 1994. Dr. Sedgewick authorized the continuation of claimant's work release "as stands." Specifically, Dr. Sedgewick authorized claimant to be on her feet three hours per day and otherwise sitting. (Ex. 8-19).

We do not adopt the ALJ's finding contained in the last paragraph on page 2 of the Opinion and Order. We do not adopt the ALJ's ultimate finding of fact.

We adopt the following supplementary findings of fact:

As a temporary worker for an employment agency, claimant was placed in either general clerical or receptionist positions. (Ex. 32 at 4-5).

Dr. Sedgewick released claimant to full duty on August 18, 1994. (Ex. 8-21). Claimant did not receive from Dr. Sedgewick a written release for regular work prior to August 18, 1994. (Tr. 9). Claimant was not told by Dr. Sedgewick that she was released to return to regular work prior to August 18, 1994. (Tr. 9).

CONCLUSIONS OF LAW AND OPINION

The ALJ held that the conditions of former ORS 656.268(3)(b)[1] were satisfied no later than June 28, 1994, when the attending physician notified claimant that she was released to return to work under conditions consistent with the physical demands of her job at injury. We disagree.

Claimant was working for a temporary employment agency, placed as a receptionist, when she sustained a left foot injury in May 1992. As a temporary worker, claimant was placed in either general clerical or receptionist positions. (Ex. 32 at 4-5). Following surgery in March 1994, claimant was released to "light duty" on April 25, 1994. (Ex. 8-15). According to Dr. Sedgewick's chart notes, claimant continued to be released to "light duty," but with gradually decreasing restrictions on standing and walking. (Ex. 8 at 16-20). On August 18, 1994, Dr. Sedgewick released claimant to "full duty." (Ex. 8-21).

On June 29, 1994, Dr. Sedgewick signed a job analysis for a receptionist/greeter position, indicating that claimant was able to perform the physical demands of that job. The signed job analysis form was sent to claimant's vocational counselor, Ms. Nichols. (Exs. 44 at 7-8; 45-3). Claimant testified that she did not receive a written release to regular work, nor was she told by Dr. Sedgewick that she was released to regular work, prior to August 18, 1994.

We have previously held that the requirements of ORS 656.268(3)(b) are clear, unambiguous and specific in what is required before an insurer may unilaterally terminate TTD benefits. Trevor E. Shaw, 46 Van Natta 1821, 1821, on recon 46 Van Natta 2168 (1994). Those requirements were not met here.

Specifically, there is no evidence that claimant received from her attending physician a written release to regular work prior to August 18, 1994. Claimant was given a release to light duty in April 1994. However, there is no indication in Dr. Sedgewick's chart notes that he gave claimant another work release, to regular work, prior to August 18, 1994. Even if the "job analysis" form signed by Dr. Sedgewick is considered to be a written release to regular work, there is no evidence that this form was given to claimant by her attending physician. Claimant testified that she did not receive a written release to regular work prior to August 18, 1994.

Under such circumstances, we conclude that claimant was not given a written release to regular work by her attending physician prior to August 18, 1994. Accordingly, the insurer was not entitled to unilaterally terminate TTD under former ORS 656.268(3)(b) prior to August 18, 1994. Eulalio M. Garcia, 47 Van Natta 96, 97 (1995); Trevor Shaw, supra, 46 Van Natta at 1822.

Subsequent to the ALJ's order in this matter, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.268(3), which now provides, in relevant part, that temporary total disability benefits shall continue until "[t]he attending physician advises the worker and documents in writing that the worker is released to return to regular employment." Or Laws 1995, ch 332, § 30(3)(b) (SB 369, § 30 (3)(b)).

While review was pending in this case, the insurer's counsel submitted a letter, urging the Board to consider this case in light of the amendments contained in Senate Bill 369. We have done so, and conclude that, assuming without deciding that the amended version of ORS 656.268 (3)(b) is applicable, the insurer was also not entitled to unilaterally terminate TTD under amended ORS 656.268(3)(b).[2]

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[1] Former ORS 656.268(3)(b) provided:

"Temporary total disability benefits shall continue until whichever of the following events first occurs: * * * (b) The attending physician gives the worker a written release to return to regular employment."

The parties do not contend that former ORS 656.268(3)(a) or (c) applies in this case.

[2] We have also received claimant's challenge to the insurer's submission, as well as to the applicability and constitutionality of the amended statute. Inasmuch as we would find claimant entitled to temporary disability benefits under either version of the statute, we need not address claimant's contentions.

We find that amended ORS 656.268(3)(b) is clear, unambiguous and specific in the requirements for unilateral termination of TTD. We find that those requirements were not met in this case.

Specifically, the attending physician must advise the worker that she is released to return to regular employment. Here, claimant testified that she was not told by her attending physician that she was released to regular work prior to August 18, 1994. (Tr. 9). Dr. Sedgewick's chart notes do not refute claimant's testimony. The chart notes do not indicate that Dr. Sedgewick told claimant she was released to regular work prior to August 18, 1994. In light of claimant's testimony, we decline to infer from Dr. Sedgewick's chart notes that he advised claimant prior to August 18, 1994 that she was released to regular work.

Furthermore, we are not persuaded that Dr. Sedgewick's approval of the "receptionist/greeter" job analysis constituted a release to regular work. At the time of her injury, claimant was employed by a temporary employment agency and was placed in either general clerical or receptionist positions. Claimant's vocational counselor prepared job analyses for "administrative assistant" and "office support specialist," both of which are representive of jobs claimant has performed and which she has the necessary skills to perform. (See Ex. 44). However, the "office support specialist" position exceeded claimant's physical restrictions as of the end of June 1994, since it required combined walking and standing up to 60 percent of the work day. (Ex. 44-5). Thus, we conclude that Dr. Sedgewick's release on June 29, 1994, which was consistent only with the physical requirements of a receptionist position, did not constitute a release to claimant's regular work which included general clerical as well as receptionist duties.

Inasmuch as we have found that the insurer was not entitled to unilaterally terminate TTD under either the former or the present version of the statute, we need not decide whether former or amended ORS 656.268(3)(b) applies in this case.

Because we have found that the insurer was not entitled to unilaterally terminate TTD under ORS 656.268(3)(b), we next consider whether the insurer's conduct was unreasonable and whether claimant is entitled to a penalty or attorney fee. Given that the terms of the statute are clear, unambiguous and specific, requiring the attending physician to give the worker a written release to regular work before TTD can be terminated, and that the record does not reveal that claimant received a written release to regular work prior to August 18, 1994, we conclude that the insurer's conduct in unilaterally terminating TTD on June 28, 1994 was unreasonable. Accordingly, we assess a penalty in the amount of 25 percent of the amount due as a result of this order, to be paid one-half to claimant and one-half to her attorney. Former ORS 656.262(10)(a); see also amended ORS 656.262(11)(a), SB 369 § 28(11)(a) (June 7, 1995).

ORDER

The ALJ's order dated November 18, 1994 is reversed. Claimant is awarded temporary total disability benefits from June 29, 1994 to August 18, 1994. The insurer is assessed a penalty in the amount of 25 percent of the amount due under this order, payable one half to claimant and one half to her attorney. Claimant's counsel is awarded an attorney fee equal to 25 percent of the increased compensation resulting from this order, not to exceed $3,800 payable directly to claimant's attorney.

In the Matter of the Compensation of
JAMES H. BLAGG, Claimant
WCB Case No. 94-08610
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that affirmed an Order on Reconsideration that set aside an award of permanent total disability and granted a total award of 40 percent (128 degrees) unscheduled permanent disability for a low back injury. Claimant also argues that the ALJ erred in admitting two surveillance videos in his order, whereas he had denied admitting those videos at hearing. On review, the issues are evidence and permanent total disability. We affirm.

FINDINGS OF FACT

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

On July 26, 1993, Dr. Seres, neurosurgeon, and Dr. Newman, psychologist, examined claimant on behalf of the SAIF Corporation. This examination was part of a permanent total disability evaluation performed at the Northwest Occupational Medicine Center (NOMC), which included an interview with claimant, a review of claimant's medical records, a physical examination, a physical capacities evaluation, and a vocational evaluation, including various aptitude tests. (Exs. 34, 35, 36, 37). The NOMC evaluation concluded that claimant was able to perform sedentary work, with the ability to alternate sitting and standing postures frequently. (Ex. 35-4). The NOMC evaluation also concluded that, given claimant's present medical and psychological state, there are no medical or psychological contraindications to claimant's returning to sedentary work. Specifically, the NOMC evaluation recommended that "this would be the best medicine for [claimant]." (Ex. 37-4). Dr. Gilsdorf, treating orthopedist, concurred with the NOMC report. (Ex. 39).

Dr. Luther, treating psychiatrist, deferred the question of claimant's physical capacity to perform work to Dr. Gilsdorf, noting that such questions were outside of his (Dr. Luther's) medical discipline. (Exs. 38-1, 42). Dr. Luther opined that there were no psychological contraindications to claimant working, "if [claimant] could do it," and that, from a psychological standpoint, claimant would benefit from working. (Exs. 38-1, 44).

At the hearing, the ALJ denied admission of Exhibits 57, 58, and 59. Exhibits 57 and 58 are surveillance videos taken on May 31, June 1, and 2, 1989 and on August 26, 27, and 28, 1989 by Don Janes, an investigator with Globe Investigations. Exhibit 59[1] is a narrative report by Mr. Janes regarding that surveillance. Claimant objected to the admission of these exhibits because Mr. Janes was not present at the hearing for cross-examination or to establish the foundation for these exhibits. At hearing, the ALJ sustained claimant's objection and denied admittance of these exhibits. (Tr. 125-126). However, in his order, the ALJ reversed his ruling and admitted "Exhibits 57 and 58 summaries and surveillance films taken May-June 1989, and August-September 1989." (Opinion and Order, page 1). The ALJ did not rely on the evidence created by Mr. Janes.

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, claimant argues that the ALJ erred in admitting the May-June 1989 and August-September 1989 surveillance videos and the related narrative report in his order, after properly excluding those exhibits at hearing because the investigator was not available for cross-examination or to establish the foundation regarding this surveillance evidence. We need not resolve this issue because even if we did not consider the disputed surveillance evidence, we would reach the same conclusion regarding claimant's entitlement to permanent total disability benefits.

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[1] We note that the record contains two exhibits identified as Exhibit 59. One of those exhibits is a copy of the curriculum vitae of Ms. Summers, claimant's vocational expert, the other is the copy of the narrative surveillance report discussed above. There is no contention that Ms. Summers' curriculum vitae is not admissible.

Permanent Total Disability

Claimant was previously determined to be permanently and totally disabled as of May 1, 1985. (Ex. 15). Because SAIF is attempting to terminate or modify claimant's award, it has the burden of proving that claimant presently is "currently employable or able to sell his services on a regular basis in a hypothetically normal labor market." Harris v. SAIF, 292 Or 683, 695 (1982); Norton v. SAIF, 86 Or App 447, 452 (1987); Kytola v. Boise Cascade Corp., 78 Or App 108, rev den 301 Or 765 (1986).

Claimant compensably injured his low back in 1974 and subsequently underwent five surgical procedures for that injury, none of which significantly relieved his chronic pain. In addition, as a result of the low back injury and its sequelae, claimant developed a compensable psychological component. With the following supplementation, we adopt the ALJ's reasoning and conclusions that claimant is not restricted from employment solely on the basis of his physical and psychological conditions.

At hearing and on review, claimant contends that the opinions of Drs. Luther and Gilsdorf establish that his physical and psychological conditions render him unable to work. We agree with the ALJ that the record does not support this contention. Furthermore, contrary to claimant's argument, the record establishes that Dr. Gilsdorf's opinions have "been all over the map," as the ALJ found. (Exs. 39, 43, 46, 52, 55).

Dr. Gilsdorf concurred with the NOMC evaluation, which found no physical or psychological contraindications to claimant performing sedentary work, with the ability to frequently change positions. (Exs. 34, 35, 36, 37, 39). In addition, Dr. Gilsdorf approved seven jobs as being within claimant's physical capacities,[2] even though the vocational experts later indicated that some of those jobs were greater than sedentary work. (Exs. 43, 55). Furthermore, contrary to claimant's argument, Dr. Gilsdorf was provided with specific information regarding the physical capacities required in all but one of those jobs. (Ex. 43). (We note that Exhibit 43 does not include a job analysis for the valve assembler job). Moreover, Dr. Gilsdorf later confirmed that he approved these jobs based on claimant's physical capacity. (Ex. 55).

Given this, we do not find persuasive Dr. Gilsdorf's opinion that, considering claimant's physical, emotional/psychological, and vocational aspects, Gilsdorf "could not conceive of a position where [claimant] could be gainfully employed." (Exs. 52, 55-2). In addition to the fact that this opinion is inconsistent with Dr. Gilsdorf's earlier opinion that claimant could perform several jobs, there is no evidence that Gilsdorf is qualified to give a vocational opinion. Furthermore, although Dr. Gilsdorf states that his treatment as claimant's orthopedist "has considered claimant's psychological state," claimant has received regular psychiatric treatment from Dr. Luther for a period of about 20 years. (Ex. 55-1). Therefore, we consider Dr. Luther better qualified to render an opinion regarding any psychological impediments to claimant's working. Finally, Dr. Gilsdorf conceded that others may have more expertise regarding any emotional/psychological and vocational factors, although that fact did not change his opinion. (Ex. 55-2).

Regarding claimant's physical capacities, the ALJ noted that the January 1989 surveillance video showed that claimant was reporting more limitations to his physicians at that time than the video indicated. More to the point, the NOMC examiners performed the only current physical capacities evaluation, and they opined that claimant's physical capacity evaluation was significantly self-limited and the ranges of motion were invalid. (Ex. 37-2, -3). Nevertheless, the NOMC opined that claimant was capable of sedentary work, with frequent changes of position, although they cautioned that claimant's demonstrated level of functioning may not be valid. (Exs. 35-4, 37-4). Based on the NOMC evaluation, Dr. Gilsdorf's concurrence with it and his later approval of jobs above sedentary work, we conclude that claimant is at least physically capable of sedentary work, with frequent changes of position.

For the reasons stated above, we rely on Dr. Luther's opinion regarding claimant's psychological limitations. Dr. Luther consistently deferred questions regarding claimant's physical capacities to Dr.

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[2] Dr. Gilsdorf approved the following seven jobs and "other occupations within the activities described:" valve assembler; prosthetics bench technician; gate tender; motel clerk; patrol guard; telemarketer; and cashier. (Ex. 43).

Gilsdorf, opining that such questions were outside of his (Dr. Luther's) medical discipline. (Exs. 33, 38, 42, 44). Dr. Luther stated that there were no contraindications from a psychological standpoint to claimant working and, psychologically, claimant would benefit from working. (Exs. 38, 44). Later, Dr. Luther stated that claimant remained totally disabled from work due to his chronic pain syndrome and depressive condition. (Ex. 51A-1). However, Dr. Luther explained his prior statements that claimant would benefit from work by stating that claimant "remains disabled from employment because of his chronic pain syndrome and that if his psychological condition could be taken separately from his physical condition, he would benefit from working." (Ex. 51A-2). We find that Dr. Luther's later opinions focus on claimant's physical condition, an issue he previously deferred to Dr. Gilsdorf based on his (Dr. Luther's) lack of expertise in that area. On that basis, we do not find persuasive Dr. Luther's opinions regarding claimant's physical capacities. Furthermore, Dr. Luther does not change his opinion that there is no psychological contraindication to claimant's working.

Thus, we agree with the ALJ that claimant is not restricted from employment solely on the basis of his physical and psychological conditions. However, we disagree with the ALJ's conclusion that the inquiry ends there. In this regard, we note that permanent total disability status is not limited to those situations where a worker is unable to regularly perform work at a gainful and suitable occupation based solely on his or her compensable physical and psychological conditions. Under the "odd-lot" doctrine, a claimant may be permanently totally disabled due to a combination of his or her physical and psychological conditions and nonmedical factors such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions, as well as the condition of the labor market. Clark v. Boise Cascade Co., 72 Or App 397 (1985). The essential inquiry here is whether claimant is currently employable and that inquiry may involve factors other than claimant's physical and psychological conditions.

The record contains opinions from four vocational experts regarding claimant's current employability. None of these experts provided claimant any vocational services. However, Mr. Alvarado, the vocational evaluator with NOMC, tested and interviewed claimant, and Ms. Summers, claimant's vocational expert, interviewed claimant. (Ex. 34, 37, Tr. 67, 95).

Claimant was 58 at the date of hearing and has a ninth grade education. He has not earned a GED, although he has passed all but one of the tests for that certificate. Claimant worked as a millwright in his at-injury job. After his injury, he completed a vocational training program in motorcycle repair. Subsequently, he worked for a short period in a motorcycle shop his wife owned. However, he was unable to continue that work due to low back pain.

Mr. Alvarado noted claimant tested with above average general learning aptitude, above average ability to apply mechanical principles, and average for mechanically related manual dexterity. (Ex. 34-10). He also noted that claimant had below average finger dexterity and below average ability to handle small items, noting an observable tremor in claimant's right hand. However, he found that claimant was able to efficiently handle regular size tools and demonstrated skill in the area of small engine repair. Id. He opined that a return to work in the area of small engine repair, small parts assembler, or a related field "could be worth consideration" if adjustments could be made to those occupations to render them sedentary work. (Ex. 34-11). On the other hand, Mr. Alvarado stated that it was unlikely any return-to-work effort would be successful, "considering [claimant's] demonstrated minimal endurance and stamina as it relates to work, his need to shift positions so frequently, his need to take breaks often, his often reported high discomfort levels, and his perception of [him]self as disabled." Id.

Ms. Summers relied on the NOMC physical capacities evaluation, noting that claimant was capable of sedentary, restricted work. She also considered claimant's psychological condition. She found claimant unable to do any of the seven jobs approved by Dr. Gilsdorf, finding five of those jobs greater than sedentary work, including the cashier job. In addition, although she found the motel clerk and telemarketer jobs within claimant's physical capacity, she opined that claimant would not be able to perform them due to the general learning, verbal, numerical, finger dexterity, and selling skills required. (Tr. 78-80). Ms. Summers noted that claimant tested very low in clerical, verbal, numerical and some hand dexterity tests. She opined that small engine repair was medium work and cannot be made sedentary work. (Tr. 90-91). She found that claimant had no transferable skills and was unable to find any job that claimant could do. (Tr. 92-93). Although she was impressed with claimant's rise to the at-injury millwright job, a skilled position that requires judgment and quick decision making, she was not

aware of claimant's above average general learning ability. (Tr. 103-104, 107). Furthermore, one of the factors she used in eliminating the motel clerk job was the general learning ability required, a factor that would not affect claimant.

Mr. Potocki, SAIF's vocational expert, reviewed the record and spoke with Dr. Luther, who indicated there were no psychological contraindications for work. (Tr. 170). Mr. Potocki testified that much of his opinion regarding claimant's employability was based on Dr. Gilsdorf's approval of the seven above-listed jobs, although he also relied on the NOMC's physical capacities evaluation. (Tr. 131-132, 157). Mr. Potocki found claimant capable of performing those seven jobs and jobs as a hand packer or sorter, a parking lot cashier, and a video rental clerk. (Tr. 137-147, 148).

Ms. Sturges, SAIF's vocational expert, reviewed the record. In addition, contrary to claimant's argument, in reaching her opinion as to whether claimant was employable, Ms. Sturges considered claimant's psychological condition, including the notation in the NOMC's mental status evaluation that there "was some mild memory and concentration impairment . . . [claimant's] thought processes were judged intact." (Ex. 36-4, Tr. 181-182). Ms. Sturges opined that the jobs she considered claimant capable of performing did not require intense concentration, had a variety of tasks, and flexibility of position. (Tr. 181-182). In addition, she opined that, because claimant's judgment was found to be intact, the mild memory and concentration problems would not affect claimant's judgment on the job. Id.

Ms. Sturges considered claimant capable of sedentary work, with the ability to change positions frequently. (Tr. 177,189). She determined that, of the seven jobs approved by Dr. Gilsdorf, claimant was capable of performing the assembler, telemarketer, motel clerk, and cashier jobs. (Tr. 183, 197). Ms. Sturges stated that about half of cashier jobs are sedentary work. (Tr. 180-181). In addition, she opined that claimant would be able to perform the following jobs: circulation clerk, collection clerk, customer service representative, and phone operator. Id. She performed a market survey in claimant's area and found that reasonable employment opportunities exist for the eight jobs she found claimant capable of performing. (Tr. 179-181, 183).

Of the four vocational opinions, we find Ms. Sturges' opinion most persuasive. Both Mr. Potocki and Mr. Alvarado find claimant able to perform work that exceeds the sedentary, restricted capacity found by NOMC, which we have found persuasive. In addition, Ms. Sturges provides a better reasoned opinion. In this regard, we note that Ms. Summers appeared to rely on a low general learning ability in eliminating some positions, whereas claimant has above average learning ability. Also, Ms. Summers stated that all cashier jobs were light work, and Ms. Sturges persuasively explained that half of cashier jobs are sedentary work.

Accordingly, we find that SAIF has proved that claimant is currently employable. Therefore, we affirm the ALJ's order.

ORDER

The ALJ's order dated December 27, 1994 is affirmed.

Board Member Gunn concurring in part and dissenting in part.

I agree with the majority that Exhibits 57, 58, and 59 are not admissible and that claimant is not permanently and totally disabled based solely on his compensable medical and psychiatric conditions. However, I disagree with the majority's analysis of the vocational evidence. I find that the persuasive vocational evidence establishes that claimant is not currently employable. Therefore, I must respectfully dissent.

Because SAIF is attempting to terminate or modify claimant's permanent total disability award, it has the burden of proving that claimant presently is "currently employable or able to sell his services on a regular basis in a hypothetically normal labor market." Harris v. SAIF, supra; Norton v. SAIF, supra; Kytola v. Boise Cascade Corp., supra. On this record, SAIF has failed to meet its burden of proof.

The majority finds Ms. Sturges' vocational opinion most persuasive. I disagree. Ms. Sturges selectively relies on portions of the NOMC aptitude testing to support her opinion; however, she ignores, without explanation, those portions of the aptitude testing that do not support her opinion. In this regard, Ms. Sturges postulates that claimant has adequate math and language skills based on his work history, whereas the NOMC aptitude testing establishes that claimant has low math and language skills. Furthermore, Ms. Sturges opined that claimant was able to perform various clerical jobs, whereas the NOMC aptitude testing demonstrated that claimant performed only within the first percentile in the clerical test, meaning that 99 percent of the population performed better than claimant. Based on these inconsistencies, I do not find Ms. Sturges' vocational opinion persuasive.

As the majority found, claimant's current physical capacities evaluation shows him capable of sedentary, restricted work, at most. However, Mr. Potocki opined that claimant was able to perform work that exceeded this capacity. In this regard, Mr. Potocki relied on Dr. Gilsdorf's opinion that claimant was capable of performing the following jobs: valve assembler; prosthetics bench technician; gate tender; motel clerk; patrol guard; telemarketer; and cashier. However, the persuasive opinion of Ms. Summers establishes that these jobs are beyond claimant's capacity. Because Mr. Potocki relies on jobs that are beyond claimant's physical capacity in rendering his opinion that claimant is employable, I do not find his opinion persuasive.

Of the four vocational experts rendering opinions regarding claimant's employability, only Mr. Alverado and Ms. Summers had any contact with claimant. Based on this contact, claimant's physical capacities evaluation, and his aptitude testing, both of these experts opined that claimant was not currently employable. Mr. Alverado stated that, "work in the area of small engine repair, small parts assembler, or a related field could be worth consideration if adjustments could be made to render these occupations in the sedentary work level." (Ex. 34-11). However, Ms. Summers persuasively explained that these jobs could not be made sedentary work. In any event, Mr. Alverado ultimately concluded that claimant was not employable, given claimant's demonstrated minimal endurance and stamina, his need to frequently shift positions, his need to take frequent breaks, his reported high discomfort levels, and his perception of himself as disabled. Id.

Based on the persuasive opinions of Ms. Summers and Mr. Alverado, I find that claimant is not currently able to sell his services on a regular basis in a hypothetically normal labor market. Harris v. SAIF, supra; Norton v. SAIF, supra; Kytola v. Boise Cascade Corp., supra. Therefore, SAIF has failed to meet its burden of proof. Accordingly, I would find that claimant remains permanently and totally disabled.

September 21, 1995 Cite as 47 Van Natta 1677 (1995)

In the Matter of the Compensation of
JOE A. GALLARDO, Sr., Claimant
WCB Case No. 93-10166
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall, Christian and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Schultz's order which: (1) set aside its denial of claimant's low back injury claim; and (2) assessed a penalty and attorney fee for its allegedly unreasonable denial of the claim. On review, the issues are compensability and penalties and attorney fees.

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

The ALJ found that claimant had established that his May 8, 1993 low back strain, which occurred at work, was the major contributing cause of his current low back condition, disability and need for medical treatment. In doing so, the ALJ relied on U-Haul of Oregon v. Burtis, 120 Or App 353

(1993) and Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590, rev den 318 Or 27 (1993), and held the claim compensable under ORS 656.005(7)(a)(B).[1]

We agree with the ALJ's reasoning and his conclusion that claimant's low back condition is compensable. However, to the extent the ALJ's quotation from our order, Bahman M. Nazari, 43 Van Natta 2368 (1991), implies endorsement of our two-step compensability analysis, we disagree with that portion of the ALJ's order. The court specifically rejected our two-step compensability analysis. Nazari, supra, 117 Or App at 412. Instead, the court explained:

> "If, in an initial claim, there is disability or a need for treatment as a result of the injury alone, then the claim is compensable if the injury is a material contributing cause of the disability or need for treatment. If, in an initial claim, the disability or need for treatment is due to the combination of the injury and a preexisting, noncompensable condition, then the injury is compensable only if it is the major contributing cause of the disability or need for treatment." Nazari, supra, 120 Or App at 594.

Accordingly, inasmuch as claimant established that the work injury was the major contributing cause of his low back condition, we conclude that claimant's low back condition is compensable.

The ALJ's order directs the employer to accept "claimant's May 8, 1993 injury and subsequent disability and medical treatment (including surgeries)." Opinion and Order at 9 (emphasis added). Claimant had low back surgery in August 1993 and July 1994. However, the parties agreed that all issues related to the employer's August 26, 1994 denial, including the 1994 surgery, were reserved for later adjudication. (Tr. at 7; Appellant's Brief at 2-3; Respondent's Brief at 4 n.2). Accordingly, that portion of the ALJ's order which finds the July 1994 surgery compensable is vacated.

Similarly, we do not adopt that portion of the ALJ's third finding of ultimate fact which pertains to the July 1994 surgery. Opinion and Order at 5.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. In addition, we have considered that claimant is not entitled to an attorney fee for his counsel's services regarding the penalty/attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated September 13, 1994 is affirmed, with the following exception. That portion of the order which relates to the employer's August 26, 1994 denial and finds claimant's 1994 surgery compensable is vacated. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the self-insured employer.

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[1] Subsequent to the ALJ's order, the legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.005(7)(a)(B) which now provides that where a compensable injury combines with a preexisting condition, claimant must establish that the 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." Or Laws 1995, ch 332 § 1 (SB 369 § 1). Assuming, without deciding, that the amendments to ORS 656.005(7)(a)(B) are applicable to this case, we conclude that the result would not change, since we find that claimant has established that the May 8, 1993 work injury was the major contributing cause of his disability and need for treatment for the combined condition. Consequently, we do not address which version of the statute should apply to this case.

Board Member Haynes dissenting.

Because I disagree with the ALJ's analysis and conclusion, which the majority adopted and affirmed, I respectfully dissent.

Relying on U-Haul of Oregon v. Burtis, 120 Or App 353, rev den 318 Or 26 (1993), the ALJ found claimant's low back condition, disability and need for treatment compensable under former ORS 656.005(7)(a)(B).[1] I disagree.

Subsequent to the ALJ's order in this case, the Court of Appeals decided Dietz v. Ramuda, 130 Or App 397 (1994). In that case, the court held that an event that precipitates symptoms of a preexisting condition is not necessarily the major contributing cause of those symptoms. In Dietz, the claimant, who had been diagnosed with preexisting, albeit asymptomatic, coronary artery disease, experienced a heart attack after a prolonged period of smoke inhalation. The court agreed with our application of former ORS 656.005(7)(a)(B) in determining whether the work event was the major contributing cause of the claimant's resultant condition. The court rejected the claimant's argument that a work event that is the precipitating cause of a disease or injury was necessarily the major cause, explaining that, although a work event that is the precipitating cause of a disease or injury may be the major contributing cause, the proper application of ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause, including the precipitating cause, to establish which is the primary cause. Id. at 401.

Here, however, the medical opinions on which the ALJ and majority rely persuasively establish no more than that the work incident was the precipitating cause of claimant's disability and need for medical services. This is not legally sufficient to carry claimant's burden of proving that the work injury was the major contributing cause of his disability and need for medical treatment. Dietz, supra; see also Stacy v. Corrections Div., 131 Or App 610, 614 (1994). Indeed, we have previously stated that Burtis does not set forth a rule of law that in all cases where a work injury causes a previously asymptomatic condition to become symptomatic, the work incident is deemed to be the major contributing cause of the resultant condition. Alec E. Snyder, 47 Van Natta 838, 839 (1995). Rather, it is claimant's burden to prove in each case, based on evaluation of the relative contributions of the different causes involved, that the work injury was the major or primary cause of his disability and need for medical treatment.

Dr. Treible, claimant's initial treating surgeon, simply opined that claimant's work injury triggered the onset of symptoms. (Ex. 11). He acknowledged that claimant had significant preexisting spinal disease, which made him susceptible to developing a back injury. He concluded that the work injury was "the major cause precipitating his need for medical treatment." (Ex. 24) (emphasis added). I conclude that Dr. Treible's opinion expresses only that the work injury was the major cause which triggered or precipitated claimant's disability and need for treatment. However, his opinion does not evaluate the relative contributions of the different causes, and it does not establish that the work injury is the major or primary cause of claimant's disability and need for treatment, as required by ORS 656.005(7)(a)(B) and the court's decision in Dietz.

The ALJ and the majority also rely on the opinion of Dr. Brett, claimant's subsequent treating neurosurgeon. Dr. Brett, who performed a second surgery in July 1994, did opine that the work injury caused a pathological worsening of claimant's L4-5 disk which "is the major contributing factor to the development of his radiculitis, nerve root impingement, and need for his surgery." (Ex. 29). His opinion was based on the explanation that the work injury resulted in an L4-5 disk protrusion with bilateral impingement of the L5 nerve roots. (Id.)

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[1] Subsequent to the ALJ's order in this case, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.005(7)(a)(B), which now 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."

Or Laws 1995, ch 332 § 1(7)(a)(B) (SB 369, § 1(7)(a)(B)). Generally, absent a specific exception, the amendments in SB 369 apply to all cases currently pending before the Board. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995). There is no specific exception to the retroactive application of amended ORS 656.005(7)(a)(B). Therefore, I conclude that ORS 656.005(7)(a)(B), as amended by SB 369, applies to this case.

However, I do not find Dr. Brett's opinion persuasive, since the medical evidence does not support the existence of a clinically significant disk protrusion, which is the basis for Dr. Brett's opinion. When Dr. Treible performed low back surgery in August 1993, he found extensive degenerative disk disease, as well as a bulge in the L4-5 disk space. However, because no free fragments or true herniations were seen, Dr. Treible elected to leave the disk alone. (Ex. 22-2). His operative diagnosis was "L4-5 lumbar nerve impingement secondary to spinal stenosis and probable synovial cyst." (Ex. 22-1). When Dr. Brett performed surgery in July 1994, he found no evidence of a disk bulge or herniation. (Ex. 28D-1). Thus, I would conclude that Dr. Brett's opinion is based on an assumption not supported by the medical evidence. Therefore, I would give Dr. Brett's opinion no weight.

Instead, I find that the opinion of Dr. Wilson, a neurologist who examined claimant at the employer's request, is consistent with the medical evidence. Dr. Wilson opined that claimant's surgeries were due to his degenerative disk disease and canal stenosis, not to any acute disk herniation. (Ex. 30). He explained that Dr. Treible's surgery addressed only claimant's degenerative disease, since he elected not to touch the bulging disk he found. (Tr. 18). Dr. Wilson also disagreed with Dr. Brett that there was any evidence of an L4-5 disk protrusion, noting that neither Dr. Treible nor Dr. Brett described a herniated disk when they performed surgery. (Tr. 19-20).

Accordingly, because I would give no weight to Dr. Brett's opinion and because I find that Dr. Treible's opinion fails to address the major contributing cause standard, I would conclude that claimant has failed to carry his burden of proof. Because I would find the claim not compensable, I would also not assess a penalty for the employer's allegedly unreasonable denial. Therefore, I dissent.

In the Matter of the Compensation of
CORY L. KISHPAUGH, Claimant
WCB Case No. 94-13830
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) upheld the SAIF Corporation's denial of his claim for a head and neck injury, contusion, concussion and post concussion syndrome condition; and (2) declined to award penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, a shop helper, was assigned to do some welding on August 9, 1994. Claimant was not an experienced welder. While he was welding, claimant was startled by sparks and jumped back and struck his head on metal located a few feet behind him. This produced a bump on claimant's head, but did not break the skin.

Claimant sought medical attention the next day and filed a claim. The emergency room physician diagnosed a "closed head injury." (Ex. 1a). Dr. George examined claimant on August 10, 1994 and reported a "one inch in diameter swelling on the occipital region of the skull." (Ex. 2a). Dr. George's impression was "[s]tatus post head contusion," mild concussion suspected and a functional component. (Id.) Diagnostic tests were performed. Claimant's cervical spine was normal and a CT scan revealed no skull fracture or acute intracranial injury. (Exs. 3 & 4).

Dr. Miller examined claimant and diagnosed a head contusion and a mild concussion. Dr. Miller referred claimant to Dr. Rosenbaum because of continued symptoms.

On August 24, 1994, Dr. Rosenbaum, neurosurgeon, examined claimant and diagnosed post concussion syndrome. (Ex. 4c). Dr. Rosenbaum did not find objective abnormalities during claimant's examination, but he noted that his "symptoms are quite severe." (Id.) Dr. Rosenbaum recommended an MRI to rule out any intracranial pathology. Claimant had a normal brain MRI. (Ex. 5).

Dr. George examined claimant again on September 7, 1994. Claimant complained of headaches, dizziness, occasional nausea and neck pain. Dr. George noted that claimant appeared "somatically preoccupied." (Ex. 5b). Dr. George's impression was "[s]tatus.post head contusion," mild concussion, mild cervical strain and a functional component. (Id.)

On September 20, 1994, Dr. Cline, neurologist, examined claimant and reported that claimant's complaints were consistent with post-concussion syndrome. (Ex. 5c). Dr. Cline noted that "[d]espite the multiplicity of subjective symptoms, he does not have any obvious objective abnormalities on his examination." (Id.) However, Dr. Cline did not have any impression that claimant was exaggerating or embellishing his symptoms. Dr. Cline thought that claimant had sustained some degree of whiplash injury.

Dr. George reviewed Dr. Cline's report and examined claimant on October 5, 1994. Claimant reported that his symptoms were the same. Dr. George reported that claimant appeared a bit unsteady walking, but "there is a very functional aspect to this." (Ex. 7). Claimant's neck range of motion was approximately 50 percent decreased in all directions. Dr. George reported that "I did catch him before I asked him to move his neck just when he was getting up on the examination table, I saw him rotate his neck to the left completely normally." (Id.)

On October 17, 1994, Dr. Binder performed a neuropsychological evaluation on claimant and diagnosed malingering. (Ex. 8). In making that diagnosis, Dr. Binder relied on claimant's "significantly worse than chance performance" on the recognition memory task, implausibly poor performances on a number of other measures, his worsening symptoms and his MMPI profile, which was invalid. Claimant had nonorganic findings on measures of tactile sensation and upper extremity motor skill. Dr. Binder referred to the "extremely mild nature" of claimant's head injury and he described it as a trivial injury.

Dr. Cline subsequently concurred with Dr. Binder's report. (Ex. 10). Dr. George also concurred with Dr. Binder's report. Dr. George stated: "There is certainly a functional component which is quite strong in this case. I want to be careful to not overlook a cervical strain and mild concussion, which were thought to be present by Dr. Martha Cline, neurologist." (Ex. 11).

After reviewing Dr. Binder's report and the concurrence letters from Drs. Cline and George, Dr. Rosenbaum reported:

> "I felt the patient had no objective abnormalities and a prominent functional overlay but can't personally make the diagnosis of malingering. The psychological exam speaks for itself." (Ex. 12).

On November 9, 1994, Dr. Aversano, osteopathic physician and surgeon, diagnosed claimant with "[c]ranial cerebral trauma with post-concussion syndrome" and "[l]abyrinthine concussion -- doubt, but consider perilymphatic fistula." (Ex. 11A).

SAIF denied the claim for "an alleged injury to your head and neck" on the basis that there was insufficient evidence that claimant's head injury and cervical strain were the result of either a work-related injury or disease. (Ex. 9).

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that, although claimant may have sustained a trivial bump on his head during the course of his employment, there was no objective evidence that claimant needed medical services or had any disability. The ALJ concluded that claimant's disability and need for medical services was based upon claimant's untruthful presentation of symptoms, rather than his compensable injury.

Claimant argues that his claim is compensable because he suffered a blow to the head at work that led him to seek medical care and the physicians who examined claimant concluded that an injury had been sustained.

In order to prevail under an injury theory, claimant must establish, by medical evidence supported by objective findings, that his work activities were a material contributing cause of his disability or need for medical treatment. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). A claimant who lacks credibility in certain matters can still meet his burden of proof if the remainder of the record supports his version of how he was injured. Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985); Michael S. Plybon, 46 Van Natta 1099 (1994).

We are persuaded that claimant sustained a bump on his head at work on August 9, 1994.[1] The employer's office manager/bookkeeper testified that she saw the bump on claimant's head. (Tr. 31). Dr. George examined claimant on August 10, 1994 and reported a "one inch in diameter swelling on the occipital region of the skull." (Ex. 2a).

Although several physicians originally diagnosed different conditions, Dr. Binder subsequently performed a neuropsychological evaluation on claimant and diagnosed malingering. (Ex. 8). Notwithstanding Dr. Binder's diagnosis of malingering, he acknowledged that claimant had a head injury of an "extremely mild nature."

Dr. Cline subsequently concurred with Dr. Binder's report. (Ex. 10). In light of Dr. Cline's concurrence with Dr. Binder, we are not persuaded by her previous diagnosis of post concussion syndrome.

Dr. George also concurred with Dr. Binder's report. Dr. George stated: "There is certainly a functional component which is quite strong in this case. I want to be careful to not overlook a cervical strain and mild concussion, which were thought to be present by Dr. Martha Cline, neurologist." (Ex. 11). Since there is no indication that Dr. George was aware of Dr. Cline's subsequent concurrence with Dr. Binder, Dr. George's reliance on Dr. Cline's earlier report is misplaced.

After reviewing Dr. Binder's report and the concurrence letters from Drs. Cline and George, Dr. Rosenbaum reported that the "psychological exam speaks for itself." (Ex. 12). He reported that he thought claimant had no objective abnormalities and a prominent functional overlay, but he could not personally make the diagnosis of malingering. In light of Dr. Rosenbaum's subsequent report, we are not persuaded by his earlier diagnosis of post concussion syndrome.

Although Dr. Aversano diagnosed claimant with "[c]ranial cerebral trauma with post-concussion syndrome" and "[l]abyrinthine concussion -- doubt, but consider perilymphatic fistula," there is no evidence in the record that Dr. Aversano was aware of Dr. Binder's diagnosis of malingering or with the concurrences from claimant's prior treating physicians. (Ex. 11A). For that reason, we are not persuaded by Dr. Aversano's diagnosis of claimant's condition. Similarly, there is no evidence in the record that Dr. Miller was aware of Dr. Binder's diagnosis of malingering or with the concurrences from claimant's prior treating physicians.

Nevertheless, claimant did sustain an injury to his head. In light of Dr. Binder's report that acknowledges that claimant had a head injury of an "extremely mild nature" and Dr. George's original diagnosis of "[s]tatus post head contusion" and "mild concussion suspected," we conclude that claimant's compensable conditions are a head contusion and a mild concussion. Consequently, to the extent that SAIF's denial purports to deny claimant's injury claim for those conditions, the denial is set aside.

Penalties for Unreasonable Denial

Claimant argues that penalties for unreasonable denial are appropriate since the evidence suggesting that the incident could not have occurred is not credible. Claimant asserts that the medical opinions support the conclusion that claimant did suffer an on-the-job injury.

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[1] We note that after the ALJ's order, the legislature enacted Senate Bill 369, which amended ORS 656.005(19). Or Laws 1995, ch. 332, § 1(19) (SB 369, § 1(19)). We need not determine the retroactive effect of this amendment, inasmuch as under the current, as well as the former, version of the statute, we would find that claimant's injury was supported by objective findings.

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." Amended ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and " legitimate doubt" are to be considered in the light of all the evidence available. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

At the time SAIF issued its denial, it was aware of Dr. Binder's report that cast considerable doubt on claimant's credibility, his symptoms and his version of the injury. In light of Dr. Binder's report, we conclude that SAIF had a legitimate doubt as to its liability. Consequently, its denial was not unreasonable.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's 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 January 13, 1995 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld SAIF's denial insofar as it pertained to claimant's head contusion and mild concussion is reversed. The claim is remanded to SAIF for processing in accordance with law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's attorney is awarded $3,000, payable by SAIF.

September 21, 1995 Cite as 47 Van Natta 1683 (1995)

In the Matter of the Compensation of
SUSAN L. KOZLOWSKI, Claimant
WCB Case No. 94-01709
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of her occupational disease claim for a mental disorder. In its respondent's brief, the insurer moves to strike portions of claimant's brief. On review, the issues are motion to strike and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following modification and supplementation. We do not adopt the ALJ's ultimate finding of fact.

The employer is in the hotel and restaurant business. Claimant was hired in 1989 as a bookkeeper in the accounts payable department of the restaurant division. Mr. Hayden was the head of that division.

As bookkeeper, claimant was paid $1,450 per month. (Tr. 11). Claimant was promoted to general ledger in October 1989, with an increase in job duties and an increase in pay to $1,500 per month. (Tr. 12, 13). Claimant was promoted to lead general ledger, at a pay rate of $1,600 per month, and, in February 1993, to administrative assistant to Mr. Hayden, at a rate of $1,875 per month. (Tr. 13, 14, 117). Claimant's positions as bookkeeper and general ledger were clearly nonexempt from the payment of overtime. Claimant continued to perform general ledger work as part of her administrative assistant duties.

In September 1993, Mr. Hayden offered, and claimant accepted, a promotion that would entail supervisory responsibilities and an increase in pay.

CONCLUSIONS OF LAW

Motion to Strike

The insurer moves to strike the portions of claimant's brief that refer to the Federal Fair Labor Standards Act (FLSA) and related federal case law, on the basis that, to the extent that claimant is asking the Board to take actions in this forum based on the federal cases, they are beyond the jurisdiction of the Board.

Although we have no authority to consider additional evidence not admitted at the hearing and not a part of the record, we may take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 656.295; Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); ORS 40.065(B). We have previously taken official notice of, e.g., the laws of the state of California. James D. Yerby, Jr., 43 Van Natta 2549 (1991). Consequently, we may take administrative notice of federal laws and cases which may be relevant to the facts of this case.

In her brief, claimant contends that her demotion by the employer was in retaliation for her exercise of rights under the FLSA, and such action was therefore illegal and not "reasonable" within the meaning of ORS 656.802. Absent more than an allegation, we find claimant's references to the FLSA not relevant to the facts of this case.

Compensability

The ALJ found that claimant had established that: (1) she had been diagnosed with a mental disorder which is generally recognized in the medical or psychological community; (2) the employment conditions producing the mental disorder existed in a real and objective sense; and (3) the employment conditions were conditions other than conditions generally inherent in every working situation. See ORS 656.802(3). We adopt the ALJ's findings establishing these statutory requirements. However, the ALJ found that claimant's demotion was the result of reasonable disciplinary actions by the employer and that, therefore, her claim was not compensable. We disagree.

Beginning in 1991, the employer began to downsize its restaurant division, which resulted in the elimination and consolidation of some jobs and changes in some job duties and classifications.

In the spring of 1993, claimant was promoted to administrative assistant to Mr. Hayden, the director of operations for the restaurant division. In addition to administrative assistant duties, claimant continued to perform general ledger work, which, by late summer of 1993, occupied 30 to 40 percent of her time, due to the restaurant division downsizing. (Tr. 96).

Prior to claimant's promotion, the administrative assistant position had been exempt from the payment of overtime, but, because of changing job duties due to downsizing, the employer's attorney determined that the position was nonexempt, as the "management" duties of the administrative assistant had been moved to the hotel division. (Tr. 95, 99,105, 123, 131).

When claimant accepted the administrative assistant position, Mr. Hayden told her that her new position was exempt, so she stopped submitting biweekly overtime hours. Mr. Hayden told claimant to keep track of her schedule and duties, including who she was "managing." (Tr. 41, 99). In June 1993, claimant became aware that Mr. Hayden had been keeping track of her hours, including overtime. (Tr. 19, 111). Claimant offered to keep track of her hours for him, which she did. (Tr. 41).

In September 1993, claimant attempted to use some "comp time" (the use of overtime hours in place of vacation hours), which she had done in the past. Because Mr. Hayden was away, claimant was referred to the Human Resources Department. Ms. Harman, the Assistant Human Resource Director and General Office Manager of the corporate office, told claimant that the employer's attorneys had classified her administrative assistant position as nonexempt and asked her if she wanted to be paid for her accrued overtime. Claimant said "Yes." (Tr. 17, 18, 19, 20, 91, 92).

Meanwhile, just prior to claimant's payment for accrued overtime, Mr. Hayden offered claimant a supervisory position and an increase in pay, which she accepted. (Tr. 21, 46, 51, 88, 91, 92, 102, 106, 127, 128). This new position would have been classified as exempt from overtime. (Tr. 127, 128).

After Mr. Hayden was informed by Ms. Harman that claimant had made a claim for her accrued overtime, which he authorized, he became irate. He refused to speak with claimant, and, through Mr. Harman (who shared Ms. Harman's position as Human Resources Director), he summarily withdrew the new job offer and demoted claimant to general ledger. (Tr. 23, 25, 27, 113, 128, 129, 130, 133). Claimant refused to take the general ledger job because she was upset by Mr. Hayden's reaction and was afraid to continue with him as her supervisor. Instead, claimant interviewed for a position in the maintenance department, but she was informed that it was unavailable due to a hiring freeze. (Tr. 27, 149). Claimant then left her employment with the employer.

Claimant filed a claim for work-related stress. She was subsequently treated by Dr. Johnson, psychiatrist, who diagnosed claimant with "Mixed Disorder as a reaction to Stress with Physical and Emotional symptoms," (ICD-9 308.4). (Ex. 8-3).

Two issues are raised on review: (1) whether claimant has a mental disorder; and (2) whether the employer's disciplinary action was reasonable.

The insurer contends that claimant does not have a mental disorder by definition, citing to the diagnosis provided by Dr. Johnson. We disagree. Subsequent to the demotion by Mr. Hayden, claimant sought treatment for her symptoms of anxiety from Dr. Johnson, psychiatrist, on three occasions. Dr. Johnson had claimant complete a symptom Check List-90 and an MMPI-II before diagnosing Mixed Disorder as a reaction to stress with physical and emotional symptoms, a diagnosis recognized by the World Health Organization. See DSM-III-R, Appendix E, Page 433 ff. (APA, 1987). Under such circumstances, we conclude that this mental disorder, diagnosed by Dr. Johnson, a psychiatrist, is one that is recognized in the medical or psychological community. See ORS 656.802(3)(c); Ronald V. Dickson, 42 Van Natta 1102, 1108-09 (1990), aff'd Dickson v. Carolina Casualty, 108 Or App 499 (1991).

Claimant contends that her demotion ws not a reasonable disciplinary action. We agree.

The ALJ found that claimant was an "at will" employee and that her demotion was a reasonable disciplinary action by the employer, since she had displeased her supervisor and the action was taken within the scope of his supervisory authority. We disagree with the ALJ's reasoning and conclusions and reverse.

Whether or not discipline is reasonable must be decided on a case-by-case basis, taking into account the particular facts of the case. David B. Koepping, 46 Van Natta 751 (1994). Moreover, reasonable disciplinary procedures involving an employee require sufficient notice of what constitutes a transgression inviting discharge or demotion. Id.

Here, claimant had an exemplary work record, advancing rapidly and carrying her share of the workload in the difficult environment of downsizing. Her abilities are evidenced by the employer's offer of a promotion to a supervisory position. Thus, there is no evidence that claimant's work performance contributed to her demotion. Instead, the precipitous demotion appears to be summary punishment for claimant's assertion of her right to accrued overtime pay.

The employer had been informed by its counsel that claimant's position was not exempt from the payment of overtime. Nevertheless, Mr. Hayden, claimant's supervisor, misled claimant to believe that her position was exempt. This is underscored by the fact that there was no disagreement by the supervisor that claimant's overtime had been validly accrued: he authorized payment. Thus, rather than clearly communicating to claimant that she was entitled to overtime in her administrative position, and continuing the former procedure of submitting overtime hours on a regular basis, the supervisor, at best, created the problem. Although claimant was aware of her supervisor's dislike of the "storing" of overtime hours, his telling her that her position was exempt subsequently led to the discovery that she was owed a considerable lump sum in overtime pay. Moreover, claimant's supervisor did not inform her that her personal "storing" of overtime hours would subject her to demotion. We conclude that the employer's action of summarily demoting claimant in retaliation for claiming her earned pay did not constitute reasonable discipline.

We also conclude that the actions taken were not conditions generally inherent in every working situation. On the contrary, the facts of this case are extremely unusual. An employee is normally told whether his or her position is exempt or nonexempt from overtime, particularly where the position had been evaluated by the employer's attorney and that information was known in the corporate headquarters and, presumptively, by claimant's supervisor. In sum, we conclude that being subject to severe discipline that does not comport with the most fundamental tenets of personnel administration is not a condition that is generally inherent in every working situation.

Accordingly, we conclude that claimant has established, by clear and convincing evidence, that work-related stressors, not otherwise excluded by statute, were the major contributing cause of the mental disorder. Therefore, we reverse the ALJ's order and set aside the employer'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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 1, 1994 is reversed. The insurer's denial is set aside and claimant's claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,500, payable by the insurer.

In the Matter of the Compensation of
DEANA F. MARSHALL, Claimant
WCB Case No. 92-09708
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
James W. Moller (Saif), Defense Attorney

Reviewed by the Board en banc.[1]

This matter is before the Board on remand from the Court of Appeals. SAIF v. Marshall, 130 Or App 507, rev den 320 Or 492 (1994). The court reversed our prior order, Deanna F. Marshall, 45 Van Natta 1680 (1993), which, in affirming an ALJ's order that set aside SAIF's denial of claimant's right shoulder and arm claim, held that ORS 656.128(3) does not require corroborative evidence of compensability, as distinguished from coverage, from sole proprietors claiming coverage under that statute. Concluding that ORS 656.128(3) requires sole proprietors or partners making a claim for compensation under that statute to provide corroborative evidence concerning the facts essential to compensability, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a hairdresser, is a sole proprietor. In April 1992, she filed a claim for a right shoulder and arm condition, allegedly caused by her work activities. As a sole proprietor, claimant may elect, under ORS 656.128,[2] to have workers' compensation coverage. That statute provides, in pertinent part:

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[1] Member Hall has recused himself from participation in the review of this case. See OAR 438-11-023.

[2] ORS 656.128 was amended by Senate Bill 369, 68th Leg., Reg. Sess., § 11 (June 7, 1995). However, those amendments do not change our analysis in this case.

"(3) No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant."

The ALJ found that ORS 656.128(3) was not applicable, holding that the statute requires corroborative evidence only of workers' compensation insurance coverage, not of compensability. On review, we agreed that ORS 656.128(3) relates to coverage rather than compensability, relying on our earlier decision in Ricky A. Stevens, 38 Van Natta 148, 151-52 (1986). Deanna F. Marshall, supra.

On appeal, the Court of Appeals reversed our decision. Reasoning that the statutory text clearly provides that the corroborative evidence requirement pertains to "facts essential to the allowance or payment of claims for compensation, i.e., compensability," the court concluded that "[s]ole proprietors or partners making claims for compensation by virtue of ORS 656.128 must present corroborative evidence of compensability." SAIF v. Marshall, supra, 130 Or App at 510. Therefore, the court has remanded for reconsideration of the question of whether there is corroborative evidence of the compensability of claimant's claim. In accordance with the Court's mandate, we proceed with our reconsideration.

On remand, claimant has moved to remand to the ALJ for the taking of additional evidence consistent with the court's decision. SAIF opposes the motion. We deny claimant's motion.

We may remand to the ALJ for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis 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); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board).

Here, claimant contends that the record is incompletely developed because SAIF did not timely raise the ORS 656.128(3) "defense." In addition, claimant contends that the evidence could not have been obtained at hearing because the court developed a new interpretation of the statute, departing from prior caselaw that interpreted the statute. On these grounds, claimant contends that there is a compelling reason to remand to the ALJ. We disagree.

ORS 656.128(3) provides that no claim shall be allowed or paid, except upon corroborative evidence in addition to the evidence of the claimant. It is claimant's burden to prove the compensability of her claim. ORS 656.266. Thus, we find that ORS 656.128(3) sets forth an element of claimant's proof of her claim as a sole proprietor. We do not find that the statute sets forth merely a potential affirmative defense. Therefore, we reject claimant's argument regarding SAIF's alleged failure to timely raise a "defense."

In any event, we note that SAIF announced its potential reliance on ORS 656.128(3) at the beginning of the hearing. (Tr. 3). Claimant failed to ask for a continuance in order to present evidence in light of ORS 656.128(3), either at the beginning of the hearing, or during post-hearing argument. Likewise, she did not seek remand on review, but rather alternatively argued that the record supported the compensability of her claim. Finally, claimant has not argued on remand that she was unable to obtain relevant evidence at the time of the hearing. Under such circumstances, we conclude that claimant has failed to prove that relevant evidence could not have been obtained at the hearing.

Finally, we reject claimant's argument that she is entitled to remand on the ground that the Court of Appeals announced a "new" statutory interpretation, departing from prior caselaw. The court stated that its decision was one of first impression, noting that no reported cases had previously construed ORS 656.128(3). SAIF v. Marshall, supra, 130 Or App at 509. The only Board decision cited by the parties, Rickey A. Stevens, 38 Van Natta 148 (1986), did not address the question of the scope of the corroborative evidence requirement under ORS 656.128(3). In other words, the Stevens decision held that corroborative evidence of coverage was required, but it did not address whether the statute also required corroborative evidence of compensability.

Thus, the circumstances here are analogous to the circumstances under which the Board reconsidered its decision on remand in Rosalie S. Drews, 46 Van Natta 408, recon den 46 Van Natta 708 (1994). In Drews, we held that the court's interpretation of a statute, when there was no prior caselaw interpreting the statute, was not a compelling reason to remand to the Hearings Division for the taking of additional evidence. We reasoned that "every party is presented with such circumstances when litigating a claim under a new statutory enactment or amendment." Drews, supra, 46 Van Natta at 410. An analogous situation is present here, where there have been no prior cases interpreting ORS 656.128(3). Under such circumstances, we conclude that there is no compelling basis for remand.

We proceed with our reconsideration of the merits of the claim. As a sole proprietor, claimant elected, under ORS 656.128, to have workers' compensation coverage, and she may recover under that statute. ORS 656.128(3) provides that "[n]o claim shall be allowed or paid. . . except upon corroborative evidence in addition to the evidence of the claimant." The Court of Appeals held that the statute requires corroborative evidence of compensability, specifically stating that "the corroboration requirement pertains to facts essential to the allowance or payment of claims for compensation." Marshall, supra, 130 Or App at 510. Thus, claimant, as a sole proprietor claiming compensation under ORS 656.128, must provide corroborative evidence of compensability in order to establish the compensability of her claim. One of the elements of compensability is causation. See ORS 656.005(7)(a); 656.802.

We turn now to determining the meaning of the term "corroborative evidence." To resolve this issue, we must ascertain what the legislature intended when it enacted ORS 656.128(3). ORS 174.020. We begin with the text and context of the statute. ORS 174.020. At this first level of analysis, we consider the context of the statutory provision at issue, as well as rules of construction of the statutory text that bear directly on how to read the text. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-12 (1993). For example, we consider the rule that "words of common usage typically should be given their plain, natural, and ordinary meaning." Id. at 611 (citations omitted). If the legislature's intent is clear from the inquiry into text and context, further inquiry is unnecessary. Id.

The plain and ordinary meaning of the term "corroborate" is "to confirm by law, to give confirmation of or evidence to support." The New Lexicon Webster's Encyclopedic Dictionary of the English Language (1989). Similarly, Black's Law Dictionary (5th edition 1979) defines "corroborating evidence" as "evidence supplementary to that already given and tending to strengthen or confirm it. Additional evidence of a different character to the same point." Under ORS 656.128(3), the corroborative evidence must be in addition to the evidence of the claimant. Thus, considering the text of the statute, we conclude that the corroborative evidence must be supplementary to and of a different character from claimant's evidence.

Claimant relies on the consistent medical histories, as well as her own consistent statement to SAIF's investigator (Ex. 16), for corroborative evidence. We find that neither the medical reports nor claimant's statement constitute corroborative evidence in addition to the evidence of the claimant. Claimant's statement to the investigator is clearly not supplementary to nor different in character from claimant's evidence, since it is merely claimant's own testimony.

To the extent claimant relies on medical reports for corroborative evidence regarding causation, we find that the medical reports do not constitute corroborative evidence. Medical reports presented by claimants for compensation constitute prima facie evidence as to the matters contained therein. ORS 656.310(2). However, in Zurita v. Canby Nursery, 115 Or App 330, 334 (1992), rev den 315 Or 443 (1993), the court held that medical reports are prima facie evidence only of medical matters, not of causation. Thus, in Zurita, the court held that evidence of causation contained in the medical reports was not sufficiently persuasive to carry claimant's burden of proof. Id.

Here, to the extent that medical reports tend to corroborate causation, they do so based only on the history provided by claimant to the medical providers. (See e.g., Exs. 1, 4). Yet, the history provided to the medical providers is no more than claimant's evidence; that is, her own testimony. Thus, we conclude that the medical reports do not corroborate claimant's testimony regarding causation, since the medical histories, which conceivably could corroborate causation, are no more than claimant's own description of causal circumstances. The medical reports corroborate the existence of a medical condition, but they do not corroborate the cause of that condition.

To hold otherwise would render meaningless the statutory mandate that corroborative evidence must be in addition to the evidence of the claimant. If a physician could corroborate the claimant's evidence simply by reciting as medical history what the claimant told the physician, the requirement for corroborative evidence in addition to the evidence of the claimant would be effectively eliminated.

While we recognize that it is more difficult for sole proprietors and partners to prove the compensability of their claims under the statute, the difficulty is not insurmountable. For example, corroborating evidence could be provided by another person who saw the injury happen, or by a person who could confirm that an injury happened at some time during a particular day (e.g., by someone who saw the claimant before and after work). Corroborating evidence could also be provided by testimony that the piece of equipment that caused the injury is located only at the claimant's workplace. In this case, for example, corroborating evidence could have been provided by the hairdressers who leased work space from claimant, or by her husband, regarding the type of activities involved in hair styling, claimant's arm complaints, or the increased hours claimant worked in early 1992. (See Tr. 13-15, 47). Here, however, claimant did not present such corroborating evidence.

In conclusion, we hold that the record contains no corroborative evidence of compensability, in addition to claimant's evidence. Therefore, claimant's claim fails under ORS 656.128(3).

Accordingly, the ALJ's order dated January 13, 1993 is reversed. The SAIF Corporation's denial of June 4, 1992 is reinstated and upheld. The ALJ's attorney fee award is reversed.

IT IS SO ORDERED.

Board Member Gunn dissenting.

I agree with my colleagues that the "corroborative evidence" requirement in ORS 656.128(3) was designed to defeat fraudulent claims asserted by sole proprietors. Such an interpretation is likewise consistent with the court's reasoning that the statutory requirement "more plausibl[y]" reflected a "legislative concern that sole proprietors or partners might seek compensation for nonwork-related conditions." Unfortunately, the majority has so narrowly construed "corroborative evidence" that even legitimate claims will be defeated. Because that is a result clearly not intended by the legislature, I must dissent.

ORS 656.128(3) provides that "[n]o claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant." Unlike my colleagues, I believe the medical reports in the record constitute "corroborative evidence in addition to the evidence of the claimant."

Dr. Rabie, who examined claimant, concluded that claimant's right hand, elbow and shoulder conditions were due to the "repetitive and fast type of activity carried out in hair dressing." He added that "having worked five to six hours per day is probably a significant aggravating factor." (Ex. 1-2). The majority dismissed Dr. Rabie's report because it was based on history claimant provided to the doctor concerning her work activity.

However, Dr. Rabie's medical opinion is not merely a reflection of claimant's history; it is also based on the doctor's own medical training, experience, expertise and judgment. That is, Dr. Rabie's opinion is a medical judgment that claimant's conditions were caused by the type of extensive, repetitive hand and arm activity which claimant performed at work. Although claimant told the doctor that she performed such activity at work, it was Dr. Rabie who related claimant's conditions to the activity, based on his medical knowledge of the physiological impact of such activity on the human body. Thus, Dr. Rabie's opinion is of a different character from claimant's history, which tends to support and confirm claimant's claim.

The majority, on the other hand, suggests that claimant should have presented corroborative evidence, in the form of witness testimony, concerning the type of activities she performed at work, her arm complaints, or the increased hours she worked in 1992. In effect, the majority is requiring that sole proprietors, as well as partners and independent contractors, provide sufficient non-claimant evidence to establish the claim. I suspect that in instances where the claimant works alone, (as often happens in sole proprietorships), the majority would be satisfied with nothing less than a videotape of claimant's work activities, to independently establish the claim. That would be an absurd result. By definition,

"corroborative evidence" is evidence tending to support the claim; it need not independently establish the claim. There is no need for the majority to go further then the legislature intended to prevent fraudulent claims.

Accordingly, I would conclude that Dr. Rabie's medical opinion constitutes corroborative evidence, in addition to claimant's evidence, of the compensability of her condition, consistent with ORS 656.128(3). Based on that opinion, I would find claimant's claim to be compensable and affirm the ALJ's order setting aside SAIF's denial.

September 21, 1995 Cite as 47 Van Natta 1690 (1995)

In the Matter of the Compensation of
SUN C. ST. JOHN, Claimant
WCB Case No. 93-08749
ORDER ON REVIEW
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Hall and Haynes.

A medical service provider requests review of those portions of Administrative Law Judge (ALJ) T. Lavere Johnson's order that modified a Director's medical services dispute order under former ORS 656.327 by finding that the provider was not entitled to reimbursement for a diagnostic study from either claimant or the self-insured employer. On review, the issues are jurisdiction and, alternatively, medical services. We vacate the ALJ's order and dismiss the claimant's and the self-insured employer's hearing requests.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's January 6, 1992 lumbar CT scan for a compensable low back condition was a noncompensable claim cost and, hence, that neither claimant nor the employer was responsible for providing reimbursement to the medical service provider. The ALJ determined that this case arose under former ORS 656.327(1)(a). The medical service provider asserts that this case is governed by former ORS 656.245. In either case, we lack jurisdiction over this matter.

Both ORS 656.327 and 656.245 were amended by the 1995 legislature. Or Laws 1995, ch 332, §§ 25, 41 (SB 369, §§ 25, 41). Our first task is to determine whether those amendments apply to this case. They do.

Except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565 (1995) (interpreting SB 369, § 66(1) and (5)(a)[1]); see Walter I. Keeney, 47 Van Natta 1387 (1995) (amended ORS 656.327 and 656.245(6) apply to actions currently pending before the

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[1] Section 66(1) provides:

"Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

Section 66(5)(a) provides: "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which an order or decision has become final on or before the effective date of this Act."

SB 369 went into effect on June 7, 1995, the day the Governor signed the bill into law. See SB 369, § 69 (declaring emergency); Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) (effective date of act containing emergency clause is day Governor signs it).

Board).[2] Amended ORS 656.327 and 656.245 are not among the exceptions to this general rule. See SB 369, § 66 (listing exceptions to general retroactivity provision). Consequently, they govern this matter.[3] E.g., Walter L. Keeney, supra. We now address the effect of each amended statute separately.

Amended ORS 656.327(1) provides that, if an injured worker, a carrier or the Director believes that an injured worker's medical services, not subject to ORS 656.260,[4] are excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." SB 369, § 41 (emphasis added). The Director now has exclusive jurisdiction over all ORS 656.327(1) medical services disputes, including those that are currently pending before the Board. E.g., Walter I. Keeney, supra.

Assuming that this is a "327" case, exclusive jurisdiction over this matter now rests with the Director. Walter L. Keeney, supra. Accordingly, we lack jurisdiction to address the merits of this dispute.

We reach the same conclusion under amended ORS 656.245. Amended ORS 656.245(6) provides:

> "If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550." SB 369, § 25.

The Director has exclusive jurisdiction over medical services disputes arising under ORS 656.245, so long as the compensability of a worker's underlying claim is not contested. Thomas L. Abel, 47 Van Natta 1571 (1995).

Here, no one contests the compensability of claimant's underlying claim for her compensable low back condition. Rather, the dispute pertains to whether a medical service provider should be reimbursed for a diagnostic study. Accordingly, if this is characterized is a "245" case, the Director now has exclusive jurisdiction over it.

In sum, regardless of whether this claim arises under ORS 656.327 or 656.245, neither we nor the Hearings Division has jurisdiction over it. Consequently, we vacate the ALJ's decision modifying the Director's medical services order and dismiss claimant's hearing request. In light of this decision, we do not reach the medical services issue.

ORDER

The ALJ's order dated December 30, 1994 is vacated. Claimant's hearing request is dismissed.

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[2] Board Member Hall acknowledges that he is bound by the majority's decision in Keeney. However, for the reasons stated in his dissent in Keeney, he would object to the retroactive application of SB 369 to the instant case.

[3] Under section 66(6) of SB 369, amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively. Cigna Insurance Co. v. McMasters, 135 Or App 583 (1995). Because amended ORS 656.327(1) and 656.245(6) do not alter procedural time limitations, section 66(6) does not apply to them.

[4] ORS 656.260 concerns managed care organizations, which are not at issue here.

In the Matter of the Compensation of
JANET ANDERSON, Claimant
WCB Case No. 94-04828
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Christian, Hall and Neidig.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's claim for a torn lateral meniscus and proposed surgery; (2) awarded claimant interim compensation; (3) awarded an attorney fee under ORS 656.382(1) for the insurer's allegedly unreasonable failure to pay interim compensation; and (4) assessed a penalty for the insurer's allegedly unreasonable denial. On review, the issues are compensability, jurisdiction, proposed surgery, interim compensation, penalties and attorney fees. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with two exceptions. We do not adopt the ultimate findings of fact and we change the eighth paragraph on page 2 to reflect that the MRI examination was on April 15, 1993, rather than April 15, 1994.

CONCLUSIONS OF LAW AND OPINION

Request to Reopen the Record

In regard to the issues of interim compensation and proposed surgery, the ALJ found that the insurer had not established that it had provided claimant with the necessary notice of the managed care organization (MCO) and its limitations before claimant sought medical services from Dr. Puziss. After the ALJ 's order, the insurer requested reconsideration, arguing that both claimant and Dr. Puziss were aware of MCO limitations before she sought treatment with Dr. Puziss. The insurer attached copies of two letters dated March 23, 1993 from the insurer to claimant and the medical providers that provided notice of the MCO limitations. On reconsideration, the ALJ denied the insurer's request to reopen the record because the letters had been available at the time of the hearing and the insurer had not established circumstances that were beyond its control to justify reopening the record.

On review, the insurer argues that the ALJ erred in declining to reopen the record. According to the insurer, the admission of these exhibits will affect the final resolution of issues in this case. We disagree.

OAR 438-07-025(1) allows an ALJ discretion to reopen the record for consideration of new material evidence. OAR 438-07-025(2) provides that the party moving for reconsideration must provide an explanation why such "newly discovered evidence" could not reasonably have been discovered and produced at the hearing. Renia Broyles, 42 Van Natta 1203 (1990). We review the ALJ's evidentiary rulings for abuse of discretion. Id.

The insurer asserts that the specific issue was raised by the ALJ on his own initiative and the insurer was surprised by the ALJ's ruling. Since the insurer presented evidence at hearing as to whether Dr. Puziss was a member of the MCO and how it affected the insurer's claims processing decisions, we reject the insurer's contention that this issue was raised by the ALJ on his own initiative.

We agree with the ALJ that the exhibits at issue could reasonably have been discovered and produced at the hearing. Consequently, we conclude that the ALJ did not abuse his discretion by declining to reopen the record.

In any event, even if we considered the exhibits, the result in this case would not be changed. Under OAR 436-15-035(1), the insurer could not require claimant to seek treatment through an MCO

because it had not yet accepted her claim.[1] Therefore, to the extent that the insurer's argument can be construed as a motion to remand, we deny such motion because the evidence that the insurer seeks to have introduced is not reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Compensability of Torn Lateral Meniscus

In January 1986, Dr. Loch performed arthroscopic surgery to repair a torn medial meniscus in claimant's right knee. Claimant returned to regular work in April 1986 and regained full use of her right knee. Claimant did not have any medical treatment for her right knee until March 2, 1993, when she fell at work. Before the March 1993 injury, claimant performed her regular work activities without difficulty. She also regularly played tennis and walked.

The insurer accepted the claim for a nondisabling right knee contusion on March 23, 1993. On April 15, 1993, an MRI examination revealed a torn lateral meniscus and other degenerative conditions of the right knee. On June 20, 1994, the insurer denied benefits for the torn right lateral meniscus and degenerative arthritis in the medial compartment of the right knee, and denied claimant's request for knee surgery.[2]

There are five opinions addressing the cause of claimant's torn lateral meniscus.[3] Dr. Puziss reported that it was "quite clear" that claimant had sustained a torn lateral meniscus as a result of her March 1993 injury. (Ex. 43). Dr. Puziss noted that all of claimant's current symptoms were lateral rather than medial and that claimant had no knee pain before the injury despite the arthritis in the medial compartment of her right knee. Dr. Puziss reported that claimant had not previously had lateral symptoms, but she had been symptomatic laterally since the March 1993 injury. Dr. Puziss explained that the "fact that [claimant] had no symptoms of medial arthritis before and still has no symptoms of medial arthritis indicate[s] that the pathology is lateral and the injury which is work related, is also lateral." (Id). Dr. Puziss concluded that the major need for treatment was the result of the work injury.

The insurer argues that Dr. Puziss' opinion should be discounted because it is based on an inaccurate history. The insurer describes claimant's history as one of ongoing complaints of popping in the knee and pain with twisting of the knee. We disagree with the insurer's description of claimant's history. Although claimant testified that she had an occasional popping sound in her knee, she said that her knee never hurt or bothered her. Claimant has not had any medical treatment for her knee since 1986 and has not had any limitations on the use of her knee. Claimant testified that before the March 1993 injury, she performed her regular work activities without difficulty. She also regularly played tennis and walked. Inasmuch as Dr. Puziss relied on a history consistent with claimant's credible testimony, we find that Dr. Puziss' opinion was based on an accurate history. Furthermore, we are persuaded by his opinion because it is well-reasoned. See Somers v. SAIF, 77 Or App 259 (1986).

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[1] OAR 436-15-035(1) (WCD Admin. Order 4-1992) provided, in part: "An injured worker may seek treatment through an MCO, prior to claim acceptance and after a claim is denied, but shall not be required to do so."

Amended ORS 656.245(4)(a) provides, in part: "Workers subject to the [MCO] contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract." Or Laws 1995, ch 332 § 25(4)(a) (emphasis added). ORS 656.245(4)(a) also provides that a worker becomes subject to the contract "upon the worker's receipt of actual notice of the worker's enrollment" in the MCO. Since claimant was receiving treatment for a torn lateral meniscus, which had not been accepted, ORS 656.245(4)(a) does not apply.

Amended ORS 656.245(4)(b)(A) provides: "For initial or aggravation claims filed after the effective date of this 1995 Act, the insurer or self-insured employer may require an injured worker, on a case-by-case basis, immediately to receive medical services from the managed care organization." SB 369, § 25(4)(b)(A). Since the claim in this case was filed before June 7, 1995, the effective date of the act, ORS 656.245(4)(b)(A) does not apply. For purposes of this case, claimant was not subject to the MCO requirements.

[2] The ALJ concluded that the degenerative arthritis condition was not compensable because the March 1993 injury did not objectively worsen that condition. Since the parties do not contest that determination, we do not address it.

[3] Although Dr. O'Keefe issued an opinion on causation, he did not specifically discuss claimant's torn lateral meniscus. (Ex. 30). Therefore, his opinion has no probative value and we do not consider it.

The insurer relies on Dr. Loch's opinion. Although Dr. Loch performed knee surgery on claimant in 1986, he has not examined her since that time. Dr. Loch reviewed claimant's medical records and opined that the type of tear in claimant's lateral meniscus was a "wear and tear type" tear. (Ex. 50). Dr. Loch did not believe that the March 1993 fall by itself caused the lateral meniscus to tear. Rather, Dr. Loch believed that the preexisting "wear and tear" changes were the major contributing cause of claimant's torn lateral meniscus. Dr. Loch acknowledged that "a fall could accelerate the tear or complete a partial tear." (Id).

We do not find Dr. Loch's opinion persuasive because it lacks sufficient explanation. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Dr. Loch does not address the fact that claimant's right knee has been asymptomatic since 1986. Moreover, Dr. Loch does not distinguish between claimant's lateral and medial symptoms. Consequently, we afford Dr. Loch's opinion little probative value.

Drs. Breen, Corrigan and Mandiberg indicated that claimant's lateral meniscus tear appeared to be a new injury. However, they differed as to whether the lateral meniscus tear or claimant's preexisting arthritis was causing her current symptoms. Although Dr. Breen initially reported that it appeared that the lateral meniscus tear was new and that claimant's work injury was the major contributing cause of her problems, he later reported that it was more likely than not that her current right knee complaints were due to degenerative changes. (Ex. 28, 46). Because Dr. Breen did not offer an explanation for his change of opinion, we do not find his opinion persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987).

Dr. Mandiberg reported that claimant's meniscal tear was related to her March 1993 injury. (Exs. 41, 42). However, since Dr. Mandiberg said that the tear may or may not be one of claimant's symptomatic problems, we afford his opinion little probative weight.

Dr. Corrigan believed that claimant's lateral meniscus tear was most likely the result of her March 2, 1993 injury. (Ex. 39). However, Dr. Corrigan concluded that claimant's lateral meniscus tear was not producing any significant disability and the greater component of her symptoms was related to her preexisting degenerative arthritis in the medial compartment. (Ex. 39). In light of Dr. Puziss' comments that all of claimant's symptoms were lateral rather than medial, we are not persuaded by Dr. Corrigan's opinion.

In sum, we are persuaded by Dr. Puziss' well-reasoned opinion that claimant's March 2, 1993 injury was the major contributing cause of her lateral meniscus tear. Therefore, regardless of whether the appropriate standard of proof is major or material contributing cause, we conclude that claimant proved the compensability of the lateral meniscus tear.[4]

Jurisdiction over Proposed Surgery

The insurer denied compensability of claimant's torn right lateral meniscus and her request for surgery on the basis that the condition preexisted the March 2, 1993 incident and was not caused in major part by the incident or her work activities with the employer. (Ex. 45). The ALJ concluded that claimant was entitled to have the knee surgery proposed by Dr. Puziss. On review, the insurer argues that claimant is not entitled to the proposed surgery because the surgery requested by Dr. Puziss is neither reasonable nor necessary and Dr. Puziss was not a member of the MCO.

The 1995 legislature amended ORS 656.327(1) in Senate Bill 369, section 41, effective June 7, 1995. Amended ORS 656.327(1) provides that if an injured worker, a carrier, or the Director believes that an injured worker's medical services, not subject to ORS 656.260, are excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." (Emphasis added). SB 369, § 41(1). The legislature also added ORS 656.245(6), which provides that, if a medical services claim is disapproved for any reason other than the formal denial of compensability of the underlying claim and the disapproval is disputed, the injured worker or carrier "shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327." (Emphasis added). SB 369, § 25(6).

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[4] We need not address the applicability of the 1995 amendments to ORS 656.005(7)(a)(B) in this case since it would not affect our decision.

In Walter L. Keeney, 47 Van Natta 1328 (1995), we concluded that the amendments to ORS 656.327, as well as the new provision, ORS 656.245(6), apply to claims currently pending before the Board. We held that the language of amended ORS 656.327(1) and amended ORS 656.245(6) clearly revealed the legislature's intent that medical services disputes be resolved exclusively by the Director, not the Board or Hearings Division. Accordingly, based on the text and context of amended ORS 656.327(1), as read in conjunction with SB 369's retroactivity provisions (§ 66), we concluded that the Director has exclusive jurisdiction over ORS 656.327(1) medical services disputes, including those presently pending before the Board.

Here, although the claim for surgery was initially denied on the basis that the underlying claim was not compensable, we have concluded that claimant's torn right lateral meniscus claim is compensable. Therefore, the medical service dispute regarding proposed surgery no longer pertains to the compensability of claimant's underlying claim. Rather, the issue to be decided is whether the proposed surgery requested by Dr. Puziss is reasonable and necessary. Because jurisdiction over this matter rests with the Director, rather than the Hearings Division, we vacate the portion of the ALJ's order that purported to decide the issue of proposed surgery.[5] See Lynda J. Zeller, 47 Van Natta 1581 (1995).

Interim Compensation

The ALJ concluded that claimant was entitled to interim compensation from the time Dr. Puziss authorized time loss on March 15, 1994 until the denial was issued on June 20, 1994. The insurer argues that since Dr. Puziss did not qualify as an attending physician under the MCO rules, he could not authorize time loss.

Before the enactment of Senate Bill 369, a claimant was entitled to receive interim compensation for disability from the date the claim was filed until the claim was accepted or denied. See ORS 656.262(2); Bono v. SAIF, 298 Or 405 (1984); Jones v. Emanuel Hospital, 280 Or 147 (1977). ORS 656.262(4)(a), as amended, provides that the "first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." SB 369, § 28(4)(a). See also amended ORS 656.245(2)(b)(B) (a medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation). SB 369, § 25(2)(b)(B).

Here, we must first determine whether Dr. Puziss was claimant's attending physician. ORS 656.005(12)(b), as amended, provides, in part: "Except as otherwise provided for workers subject to a managed care contract, 'attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury * * *."

To begin, we reject the insurer's argument that Dr. Puziss could not authorize time loss because he did not qualify as an attending physician under the MCO rules. As we discussed earlier, OAR 436-15-035(1) provides that the insurer could not require an injured worker to seek treatment through an MCO prior to claim acceptance. For purposes of this case, claimant was not subject to the MCO requirements. At the time Dr. Puziss authorized time loss, claimant's torn lateral meniscus claim had not been accepted. Therefore, the fact that Dr. Puziss did not qualify as an attending physician under the MCO rules does not mean that he could not be her "attending physician" pursuant to ORS 656.005(12)(b).

On March 15, 1994, Dr. Puziss recommended surgery and limited claimant's work activities to four hours standing and one or two hours walking in an eight-hour day. (Ex. 43). On the same day, claimant signed a "change of attending physician form" requesting Dr. Puziss as her attending physician. (Ex. 44). Dr. Puziss signed the form on March 18, 1994. Under these circumstances, we find

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[5] We note that, unlike Walter L. Keeney, supra, the issue here is proposed medical services, rather than a request for reimbursement. OAR 436-10-046(3) (WCD Admin. Order 13-1992) provided that "when compensability of treatment is at issue before the Hearings Division of the Workers' Compensation Board or any other appellate body, the insurer may request director's review after the compensability is decided." The request for review must be submitted within 30 days of when the order finding then treatment to be compensable is resolved. Here, the time limits for seeking Director review of the proposed surgery issue are not triggered until we have issued a final order on the compensability issue. See OAR 436-10-046(3).

that Dr. Puziss was primarily responsible for claimant's treatment. Since Dr. Puziss is also a medical doctor, we conclude that he was claimant's "attending physician" pursuant to ORS 656.005(12)(b). Therefore, Dr. Puziss was qualified to authorize payment of temporary disability compensation. See amended ORS 656.262(4)(a). We agree with the ALJ that claimant is entitled to "interim compensation."

Penalty for Failure to Pay Interim Compensation

The ALJ assessed an attorney fee pursuant to ORS 656.382(1) for the insurer's failure to pay interim compensation.[6] Although the insurer's reason for not paying interim compensation was Dr. Puziss' non-membership in the MCO, the ALJ found that the insurer had not presented any evidence that it had notified claimant that she could not seek treatment or time loss from Dr. Puziss. The ALJ concluded that the insurer could not use its failure to provide notice to justify its failure to process the claim.

Here, the insurer had notice that claimant had been disabled by her torn lateral meniscus. The insurer's claims person testified that she had notice on March 21, 1994 that Dr. Puziss had authorized time loss for claimant. (Tr. 94, 95). The insurer did not pay interim compensation because Dr. Puziss was not an approved physician under the MCO. (Tr. 89). However, since the insurer had not accepted the claim, it could not require claimant to seek treatment through the MCO. See OAR 436-15-035(1). Thus, the insurer's purported reason for failing to pay interim compensation lacked a legal basis.[7] Under these circumstances, we agree with the ALJ that the insurer's failure to pay interim compensation was unreasonable.

Penalty for Unreasonable Denial

We adopt the ALJ's reasoning and conclusion regarding the penalty for unreasonable denial of benefits. See amended ORS 656.262(11)(a).

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). 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 concerning the compensability and interim compensation issues is $2,000, to be paid 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 and claimant's counsel's statement of services), the complexity of the issues, and the value of the interests involved. Since penalties and attorney fees are not "compensation" for the purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for defending such issues. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986). Finally, claimant is not entitled to an attorney fee for services on review regarding the proposed surgery issue.

ORDER

The ALJ's order dated August 19, 1994 is vacated in part and affirmed in part. That portion of the order which pertained to the issue of proposed surgery is vacated and claimant's request for hearing on that issue is dismissed for lack of jurisdiction. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by the insurer.

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[6] We note that ORS 656.382(1) was amended to provide an exception under section 42d. Section 42d applies to cases involving a dispute over compensation benefits pursuant to ORS 656.245, 656.260, 656.327 or 656.340. We note that section 42d is not applicable to the attorney fee issue in this case. SB 369, § 42b(1).

[7] For initial claims filed after June 7, 1995, we note that the carrier may "require an injured worker, on a case-by-case basis, immediately to receive medical services from the managed care organization." ORS 656.245(4)(b)(A) (SB 369, § 25(4)(b)(A)).

Board Member Neidig concurring in part and dissenting in part.

I agree with the majority's decision except for the portion of the order that adopts the ALJ's conclusion that claimant was entitled to a penalty for unreasonable denial of benefits. Accordingly, I dissent from that portion of the majority's decision.

The ALJ reasoned that, at the time of the denial, no doctor had provided any evidence that the March 2, 1993 injury was not at least a material contributing cause of the torn lateral meniscus. The ALJ found that the fact that the insurer had doubts about the major contributing cause was immaterial.

A penalty may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." Amended ORS 656.262(11)(a); SB 369, § 28(11)(a). The standard for determining unreasonable resistance to payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, at the time the insurer issued its denial, the insurer had medical evidence indicating that claimant could be subject to the major contributing cause standard imposed by ORS 656.005(7)(a)(B). The insurer had had conversations with Dr. Breen and Dr. Loch that indicated that claimant had a preexisting knee condition that could be the major cause of her current knee condition. Dr. Breen said that it was more likely than not that claimant's current complaints with respect to her right knee were due to degenerative changes in the knee. (Ex. 46). Dr. Loch opined that the pre-existing wear and tear changes in the knee were the major cause of claimant's torn lateral meniscus. (Exs. 44A & 50).

In light of the insurer's conversations with Drs. Breen and Loch, the insurer had a legitimate question as to which standard of proof applied, i.e., material or major contributing cause, and it had a legitimate doubt that the work injury was the major cause of the torn lateral meniscus. Therefore, the insurer's denial was not unreasonable. See Lauri A. Terrell, 46 Van Natta 2273 (1994) (no penalty assessed where the insurer was aware that the claimant would probably be subject to the major contributing cause standard and it had a medical report indicating that the claimant's preexisting condition was a significant cause of her back problems).

For these reasons, I respectfully dissent from that portion of the decision which assessed a penalty for an unreasonable denial.

Member Hall specially concurring and dissenting in part.

I agree with those portions of the majority opinion which denied the remand motion, found the surgery related to claimant's compensable condition, and awarded interim compensation, penalties, and attorney fees. I write separately to register my disagreement with the majority's decision regarding the propriety of the proposed surgery.

The record does not establish that the propriety of the proposed surgery was either denied, raised, or litigated at hearing. Under such circumstances, I consider it unnecessary to address the jurisdictional issue regarding the proposed surgery. However, had such an inquiry been required, I would then have determined that jurisdiction over such a dispute rests with the Director. See Walter L. Keeney, 47 Van Natta 1387 (1995).

In the Matter of the Compensation of
JASON S. PALMER, Claimant
WCB Case Nos. 94-13017 & 95-00583
ORDER ON REVIEW (REMANDING)
Coons, Cole & Cary, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) McCullough's order that set aside its denial of claimant's aggravation claim for a bilateral arm condition. Claimant cross-requests review of those portions of the order that: (1) declined to award interim compensation from August 19, 1994 to December 6, 1994; and (2) declined to assess penalties or attorney fees for allegedly unreasonable claim processing. On review, the issues are aggravation, interim compensation, penalties and attorney fees. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ's order addressed whether claimant had established the compensability of his current bilateral arm condition as either an aggravation of his accepted 1990 occupational disease claim or as a new occupational disease claim with the same employer, as well as interim compensation and penalty issues that flowed therefrom. The ALJ concluded that claimant's increased upper extremity symptoms caused claimant's disability and were sufficient to establish an aggravation claim. For the following reasons, we vacate the ALJ's order and remand.

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.273(1) to read in part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by evidence of an actual worsening of the compensable condition supported by objective findings." Or Laws 1995, ch 332, § 31 (SB 369, § 31) (emphasis added). Under former ORS 656.273(1), either a symptomatic worsening or a pathologic worsening was sufficient to establish an aggravation. See, e.g., Caroline F. Wood, 46 Van Natta 2278 (1994). The 1995 amendments do not define the term "actual worsening."

Except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, have not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565 (1995). Because amended ORS 656.273(1) is not among the exceptions to this general rule, see SB 369, § 66 (listing exceptions to general retroactivity provision), the amended version of the statute now governs this matter.[1] See Bills Kwik Market v. Wood, 135 Or App 692 (1995).

We may remand a case for further evidence taking if we find that the case 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, supra, 79 Or App at 420. A compelling basis for remand exists when the record is devoid of evidence regarding a legal standard that goes into effect while Board review of a case is pending. See, e.g., Troy Shoopman, 46 Van Natta 21, 22 (1994) (case remanded to ALJ because record devoid of evidence regarding legal standard recently announced by Supreme Court); see also Betty S. Tee, 45 Van Natta 289 (1993) (Board remanded matter to ALJ in light of Supreme Court's intervening definition of relevant statutory term); cf. Rosalie S. Drews, 46 Van Natta 408, recon den 46 Van Natta 708 (1994) (Board declined to remand case to ALJ for additional evidence under Supreme Court's recent interpretation of statute, when record was sufficiently developed to analyze issue under that interpretation).

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[1] Under section 66(6) of SB 369, amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively. Motel 6 v. McMasters, 135 Or App 583, 587 (1995). Because ORS 656.273(1) does not alter a procedural time limitation, section 66(6) does not apply to this case.

Here, while Board review of this matter was pending, the "actual worsening" standard of amended ORS 656.273(1) went into effect. The record contains evidence that claimant's 1994 condition constituted a symptomatic worsening of his compensable bilateral arm condition.[2] However, the record is insufficiently developed to assist us in determining whether claimant sustained an "actual worsening" of his condition. See Helen M. Callander, 47 Van Natta 1626 (1995).

Under the circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant sustained a compensable aggravation. Moreover, because amended ORS 656.273(1) went into effect after this record was developed and while Board review of this matter was pending, we find that there is a compelling reason to remand for the submission of additional evidence regarding whether claimant sustained an "actual worsening" with respect to his bilateral arm condition.[3] Finally, since the interim compensation and penalty issues are inter-related with the aggravation claim and the "actual worsening" requirement, we also consider it appropriate to return those issues to the hearing level for further development.

Accordingly, the ALJ's order dated February 21, 1995 is vacated. This matter is remanded to ALJ McCullough for further proceedings regarding the compensability of claimant's aggravation claim and his new occupational disease claim for his bilateral arm condition, as well as the interim compensation and penalty claims that flow therefrom. Those proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[2] The evidence supporting claimant's 1994 aggravation claim suggests that he sustained a symptomatic worsening of his 1990 bilateral arm condition (Exs. 10-1, 10B, 10E, 10G, 15, 15A, 18, 18C, 24). Claimant's treating doctors also refer to his condition as an "exacerbation" (Ex. 18D) or a "material worsening" (Exs. 10G, 15A) of his condition. None of the evidence addresses whether claimant experienced a pathological worsening or an "actual worsening." Had the evidence supported a pathological worsening, it would have been unnecessary to precisely determine the definition of an "actual worsening," because proof of a pathological worsening would meet, if not exceed, such a definition. Consequently, had such circumstances existed, remand would not have been required.

[3] We recognize that claimant's claims are based on both aggravation and new occupational disease theories. Because resolution of this issue under either theory requires an inquiry into a worsening analysis, see Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990) (A worsening of symptoms alone is insufficient to establish an occupational disease unless the medical evidence establishes that the manifested symptoms are the disease), we consider it appropriate to remand both claims to the Hearings Division. On remand, claimant shall be free to continue to press his new occupational disease theory.

September 22, 1995 Cite as 47 Van Natta 1699 (1995)

In the Matter of the Compensation of
ARTHUR R. SCHOOLEY, Claimant
WCB Case No. 95-01787
ORDER ON REVIEW (REMANDING)
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that dismissed his request for hearing because of his failure to appear at hearing. On review, the issue is the propriety of the dismissal. We remand.

FINDINGS OF FACT

In February 1995, claimant, pro se, requested a hearing concerning non-payment of medical bills and a denial of requested palliative care. A Notice of Hearing was mailed to the parties, setting the hearing on May 2, 1995. The hearing notice was mailed to claimant's last mailing address provided to

the Hearings Division and was not returned as undelivered. Claimant failed to appear at the May 2, 1995 hearing, nor was he represented by counsel. Noting that claimant had failed to notify the Hearings Division of his inability to attend the scheduled hearing, the ALJ granted the insurer's motion to dismiss on the grounds of abandonment under OAR 438-06-071(2).

On May 4, 1995, the ALJ issued an order dismissing claimant's hearing request based on claimant's failure to appear at the hearing. On May 11, 1995, the Board received claimant's letter requesting "another date to argue this matter." Claimant's letter was processed as a request for review of the ALJ's order.

In a subsequent letter received by the Board on May 19, 1995, claimant expressed frustration with the handling of his claim and noted that he had a busy schedule. No other explanation of why he failed to attend the scheduled hearing was given in this letter or in his subsequent "brief."

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant and his attorney fail to attend a scheduled hearing unless extraordinary circumstances justify postponement or continuance of the hearing. OAR 438-06-071(2). We have previously held that an ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. Olga G. Semeniuk, 46 Van Natta 152 (1994); Harold Harris, 44 Van Natta 468 (1992); Vincent G. Jacoban, 42 Van Natta 2866, 2867 (1990); Mark R. Luthy, 41 Van Natta 2132 (1989). In Luthy, we treated a "post-hearing" request to reschedule a hearing as a motion for postponement.

Here, in response to the ALJ's May 4,1995 dismissal order, claimant sought another opportunity to present his arguments. In his "brief," claimant contends that his medical bills should be paid. Considering these circumstances, we interpret claimant's contention as a motion for postponement of the scheduled hearing. Inasmuch as the ALJ did not rule on the motion, this matter must be remanded to the ALJ for consideration of the motion. See Olga G. Semeniuk, supra; Harold Harris, supra; Ray Eaglin, supra.

In determining that remand is appropriate, we wish to emphasize that our decision should not be interpreted as a ruling on the substance of any of the representations contained in claimant's submission or a finding on whether postponement of the previously scheduled hearing is warranted. Rather, as we have explained in similar rulings, we take this action because we consider the ALJ to be the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Olga G. Semeniuk, supra; Harold Harris, supra; Ray Eaglin, supra.[1] In other words, on remand, it will be claimant's responsibility to persuade the ALJ that his reason for failing to appear at the scheduled hearings was justified and constituted extraordinary circumstances beyond his control. The presentation of this "justification" may be made in any manner that the ALJ deems appropriate. If the ALJ finds that claimant's explanation satisfies the "'extraordinary circumstances"' standard then, and only then, will a hearing be convened on the issues raised by claimant's hearing request.

Accordingly, the ALJ's order dated May 4, 1995 order is vacated. This matter is remanded to ALJ Garaventa to determine whether postponement of claimant's hearing request is justified. In making this determination, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the ALJ finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ finds that a postponement is not justified, the ALJ shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

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[1] The insurer may present its objections, if any, to claimant's motion for postponement of the hearing to the ALJ when this case is returned to the Hearings Division.

In the Matter of the Compensation of
RAYMOND D. HARRIS, Claimant
WCB Case No. 93-14069
CORRECTED ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by Members Neidig, Christian, and Hall.

It has come to our attention that the Board's September 20, 1995 Order on Review contained a clerical error. Specifically, a dissent by Board Member Hall was inadvertently omitted from the order.

To correct this oversight, we withdraw our September 20, 1995 order and replace it with the following order. The parties' rights of appeal shall begin to run from the date of this order.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that upheld the SAIF Corporation's denial of his injury claim for aortic dissection. On review, the issue is compensability.

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

The ALJ concluded that claimant's work activities on July 27, 1993 (removing a stump) were not the major contributing cause of his need for treatment for an aortic dissection. On review, claimant contends that, because this is a claim for an accidental injury, he need only show that work activities were a material cause of the initial "injury which resulted; then, if that injury subsequently combines with a preexisting condition to 'cause or prolong disability or a need for treatment,' such disability or treatment is compensable if the major cause test is satisfied."

Since claimant's heart condition was allegedly caused by physical exertion, his aortic dissection is compensable if it meets the statutory requirement for accidental injuries. ORS 656.005(7)(a); See Mathel v. Josephine County, 319 Or 235 (1994).

According to the preponderance of the medical evidence, physical exertion during claimant's employment caused the aortic wall, weakened from preexisting hypertension, an aneurysm, and atherosclerotic plaque, to perforate, resulting in a tear to the aorta. We construe such evidence as showing that claimant has preexisting atherosclerotic heart disease that allegedly combined with work activity to produce the aortic dissection. Our threshold inquiry then is whether claimant's heart injury claim is subject to the statutory limitations in subparagraph (B) of ORS 656.005(7)(a), which applies to "combined conditions."[1]

In SAIF v. Batchelor, 130 Or App 414 (1994), the court considered whether a heart attack claim was compensable. Applying the major contributing cause standard, the Board had determined that the decedent's claim was compensable under ORS 656.802. The court first noted that, under Mathel, supra, the claim should be analyzed as an injury claim, rather than as a disease claim. The court explained, however, that because the decedent's work activities were the major contributing cause of his death, the claim would be found compensable if analyzed under ORS 656.005(7)(a)(B) as involving a preexisting condition.[2]

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[1] ORS 656.005(7)(a)(B) was amended by the 1995 legislature. The amended statute now provides that where a compensable injury combines with the preexisting condition, the injury is not compensable unless 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." Or Laws 1995, ch 332, § 1(7)(a)(B) (SB 369, § 1(7)(a)(B)). Since the result would be the same under either version of the statute, we need not resolve the question of which version is applicable.

[2] In construing former ORS 656.005(7)(a)(B), the court distinguished between preexisting and predisposing conditions. See Liberty Northwest Ins. Corp. v. Spurgeon, infra. That distinction is no longer viable under the June 7, 1995 legislative amendments. "Preexisting condition" now includes any injury, disease, or condition that "contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury[.]" SB 369, § 1(24). Nevertheless, once again, since the medical evidence establishes that claimant's current condition would not be compensable under either version of the statute, we need not determine the applicability of SB 369 to this case. But see, Volk v. America West Airlines, 135 Or App 565, 572-73 (1995) (except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, have not been finally resolved on appeal).

We infer from the court's discussion in Batchelor that where a claimant has a preexisting heart condition, review of the claimant's heart injury claim should include consideration of all applicable standards for accidental injuries in ORS 656.005(7)(a), including those set forth in subparagraph (B). This inference is further supported by our obligation as a fact finder to apply the appropriate legal standard in determining the compensability of a worker's claim. See also Dibrito v. SAIF, 319 Or 244, 249 (1994); Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995); Michelle K. Dibrito, 47 Van Natta 970, on recon 47 Van Natta 1111 (1990).

Therefore, inasmuch as we have found that a work event/injury combined with a preexisting, noncompensable condition to cause or prolong disability or a need for treatment, in order to prove the compensability of his accidental injury claim, claimant must prove that work activity was the major contributing cause of his aortic dissection. See SAIF v. Batchelor, supra; Deitz v. Ramuda, 130 Or App 397, (1994); Tektronix, Inc. v. Nazari, 117 Or App 409, mod 120 Or App 590, rev den 318 Or 27 (1993) (rejecting the two-step analysis under ORS 656.005(7)(a)(B) proposed by claimant.)

Alternatively, claimant contends that if ORS 656.005(7)(a)(B) is applicable, because the "triggering mechanism" of increased blood pressure due to physical exertion and stress caused the onset of the aortic dissection, the medical evidence shows that the injury resulted "in a major sense" from work activity. We disagree.

ORS 656.005(7)(a)(B) requires an assessment of the "major contributing cause." Deitz v. Ramuda, supra. Determining the major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. See McGarrah v. SAIF, 296 Or 145 (1983); Dethlefs v. Hyster Co., 295 Or 298 (1983); Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991), rev den 313 Or 210 (1992). Although work activities that precipitate a claimant's injury or disease may be the major contributing cause, that is not necessarily always true. Under ORS 656.005(7)(a)(B), the relative contribution of each cause, including the precipitating cause, must be evaluated under the particular circumstances.

On this record, we agree with the ALJ that claimant has failed to sustain his burden of proving that his work activities were the major contributing cause of his need for treatment for the aortic dissection. Thus, his claim is not compensable.

ORDER

The ALJ's order dated September 30, 1994 is affirmed.

Board Member Hall dissenting.

The legislature intended the changes in those provisions of Senate Bill 369 at issue in this case to apply retroactively. Or Laws 1995, ch 332, § 66 (SB 369, § 66); Volk v. America West Airlines, 135 Or App 565 (1995). Nonetheless, because fundamental fairness requires that we at least hear from the parties before rendering our decision, I respectfully dissent.

This case was litigated, appealed, and briefed before the Board prior to the passage of SB 369. What conditions are "preexisting" turns on the medical evidence. Therefore, we should not issue a decision in this case without the benefit of supplemental briefs, points, authorities, and arguments from the parties.

For this reason, I must respectfully dissent.

In the Matter of the Compensation of
FRANK A. SARMENTO, Claimant
WCB Case No. 94-12334
ORDER ON RECONSIDERATION
Coughlin, et al, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

On August 7, 1995, we withdrew our July 25, 1995 order that had affirmed an Administrative Law Judge's order which set aside the SAIF Corporation's termination of claimant's temporary total disability benefits. We took this action in response to SAIF's announcement that the parties had resolved their dispute and would soon be forwarding the settlement documents. On September 20, 1995, we approved the parties' Claim Disposition Agreement (CDA), in which claimant fully released all past, present, and future rights to benefits (including temporary disability), except medical services, related to his November 1993 claim.

Inasmuch as the issue on review pertains to claimant's entitlement to temporary disability and since such benefits have been released pursuant to the approved CDA, we conclude that this case has been resolved, in lieu of all prior orders. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JANET ANDERSON, Claimant
WCB Case No. 94-04828
CORRECTED ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

On September 22, 1995, we issued an order which affirmed in part and vacated in part an Administrative Law Judge's (ALJ's) order that: (1) set aside the insurer's denial of claimant's claim for a torn lateral meniscus and proposed surgery; (2) awarded claimant interim compensation; (3) awarded an attorney fee under ORS 656.382(1) for the insurer's allegedly unreasonable failure to pay interim compensation; and (4) assessed a penalty for the insurer's allegedly unreasonable denial. Upon further reflection, we wish to alter some of the reasoning expressed in several sections of the order. These modifications will not effect the ultimate conclusions reached in our decision. The changes are as follows.

In the section of our order entitled "Request to Reopen the Record," we delete the last paragraph of that section (Pages 2 - 3) in its entirety, including footnote 1.

In addition, the following corrections are made to the "Interim Compensation" section (Page 7). Paragraph 4 of that section is replaced by the following paragraph.

> "To begin, we reject the insurer's argument that Dr. Puziss could not authorize time loss because he did not qualify as an attending physician under the MCO rules. As we discussed earlier, it was not an abuse of discretion for the ALJ to deny the insurer's request to reopen the record for admission of "MCO limitation" letters. In light of such circumstances, the admissible evidence in this record does not establish that claimant was subject to MCO limitations. Therefore, under these particular circumstances, the fact that Dr. Puziss might not have qualified as an attending physician under MCO rules does not mean that he could not be her "attending physician" pursuant to ORS 656.005(12)(b)."

Finally, the second paragraph in the section entitled "Penalty for Failure to Pay Interim Compensation" (Pages 8 - 9) is replaced with the following paragraph.

"Here, the insurer had notice that claimant had been disabled by her torn lateral meniscus. The insurer's claims person testified that she had notice on March 21, 1994 that Dr. Puziss had authorized time loss for claimant. (Tr. 94, 95). The insurer did not pay interim compensation because Dr. Puziss was not an approved physician under the MCO. (Tr. 89). However, as previously discussed, the record does not establish that claimant was subject to, or received notice of, MCO limitations. Under these circumstances, we agree with the ALJ that the insurer's failure to pay interim compensation was unreasonable."

Accordingly, we withdraw our September 22, 1995 order. Subject to the aforementioned corrections, we republish our prior order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

September 26, 1995 Cite as 47 Van Natta 1704 (1995)

In the Matter of the Compensation of
DAVID L. BLACK, Claimant
WCB Case No. 94-12251
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Neal's order which found that claimant's was entitled to the drug Stadol as a reasonable and necessary medical treatment for his compensable injury. On review, the issue is jurisdiction. We conclude that the Hearings Division lacks jurisdiction over this issue and we vacate the ALJ's order.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

At hearing, the ALJ determined that the Hearings Division had jurisdiction over the issue of whether claimant was entitled to medical services. On review, SAIF contends that the Hearings Division and the Board do not have jurisdiction over medical treatment disputes.

Subsequent to the ALJ's order, the legislature enacted Senate Bill 369, which applies retroactively to "all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented * * *." See Walter L. Keeney, 47 Van Natta 1387 (1995); Or Laws 1995, ch 332, § 66(1) (SB 369 § 66 (1)). None of the exceptions to the retroactivity clause in section 66 apply to this case. See Volk v. America West Airlines, 135 Or App 565 (1995). Therefore, we apply the relevant amendments to this case.

Section 25 of Senate Bill 369 amends ORS 656.245 to add subsection (6), which provides:

"If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550." Id. at §25.

Further, ORS 656.327(1)(a), as amended by Senate Bill 369, provides that disputes regarding medical treatment not subject to ORS 656.260 must be reviewed by the Director. Id. at §41.

Here, the medical service dispute does not pertain to the compensability of claimant's underlying claim. Rather, the issue is whether the drug Stadol was a reasonable or necessary medical treatment for claimant's compensable injury. Because jurisdiction over this matter rests with the Director, rather than the Hearings Division, we vacate the ALJ's order.

ORDER

The ALJ's order dated February 3, 1995, as corrected February 15, 1995, is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

Board Member Gunn specially concurring.

Although we have concluded that we lack jurisdiction over medical treatment disputes such as in this case, I write separately to document the history of claimant's condition which resulted in his treating physician prescribing the drug Stadol. Based on that history, I would conclude that the prescription is reasonable and necessary treatment for claimant's compensable condition. Further, I write to note my discontent with the retroactive application of Senate Bill 369 to this matter.

In April 1977, claimant compensably fractured his left foot. Because of his injury, claimant has had an array of physical, mental and chemical dependency problems for the past 17 years. Claimant's depression and addiction to various pain medicines has resulted in an attempted suicide, hospitalization for depression, as well as treatment with a psychiatrist. The difficulties which have confronted claimant, as a result of his compensable injury, are on-going with no resolution in sight.

In light of claimant's continuous problems, stemming from his compensable injury, his treating physician prescribed the drug Stadol which in his opinion was a reasonable and necessary medical treatment. (Ex. 73-1). There is no contrary medical opinion. However, unlike the Board, the Director is not required to defer to the attending physician's opinion. Weiland v. SAIF, 63 Or App 810 (1983). Even so, based on this record, it would appear that claimant's prescription for Stadol is appropriate and should be approved by the Director.

Additionally, I note that the retroactive application of SB 369 requiring claimant to re-litigate his medical services claim before the Director, conflicts with the legislative policy of providing prompt and complete medical treatment for injured workers. ORS 656.012. Finally, the retroactive provisions of SB 369 have increased litigation for the injured worker, thereby further obscuring the Legislature's mandates contained in ORS 656.012.

In the Matter of the Compensation of
VERNAL M. DAVIDSON, Claimant
WCB Case Nos. 93-02875 & 93-02863
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Davidson, 135 Or App 204 (1995). The court reversed our prior order, Vernal M. Davidson, 46 Van Natta 704 (1994), which held that claimant was entitled to a penalty under ORS 656.268(4)(g) when, on reconsideration of a Notice of Closure, his scheduled permanent disability award was increased from 14 percent (21 degrees) to 23 percent (34.5 degrees) for the loss of use or function of his left knee. Citing SAIF v. Cline, 135 Or App 155 (1995), the court has remanded for reconsideration.

The relevant facts are as follows. A Notice of Closure awarded claimant 14 percent (21 degrees) scheduled permanent disability for the loss of use or function of his left knee. Claimant requested reconsideration.

On reconsideration, the Department increased the scheduled permanent disability award to 23 percent (34.5 degrees). Finding claimant to be at least 20 percent disabled, the Department also awarded a penalty under former ORS 656.268(4)(g).[1]

SAIF requested a hearing, objecting, inter alia, to the assessment of a penalty under former ORS 656.268(4)(g). The Administrative Law Judge (ALJ) (formerly Referee) affirmed the Order on Reconsideration, including the penalty. SAIF requested review of that portion of the ALJ's order which affirmed the assessment of a penalty under former ORS 656.268(4)(g).

On review, we adopted and affirmed the ALJ's order. We reasoned that the Department properly disregarded the Director's rule that provided that, for purposes of assessing a penalty under former ORS 656.268(4)(g), "a worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20% disabled." Former OAR 436-35-050(13) (renumbered OAR 436-30-175(3), WCD Admin. Order 94-059, effective January 1, 1995).

The court has reversed our decision, relying on SAIF v. Cline, supra. In Cline, the court reversed our prior order in Steven L. Cline, 46 Van Natta 132, on recon 46 Van Natta 512 (1994), which assessed a penalty under ORS 656.268(4)(g) when an Order on Reconsideration increased the claimant's scheduled permanent disability award from 23 percent for her thumb and 6 percent for the hand. The carrier contended that a penalty was not appropriate because the percentage of the claimant's disability, when converted to that of the whole worker, was less than 20 percent disabled. The court identified the issue as the validity and applicability of former OAR 436-30-050(13), which provided that a total sum of 64 degrees of scheduled or unscheduled disability shall constitute at least 20 percent disabled.

The court reasoned that, because the text of former ORS 656.268(4)(g) refers to the disability of "the worker," not a particular body part, percentage of disability of a particular body part must be converted to a percentage of the whole worker before the statute may apply. Cline, supra, 135 Or App at 159. The court instructed that, in order to determine the extent of disability to the whole worker, the disability must be translated into degrees, the statutory measuring unit. Id. Because 320 degrees comprises the whole worker, he or she must have suffered at least 64 degrees of permanent disability (20 percent of 320 degrees) in order to be at least 20 percent disabled for purposes of former ORS 656.268(4)(g). See id. at 160. Because former OAR 436-30-050(13) was consistent with that reasoning, the court concluded that the rule was valid. Id.

Consequently, in accordance with Cline, the court has remanded for reconsideration. Pursuant to the court's mandate, we proceed with our reconsideration.

Here, claimant received a scheduled permanent disability award of 34.5 degrees (23 percent) for the loss of use or function of his left knee. Because claimant has received less than 64 degrees of disability, he is not entitled to a penalty under former ORS 656.268(4)(g). Cline, supra; former OAR 436-30-050(13).

Accordingly, on reconsideration of our April 11, 1994 order, we reverse that portion of the ALJ's August 27, 1993 order which had affirmed the Order on Reconsideration's award of a penalty under former ORS 656.268(4)(g).

IT IS SO ORDERED.

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[1] Former ORS 656.268(4)(g) provided:

> If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

We note that ORS 656.268(4)(g) has been amended by the 1995 Legislature. Or Laws 1995, ch 332 §30(4)(g) (SB 369, §30). Those amendments apply only to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. SB 369, §§66(4), 69. Claimant became medically stationary on August 27, 1992. (Ex. 36). Therefore, the amendments do not apply, and we analyze this matter under former ORS 656.268(4)(g).

In the Matter of the Compensation of
RONALD G. DORRY, Claimant
WCB Case No. 94-05776
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) found that claimant had established "good cause" for his untimely hearing request; and (2) set aside the insurer's denial of claimant's neck injury claim. Claimant cross-requests review of the ALJ's attorney fee award. On review, the issues are timeliness of hearing request and, alternatively, compensability, aggravation and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the last paragraph on page 2 of the Opinion and Order, and the findings of ultimate fact.

In lieu of the last paragraph on page 2, we find: Before the insurer issued its written denial, claimant discussed his claim with an insurer claims examiner. The conversation concerned the effect of the insurer's denial of claimant's new injury claim and acceptance of his aggravation claim; claimant understood that he would not lose any benefits under the denial. (See Tr. 6-7).

On May 9, 1994, more than five months after the denial issued, claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ reasoned that, because claimant was misled into inaction by a conversation with one of the insurer's claims examiners and the issuance of the insurer's written denial, claimant had good cause for filing a late hearing request. We disagree and reverse.

Claimant filed his hearing request over 5 months after the insurer denied his current neck condition as a new injury and accepted that condition as an aggravation of a prior accepted neck claim. (Ex. 48; see Ex. 51). Claimant asserts that, based on a pre-denial conversation with one of the insurer's claims examiners, and the text of the written denial, he mistakenly concluded that he did not need to take any action regarding the new injury claim denial. Therefore, he asserts, he had good cause for filing an untimely hearing request. We disagree.

A hearing request must be filed no later than the 60th day after a claimant is notified of a denial. Former ORS 656.319(1)(a) (since amended by Oregon Laws 1995 ch 332, § 39 (SB 369, § 39).[1] A hearing request that is filed after 60 days, but within 180 days, of a denial confers jurisdiction if the claimant has good cause for the late filing. Former ORS 656.319(1)(b).[2]

Mistake, inadvertence, surprise or excusable neglect constitute good cause. E.g., Hempel v. SAIF, 100 Or App 68, 70 (1990). However, confusion regarding the contents of a denial, without evidence demonstrating the claimant's reasonable diligence in attempting to resolve the confusion, does not constitute good cause. See, e.g., Debra A. Gould, 47 Van Natta 1072, 1073 (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). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1984).

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[1] Amended ORS 656.319(1)(a) allows a claimant 60 days after the mailing of a denial to request a hearing on the denial. SB 369, § 39. ORS 656.319(1)(b) was similarly amended to allow a late hearing request for good cause up to 180 days after the mailing of a denial. SB 369, § 39. Because claimant did not file his hearing request until more than 5 months after the mailing of the insurer's denial, we need not determine which version of the statute applies.

[2] See note 1, supra.

The gist of claimant's argument is that he was confused about the insurer's simultaneous denial of his current neck condition as a new injury and its acceptance of that condition as an aggravation of his accepted neck claim. There is no evidence that claimant exercised any diligence in attempting to resolve his confusion until several months after the 60-day statutory time period for filing a hearing request had expired. Claimant's failure to act in the face of his confusion does not constitute good cause for failing to file a timely hearing request. Debra A. Gould, supra, 47 Van Natta at 1073. Accordingly, we reverse the ALJ's decision denying the insurer's motion to dismiss the hearing request.[3] In light of that decision, we do not address the other potential issues on review.

ORDER

The ALJ's order dated January 26, 1995 is reversed. Claimant's hearing request is dismissed. The ALJ's attorney fee award is reversed. The insurer's denial is reinstated.

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[3] The parties refer us to several cases in which the claimants argued that a carrier's post-denial statements misled them to delay filing their hearing requests. E.g., Altagrasia Lamm, 46 Van Natta 252 (1994); Joe Ann Aquilar, 43 Van Natta 246 (1991). Those cases are inapposite, in that this case involves a carrier's pre-denial statements.

Board Member Gunn dissenting.

The majority, yet again, concludes that a claimant's confusion in the face of perplexing claim processing activities does not constitute good cause for failure to file a timely hearing request. Because I believe that such confusion is the epitome of good cause in this setting, I dissent.

In his dissent in Debra A. Gould, 47 Van Natta 1072, 1073 (1995), Member Hall said that he "would hold that 'good cause' for failure to file a hearing request within 60 days can be established by showing actual and reasonable confusion regarding particular claims processing activities." Member Hall's reasoning was based, in part, on the liberal construction of "good cause." See id.

I would hold likewise. In light of the intervening addition of subsection (3) to ORS 656.012, Or Laws 1995, ch 332, § 4 (SB 369, § 4), however, it appears that we may no longer be at liberty to liberally construe "good cause." That subsection provides that, "[i]n recognition that the goals and objectives of this Workers' Compensation Law are intended to benefit all citizens, it is declared that the provisions of this law shall be interpreted in an impartial and balanced manner." (Emphasis added).

Before the enactment of SB 369, we construed the Workers' Compensation Act in favor of injured workers. Stovall v. Sally Salmon Seafood, 306 Or 23, 38-39 (1988). That appears to be a thing of the past.[1] ORS 656.012(3) mandates that, henceforth, we interpret the law impartially and in a balanced manner, which I understand to mean in favor of no particular party.

That mandate flies in the face of the long-standing principle that one construes insurance contracts against insurers and in favor of coverage. E.g., Montee v. State Farm Fire and Casualty Co., 99 Or App 401, 408 (1989), rev den 309 Or 521 (1990) (citing Totten v. New York Life Ins. Co., 298 Or 765, 771 (1985), and Shadbolt v. Farmers Insur. Exch., 275 Or 407, 411 (1976)).[2] Because workers'

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[1] Except as provided otherwise, SB 369's amendments apply to matters for which the time to appeal the Board's decision has not expired or, if appealed, have not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565 (1995). Under section 66(6) of SB 369, however, amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively. Motel 6 v. McMasters, 135 Or App 583 (1995). Because the application of ORS 656.012(3) to the good cause analysis under ORS 656.319 appears to alter a procedural time limitation (the time within which an injured worker may file a hearing request), section 66(6) arguably bars the retroactive application of the "impartial and balanced manner" rule to this case. Because analysis on which I ultimately rely does not depend on ORS 656.012(3), however, I do not resolve that issue.

[2] This principle applies to ambiguous insurance contracts. E.g., Montee, supra, 99 Or App at 408. Likewise, it should apply to ambiguous statutory terms that pertain to insurance contracts. Since "good cause" is not plain on its face, it is ambiguous. In view of that ambiguity, and because that term pertains to workers' compensation insurance contracts, our interpretation of "good cause" should be governed by the abovementioned rule of construction.

compensation benefits flow through individual insurance contracts, I believe that we should continue to interpret the Workers' Compensation Act, which governs those contracts, against insurers and self-insured employers, and in favor of coverage for injured workers. However, because the Legislature has disregarded this well-established doctrine by adding ORS 656.012(3) to the Act, I must turn elsewhere for authority for the holding I propose.

ORS 656.012(2)(b) provides that authority. That subsection, which the 1995 Legislature did not amend, states that one of the primary objectives of the workers' compensation law is to assure that benefits are provided to injured workers by a fair and just administrative system that, to the greatest extent practicable, reduces litigation. Therefore, I would hold that, in the interests of fairness and justice, and of reducing litigation of good cause/confusion cases, good cause for failure to file a timely hearing request can be established by showing actual and reasonable confusion regarding particular claim processing activities, which resulted in the late filing of a hearing request.

Here, claimant has established actual and reasonable confusion regarding his conversation with a claims examiner, and the insurer's denial of his current neck condition as a new injury and acceptance of that condition as an aggravation of a prior claim. Moreover, he has shown that his failure to file a timely hearing request regarding the denial was the result of that confusion. Consequently, I would hold that claimant has established good cause for filing an untimely hearing request. Because the majority concludes otherwise, I dissent.

September 26, 1995 Cite as 47 Van Natta 1709 (1995)

In the Matter of the Compensation of
JONATHAN E. GRANT, Claimant
WCB Case No. 94-14031
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order which: (1) reduced his scheduled permanent disability award for loss of use or function of his left leg from 7 percent (10.5 degrees), as awarded by an Order on Reconsideration, to zero; and (2) awarded an additional 6 percent (19.2 degrees) unscheduled permanent disability award for a low back condition whereas an Order on Reconsideration had not awarded unscheduled permanent disability beyond the 13 percent (41.6 degrees) claimant had previously been awarded. The SAIF Corporation filed a cross-request for review, but has since withdrawn that request. On review, the issues are extent of scheduled and unscheduled permanent partial disability.

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

Scheduled Permanent Disability

The ALJ found that claimant was not entitled to the scheduled permanent disability award granted by the Order on Reconsideration. In so doing, the ALJ was not persuaded by the medical opinion of Dr. McNabb.

On review, claimant contends that Dr. McNabb became claimant's treating physician after the date of closure. Therefore, according to claimant, Dr. McNabb's impairment findings should not have been rejected by the ALJ. We disagree.

ORS 656.245(3)(b)(B) states that "[e]xcept as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." (Emphasis added). See Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666, 668 (1994).

Here, whether or not Dr. McNabb became claimant's treating physician after closure does not alter the outcome of this issue. As conceded by claimant, at the time of closure, claimant's treating physician was Dr. Lewis. Therefore, only Dr. Lewis' impairment findings may be used to evaluate claimant's disability. ORS 656.245(3)(b)(B); Roseburg Forest Products v. Owen, 129 Or App 442, 445 (1994); Dennis E. Conner, 43 Van Natta 2799 (1991). Further, Dr. Lewis did not ratify the impairment findings of Dr. McNabb. See Tektronix, Inc. v. Watson, 132 Or App 483 (1995); Alex I. Como, 44 Van Natta 221 (1992) (impairment findings from a physician, other than the attending physician at the time of closure, may be used only if those findings are ratified by the attending physician).

Consequently, because Dr. Lewis did not rate claimant's loss of strength or ratify Dr. McNabb's findings, there is no evidence upon which to award claimant scheduled permanent disability. Accordingly, the ALJ correctly reduced claimant's 7 percent scheduled permanent disability award to zero.

Unscheduled Permanent Disability

The ALJ found that claimant had lost additional earning capacity since the prior claim closure (for which claimant had received a 13 percent unscheduled permanent disability award). Specifically, the ALJ awarded claimant 6 percent unscheduled permanent disability (2 percent for surgery involving two discs (L3-4 and L4-5) and 4 percent for decrease in low back flexion). OAR 436-35-280(1).

On review, claimant disputes the ALJ's award. Specifically, claimant contends, that based on his surgery, flexion and extension findings, his award should be increased from 6 percent to 7 percent unscheduled permanent disability.

A claimant is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question but which had already been produced by an earlier accident and compensated by a prior award. OAR 436-35-007(3)(b)(B); Mary A. Vogelaar, 42 Van Natta 2846, 2850 (1990).

Here, pursuant to a March 1993 Stipulation Order, claimant was awarded 13 percent unscheduled permanent disability (9 percent for surgery to the lumbosacral region and 4 percent for 12 degrees extension). (Exs. 12, 17). Subsequent to this Stipulation Order, claimant's low back condition worsened.

In September 1993, Dr Lewis performed surgery on claimant's L3-4 and L4-5 discs. Dr. Lewis' range of motion findings following surgery were: Forward flexion 38 degrees (4 percent), extension 12 degrees (4 percent), right bending 30 degrees (0 percent) and left side bending 26 degree (0 percent). (Ex. 25). Based on these range of motion findings and surgery to the two discs (2 percent) and before consideration of claimant's previous 13 percent unscheduled permanent disability award, claimant is entitled to 10 percent unscheduled permanent disability. OAR 436-35-360(2)(a); OAR 436-35-360(19-21).

In reaching this conclusion, we disagree with claimant's contention that he is entitled to 3 percent impairment for allegedly undergoing three surgical procedures (L3-4 and L4-5 decompression, as well as L3-4 laminectomy). Under OAR 436-35-350(2)(a), claimant is awarded 1 percent impairment for "each disc(s) or vertebra treated within the same region." Therefore, regardless of the number of procedures performed during surgery, claimant is entitled to 2 percent impairment for undergoing surgical treatment to two discs.

Thus, without consideration of his prior 13 percent unscheduled permanent disability award, claimant's current permanent disability under the standards totals 10 percent. However, as previously noted, claimant is not entitled to be doubly compensated for a permanent loss of earning capacity which existed prior to his compensable aggravation. See OAR 436-35-007(3)(b)(B); Mary A. Vogelaar, supra. After considering claimant's prior award (which was based on his prior surgery and physical limitations) we are not persuaded that claimant is entitled to unscheduled permanent disability beyond the 6 percent granted by the ALJ's order.

ORDER

The ALJ's order dated November 15, 1994 is affirmed.

In the Matter of the Compensation of
TERRI LINK, Claimant
WCB Case No. 94-12863
ORDER ON REVIEW
James Edmunson, Claimant Attorney
Beers, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that declined to award her temporary total disability benefits. On review, the issue is procedural entitlement to temporary disability benefits.

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

Relying on Viking Industries v. Gilliam, 118 Or App 183 (1993), the ALJ found that claimant was not entitled to temporary total disability benefits because she returned to modified work prior to her September 7, 1994 termination. The ALJ further found that claimant was terminated from her employment due to reasons unrelated to her work injury.

On review, claimant argues that she is entitled to temporary total disability benefits because the employer failed to make a written offer of modified work as required by former ORS 656.268(3)(c).[1] Although claimant physically returned to work following her September 1, 1994 injury (until her September 7 termination), she contends that this return to work was not valid as a matter of law because the employer never issued a written modified job offer and the work she returned to was not suitable modified work. We disagree.

ORS 656.268(3) sets forth the grounds under which an employer may unilaterally discontinue payment of temporary disability compensation. See Soleda Flores, 43 Van Natta 2504 (1991) (discussing legislative intent behind the 1990 amendments to former ORS 656.268). In order for this section to apply, however, the employer must first be procedurally required to commence payment of temporary total disability benefits. The pivotal question, therefore, is not whether the employer complied with ORS 656.268(3), but whether claimant has established an entitlement to temporary total disability in the first instance.

In order for claimant's entitlement to temporary disability benefits to begin, she must have "left work," i.e., either been absent from work or, if not working, sustained diminished earning power, for such period as is attributable to work-related disability. Randel G. Jensen, 45 Van Natta 898 (1993) (citing Bono v. SAIF, 298 Or 405 (1984); Nix v. SAIF, 80 Or App 656, 659 (1986); Weyerhaeuser Company v. Bergstrom, 77 Or App 425 (1986)), aff'd RSG Forest Products v. Jensen, 127 Or App 247 (1994).

Here, on September 2, 1994, claimant left work to seek emergency room treatment. She was released for and returned to modified work on her next scheduled work day, September 6, 1994.[2] She did not lose any pay until her September 7, 1994 termination. In light of such circumstances, the record does not establish that claimant left work as a result of her compensable injury or that she suffered diminished earning capacity. Therefore, unless claimant can show that she was terminated because of an inability to work due to her compensable injury, she is not entitled to temporary total disability. See Bruce A. Conklin, 44 Van Natta 134 (1992) (although the claimant's termination was related to his filing of a claim, the termination did not give rise to temporary total disability benefits since the claimant was able to work and working with full pay).

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[1] ORS 656.268(3) was amended by Oregon Laws 1995, ch 332, § 30 (SB 369,§ 30). We need not decide which version of the statute is applicable because under either version, we would reach the same result.

[2] Although claimant returned to her position on the "shim" line, the employer made accommodations for her light duty restrictions. The employer advised claimant how to perform her job without twisting or bending and accepted that claimant's production would decrease during this time. When claimant returned to the doctor on September 7, she was re-released to modified work with the same restrictions.

After our review of the record, we find that claimant was not terminated because of an inability to work due to her compensable injury.[3] Under these circumstances, claimant is not entitled to benefits for temporary total disability.

ORDER

The ALJ's order dated February 2,1995 is affirmed.

[3] The propriety of claimant's discharge is an issue for another forum. See ORS 659.410.

In the Matter of the Compensation of
MARILYN Y. McINTIRE, Claimant
WCB Case No. 94-08272
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Judy L. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order which upheld the SAIF Corporation's denial of her medical services claim from "non-MCO" medical providers. On review, the issue is jurisdiction. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On April 27, 1993, SAIF accepted a claim for a cervical strain which resulted from claimant's January 30, 1993 injury. That day, SAIF enrolled the claim into its Managed Care Organization (MCO). Claimant was provided with notice and an explanation of the MCO's requirements for treatment.

On July 26, 1993, SAIF issued a partial denial of multiple cervical conditions, including degenerative conditions, thoracic outlet syndrome, mid and low back "discomfort," a cervical disc herniation and carpal tunnel syndrome. By order of an ALJ on May 5, 1994, SAIF's denial was partially set aside and SAIF was ordered to accept several of the above conditions.

SAIF requested review of the ALJ's order. In the meantime, while the request for review was pending, claimant received biofeedback treatment from non-MCO providers. This prompted SAIF to issue a July 5, 1994 denial of the medical treatment on the ground that the medical providers were not members of the MCO or a qualified family physician. (Ex. 1).

The ALJ upheld SAIF's denial, reasoning that claimant's treatment, provided after the prior ALJ's order, occurred while claimant had an "accepted" claim. Inasmuch as workers with "accepted" compensable injuries were required under OAR 436-15-035(4)(c) to receive treatment in accordance with the provisions of the MCO contract, the ALJ found that claimant's medical treatment with non-MCO providers was not compensable.

On review, claimant contends that she was entitled to treat outside the MCO while SAIF was "staying" payment of medical services pending Board review of the prior ALJ's order reversing SAIF's compensability denial. Claimant reasons that she was not required to seek treatment from an MCO provider until all disputed conditions were "accepted and compensable." SAIF responds by asserting that the Board lacks jurisdiction over the medical services dispute in light of the amendments to ORS 656.245(6)and 656.260(6) contained in Senate Bill 369. We agree with SAIF and vacate the ALJ's order.

On June 7, 1995, Senate Bill 369 amended Oregon workers' compensation law. Many of the amendments were intended to apply retroactively to cases already in litigation. See Or Laws 1995, ch 332 Sec. 66 (SB 369, Sec. 66). Amended ORS 656.245(6) provides:

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

The issues in this case are whether this statute applies retroactively and then, if so, its impact on this case, if any. Section 66 of Senate Bill 369 sets forth in subsection 1 the general principle regarding applicability of the amendments in that legislation:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

Subsections (2) through (13) list specific exceptions to subsection (1), none of which specifically addresses the applicability of ORS 656.245(6). Cf. Motel 6 v. McMasters, 135 Or App 583, 587 (1995) (If case involves procedural time limit, changes made by Senate Bill 369 are not applicable).

We continue to hold that the plain language of the statute is clear and provides, without ambiguity, that the amendments to ORS 656.245(6) apply to claims currently pending before the Board. Walter L. Keeney, 47 Van Natta 1387 (1995); See also Volk v. America West Airlines, 135 Or App 565 (1995) . The question then is what affect these amendments have on this case.

Claimant concedes that her medical bills constituted a request for compensation. A "claim" is defined in ORS 656.005(6) as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." That definition encompasses not only claims for compensation for particular conditions, e.g., initial claims and aggravation claims, but also any claim for medical treatment, vocational assistance, and any other element of compensation. See ORS 656.005(8); Altamirano v. Woodburn Nursery, Inc., 133 Or App 16, 22 (1995).

Therefore, each billing for which claimant requested reimbursement was a "claim" for medical services. Amended ORS 656.245(6) provides that if a "claim" is disapproved for any reason other than the formal denial of compensability of the underlying condition and the disapproval is disputed, then the aggrieved party must request administrative review by the Director. Inasmuch as SAIF denied claimant's medical bills on the ground that the treatment was not provided by MCO physicians, claimant's claim for medical services was disapproved for a "reason other than the formal denial of compensability of the underlying claim." Thus, jurisdiction over this medical services dispute lies with the Director, not the Board. ORS 656.245(6); Walter Keeney, supra.

Furthermore, amended ORS 656.260(6) provides, in part, that "[a]ny issue concerning the provision of medical services to injured workers subject to a managed care contract * * * shall be subject solely to review by the director [of the Department of Consumer and Business Services (DCBS)] or the director's designated representatives, or as otherwise provided in this section." SB 369, § 27 (emphasis added). We have held that these amendments apply retroactively to MCO or "MCO-related" medical service disputes currently pending before the Board. Ronald R. Streit, 47 Van Natta 1577 (1995); Theresa G. Peterson, 47 Van Natta 1612 (1995).

There is no dispute that claimant was subject to SAIF's MCO contract with respect to his cervical strain. Claimant argues that she was not subject to the MCO contract with respect to medical treatment for the conditions that SAIF denied since those conditions were not accepted. See ORS 656.260(4)(a). Inasmuch as those conditions were not accepted by SAIF at the time claimant treated outside the MCO, claimant asserts that she was not subject to the MCO contract. Given our finding that jurisdiction over this "MCO-related" dispute lies with the Director pursuant to ORS 656.245(6), we need not address claimant's contention.

ORDER

The ALJ's order dated November 28, 1994 is vacated. Claimant's request for hearing on the issue of medical services is dismissed for lack of jurisdiction.

September 26, 1995 Cite as 47 Van Natta 1714 (1995)

In the Matter of the Compensation of
TAMARA L. OATES, Claimant
WCB Case No. 94-06627
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order which upheld the insurer's denial of her occupational disease claim for a psychological condition. On review, the issue is compensability.

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

Claimant, a certified medication aide (CMA), filed an occupational disease claim in April 1994. She alleged that employment conditions were the major contributing cause of her mental disorder, diagnosed by her attending psychiatrist, Dr. Paltrow, as a major depressive disorder and psychological factors affecting physical condition.

The ALJ upheld the insurer's denial of claimant's psychological claim. The ALJ found that, despite Dr. Paltrow's diagnosis, claimant did not suffer from a mental or emotional disorder generally recognized in the medical or psychological community. ORS 656.802(3)(c). The ALJ also concluded that the employment conditions allegedly producing claimant's psychological disorder were generally inherent in every working situation. Former ORS 656.802(3)(b).[1]

On review, claimant contends that Dr. Paltrow's medical opinion establishes that she suffers from a generally recognized diagnosis of a mental or emotional disorder. Further, claimant asserts that the employment conditions to which she was subjected were not generally inherent in every working situation. We need not decide whether claimant suffers from a generally recognized mental or emotional disorder, for we agree with the ALJ that the employment conditions to which claimant was exposed are generally inherent in every working situation.

To establish the compensability of a mental disorder under former ORS 656.802(1)(b), claimant must prove, inter alia, that the employment conditions that allegedly caused her condition, or its worsening, were not "generally inherent in every working situation." Former ORS 656.802(3)(b). Conditions "generally inherent in every working situation" are those common to all employment, not merely the specific occupation involved. Housing Authority of Portland v. Zimmerly, 108 Or App 596, 599 (1991). We are authorized to determine what conditions are common to all employment on a case-by-case basis. SAIF v. Campbell, 113 Or App 93, 96 (1992).

In this case, claimant alleges that employment conditions, consisting of frequent reassignment from her position of CMA to the position of certified nurse's aide because of understaffing, performance of double shifts, and lack of time off, are not generally inherent in every working situation. We disagree.

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[1] On June 7, 1995, Senate Bill 369 amended ORS 656.802, including ORS 656.802(3)(b). We need not determine whether the amendments to ORS 656.802 apply retroactively to this claim since their application would not change the result.

We have held that, in the context of a new administration in a nursing home, "changes in procedures, turnover in personnel, understaffing, altered job descriptions and decreased patient care" constituted conditions generally inherent in every working situation. Karen M. Colerick, 46 Van Natta 930 (1994). We do not find the frequent reassignment of which claimant complains to be significantly different from the conditions of understaffing and altered job descriptions in Colerick, which we found to be conditions generally inherent in the workplace.

Moreover, claimant testified that she volunteered to work double shifts and extra days for financial reasons, and claimant's supervisor verified that claimant often requested extra hours and double shifts. (Trs. 26, 66, 67). Claimant's supervisor further testified that she never required claimant to work extra days without time off. (Tr. 67). In light of this testimony, claimant has failed to establish that she was exposed to unusual work conditions, even assuming that double shifts and long hours would constitute conditions not inherent in every workplace.

Therefore, we agree with the ALJ that claimant has failed to sustain her burden of proving a compensable mental disorder under former ORS 656.802(1)(b). Thus, we affirm.

ORDER

The ALJ's order dated February 13, 1995 is affirmed.

September 26, 1995 Cite as 47 Van Natta 1715 (1995)

In the Matter of the Compensation of
ELEANOR R. SAHLY, Claimant
WCB Case No. 94-13435
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that: (1) declined to grant its motion to dismiss claimant's hearing request for lack of the jurisdiction; and (2) set aside a managed care organization's (MCO's) disapproval of medical services. On review, the issues are jurisdiction and, alternatively, medical services. We vacate the ALJ's order and dismiss claimant's hearing request.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on Job G. Lopez, 47 Van Natta 193 (1995), the ALJ concluded that the Hearings Division had jurisdiction over this matter and that the denied medical services were both reasonable and necessary. On review, SAIF asserts that, because claimant's current treating physician has withdrawn the request to perform the denied medical services, this matter has been rendered moot. Alternatively, SAIF asserts that neither we nor the Hearings Division has jurisdiction over this dispute. Because we agree that we lack jurisdiction over this matter, we do not address the mootness issue.[1]

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[1] If we lack jurisdiction over the subject matter of a claim, we do not have authority to address any other issues raised by the parties. See, e.g., Mary S. Leon, 45 Van Natta 1023, 1024 (1993) (if Board lacks jurisdiction over claim, it also lacks authority to address claimant's constitutional arguments); but see Amalgamated Transit v. Lane Co. Mass Transit, 295 Or 117, 119 n 1 (1983) (having determined that matter was moot, court did not reach jurisdictional issue).

This case arose under former ORS 656.260. That statute was amended by the 1995 legislature. Amended ORS 656.260(6) provides, in part, that "[a]ny issue concerning the provision of medical services to injured workers subject to a managed care contract * * * shall be subject solely to review by the director [of the Department of Consumer and Business Services (DCBS)] or the director's designated representatives, or as otherwise provided in this section." Or Laws 1995, ch 332, § 27 (SB 369, § 27) (emphasis added). Amended ORS 656.260(6) applies retroactively to MCO medical services disputes that arose under former ORS 656.260 and that are currently pending before the Board. Ronald R. Streit, 47 Van Natta 1577 (1995). Under amended ORS 656.260(6), the Director now has exclusive jurisdiction over MCO medical services disputes arising under the former and present versions of that statute. Id. Moreover, our decision in Job G. Lopez, supra, is no longer good law. Streit, supra.

Because this case arose under former ORS 656.260, amended ORS 656.260(6) applies. Under that statute, exclusive jurisdiction over this case now rests with the Director, not the Board or the Hearings Division. Further, because Lopez is no longer good law, it does not alter that conclusion. Consequently, we vacate the ALJ's order and dismiss claimant's hearing request. In light of this decision, we do not address the merits of the medical services issue.[2]

ORDER

The ALJ's order dated March 8, 1995 is vacated. Claimant's hearing request is dismissed.

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[2] In Walter I. Keeney, 47 Van Natta 1387 (1995), the Board held that amended ORS 656.245(6) and 656.327(1) applied retroactively to cases currently pending before the Board and, therefore, that the Board lacked jurisdiction over the case. Member Hall dissented, expressing his concerns that the parties had not been afforded an opportunity to brief fully the retroactivity issue, and that the wholesale retroactive application of SB 369 to pending cases may be constitutionally infirm. He has the same concerns regarding this case. In view of the principle of stare decisis, however, Member Hall acknowledges that current precedent supports the Board's decision to vacate the ALJ's order for lack of jurisdiction. Therefore, he agrees with that decision.

In the Matter of the Compensation of
HERBERT LAWRENCE, Claimant
WCB Case Nos. 93-15086, 93-02284 & 93-02285
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Christian, Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) upheld Johnston & Culberson's denial of his claim for low back and right shoulder injuries, on behalf of Puget Sound Truck Lines (Puget Sound); and (2) upheld the SAIF Corporation's denial, on behalf of Sea-Trans, a noncomplying employer, of claimant's claim for a right shoulder condition. On review, the issues are compensability and, if compensability is established, responsibility. 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 two sentences.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not established a compensable low back or right shoulder injury. We first address the compensability of claimant's low back condition.

Compensability of Low Back Condition

Despite finding that claimant was struck on the head and knocked down by a pallet on October 8, 1992, the ALJ concluded that claimant did not sustain a low back injury as a result of the work incident. In reaching her conclusions regarding the compensability of claimant's low back condition, the ALJ found that claimant was not credible concerning a low back injury. Specifically, the ALJ did not believe claimant's explanation for not seeking medical treatment for his low back until January 6, 1993. The ALJ did not base her credibility finding on claimant's demeanor while testifying.

When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our review of the record, we disagree with the ALJ's conclusion that claimant's testimony lacked credibility.

Claimant testified that he did not seek medical treatment for his back sooner because he did not like to go to doctors and was hoping the pain would go away. Claimant also was not sure if he could still file a claim against Puget Sound. (Tr. 24). Claimant further testified that he called the employer the morning of October 9, 1992, to report the injury. Claimant spoke to Jack Robins, a dispatcher, and told him his head, back and foot had been injured. Robins' testimony confirms that claimant reported the incident to him the morning after it occurred. Claimant's testimony regarding a low back injury on October 8, 1992 is also confirmed by claimant's wife, who testified that when claimant came home that day, his back was bruised and he appeared to be in pain.

The only inconsistency between claimant's testimony and that of Robins was that claimant testified that Robins told him that he would prefer that claimant take a few days off and not go to a doctor in order to keep insurance costs down. Robins denied that he discouraged claimant from seeing a doctor. In spite of this difference, Robins' testimony generally corroborates claimant's testimony that he reported an injury on October 9, 1992. As a result of the October 8, 1992 incident, claimant took three days off work (Friday, Saturday and Sunday), then returned to work. The dispatch log book contains an entry which says "hurt toe" next to claimant's name. However, Robins testified he did not know which body part kept claimant off work. Claimant was discharged from employment by Puget Sound on October 19, 1992.

Claimant went to work for Sea-Trans on November 4, 1992. He did not reveal the October 8, 1992 injury at Puget Sound on his employment application with Sea-Trans. One of his co-employees at Sea-Trans testified that claimant had told her that he had injured his back when he was younger. However, that witness' husband, who also worked for Sea-Trans, as well as another Sea-Trans employee, testified that claimant told them he had injured his back working for a prior employer. (Tr. 106; 115). Claimant denied that he had injured his low back when he was younger. (Tr. 64). There is no other evidence in the record that claimant had sustained any prior low back injuries. Claimant eventually sought treatment for his low back from Dr. Gambee on January 6, 1993. The history obtained by Dr. Gambee is consistent with claimant's testimony regarding the October 8, 1992 incident.

We consider claimant's failure to seek treatment sooner to be insufficient on its own to cast doubt on the truthfulness of claimant's testimony concerning the occurrence of the October 8, 1992 low back injury. Claimant's testimony concerning the October 8, 1992 injury is generally consistent with the testimony of other witnesses. Although one former co-employee at Sea-Trans testified to a prior low back injury by claimant, there is no medical or other lay evidence which corroborates that allegation. To the contrary, two other co-workers testified that claimant told them that he hurt his back at a prior employer. This testimony is consistent with claimant's report of an October 8, 1992 low back injury at Puget Sound.

The medical evidence likewise supports claimant's testimony concerning a low back injury on October 8, 1992. Dr. Gambee, orthopedist, is claimant's attending physician. Dr. Gambee diagnosed claimant's low back condition as a low back strain superimposed on preexisting spondylolisthesis. Dr. Gambee found reduced range of motion. He also opined that claimant's need for treatment was more than 51 percent related to the October 8, 1992 injury. Dr. Gambee indicated that the spondylolisthesis was preexisting and that the existence of the spondylolisthesis made the back strain last much longer than would an ordinary back strain. Dr. Gambee last examined claimant on June 21, 1993.

On January 5, 1993, the day before claimant saw Dr. Gambee with complaints of low back and right shoulder pain, claimant, a truck driver, had a physical examination which was required by the Department of Transportation (DOT). The examination was performed by a physician at an urgency care clinic. The examination included a "back strength and flexibility rating," which was apparently normal. Claimant passed the DOT physical.

Dr. Gambee testified that he was not surprised by the DOT examination findings. He attributed any differences in findings to examination methods. Describing his examination as sophisticated examination and performed in accordance with the methods prescribed by the workers' compensation rules (including testing range of motion three times using the double inclinometer), Dr. Gambee concluded that his range of motion findings were consistent and valid.

In contrast, the DOT examination does not indicate how claimant's range of motion was tested and does not give specific range of motion findings. Based on Dr. Gambee's thorough explanation, we are not persuaded that the DOT examination establishes that claimant did not have a back strain injury when the examination was performed on January 5, 1993.

Claimant was examined by Drs. Duff and Snodgrass on February 14, 1995, on behalf of Puget Sound. These physicians diagnosed a lumbar contusion and strain, by history. They further opined that claimant's preexisting lumbosacral spondylolisthesis was now the major contributing cause of claimant's ongoing back symptoms. (Ex. 32).

Considering the record as a whole, we are unable to conclude that claimant's testimony concerning an October 8, 1992 injury is not credible. Claimant's testimony is generally consistent with that of other witnesses. There is no persuasive evidence that claimant suffered from prior low back problems. In addition, the medical and lay evidence supports a conclusion that claimant injured his low back during the October 8, 1992 incident.

We generally defer to the conclusions of a treating physician unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In addition, when there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Here, we find no persuasive reason not to defer to Dr. Gambee's opinion. Moreover, we find Dr. Gambee's opinion to be well-reasoned and based on complete information. Accordingly, we defer to Dr. Gambee's opinion.

Dr. Gambee diagnosed claimant's low back condition as a lumbar strain superimposed on preexisting spondylolisthesis. We conclude, based on Dr. Gambee's opinion, that claimant's compensable injury combined with his preexisting condition to cause or prolong disability or a need for treatment. Accordingly, ORS 656.005(7)(a)(B) applies.[1]

Because claimant's injury combined with his preexisting spondylolisthesis to cause or prolong disability or need for treatment, his condition is only compensable if the compensable injury is the major contributing cause of the disability of the combined condition or of the need for treatment of the combined condition. Based on Dr. Gambee's opinion, we conclude that the October 8, 1992 injury is the major contributing cause of claimant's disability and need for treatment. Accordingly, we conclude that claimant has established compensability of his low back strain injury.

Claimant also contends that his preexisting spondylolisthesis condition is compensable. We disagree. There is no medical evidence in the record relating the preexisting spondylolisthesis to the October 8, 1992 injury. Thus, the spondylolisthesis condition is not independently compensable.

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[1] Subsequent to the date of the ALJ's order, the Legislature amended ORS 656.005(7)(a)(B). Or Laws 1995, ch 332, § __ (SB 369, §1). ORS 656.005(7)(a)(B), as amended 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."

We need not determine whether amended ORS 656.005(7)(a)(B) applies, because we conclude that the result would be the same under either version of the statute.

Responsibility for Low Back Condition

Claimant and Sea-Trans contend that Puget Sound's responsibility disclaimer was untimely. On this basis, claimant and Sea-Trans contend that Puget Sound may not contend that another employer/insurer is responsible for the claim. Subsequent to the ALJ's order in this case, the legislature amended ORS 656.308(2).[2] The statute, as amended, no longer requires carriers to issue responsibility disclaimers. Nevertheless, we need not determine whether amended ORS 656.308(2) applies or whether Puget Sound's responsibility disclaimer was timely because the record establishes that the October 8, 1992 injury at Puget Sound actually caused claimant's low back condition. Thus, under either the amended or former version of ORS 656.308(2), responsibility lies with Puget Sound.

Since there is no accepted claim for a low back condition, ORS 656.308 does not apply. Kristin Montgomery, 47 Van Natta 961 (1995). When ORS 656.308(1) does not apply, the last injurious exposure rule applies to assign responsibility. SAIF v. Yokum, 132 Or App 18 (1994). However, where actual causation with respect to a specific identifiable employer is proven, it is not necessary to rely on the judicially created last injurious exposure rule in determining responsibility. See, e.g., Runft v. SAIF, 303 Or 493 (1987); Ronald A. Krasneski, 47 Van Natta 852 (1995); Eva R. Billings, 45 Van Natta 2142, 2143 (1993).

Here, Dr. Gambee has opined that claimant's October 8, 1992 low back injury at Puget Sound was the major contributing cause of his need for treatment for his back strain. Dr. Gambee also opined that claimant's subsequent employment at Sea-Trans merely aggravated or irritated the low back problem caused by the October 8, 1992 injury. (Ex. 33). Under such circumstances, we conclude that claimant's low back condition was actually caused by his October 8, 1992 injury at Puget Sound.

Compensability of Right Shoulder Condition

The ALJ concluded that claimant had not made a claim for a right shoulder condition since he received no medical treatment specifically for that condition. We disagree.

In a "First Medical Report," Dr. Gambee asserted a right shoulder strain claim on claimant's behalf with Puget Sound. Considering this report was authored by claimant's treating physician and included a diagnosis for claimant's allegedly work-related condition, we find that the report constituted a claim. See Scott C. Rice, 47 Van Natta 373 (1995). In addition, Puget Sound acknowledged that it received a right shoulder strain claim in its denial and responsibility disclaimer. (Exs. 13; 18). Accordingly, we conclude that a claim for a right shoulder condition was made.

Turning to the merits of the claim, we nevertheless conclude that claimant has failed to establish a compensable right shoulder condition. Dr. Gambee noted that claimant had some pain in his right shoulder which preceded the October 8, 1992 injury. Claimant related his shoulder pain to repeated stress from uncoupling the tractor from the trailer. Dr. Gambee diagnosed the condition as a right shoulder strain. Dr. Gambee indicated that he examined claimant's upper extremity and failed to find much except tenderness in the right shoulder region.

We find Dr. Gambee's opinion regarding the cause of claimant's right shoulder condition unpersuasive. Although Dr. Gambee subsequently opined that claimant had a right shoulder strain related to the October 8, 1992 injury, Dr. Gambee had previously indicated that the right shoulder condition preceded the October 8, 1992 injury. In addition, Dr. Gambee was apparently not aware until his deposition that claimant related the right shoulder condition to uncoupling the tractor and trailer. In light of the fact that Dr. Gambee did not explain these inconsistencies in his apparent change of opinion regarding claimant's right shoulder condition, we attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987). Accordingly, we conclude that claimant has not established the compensability of his right shoulder condition.

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[2] The court recently declined to apply amended ORS 656.308(2) because it held, relying on § 66(6) of SB 397, that the case before it involved a procedural time limit. Motel 6 v. McMasters, 135 Or App 583 (1995).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review concerning the low back condition. ORS 656.386(1). 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 at hearing and on review is $3,000, payable by Johnston and Culberson on behalf of Puget Sound. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 30, 1994 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld Johnston and Culberson's denial of a low back condition is reversed. Johnston and Culberson's low back denial is set aside and the claim is remanded to Johnston and Culberson for processing according to law. For services at hearing and on review with regard to the low back condition, claimant's attorney is awarded $3,000, payable by Johnston and Culberson. The remainder of the ALJ's order is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that claimant's right shoulder condition is not compensable. I would conclude, based on Dr. Gambee's persuasive opinion, that claimant has established a right shoulder strain as a result of his work activities. (Ex. 35-33 to 34). The majority is willing to grant Dr. Gambee deference as the treating physician on every other issue except for the compensability of the right shoulder condition. I find the majority's refusal to rely on Dr. Gambee's opinion concerning the right shoulder to be inconsistent with their earlier reliance on Dr. Gambee's opinion concerning the low back condition.

Dr. Gambee had an accurate history and made objective findings of injury. There is no contrary opinion. Under such circumstances, I would conclude that claimant established a compensable right shoulder injury. Therefore, I respectfully dissent.

In the Matter of the Compensation of
DARLENE J. REED, Claimant
WCB Case No. 94-10609
ORDER ON REVIEW
Myrick, Seagraves, et al, Claimant Attorneys
Charles L. Lisle, Defense Attorney

Reviewed by Board Members Haynes and Christian.

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

Subsequent to the ALJ's order, the legislature passed Senate Bill 369 (SB 369), which became effective June 7, 1995. The bill, which is applicable in this case,[1] amended ORS 656.005(7)(a)(B) and defined the term "preexisting condition." Or Laws 1995, ch 332 § 1 (SB 369, § 1). Accordingly, a "preexisting condition" now means:

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[1] Section 1 of Senate Bill 369 applies retroactively to this case. SB 369, §66; Volk v. America West Airlines, 135 Or App 565 (1995) (unless specifically excepted by section 66, the provisions of SB 369 apply retroactively to all pending cases).

"any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273." Amended ORS 656.005(24) (emphasis added).

In this case, the parties agree that claimant probably had a preexisting (or predisposing) relaxing or weakening of her pelvic tissue, and that her preexisting condition combined with the July 1994 work incidents (when claimant, on two separate occasions three days apart, felt an abdominal tear while unplugging a jam in a dryer feeder) to cause her subsequent disability and need for treatment. The applicable statute, therefore, is amended ORS 656.005(7)(a)(B),[2] and the dispositive issue is whether the July 1994 work incidents were the major contributing cause of the combined condition or claimant's need for treatment.

Relying on former ORS 656.005(7)(a)(B) and the Court of Appeals' decision in U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), the ALJ reasoned that, since claimant's preexisting condition was asymptomatic before the work incident of July 11, 1994, the July 1994 work activity was the major contributing cause of her subsequent disability and need for treatment. The employer argues that, while the July 1994 work incidents may have precipitated claimant's symptoms and need for treatment, the medical evidence does not establish that the work incidents were the major contributing cause of her current condition. We agree.

We have previously explained that Burtis does not stand for the proposition that in all cases where a work incident causes a previously asymptomatic condition to become symptomatic, the work incident shall be deemed the major contributing cause of the resultant condition. See Alec E. Snyder, 47 Van Natta 838 (1995). Rather, the proper application of amended ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause, including the precipitating cause, to establish which is the primary cause. Id.; see also Dietz v. Ramuda, 130 Or App 397 (1994).

This case presents a complex medical causation question which must be resolved on the basis of expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 281 (1993). Claimant was examined by two gynecological experts, Dr. Harris and Dr. Palamara, who agreed that her condition (diagnosed as a cystocele, rectocele and uterine prolapse) is usually caused by multiple vaginal childbirths. They also agreed that such a condition generally develops progressively and is most common in post- menopausal women. Neither gynecologist indicated that claimant's work activity was the major contributing cause of her condition.[3]

Dr. Harris explained that claimant's "multiparity is the major contributing factor towards the cystocele." She also indicated that "increased intra-abdominal pressure contributes to the development of this problem" and that "sudden increases in intra-abdominal pressure can cause the tissue which had previously been weakened by aging, menopause and childbirth, to give way and suddenly herniate." (Ex. 12).

Dr. Palamara refused to speculate as to the specific cause or causes of claimant's condition. He indicated that in the absence of historical information regarding the preexisting condition of claimant's vaginal and uterine muscles, he could not assign, with any degree of medical probability, any specific weight to the various factors contributing to or causing claimant's condition. (Ex. 14-3).

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[2] Amended ORS 656.005(7)(a)(B) provides: "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the combined condition or the major contributing cause of the need for treatment of the combined condition."

[3] We note that Dr. Snook, the emergency room physician, and Dr. Tyner, who treats claimant's degenerative back condition, related claimant's condition to her work activity based upon claimant's history of the July 1994 work incidents. Neither of these physicians discussed the contribution of claimant's preexisting condition to her current pelvic condition, however. Furthermore, to the extent their reports can be read to suggest the cause of claimant's pelvic condition, we do not find them complete or persuasive since these physicians are not experts in the field of gynecology. See Abbott v. SAIF, 45 Or App 657 (1980) (Board will generally defer to the expert opinions of physicians who are specialists in the field in question).

The gynecology texts included in the record (and discussed by Dr. Palamara) indicate that cystocele, rectocele and prolapse of the uterus generally occur in association with one or the other being predominant. (Ex. 15-51, 15-58). The texts state that while the actual damage to the vaginal muscles usually occurs in the childbearing era, problems may not manifest themselves until a women is in her fifties or sixties. (Ex. 15-51, 15-58). One text explains that childbearing can weaken the vaginal muscles and subsequent strenuous work can increase the intra-abdominal pressure and eventually produce herniation into the vagina. (Ex. 15-55). This is consistent with Dr. Harris' assessment of claimant's condition. (Ex. 12).

As noted above, the proper analysis under amended ORS 656.005(7)(a)(B) turns on whether the medical evidence establishes that the injury is the major contributing cause of a claimant's resultant disability and need for treatment.[4] Alec E. Snyder, supra. The application of this statute is therefore largely dependent upon an evaluation of the medical evidence in the record. Id.; Lance A. Banaszek, supra.

Here, the record establishes that the July 1994 work incidents precipitated claimant's pelvic symptoms. She felt an abdominal tear while lying on her back and pulling on the wood, and felt like something dropped once she stood up. However, a work incident that precipitates a condition or symptoms is not necessarily always the major cause of a claimant's condition or symptoms. See, e.g., Dietz v. Ramuda, supra (exposure to smoke at work precipitated the claimant's heart attack, but preexisting coronary artery disease was major contributing cause of the injury); Alec E. Snyder, supra (the claimant's stepping into a hole at work precipitated his low back injury, but preexisting asymptomatic lumbar spine condition was the major contributing cause); James Hoffman, 47 Van Natta 394 (1995) (the claimant's fall at work was the precipitating event, but the injury actually resulted from claimant's preexisting knee condition).

In this case, given the medical evidence, we conclude claimant has not established that the July 1994 work incidents were the major contributing cause of her resultant disability and need for treatment. In so concluding, we rely on Dr. Harris' opinion that claimant's five vaginal childbirths were the major contributing factor towards the development of her pelvic condition, as well as Dr. Palamara's refusal to assign any specific weight to the various factors contributing to claimant's condition. We accept that claimant's straining at work may have been a cause of her condition. However, the record does not establish, as it must for claimant to prove the compensability of her condition, that her work activity was the major or primary cause. See Dietz v. Ramuda, supra; McGarrah v. SAIF, 296 Or 145 (1983). Accordingly, we reverse the ALJ's order.

ORDER

The ALJ's order dated December 20, 1994 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

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[4] On review, claimant argues that her weakened vaginal muscle condition was merely a predisposing factor. We have held that where the medical evidence indicates that a prior defect or condition is a predisposition rather than a preexisting condition, former ORS 656.005(7)(a)(B) is inapplicable and the material causation standard applies. See John E. Perkins, 44 Van Natta 1020 (1992) (decided under former law, when a "predisposition" was not necessarily a "preexisting condition"). Here, however, the expert gynecologists' opinions as supported by references to the medical treatises establish that claimant's weakened vaginal muscles were a "preexisting condition" within the meaning of new ORS 656.005(24) and amended ORS 656.005(7)(a)(B).

In the Matter of the Compensation of
GUILLERMO RIVERA, Claimant
WCB Case No. 94-00923
ORDER ON RECONSIDERATION
Steven M. Schoenfeld, Claimant Attorney
Roberts, et al, Defense Attorneys

On June 29, 1995, we withdrew our June 7, 1995 Order on Review. We took this action to consider the self-insured employer's request for reconsideration of that portion of our order that affirmed an Administrative Law Judge's (ALJ's) order that awarded claimant's counsel an assessed attorney fee of $2,200 for prevailing over the employer's "de facto" denial of claimant's cervical and lumbar strains. The employer challenges the propriety of the award as to the cervical strain based on the recent amendments to ORS 656.386(1). Or Laws 1995, ch 332, § 43 (SB 369, § 43). Having received supplemental briefs from the parties, we proceed with our reconsideration.

Claimant suffered a compensable injury on June 29, 1993, when he fell approximately 16 feet from a ladder. The employer's August 24, 1993 "1502" form reflects that it accepted a disabling right elbow and right wrist sprain. (Ex. 8B). On September 27, 1993, Dr. Thomas also diagnosed a cervical strain and lumbar strain resulting from claimant's injury. (Ex. 11).

On January 19, 1994, claimant requested a hearing, alleging, among other things, a "de facto" denial of lumbar strain and a right shoulder strain. On April 19, 1994, two days before the hearing, claimant filed another request for hearing, alleging, among other things, a "de facto" denial of lumbar strain, right shoulder strain and cervical strain. Shortly before the hearing, the employer accepted claimant's cervical strain claim. Thus, the compensability issue at hearing was confined to a lumbar strain. The ALJ concluded that claimant suffered a new lumbar strain injury as the result of the June 1993 fall. In addition, the ALJ awarded an assessed attorney fee of $2,200 for prevailing against the employer's "de facto" denial of claimant's cervical strain and lumbar strain.

The employer requested review, arguing, among other things, that the $2,200 attorney fee award should be reduced. In seeking review, the employer did not challenge the proposition that claimant's counsel was entitled to an attorney fee for obtaining the acceptance of claimant's cervical condition without a hearing. On review, we adopted and affirmed that portion of the ALJ's order without comment.

On reconsideration, the employer challenges the propriety of the attorney fee award as to the cervical strain based on the recent amendments to ORS 656.386(1). The employer argues that amended ORS 656.386(1) applies retroactively because the Board's order did not become final on or before the effective date of the Act. The employer also asserts that claimant did not provide a written objection to its notice of acceptance as required by amended ORS 656.262(6)(d). Furthermore, the employer contends that it did not expressly deny the cervical condition and that amended ORS 656.386(1) precludes an attorney fee award on a "de facto" denial.

Claimant asserts that he was entitled to an attorney fee under the law in effect at the time of the hearing and he argues that applying a retroactive law in this case is wholly unreasonable and would result in injustice. Moreover, claimant argues that the employer did deny the condition at the time of the hearing. Alternatively, claimant requests remand to the ALJ to determine what portion of the attorney fee award pertained to the cervical strain.

At the time of the hearing and Board review, claimant was entitled to an attorney fee pursuant to former ORS 656.386(1) for his counsel's services in obtaining a pre-hearing rescission of a "de facto" denial of his cervical condition. See former ORS 656.386(1) ("[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by a referee is not held, a reasonable attorney fee shall be allowed"); Sentrol, Inc. v. Bronson, 112 Or App 354 (1992); Jones v. OSCI, 108 Or App 230, 232 (1991).

After the ALJ's order and before our order became final, the legislature enacted Senate Bill 369. Amended ORS 656.262(6)(d) prohibits a worker from alleging a de facto denial at any hearing or other proceeding on the claim if the worker did not provide a written objection to the carrier's notice of acceptance. Or Laws 1995, ch 332, § 28(6)(d) (SB 369, § 28(6)(d)). Amended ORS 656.386(1) provides for a reasonable attorney fee in 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. SB 369, 68th

Leg., Reg. Sess., § 43(1) (June 7, 1995). A "denied claim" is defined, in part, as a claim for compensation which a carrier "refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

We must first decide whether the legislature intended the amended provisions to apply retroactively to disputes pending before the Board. In Volk v. America West Airlines, 135 Or App 565 (1995), the court considered the effect of the 1995 amendments to ORS 656.386(2) adopted in Senate Bill 369. Or Laws 1995, ch 332, § 43 (SB 369, § 43). Specifically, the court examined Section 66 of SB 369 to determine whether the amendment was retroactively effective to the case.

The court identified (5)(a) as the only potentially relevant exception to the retroactive clause of Section 66 insofar as the provisions pertained to the case at hand. Subsection (5)(a) provides that the statutory amendments do not apply to any matter for which an order or decision has become final on or after the effective date of SB 369.

After examining the text and context of the statute, as well as the legislative history, the Volk court concluded that the legislature's intent in Section 66(5)(a) was to make the new law applicable to matters for which the time to appeal the Board's decision had not expired or, if appealed, had not been finally resolved by the courts. Since the Board's order had been appealed and was not finally resolved by the time of the effective date of the Act, the court determined that the amended version of the statutes were applicable.

Here, the Board's Order on Review issued on June 7, 1995. The employer requested reconsideration and we withdrew our order on June 29, 1995 to further consider the matter. Since our prior order has not become final, the amended versions of ORS 656.262(6)(d) and ORS 656.386(1) apply to this case. See also Newell v. SAIF, 136 Or App 280 (1995) (Court allowed reconsideration of its prior opinion and applied 1995 legislative amendments because the time for seeking reconsideration or Supreme Court review of its prior opinion had not expired when the 1995 amendments became effective).

Claimant filed a second request for hearing on April 19, 1994, alleging, among other things, a "de facto" denial of lumbar strain, right shoulder strain and cervical strain. On the day of the hearing, April 21, 1994, the employer accepted claimant's cervical strain claim.

We find that claimant's April 19, 1994 request for hearing, which alleged a "de facto" denial of a cervical strain, constituted "communication in writing" to the employer of claimant's objections to the notice of acceptance pursuant to amended ORS 656.262(6)(d). The April 19, 1994 hearing request was a written communication that effectively challenged the scope of the notice of acceptance with regard to the cervical strain. The employer had 30 days to respond to claimant's written communication concerning the notice of acceptance. Since the employer accepted the cervical strain on April 21, 1994 and effectively revised the notice of acceptance to include the cervical strain, we conclude that the provisions of amended ORS 656.262(6)(d) were satisfied.[1]

Under amended ORS 656.386(1), claimant's attorney is entitled to an attorney fee "in 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." Or Laws 1995, ch 332, § 43(1) (SB 369, § 43(1)). We must determine whether claimant's cervical claim was a "denied claim." Amended ORS 656.386(1) defines a "denied claim" as:

> "[A] claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation. A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in a timely fashion."

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[1] In reaching this conclusion, we note that a claimant's failure to first provide such written communication to the carrier to allow it 30 days within which to respond precludes the claimant from alleging a "de facto denial" at any hearing or other proceeding. Thus, had the employer not accepted the cervical condition on the date of hearing (two days after claimant's "written communication"), it could likely have challenged claimant's cervical "de facto denial" allegation as premature.

Here, the employer asserts that it did not expressly deny claimant's cervical condition. Claimant disputes the employer's contention.

At hearing, the employer's attorney acknowledged that claimant had raised the issue of a "de facto" denial of a cervical strain pursuant to a request for hearing dated April 19, 1994. (Tr. 6). The employer's attorney stated that, prior to going on the record, it had agreed to accept the cervical strain. (Id.) The parties disputed the appropriate amount of the attorney fee. At the end of the hearing, the employer's attorney acknowledged that there would be a "fee for the cervical de facto denial." (Tr. 99).

At the end of the hearing, the ALJ discussed the separate issue of the employer's unreasonable "de facto" denial of the cervical condition. When the ALJ asked the employer's attorney what he considered an appropriate amount for unreasonable denial of the cervical condition, the employer's attorney responded:

> "Given the fact that the initial diagnoses only did not reference any neck problem and it just gradually -- the spreading disability theory brought in the cervical condition which was not processed but should have, *** it would appear appropriate somewhere between $250 and $500 as a penalty to be split between claimant and his attorney for the unreasonableness." (Tr. 101).

The ALJ awarded an assessed fee of $350 for the employer's unreasonable "de facto" denial of claimant's cervical strain. On review, the employer argued that the Board should reverse the penalty-based fee. The employer explained:

> "The initial medical reports documented only low back and upper extremity problems. No physician diagnosed a cervical condition until Dr. Zapf did so on September 18, 1993. (Ex. 10). That was two-and-a-half-months after the injury. Under these circumstances, employer had reason to question causation and defer acceptance or denial of the claim." (Appellant's brief at 5).

Based on these portions of the record, we conclude that claimant's cervical condition constitutes a "denied claim" pursuant to amended ORS 656.386(1). At hearing, the employer acknowledged that a "fee for the cervical de facto denial" would be appropriate and that a penalty for the unreasonable denial of the cervical condition would be appropriate.[2] Moreover, the employer acknowledged in its brief that it had questioned the causation of claimant's cervical condition.

Under these circumstances, we find that the employer refused to pay on the express ground that the condition was not compensable.[3] See amended ORS 656.386(1). Therefore, claimant's cervical condition constitutes a "denied claim" pursuant to amended ORS 656.386(1). Consequently, since claimant's attorney was instrumental in obtaining a rescission of the denial prior to the hearing, claimant is entitled to a reasonable attorney fee pursuant to amended ORS 656.386(1). We adopt and affirm the ALJ's award of an assessed fee of $2,200 for prevailing over the employer's denial of claimant's cervical and lumbar strains.

On reconsideration, as supplemented herein, we republish our June 7, 1995 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] On review, we reversed the portion of the ALJ's order that awarded claimant an assessed fee of $350 for the allegedly unreasonable "de facto" denial of claimant's cervical strain because all compensation for the cervical strain had been paid.

[3] Alternatively, we consider the parties' positions at hearing to effectively constitute an agreement that claimant's counsel was entitled to a carrier-paid attorney fee for "pre-hearing" services in obtaining the acceptance of the cervical condition. The final component of that agreement was the amount of the attorney fee, which would be determined by the ALJ. Regardless of whether claimant would be entitled to such an award under the former or current version of the pertinent law, it would be inappropriate for us to now alter that arrangement. See Evans v. Rookard, Inc., 85 Or App 213 (1987).

In the Matter of the Compensation of
KURT M. WIEDERHOLD, Claimant
WCB Case No. 94-09362
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of his injury claim for left inguinal hernia. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Applying former ORS 656.005(7)(a)(B), the ALJ found that claimant's work activity was a precipitating event, but not the major cause of his indirect inguinal hernia. On review, claimant argues that, while his asymptomatic congenital defect (a preformed peritoneal sac) predisposed him to developing the hernia, it did not constitute a "preexisting condition" warranting the application of the major contributing cause standard of former ORS 656.005(7)(a)(B).

Subsequent to the ALJ's order, the legislature passed Senate Bill 369 (SB 369) which, among other things, amended ORS 656.005(7)(a)(B) and added a definition for the term "preexisting condition." Or Laws 1995, ch 332, § 1 (SB 369, § 1). Accordingly, a "preexisting condition" now means:

> "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273." Amended ORS 656.005(24) (emphasis added).

The Court of Appeals has determined that the provisions of Senate Bill apply retroactively to all pending cases, unless specifically excepted from retroactive application by Section 66. Volk v. America West Airlines, 135 Or App 565 (1995); see also Walter L. Keeney, 47 Van Natta 1387 (1995). Since there is no specific exception to the retroactive application of amended ORS 656.005(7)(a)(B) and amended ORS 656.005(24), we must apply the new law in this case.[1]

In light of the statutory definition of "preexisting condition" and the amendments to ORS 656.005(7)(a)(B), we find claimant's asymptomatic preformed peritoneal sac is a "preexisting condition" warranting the application of the major contributing cause standard.[2] We further find, as did the ALJ, that claimant has not established that his work activity was the major cause of his current condition and need for treatment.

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[1] Although a signatory to this order, Member Hall directs the parties to his dissent in Walter L. Keeney, supra. There, Member Hall expressed his concerns that the parties had not been afforded an opportunity to brief the retroactivity issue, and that the wholesale retroactive application of SB 369 to pending cases might be constitutionally infirm. He has the same concerns regarding this case. In view of the principal of stare decisis, however, Member Hall acknowledges that current precedent supports the Board's decision to apply the new law to cases on review. He therefore agrees with the retroactive application of amended ORS 656.005(7)(a)(B) and amended ORS 656.005(24) and the result in this case.

[2] Prior to the effective date of SB 369, we decided Dennis Rauschert, 47 Van Natta 948 (1995), a case with strikingly similar facts. There, based on the medical records, we concluded that the claimant's congenital peritoneal sac was a predisposition but not a "preexisting condition" within the meaning of former ORS 656.005(7)(a)(B). We therefore upheld the ALJ's application of a material contributing cause standard, and found that the claimant had sustained his burden of proving that his lifting incident at work was a material contributing cause of his need for medical treatment. Rauschert, supra. To the extent Rauschert would have been applicable in this case, it has been overruled by Section 1 of SB 369.

Claimant's treating physician, Dr. Wood, opined that claimant's work was the major cause of the hernia. However, Dr. Wood did not diagnose a preexisting defect or believe that claimant had any exceptional predisposition for hernia formation. (Ex. 15).

Conversely, Dr. Gross, the reviewing physician, opined that the major cause of claimant's hernia is the presence of a "congenital preexisting hernia sac." Dr. Gross noted that the hernia would have presented itself eventually, regardless of the lifting at work. (Ex. 11). In a supplemental report, Dr. Gross explained that an "indirect hernia arises from a congenital defect of a patent processus vaginalis; that is, there is a preexisting sac from the failure of the processus to obliterate in utero." The doctor further explained that claimant's work activity "pushed the abdominal contents into an already present sac" thus making claimant aware of his condition. Dr. Gross added that "hernias such as this do not occur without the preexisting sac, no matter what the force" and included an excerpt from a medical treatise for reference.[3] (Ex. 13).

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). In this case, we find persuasive reasons not to rely on Dr. Wood's report, since he failed to address the existence or the effect of claimant's congenital peritoneal sac defect in his causation analysis. Rather, we give greater weight to Dr. Gross' opinion because it is well-reasoned and based on the most complete information.

Given Dr. Gross' thorough and complete opinion (which relies on a persuasive description of a preformed peritoneal sac as a "congenital predisposing factor"), we conclude that claimant's congenital defect is a "preexisting condition" within the meaning of amended ORS 656.005(7)(a)(B) and amended 656.005(24). We therefore analyze the compensability of claimant's condition under the major causation standard.

Applying this standard, we conclude that claimant has not sustained his burden of proving that his work activity was the major contributing cause of his need for treatment. While the record establishes that claimant's work activity in March 1994 was a cause (i.e., the precipitating event) of his need for treatment (Ex. 13), Dr. Gross clearly identified claimant's congenital defect as "the major cause" of claimant's hernia. Under these circumstances, claimant's condition is not compensable. Amended ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated November 28, 1994 is affirmed.

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[3] The medical treatise which Dr. Gross referred to and enclosed in his report, entitled "Anatomy and Surgery of Hernia," states that an indirect hernia does not occur in the absence of a "performed peritoneal sac of congenital origin," irrespective of the amount of force or trauma to which the abdomen is subject." (Ex. 13-3). According to the article, the "sac of the peritoneum" is a "congenital predisposing factor," essential to the development of indirect inguinal hernia. Id. (emphasis added).

In the Matter of the Compensation of
JOHNNY C. TINKER, Claimant
WCB Case Nos. 92-10036 & 92-03014
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our August 31, 1995 Order on Reconsideration which clarified our prior order by finding that although Maryland Casualty remained responsible for claimant's L4-5 condition (herniated nucleus pulposus with right-sided L-5 nerve root impingement), it was not responsible for claimant's L3-4 and L5-S1 conditions. Consequently, we upheld Maryland Casualty's denial to the extent that it denied claimant's L3-4 and L5-S1 conditions. Specifically, claimant contends that Maryland Casualty's denial only denied his current condition which did not include an L3-4 or L5-S1 condition. Therefore, claimant asserts that we erred in upholding the denial to the extent it denies those conditions and requests that we set aside the denial in its entirety.

In order to further consider this matter, we withdraw our order. Maryland Casualty is granted an opportunity to respond. To be considered, the response must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LYNDA J. ZELLER, Claimant
WCB Case No. 93-13381
ORDER OF ABATEMENT
Welch, Bruun, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

The insurer requests reconsideration of that portion of our September 6, 1995 Order on Review that affirmed an Administrative Law Judge's order that set aside its denial of claimant's neuroma and reflex sympathetic dystrophy conditions. Asserting that we erred in evaluating the medical opinions, the insurer requests reconsideration.

In order to further consider this matter, we withdraw our 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 shall take this matter under advisement.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

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Cite as 321 Or 139, 894 P2d 1152 (1995) May 25, 1995

Supreme Court of Oregon,
Argued and Submitted Sept. 12, 1994.

STATE ACCIDENT INSURANCE FUND CORPORATION (SAIF), Petitioner on Review,

v.

Miles ANDERSON, D.C., and North Salem Chiropractic Clinic, an assumed business name of Miles Anderson, Respondents on Review.
STATE ACCIDENT INSURANCE FUND CORPORATION (SAIF), Petitioner on Review,

v.

Steven A. DeSHAW, D.C., and Steven A. DeShaw, D.C., P.C., an Oregon professional corporation, both doing business as Northwood Family Chiropractic Clinic, Respondents on Review.
CC 90C-10487, CC 90C-10485; CA A74840, CA A74839; SC S41088, SC S41087.

In Banc
On review from the Court of Appeals.*
Jas. Adams, Asst. Atty. Gen., Salem, argued the cause for petitioner on review. With him on the petitions were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen., Salem.
321 Or 140> Anthony A. Allen, of Law Offices of Michael B. Dye, Salem, argued the cause and filed the responses for respondents on review.
VAN HOOMISSEN, J.
The decisions of the Court of Appeals on SAIF's ORICO claims are reversed. The cases are remanded to the Court of Appeals for further proceedings.

*Appeals from Marion County Circuit Court, Robert B. McConville, Judge. *SAIF v. Anderson*, 124 Or App 651, 863 P2d 509 (1993). *SAIF v. DeShaw*, 124 Or App 677, 863 P2d 513 (1993).

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321 Or 142> VAN HOOMISSEN, Justice.

The issue in these consolidated cases is whether the circuit courts have subject matter jurisdiction to hear claims of State Accident Insurance Fund Corporation (SAIF) under the Oregon Racketeer Influenced and Corrupt Organization Act (ORICO), ORS 166.715 *et seq*, against defendant chiropractors Anderson and DeShaw,[1] for allegedly charging amounts in excess of those permitted under a provision of the Workers' Compensation Law, ORS 656.248(3).[2] The circuit courts granted defendants' motions for directed verdicts on SAIF's ORICO claims, as well as on SAIF's separate claims for common law fraud. SAIF withdrew its claims for conversion, and the courts entered judgments on jury verdicts for SAIF on its claims for money had and received. Defendants appealed the judgments awarding SAIF damages on its claims for money had and received. SAIF cross-appealed, assigning error to the dismissal of its other claims based on the same transaction.

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[1] SAIF also named North Salem Chiropractic Clinic, Anderson's assumed business name, as a defendant in its action against Anderson, and Steven A. DeShaw, D.C., P.C., DeShaw's personal corporation, as well as Northwood Family Chiropractic Clinic, DeShaw and his personal corporation's assumed business name, as defendants in its action against DeShaw. Unless otherwise indicated, we refer to all those parties as "defendants."

[2] ORS 656.248(3) provides:

"In no event shall a provider charge more than the provider charges to the general public."

In the first of the consolidated cases, *SAIF v. Anderson*, 124 Or App 651, 863 P2d 509 (1993), the Court of Appeals held that the Department of Insurance and Finance (DIF) [3] has exclusive jurisdiction in a case in which a health care provider is alleged to have made excessive charges in violation of ORS 656.248(3). Accordingly, the court reversed on defendant's appeal and affirmed on SAIF's cross-appeal. In a *per curiam* opinion, the Court of Appeals decided *SAIF v. DeShaw*, 124 Or App 677, 863 P2d 513 (1993), on identical grounds. For the reasons that follow, we reverse the decisions of the Court of Appeals and remand both cases to that court for further proceedings.

321 Or 143> FACTS AND PROCEEDINGS BELOW

Defendants are licensed chiropractors. Some of defendants' patients are insured by SAIF under the workers' compensation system. As noted, SAIF filed separate complaints against defendants in circuit court, alleging claims for civil ORICO, common law fraud, conversion, and money had and received. SAIF's underlying theory in both cases was that defendants had charged SAIF more for services than they charged the general public for the same services, in violation of ORS 656.248(3). Specifically, SAIF asserted that Anderson billed SAIF "minimum office visit" charges without billing those same charges to some of his private-pay patients. SAIF asserted that DeShaw gave some of his patients a discount for paying cash. SAIF predicated its civil ORICO claims on the ground that such conduct constituted "theft by deception." ORS 164.085.[4]

Pursuant to ORCP 21, defendants moved to dismiss all SAIF's claims. They argued that, under ORS 656.248(13),[5] DIF had exclusive jurisdiction over medical fee **<321 Or 143/144>** disputes between workers' compensation medical service providers and insurers predicated on ORS 656.248(3). The circuit courts denied those motions, but later granted each defendant's motion for a directed verdict on SAIF's ORICO and common law fraud claims for insufficient evidence of defendants' intent to deceive SAIF. SAIF withdrew its conversion claims.[6] Each jury returned a verdict for SAIF--$9,000 in *Anderson*, and $7,415.14 in *DeShaw*--on the remaining claims for money he had received. Judgments were entered on the verdicts.

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[3] Now the Department of Consumer and Business Services. Or Laws 1993, ch 744, s 10.

[4] ORS 164.085(1)(a) provides:

"A person, who obtains property of another thereby, commits theft by deception when, with intent to defraud, the person:

"(a) Creates or confirms another's false impression of law, value, intention or other state of mind which the actor does not believe to be true[.]"

In its complaint against Anderson, SAIF alleged:

"Defendant ANDERSON and his racketeering enterprise engaged in conduct constituting * * * 'Theft by Deception,' in violation of ORS 164.085 * * * as follows:

" * * * Pursuant to ORS 656.248, defendant ANDERSON was required to charge no more to SAIF for services rendered than that which was charged to the general public. Defendant ANDERSON, in the course of his practice, knowingly charged more to SAIF than he did to the general public. Defendant ANDERSON, with intent to defraud SAIF, created or confirmed SAIF's false impression that he was charging SAIF the same fees as he did to the general public for his services."

SAIF's complaint against DeShaw is similar.

[5] ORS 656.248(13) provides:

"When a dispute exists between an insurer or self-insured employer and a medical service provider regarding the amount of a fee for medical services, notwithstanding any other provision of this chapter, the director may resolve the dispute in such summary manner as the director may prescribe. Determinations of the director pursuant to this subsection are subject to review as provided in ORS 183.310 to 183.550."

[6] It is clear that SAIF had withdrawn its conversion claim against defendant Anderson, because the circuit court in that case had ordered it to elect to proceed either on a money had and received theory or on a conversion theory. Less clear is what happened to the conversion claim against defendant DeShaw. That claim was not submitted to the jury, without any apparent order from the trial court. We surmise that here, too, SAIF had withdrawn that claim from the jury's consideration.

Defendants appealed, arguing that, under ORS 656.248(13), DIF has exclusive jurisdiction over medical fee disputes and, therefore, that the circuit courts lacked subject matter jurisdiction over SAIF's money had and received claims predicated on ORS 656.248(3). SAIF cross-appealed, arguing that the circuit courts erred in directing verdicts against SAIF's civil ORICO and common law fraud.

In *Anderson*, the Court of Appeals relied on this court's opinion in *Brown v. Transcon Lines*, 284 Or 597, 588 P2d 1087 (1978), to determine whether an administrative remedy is exclusive:

> "The threshold determination is the source of the plaintiff's claim. If the claim preexists the statute, then the administrative remedy is exclusive only if, by enacting the statute, the legislature intended to abolish the previously recognized claim. However, if the claim derives from the statute, and the statute does not imply a claim in a court, then the administrative remedy is exclusive, provided that it is not 'demonstrably inadequate.' [*Brown*,] 284 Or at 602 [588 P2d 1087]." *Anderson*, 124 Or App at 654, 863 P2d 509.

Applying that test, the Court of Appeals determined that SAIF's civil ORICO, common law fraud, and money had and received claims derived solely from ORS 656.248(3) (provider shall not charge an insurer more than the provider charges the general public). The court concluded that that statute **<321 Or 144/145>** does not imply the availability of a claim in court. *Id.* at 655, 863 P2d 509. Therefore, the court reasoned, the administrative remedy is exclusive, provided that it is not "demonstrably inadequate." *Id.* The court determined that that administrative remedy is not "demonstrably inadequate." Id. at 655-56, 863 P.2d 509.[7] As a result, the court concluded, the circuit court lacked subject matter jurisdiction over all of SAIF's claims.[8]

Accordingly, the Court of Appeals held that the circuit court erred in failing to dismiss SAIF's claim for money had and received, but correctly dismissed SAIF's ORICO and common law fraud claims. *Id.* at 657, 863 P2d 509. The Court of Appeals did not reach the merits of SAIF's cross-appeal, viz., it did not determine whether there was sufficient evidence to submit SAIF's ORICO and common law fraud claims to the jury.

On review, SAIF argues that, notwithstanding that ORS 656.248(13) provides an administrative remedy for medical fee disputes, the circuit courts have jurisdiction over SAIF's ORICO claims.[9] Defendants argue that DIF has exclusive jurisdiction over medical fee disputes and that the circuit courts therefore have no jurisdiction to consider SAIF's ORICO claims.

ORICO

The legislature enacted ORICO in 1981. Or Laws 1981, ch 769. As pertinent here, ORICO provides:

> "It is unlawful for any person employed by, or associated with, any enterprise to conduct or participate, directly or **<321 Or 145/146>** indirectly, in such enterprise through a pattern of racketeering activity[.]" ORS 166.720(3).

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[7] The court explained that ORS 656.248(13) authorizes the director of DIF to resolve disputes arising under ORS 656.248(3) and that, pursuant to that authority, the director had promulgated rules, including one providing for sanctions for violations of ORS 656.248(3), *former* OAR 436-10-130. *Anderson*, 124 Or App at 655, 863 P2d 509.

[8] In doing so, the Court of Appeals rejected defendants' concessions that SAIF's ORICO claims were properly before the circuit court, explaining:

> "Although it is true that the remedies provided by ORICO 'shall not preclude the application of any other remedy, civil or criminal,' ORS 166.725(12), it does not necessarily follow that the ORICO civil remedies shall not be precluded by other remedies. ORICO does not have the effect of undermining DIF's exclusive jurisdiction to resolve disputes between health care providers and workers' compensation insurance carriers regarding alleged violations of ORS 656.248(3)." *Anderson*, 124 Or App at 657, 863 P2d 509.

[9] SAIF makes no argument in this court about the circuit court's jurisdiction over SAIF's common law fraud and money had and received claims.

"Pattern of racketeering activity" is defined as

> "engaging in at least two incidents of racketeering activity that have the same or similar intents, results, accomplices, victims or methods of commission or otherwise are interrelated by distinguishing characteristics, including a nexus to the same enterprise, and are not isolated incidents, provided at least one of such incidents occurred after November 1, 1981, and that the last of such incidents occurred within five years after a prior incident of racketeering activity." ORS 166.715(4).

"Racketeering activity" is defined, in part, as

> "to commit, to attempt to commit, to conspire to commit, or to solicit, coerce or intimidate another person to commit:
>
> "(a) Any conduct that constitutes a crime, as defined in ORS 161.515, under any of the following provisions of the Oregon Revised Statutes:
>
> " * * * * *
>
> "(K) ORS * * * 164.075 to 164.095 * * * relating to theft, burglary, criminal trespass and related offenses[.]" ORS 166.715(6).

As is evident from the statutes set forth above, an ORICO violation necessarily must be predicated on conduct constituting certain defined crimes. A violation of ORICO is a Class A felony. ORS 166.720(5)(a). ORICO also provides for civil remedies. ORS 166.725. [10]

321 Or 147> WORKERS' COMPENSATION LAW

In 1983, the legislature enacted ORS 656.248(3), providing that "[i]n no event shall a provider charge more than the provider charges to the general public." Or Laws 1983, ch 816, s 6; *see* OAR 436-10-090(9) (1990) (parallel regulation). [11] In 1990, the legislature enacted ORS 656.248(13), quoted *ante* at note 5, authorizing the director of DIF to resolve medical fee disputes between worker compensation

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[10] ORS 166.725(1) authorizes a court to enjoin an ORICO violation in a variety of ways, including but not limited to the following: ordering a defendant to divest any interest in the unlawful enterprise, including real property, ORS 166.725(1)(a); restricting a defendant from engaging in the same type of endeavor as the enterprise in which the defendant was engaged in violation of ORICO, ORS 166.725(1)(b); ordering the dissolution or reorganization of the enterprise, ORS 166.725(1)(c); ordering the suspension or revocation of an agency license granted to the enterprise, ORS 166.725(1)(d); and ordering the forfeiture of a corporate charter, ORS 166.725(1)(e). "Any aggrieved person" may institute a proceeding for these injunctive remedies. ORS 166.725(6). ORS 166.725(2) provides that all real or personal property derived from an ORICO violation is subject to civil forfeiture to the state. Under ORS 166.725(7), any person injured by an ORICO violation has a right to treble and, when appropriate, punitive damages, as well as a right superior to the state's right to forfeiture. The Attorney General, any district attorney, or any agency with jurisdiction over the conduct in violation of ORICO may institute civil proceedings under ORS 166.725. ORS 166.725(5). The Department of Justice or any district attorney is also entitled to seek civil penalties up to $250,000 for an ORICO violation. ORS 166.725(8).

[11] OAR 436-10-090(9) (1990) provided:

> "The medical provider shall bill the medical provider's usual fee charged to the general public. The submission of the bill by the medical provider shall serve as a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department shall have the right to require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public."

insurers and medical service providers. Or Laws 1990, ch 2, s 14; *see* OAR 436-10-110 (1990) (parallel regulation). [12]

ANALYSIS

In support of its ORICO claims, SAIF alleged that defendants committed theft by deception when, with intent to defraud, they created or confirmed SAIF's false impression that their billings to SAIF were in conformity with ORS 656.248(3). The question is whether, by authorizing the director of DIF to resolve medical fee disputes between **<321 Or 147/148>** insurers and providers pursuant to ORS 656.248(13), the legislature intended to deprive the circuit courts of subject matter jurisdiction to consider SAIF's ORICO claims.

As a threshold matter, the question argued by the parties arises only if SAIF's ORICO claims amount to "dispute[s] between an insurer * * * and a medical service provider regarding the amount of * * * fee[s] for medical services." ORS 656.248(13). Whether they do is a question of statutory interpretation and, hence, a question of legislative intent. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). We resolve such questions first by examining the text and context of the relevant statute, using rules of statutory construction that bear directly on how to read that text and context. [13] *Id.*

Defendants are "medical service provider[s]," within the plain, natural, and ordinary meaning of the terms. SAIF is an "insurer" by definition. ORS 656.005(14). The context of ORS 656.248(13) indicates that disputes "regarding the amount of a fee for medical services" include disputes over whether a provider has charged more than he or she charges the general public: ORS 656.248(3), prohibiting such charges, is a separate subsection of the same statute that contains ORS 656.248(13).

The question remains, however, whether SAIF's ORICO claims amount to disputes regarding "the amount of * * * fee[s] for medical services." SAIF suggests that they do not, because ORICO claims do not require proof of a violation of ORS 656.248(3) as a necessary element of those claims. Instead, SAIF argues, "the effect of [ORS 656.248(3)] is only of an evidentiary nature in proving [that] defendant[s] intended to engage in a pattern of [ORICO] predicate acts of theft by deception."

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[12] OAR 436-10-110(1)(a) (1990) provided:

> "In the event of a dispute about fees between the vendor and the insurer, either may request review by the [workers' compensation] division [of DIF]."

Under OAR 436-10-130(2) (1990), a violation of ORS 656.248(3) is subject to:

> " * * * one or more of the following sanctions:
>
> "(a) Reprimand by the director;
>
> "(b) Nonpayment or recovery of fees in part, or whole, for services rendered;
>
> "(c) Referral to the appropriate licensing board; or
>
> "(d) Civil penalty not to exceed $1,000 for each occurrence. In determining the amount of penalty to be assessed, the director shall consider:
>
> "(A) The degree of harm inflicted on the worker or the insurer;
>
> "(B) Whether there have been previous violations; and
>
> "(C) Whether there is evidence of willful violations."

Those sanctions are still available under OAR 436-10-130(1) (1995), currently in force.

[13] Two of those rules are pertinent here. One is required by the Workers' Compensation Law:

> "Except where the context otherwise requires, the definitions given in [the Workers' Compensation Law] governs its construction." ORS 656.003.

The other is derived from case law: words of common usage typically should be given their plain, natural, and ordinary meaning. *See State v. Langley*, 314 Or 247, 256, 839 P2d 692 (1992) (illustrating rule); *Perez v. State Farm Mutual Ins. Co.*, 289 Or 295, 299, 613 P2d 32 (1980) (same).

321 Or 149> Assuming that SAIF's ORICO claims encompass medical fee disputes premised on ORS 656.248(3), they also require proof of defendants' intent to defraud SAIF, so as to establish that defendants committed the predicate crime of theft by deception. ORS 166.715(6)(a)(K); ORS 164.085(1)(a). SAIF's ORICO claims also require proof that defendants engaged in a "pattern of racketeering activity." ORS 166.720(3). As a result, SAIF's disputes with defendants are more than medical fee disputes under ORS 656.248(13). For the reasons that follow, we hold that the legislature did not intend the DIF director's jurisdiction over medical fee disputes to be exclusive in this situation.

ORICO was enacted in 1981. As of that year, SAIF could bring a civil ORICO claim predicated on theft by deception. In 1983, the legislature enacted ORS 656.248(3), prohibiting charges in excess of those charged to the general public. Consequently, as of 1983, an ORICO predicate crime of theft by deception could be based on a violation of ORS 656.248(3).

However, in 1990, the legislature enacted ORS 656.248(13), authorizing the DIF director to resolve medical fee disputes "notwithstanding any other provision of the [Workers' Compensation Law]," and "in such summary manner as the director may prescribe." Assuming, *arguendo*, that ORICO claims based on violations of ORS 656.248(3) encompass medical fee disputes within the meaning of ORS 656.248(13), the question is whether, by enacting ORS 656.248(13), the legislature intended to abolish those ORICO claims.

Brown, on which the Court of Appeals relied, analyzed the question whether a worker had a common law claim for wrongful discharge on the day he was fired, and whether the legislature negated that claim by creating an administrative remedy for the discharge. The court said:

> "As a general rule, if a statute which provides for a new remedy shows no intention to negate, either expressly or by necessary implication, a pre- existing common law remedy, the new remedy will be regarded as merely cumulative, rather than exclusive, with the result that a plaintiff may resort to either the pre-existing remedy or the new remedy. This rule is particularly applicable when the new statutory remedy is not an adequate one. Prior decisions of this court **<321 Or 149/150>** are consistent with this general rule." 284 Or at 610-11, 588 P2d 1087 (footnotes omitted).

Consistent with *Brown*, we conclude that, by enacting ORS 656.248(13), the legislature did not intend to negate SAIF's preexisting ORICO remedy for theft by deception that involves ORS 656.248(3).

We hold, therefore, that by authorizing the director of DIF to resolve medical fee disputes between insurers and providers, ORS 656.248(13), the legislature did not intend to deprive the circuit courts of subject matter jurisdiction to consider SAIF's ORICO claims. The Court of Appeals' decisions to the contrary are in error.

In its cross-appeals to the Court of Appeals, SAIF raised the issues whether there were sufficient evidence in each case to support its ORICO claims.[14] That court did not reach the merits of SAIF's

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[14] The *Anderson* trial court ruled:

> "We're talking about whether a person has the knowledge necessary to have the intent to commit the crime. And the intent of theft by deception is the intent to deceive[.]
>
> " * * * * *
>
> "I'm not satisfied that the evidence is sufficient, and I'm granting the directed verdict as to the ORICO claim[.]"

Similarly, the *DeShaw* trial court ruled:

> "The Court grants the motion[ ] for directed verdict against the RICO * * * claim[ ]. I rule that the evidence is not sufficient to present an issue of fact under the applicable standard of proof[.]
>
> " * * * for the RICO claim[ ] at issue in this case, * * * which involve essentially the fundamental element of intent to deceive, the proof would require--required would be proof by clear and convincing evidence. And I allow the motion for directed verdict on [the ORICO claim]."

cross-appeals. SAIF does not ask us to address those issues on review. Instead, SAIF asks us to remand those issues to the Court of Appeals, in the event that we reverse that court's decision. We do so.

The decisions of the Court of Appeals on SAIF's ORICO claims are reversed. The cases are remanded to the Court of Appeals for further proceedings.

Cite as 321 Or 151, 894 P2d 1163 (1995) May 25, 1995

Supreme Court of Oregon, Argued and Submitted March 8, 1995.

In the Matter of the Compensation of Robert G. Fuls, Claimant.
Robert G. FULS, Petitioner on Review,
v.
SAIF CORPORATION, Donald R. Garner, Travelers Insurance Company and Sunset Glass Company, Respondents on Review.
WCB 91-01005, 90-17213; CA A76999; SC S41662.

In Banc

On review from the Court of Appeals.*

Edward J. Harri, Salem, argued the cause for petitioner on review. With him on the petition was Stanley Fields, of Law Offices of Michael B. Dye, Salem.

Michael O. Whitty, Sp. Asst. Atty. Gen., Salem, argued the cause for respondents on review SAIF Corp. and Donald R. Garner. With him on the brief were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen., Salem.

Jerald P. Keene, of Roberts, Reinich, MacKenzie, Healey & Wilson, P.C., Portland, argued the cause and filed the briefs for respondents on review Travelers Ins. Co. and Sunset Glass Co.

VAN HOOMISSEN, J.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

* Judicial review from the Workers' Compensation Board. 129 Or App 255, 879 P2d 869 (1994).

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321 Or 153> VAN HOOMISSEN, Justice.

In this case we are called on to decide whether claimant's mental disorder resulting from an occurrence at work is an "injury" or an "occupational disease" for purposes of the Workers' Compensation Law. *See* ORS 656.005(7) (regarding compensable injuries);[1] ORS 656.802 (regarding

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[1] ORS 656.005(7) provides:

"(a) A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

"(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.

"(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment.

"(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;

"(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure; or

"(C) Injury the major contributing cause of which is demonstrated to be by clear and convincing evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of such consumption.

"(c) A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death.

"(d) A 'nondisabling compensable injury' is any injury which requires medical services only."

occupational diseases).[2] We also must decide whether claimant's mental disorder was compensable. The Court of Appeals **<321 Or 153/154>** affirmed an order of the Workers' Compensation Board (Board) denying compensability. *Fuls v. SAIF*, 129 Or App 255, 879 P2d 869 (1994). For the reasons that follow, we affirm.

The facts are not disputed. In 1976, claimant sustained an on-the-job injury. Diagnostic tests were carried out between 1976 and 1985 which revealed no pathological, orthopedic, or neurological problem. A number of examiners who saw claimant believed that his condition may have had a strong psychological component. However, before February 1990, no treatment for that condition was recommended.

In 1989, claimant went to work for SAIF's insured, Chuck's Texaco, as an attendant. Based on an incident that occurred at work on February 23, 1990, claimant filed a workers' compensation claim with SAIF's insured.[3] SAIF denied that claim, and claimant sought a hearing.

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[2] ORS 656.802 provides in part:

"(1) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

" * * * * *

"(b) Any mental disorder which requires medical services or results in physical or mental disability or death.

" * * * * *

"(3) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:

"(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.

"(b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.

"(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

"(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

[3] Claimant also filed a claim with Travelers Insurance Company, alleging an aggravation of his 1976 injury. That claim was denied, and the Workers' Compensation Board upheld that denial. Although Travelers is a party to the litigation before this court, claimant's aggravation claim is not at issue here. In this opinion, the term "insurers" is used to describe both SAIF and Travelers.

The referee found in part:

"On February 23, 1990, while at work at Chuck's Texaco, [claimant] sustained a minor shaking incident when he was grabbed from behind in a 'bear hug.' This led to a complete collapse, including loss of sensation, strength in the legs, and paralysis from the neck down. Claimant was immediately seen at the emergency room where Dr. Lewis found no physical problem at all. He was diagnosed as having an hysterical reaction and discharged without treatment. [4]

321 Or 155> "Despite severe symptoms, claimant remained medically stationary. He returned to work on regular duty two days later. He continues to be symptomatic in the same areas as prior to the February 1990 incident. There is no change in symptoms and no new objective findings.

"[Claimant] did not return to see Dr. Paluska [who had previously treated claimant for his compensable 1976 injury] until August of 1990, approximately six months after the shaking incident. Additional diagnostic tests were again negative. Dr. Paluska found no new injury, no pathological worsening of the pre-existing condition, and at best a recurrence of symptoms dating from the prior injuries of 1976 and 1980."[5]

The referee concluded that "the shaking incident of February, 1990, is not a material contributing cause of any new physical injury" and, therefore, "that claimant has not established the compensability of any new injury." The referee further found that, "[i]n the absence of any objective findings **<321 Or 155/156>** of any worsening of [his] left shoulder condition, claimant has failed to establish an aggravation of the 1976 injury."

However, concerning claimant's conversion reaction, the referee found:

"Claimant has an hysterical condition, a conversion reaction. Claimant has had an emotional condition since the 1976 injury. By Stipulation of July 10, 1978, claimant agreed that this psychological condition was not compensable and not the responsibility of Travelers.

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[4] At the hearing, claimant described the customer's physical contact with him as "trying to be a friendly gesture" by the customer, who was a co-worker of claimant's wife, with whom claimant was acquainted. Claimant was asked: "So you wouldn't have anticipated he meant to do any harm to you at all?" Claimant replied, "No, no way."

The emergency room physician was unable to find any physical cause for claimant's subsequent collapse and diagnosed his condition as "conversion hysteria following a mild shaking by another person." Evidence was received indicating that claimant's treating physician, Dr. Paluska, believed that claimant "had a conversion reaction even before the shaking incident. This has been ongoing for years." Dr. Paluska also opined that the February 1990 event was the major contributing cause of claimant's need for treatment.

"The essential feature of [conversion disorder] is an alteration or loss of physical functioning that suggests physical disorder, but that instead is apparently an expression of a psychological conflict or need." Diagnostic and Statistical Manual of Mental Disorders 257 (3d ed (revised) 1987).

[5] The referee's ultimate findings of fact were:

"Claimant sustained no new physical injury as a result of the February, 1990 incident. There are no objective findings of any injury.

"Claimant's compensable left shoulder condition did not worsen after the February, 1990 incident. He was not more disabled and he did not need medical treatment for it. Moreover, there are no objective findings of any worsening and no pathological worsening of the underlying condition.

"Claimant has had a psychological component to his continuing problems since at least 1978, in varying degrees. The February 1990 incident produced a conversion reaction or hysteria, and resulted in a worsening of the prior psychological condition. The 1976 shoulder injury is not a material contributing cause of the need for treatment or disability resulting from the conversion reaction."

"Following the 1990 incident, claimant was diagnosed as having a conversion reaction. This diagnosis is an actual diagnosis of a mental condition recognized in the medical community. See DSM III, Sec. 100.11. There is substantial evidence in this record to indicate that claimant has this condition, and has had at least elements of it since 1976.

" * * * * *

"The February 1990 event was the material contributing cause of the conversion reaction and need for medical treatment. Claimant has established the compensability of the conversion reaction.

" * * * * *

"[T]he 1990 event produced a new injury, a psychological condition. I have found that condition to be compensable; consequently responsibility shifts to the second carrier, here SAIF Corp."

The referee rejected SAIF's argument that ORS 656.802, specifically subsection (3) of that statute relating to occupational diseases in the form of mental disorders, applied to claimant's claim for his conversion reaction. Accordingly, the referee set aside SAIF's "*de facto*" denial of claimant's claim for a conversion reaction.

SAIF requested review by the Board, seeking to set aside the portion of the referee's order regarding the compensability of claimant's psychological condition. Claimant did not seek Board review of the referee's order.

On review, the Board adopted the referee's findings of fact. The Board described the event as follows:

"On February 23, 1990, claimant was working as a gas station attendant for SAIF's insured. While he stood at the cash register processing a credit card purchase, a customer <321 Or 156/157> walked up behind him and greeted him by grasping his upper arms and briefly shaking him. Claimant immediately lost control of his legs and collapsed to the floor. He was able to stand up and walk to a chair, but then he felt completely paralyzed from the neck down. He was taken to the hospital emergency room strapped to a back board with a cervical collar. Approximately four hours later, claimant felt severe pain from his neck to his feet. He was diagnosed with conversion hysteria."

The Board agreed with SAIF that claimant's claim should be analyzed as an occupational disease claim. The Board reversed the referee's conclusion that claimant's conversion reaction was compensable. Claimant sought judicial review.[6]

The Court of Appeals affirmed, concluding that, because claimant is seeking to establish the independent compensability of a mental disorder, his claim must be analyzed as an occupational disease claim under ORS 656.802. *Fuls*, 129 Or App at 261, 879 P2d 869. The court found that claimant's claim was for an "occupational disease" and agreed with the Board's determination that claimant's February 1990 workplace incident was not compensable, because the greeting from the customer "was not outside the range of behavior or physical interaction that occurs in every working situation." *Id.* at 262, 879 P2d 869.

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[6] The Board relied on *SAIF v. Hukari*, 113 Or App 475, 480, 833 P2d 1307, *rev den* 314 Or 391, 840 P2d 709 (1992), which had held that a claim that "a condition is *independently compensable* because it was *caused by on-the-job stress*, regardless of the suddenness of onset or the unexpected nature of the condition, and regardless of whether the condition is mental or physical, must be treated as a claim for an occupational disease under ORS 656.802." (Emphasis in original.) The Court of Appeals noted, however, that this court has "rejected the holding [in *Hukari*] that any claim based on stress must be analyzed as an occupational disease claim." *Fuls*, 129 Or App at 256, 879 P2d 869 (citing *Mathel v. Josephine County*, 319 Or 235, 875 P2d 455 (1994)).

On review in this court, claimant argues that his condition is an injury, not an occupational disease, because it had a "sudden onset" and, therefore, that ORS 656.802(3) does not apply. Alternatively, claimant argues that, if ORS 656.802(3) does apply, "conditions generally inherent in every working situation" cannot include acts such as the customer's shaking of claimant, which claimant describes variously as "unconsented," "unlawful," "criminal," or "tortious."

321 Or 158> SAIF responds that the text of ORS 656.802(3) establishes that any mental disorder must be treated as an occupational disease under the Workers' Compensation Law, and that this interpretation is consistent with this court's recent pronouncements in *Mathel v. Josephine County*, 319 Or 235, 241-42, 875 P2d 455 (1994), and *DiBrito v. SAIF*, 319 Or 244, 875 P2d 459 (1994). SAIF also asserts that the text, context, and legislative history of ORS 656.802(3) indicate that a customer's physical greeting of a worker, such as the one shown here, is a condition generally inherent in every working situation and, thus, a mental disorder caused by such conduct is not compensable.

This court's task is to discern the legislative intent behind ORS 656.802, in order to determine whether a condition such as claimant's is to be treated as an "occupational disease" under that statute. The text of that statute is the starting point for interpretation. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993) (describing method of statutory construction).

Claimant argues that, despite the language of ORS 656.802, a "sudden onset injury in the form of a mental disorder" should not be analyzed under ORS 656.802 but, rather, should be treated as an "injury," as defined in ORS 656.005(7). It is true that this court's cases have drawn a distinction between occupational diseases and occupational injuries along the lines that occupational diseases are gradual rather than sudden in onset. *See, e.g., James v. SAIF*, 290 Or 343, 624 P2d 565 (1981) (so indicating); *see also Mathel*, 319 Or at 240-42, 875 P2d 455 (citing *James*, noting that heart attack was sudden onset condition, and rejecting argument that it was an occupational disease). However, ORS 656.802(1)(b) specifically includes "[a]ny mental disorder" within the definition of "occupational disease," without regard to the suddenness of its onset.

Claimant concedes that the condition for which he seeks compensation-- conversion disorder--is a mental disorder. See Diagnostic and Statistical Manual of Mental Disorders 257-59 (3d ed (revised) 1987) (describing features of "conversion disorder" or "hysterical neurosis, conversion type"). Our analysis of the statute proceeds from that concession. Because the sole condition for which claimant seeks **<321 Or 158/159>** compensation is a "mental disorder" by claimant's concession, his claim is not compensable, pursuant to the unambiguous terms of ORS 656.802(3), unless paragraphs (a) through (d) of that subsection are satisfied.

We next turn to the question whether claimant's mental disorder is compensable under ORS 656.802.[7] The dispute centers on ORS 656.802(3)(b), over whether the conditions that produced claimant's need for treatment for his conversion disorder were "conditions other than conditions generally inherent in every working situation."

Before we analyze the statute, we reiterate the Board's finding as to the nature of the "employment conditions" that produced claimant's conversion disorder. A customer, with whom claimant was acquainted, "walked up behind him and greeted him by grasping his upper arms and briefly shaking him."

Our purpose is to discern whether the legislature intended to exclude mental disorders produced by such contacts from compensation under the Workers' Compensation Law, on the basis that such contacts are "conditions generally inherent in every working situation." *PGE*, 317 Or at 611-12, 859 P2d 1143.

We turn to the text of the relevant portion of ORS 656.802(3): "conditions generally inherent in every working situation." Something that is "inherent" is "structural or involved in the constitution or essential character of something: belonging by nature or settled habit." Webster's Third New Int'l Dictionary (unabridged ed 1993), 1163. "Every" includes "each individual or part of a class or group whether definite or indefinite in number without exception." *Id.* at 788. We conclude that the phrase "conditions generally inherent in every working situation" describes conditions which, by nature or settled habit, arise in all working situations, without exception.

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[7] The parties do not dispute whether claimant's conversion disorder has satisfied the conditions set forth in ORS 656.802(3)(a), (c), and (d), and we do not address those provisions.

However, the presence of the word "generally" at the beginning of this phrase qualifies that meaning. As used in this context, "generally" means "in a reasonably inclusive **<321 Or 159/160>** manner: in disregard of specific instances and with regard to an overall picture." *Id.* at 945. The presence of the word "generally" at the beginning of the phrase may indicate a legislative intent to disregard specific instances and focus, rather, on the overall picture of what occurs in working situations. To do so, however, would alter the "without exception" meaning of the term "every."

Because "every" and "generally" as used in the text have somewhat conflicting meanings, and the context sheds no light on the legislature's intent in choosing this phrase, we turn to the legislative history of this provision.

ORS 656.802(3) was amended significantly by House Bill 2271 in 1987, adding the criterion regarding "conditions generally inherent in every working situation." Or Laws 1987, ch 713, s 4. As introduced, this provision indicated that "a mental disorder is not compensable under this chapter * * * unless the employment conditions producing the psychologic stress are extraordinary in nature." At a public hearing, it was suggested that the term "extraordinary" was too vague and, as a result, the House Committee on Labor amended the phrase to read: "Unless the employment conditions producing the mental disorder are conditions other than conditions inherent in every working situation." Public Hearing, House Committee on Labor, March 6, 1987, Tape 48, Side A; A-Engrossed House Bill 2271. [8] In response to **<321 Or 160/161>** other concerns brought out at public hearings, that the "inherent in every working situation" language was too narrow, the Senate Committee on Labor added the qualifier of "generally" to the beginning of the phrase. Senator Hill said that this change was proposed, because the current language would make it difficult for employers to defend mental disorder claims; it would be impossible to demonstrate that a condition was inherent in absolutely *every* working situation. Senate Committee on Labor, April 23, 1987, Tape 120, Side A. *See also* Senate Committee on Labor, June 8, 1987, Exhibit A (Chairman Hill's proposed amendment); B-Engrossed House Bill 2271.

Although the legislative history reveals that the legislature considered how broad or narrow this exception should be, it does not reveal whether the legislature intended the specific type of condition at issue in this case to be excluded or included from "conditions generally inherent in every working situation." From the context and the legislative history of this provision, we are able to discern, though, that the legislature intended to curtail compensable claims for mental disorders based on on-the-job

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[8] The following discussion took place in public hearings in the House Committee on Labor:

HENRY DRUMMONDS: "Mr. Chairman, members of the committee, I am speaking on behalf of the Oregon Education Association in these remarks. In support [of], with certain modifications, the so-called House task force bill 2271. * *

> "The second proposed amendment is in the area specifically defining the types of mental stress that can be compensable. And we basically propose to support the task force bill in its entirety, with the proposed amendment that you see underscored there in section 2B. What we are proposing to do is to delete the phrase where it says 'unless the employment conditions producing the psychological stress are extraordinary in nature,' which is an exception that is written into this bill, we propose to change the phrase 'extraordinary in nature' to a phrase again taken directly word for word from the bill sponsored by Senator Hill and Representative Kotulski, 'conditions other than conditions which are generally inherent in every working situation.' * * * "

There was no explanation why the language proposed by Mr. Drummonds, "generally inherent in every working situation," was altered to leave out the word "generally" in the A-Engrossed version of the bill.

stressors. *See, e.g.*, Public Hearing, Senate Committee on Labor, April 23, 1987, Tape 120, Side A (comments by legislators that bill was intended to limit stress claims).[9]

321 Or 162> Based on this information, we turn to the question whether the Board's decision that claimant's mental disorder was the result of "conditions generally inherent in every working situation" appears to be within the legislative policy that inheres in the statutory term.

Human interactions are "conditions generally inherent in every working situation."[10] Although the amount and type of interaction with supervisors, co-workers, or customers may vary depending on the type of working situation, some interaction is inherent. Human interaction involves greeting.

Claimant has asserted that the customer's greeting of him, which is at issue in this case, can be seen as tortious, and that it would be against public policy to hold that such contact could be conditions generally inherent in every working situation. We reject the characterization of the conduct in question as tortious, because the agency's unchallenged findings and claimant's own statements show that the greeting was simply that--a greeting--which lacked any intent on the part of the customer to bring about harm. *See generally Bakker v. Baza'r, Inc.*, 275 Or 245, 249, 551 P2d 1269 (1976) (battery requires actor to have intended to bring about a harmful or offensive contact or put the other party in apprehension thereof). We also reject claimant's similar assertion that the conduct in question could have constituted a criminal assault, because claimant concedes that he did not suffer a physical injury. *See* ORS 163.160-.185 (assault requires "physical injury").

321 Or 163> We affirm the Board's characterization of this type of conduct by a person with whom one is expected to interact in the workplace, which does not result in a physical injury, as a condition that is "generally inherent in every working situation."[11] Thus, claimant's need for treatment of his mental disorder brought about by this greeting is not compensable under ORS 656.802.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

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[9] The following discussion took place in a public hearing in the Senate Committee on Labor:

"[REPRESENTATIVE SHIPRACK:] Sub b says that they've got to be conditions other than those conditions inherent in any, pardon me, in every working situation. So that means that they would have to be something that everyone would, everyone would agree are inherent to what you see everyday in the workplace.

"[SENATOR HANNON:] If I may stop you just for a moment, Representative. Could that same sort of standard be used for office worker versus say like a firefighter? Would the same basis, standard, apply in the workplaces?

"[REPRESENTATIVE SHIPRACK:] The intent there, Senator, is that in the workplace, you are expected to show up on time, you are to cooperate, perhaps, with your fellow employees, you are expected to have certain things unrelated to the specific occupations involved. This may also address itself to the fact that perhaps in every, in every experience you will have times of layoff. It does not--the intent of this is not to say a firefighter has a more stressful job than someone digging ditches, perhaps, although occasionally * * * be that way. We didn't want to get into that. That's not the intent of the House, to say that this profession is something, and this isn't. But there are certain duties in the workplace that are inherent to every job. And that's what we're trying to say there."

" * * * * *

"[REPRESENTATIVE SHIPRACK:] We're not getting rid of stress disabilities in this bill, as some people may have said. We're not repealing stress disabilities. *What we are doing, we are certainly tightening it up.* I will grant you that. I think it, perhaps, in a few random cases, it has, there has been some problems. In the definitions, what you see in sub B is one thing that, I guess, is probably the part of the definition that will do the most to clarify what the intent of the house is." Public Hearing, Senate Committee on Labor, April 23, 1987, Tape 120, Side A (emphasis added).

[10] Insurers do not argue that claimant's claim is barred under the provision of ORS 656.802(1), which limits occupational disease claims to things "caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment." We express no opinion as to the applicability of this section to the present case.

[11] We note, however, that if an overzealous greeting (such as a handshake that injures the fingers or a pat on the back that knocks over the recipient) results in a physical injury, the compensation claim would be for an "injury," ORS 656.005(7), rather than for an occupational disease, and would not be subject to the restrictions found in ORS 656.802(3)(b).

Cite as 134 Or App 625, 896 P2d 16 (1995) May 31, 1995

Court of Appeals of Oregon.
Argued and Submitted May 10, 1995.

In the Matter of the Compensation of Lori A. Newell, Claimant.
Lori A. NEWELL, Petitioner,

v.

SAIF CORPORATION and Benton County, Respondents.
WCB 92-09328; CA A81960.

Judicial review from Workers' Compensation Board.

Robert Wollheim, Portland, argued the cause, for petitioner. With him on the brief were James C. Egan and Emmons, Kropp, Kryger, Alexander, Egan & Allen, P.C., Albany.

Michael O. Whitty, Sp. Asst. Atty. Gen., argued the cause, for respondents. With him on the brief were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen.

Before DEITS, P.J., and De MUNIZ and LEESON, JJ.

PER CURIAM

Reversed and remanded.

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134 Or App 626> Claimant seeks review of the Board's order holding that it lacked jurisdiction to determine whether surgery proposed by her physician was a reasonable and necessary medical treatment for her condition and upholding employer's partial denial of her claim for symptoms in her right forearm and hand.

As SAIF concedes, under the Supreme Court's decision in *Niccum v. Southcoast Lumber Co.*, 320 Or 189, 880 P2d 923 (1994), the Hearings Division of the Board has jurisdiction to consider the appropriateness of the proposed treatment for claimant's compensable deQuervains's condition. Accordingly, we remand for the Board to consider this question.

With respect to claimant's claim for symptoms in her right forearm and hand, we affirm the Board's opinion without discussion.

Reversed and remanded.

Cite as 135 Or App 62 (1995) June 21, 1995

Argued and Submitted March 27, 1995.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Susan L. Jones, Claimant.

Susan L. JONES, Petitioner,
v.
PRECISION CASTPARTS, Respondent.
WCB No. 93-02083; CA A83817.

Judicial Review from Workers' Compensation Board.

Kevin Keaney, Portland, argued the cause for petitioner. With him on the brief was Pozzi Wilson & Atchison.

Deborah L. Sather, Portland, argued the cause for respondent. With her on the brief were Tracy J. White and Stoel Rives Boley Jones & Grey.

Before RIGGS, P.J., and LANDAU and LEESON, JJ.

RIGGS, P.J.

Affirmed.

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135 Or App 64> Claimant seeks review of an order of the Workers' Compensation Board holding that her claim was not prematurely closed. We affirm the Board, because its findings are supported by substantial evidence.

Claimant injured her neck at work in October 1990. Her claim for acute cervical strain was accepted by employer. Claimant underwent surgery, including a three level diskectomy and fusion at C5-6, C6-7, and C7-T1, performed by Dr. Misko, her treating physician. In 1991, claimant began seeing Dr. Irvine for shoulder pain related to the cervical strain. In September 1991, Misko found that two of the levels on which surgery had been performed, C6-7 and C7-T1, had failed to completely fuse. To try to save the fusion, Misko prescribed an electrical collar for claimant to wear. She wore the collar for about six months. In March 1992, after reviewing claimant's x-rays, Misko found that the fusion had healed and that claimant no longer needed to wear the collar. He scheduled claimant for a follow up visit in three months. On June 15, Misko found claimant further improved, but with some continued left shoulder pain, for which Irvine had prescribed physical therapy. On June 24, 1994, Misko reported that although the fusion was not yet solid at C5-6 and C7- T1, there was no motion at those levels and he referred claimant to Dr. Snodgrass for a closing examination. Snodgrass performed a closing examination on June 25, 1992, and although claimant continued to complain of left shoulder pain, no further active treatment was recommended.

On July 31, 1992, relying on Misko's statement, Snodgrass reported that, because the fusion was not yet solid, claimant was not medically stationary. On August 3, 1992, Misko reported that, although the fusion was not yet solid, it would continue to solidify, and because there was no significant motion at those levels, claimant was medically stationary.[1] Irvine agreed with Misko and reported that claimant's shoulder was medically stationary. On September 30, 1992, the claim was closed with a determination that claimant was **<135 Or App 64/65>** medically stationary and an award of 34 percent unscheduled permanent partial disability and 7 percent loss of use of the left arm.

After claim closure, on October 23, 1992, claimant returned to Misko with complaints of shoulder discomfort, which Misko attributed to "slight motion" at C5-6 that claimant "still" has. He predicted that the fusion would become solid naturally within two years, but gave claimant the option of surgical refusion. In November 1992, Misko reported that claimant's condition had worsened and that the top level of her fusion was not solid. He recommended surgery to repair the fusion.

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[1]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."

Claimant requested reconsideration of the notice of closure, raising issues relating to the date she was declared medically stationary and her entitlement to benefits for permanent and total disability. Misko reiterated his opinion that claimant had become medically stationary on June 24, 1992, but that her condition had worsened on October 23, 1992. He expressly rejected the suggestion that his earlier opinion as to claimant's medically stationary date had been premature.

In February 1993, in an order on reconsideration, the Appellate Unit rescinded the notice of closure, based on the October 23, 1992, medical report of Misko stating that there was "slight motion" and recommending further surgery. The referee reinstated the notice of closure, saying:

> "There is no medical evidence in this record prior to claim closure that either the passage of time (in this case apparently two years for the fusion to solidify) or further medical treatment (surgery) was expected to produce material improvement. Dr. Snodgrass merely stated the conclusion that claimant was not medically stationary because her fusion was not solid, but did not indicate that solidification would cause material improvement. Dr. Misko is claimant's primary treating physician, and he reaffirmed that claimant was medically stationary in June, 1992 even after being provided with the statutory definition of medically stationary * * *. The fact that Dr. Misko found claimant worse subsequent to September 30, 1992, is immaterial in determining her medically stationary status on September 30, 1992. Therefore the claim was not prematurely closed." The Board affirmed the referee.

135 Or App 66> Claimant's contention on review is that, because the fusion had not yet solidified on the closing date and it was known at the time that it would continue to solidify, claimant's medical condition was expected to improve with the passage of time and she was not medically stationary. That view is supported, she contends, by the October 23, 1992, report of Misko, in which he noted that claimant's fusion "still" was not solid and would take two years to solidify, and offered surgery to resolve claimant's continuing pain. The suggestion from that report, claimant contends, is that claimant's fusion had never been solid, and because claimant's pain would resolve only when her fusion had solidified, she would not be medically stationary until that time.

Misko's opinion, as repeatedly expressed in his reports, was that despite the fact that claimant's fusion had not "technically" solidified as of June 1992, there was no significant motion at that time and she was medically stationary. At the time of claim closure, on September 30, 1992, those reports supported closure of the claim. Claimant's reliance on Misko's October 23 report is misplaced. In the first place, we disagree that the report suggests that claimant had not been medically stationary in June 1992. Misko's notation that claimant "still has slight motion" must be read in the light of his subsequent view that the motion reflected a recent exacerbation of claimant's condition. If anything, Misko's report may support a claim for an aggravation of her injury. However, the subsequent, post-closure changes in claimant's condition do not make an earlier closure premature. *Alvarez v. GAB Business Services*, 72 Or App 524, 527, 696 P2d 1131 (1985). We conclude that substantial evidence supports the Board's determination that claimant was medically stationary on June 24, 1992, and that the claim was not prematurely closed.

Affirmed.

Cite as 135 Or App 67 (1995), 897 P2d 335 (1995) June 21, 1995

In the Court of Appeals of the State of Oregon
In the Matter of the Compensation of William A. Strametz, Deceased, Claimant.

The BENEFICIARIES of the ESTATE OF William A. STRAMETZ, Deceased, Claimant, Petitioner,
v.
SPECTRUM MOTORWERKS, INC., Spectrum Motorwerks, Ltd., and SAIF Corporation, Respondents.
WCB Nos. 91-17385; 91-10418; CA A80582.

In Banc*
Argued and submitted Aug. 18, 1994.
Resubmitted In Banc May 3, 1995.
Kevin Keaney, Portland, argued the cause for petitioner. On the brief were Susan Frank and Pozzi, Wilson & Atchison.
Darren L. Otto, Portland, argued the cause for respondents Spectrum Motorwerks, Ltd. and SAIF Corp. With him on the brief was Scheminske & Lyons.
Michael O. Whitty, Sp. Asst. Atty. Gen., argued the cause for respondents Spectrum Motorwerks, Inc. and SAIF Corp. With him on the brief were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen.
RIGGS, J.
Reversed and remanded for reconsideration.
Deits, J., dissenting.
Edmonds, J., dissenting.
* Landau, J., not participating.

RIGGS, Judge.

135 Or App 69> Claimant[1] seeks review of a final order of the Workers' Compensation Board affirming employer's denial of his claim. He argues that the Board misinterpreted the last injurious exposure rule. We reverse and remand for reconsideration.

At the time of the hearing in 1992, claimant was a 43-year-old auto mechanic suffering from mesothelioma, a cancer of the chest cavity. The only known cause of mesothelioma is asbestos. Claimant had served in the Navy from 1963 to 1968, where he was exposed to asbestos. After his discharge, he worked as an auto mechanic for 24 years but did not begin working in Oregon until 1984. There is evidence that claimant was exposed to asbestos as an auto mechanic. In 1990, while working for Spectrum Motorwerks, Ltd., claimant sought treatment for chest pains, which were later diagnosed as symptoms of his mesothelioma.

Claimant filed a claim against his Oregon employers, and settled with all of them except Spectrum Motorwerks, Inc. (SMI) and Spectrum Motorwerks, Ltd. (SML). [2] Both employers denied the

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[1] William A. Strametz originally filed the claim at issue in this case. He pursued his claim through the hearing before the referee and before the Board on review. William Strametz has since died. The beneficiaries of his estate are allowed to proceed with his claim under ORS 656.218(3), which provides:

> "If the worker has filed a request for a hearing pursuant to ORS 656.283 and death occurs prior to the final disposition of the request, the persons described in subsection (5) of this section shall be entitled to pursue the matter to final determination of all issues presented by the request for hearing."

Thus, although we use the term claimant in referring to Strametz, it is for ease of reference. The actual claimants are the beneficiaries of his estate.

[2] SMI was an Oregon business formed by claimant and his wife in the mid 1980's. In July 1988, SMI became insured by SAIF, but the insurance did not provide coverage to claimant because of his status as a partner in SMI. *See* ORS 656.027(8). In July 1989, claimant and his wife sold the business and it was renamed SML. Claimant continued to work at SML as a subject employee. SML was later declared to be a non-complying employer.

claim and claimant requested a hearing. Dr. Dobrow, claimant's treating physician and the only medical witness to testify regarding causation, testified that mesothelioma has a minimum latency period of 10 years. The Board found that the asbestos exposure that caused the mesothelioma must have occurred before 1980. That led the Board to conclude that it was impossible for any Oregon **<135 Or App 69/70>** employment to have caused claimant's mesothelioma and the Board affirmed employer's denial. We review for errors of law, ORS 656.298(6); ORS 183.482(8)(a), and reverse.

In this case, both responsibility and compensability are at issue. In order to establish that his mesothelioma is an occupational disease, claimant must show that it arose "out of and in the course of employment" and was "caused by substances or activities to which [he was] not ordinarily subjected or exposed other than during a period of regular actual employment * * *." ORS 656.802(1). In other words, he must show that work was the major contributing cause of his disease. *Runft v. SAIF*, 303 Or 493, 498, 739 P2d 12 (1987); *Bennett v. Liberty Northwest Ins. Corp.*, 128 Or App 71, 74, 875 P2d 1176 (1994). In determining whether a claimant's occupational disease is work-related, the Board should consider all employment exposure, including out-of-state employment exposure. *Silveira v. Larch Enterprises*, 133 Or App 297, 303, 891 P2d 697 (1995). Here, the evidence as to causation indicates that claimant's lifetime work-related exposure to asbestos caused his mesothelioma.

The employers contend that, because of the latency period of mesothelioma, they could not actually have caused claimant's condition and the claim is not compensable as to them. When a claimant has been exposed to the disease-causing substance at more than one employment, questions naturally arise as to the nature and degree of exposure at each employment and how they might bear on the compensability of the claim. The Supreme Court explained the problem in *Runft*, 303 Or at 499, 739 P2d 12:

> "[O]ccupational diseases * * * often develop several decades after first exposure to the disease-causing substance. Although it may be relatively simple to identify the employments at which the claimant was or could have been exposed, it will often be difficult or impossible to establish the nature and degree of the exposure. Similarly, although the relationship between a disease and exposure to a substance may be well established, it will often be difficult to state with sufficient medical probability the degree to which, if any, a particular exposure contributed to the development of the disease."

135 Or App 71> To alleviate that problem, the courts have adopted the last injurious exposure rule. Under that rule, if a claimant

> "proves that a disease was triggered at one time, claimant has carried his burden of proof by establishing that the employer on the risk at the time disability occurred could have caused it, even though previous employers provided conditions which could have caused it, and the rule relieves the claimant of any burden of proving actual causation." *Bracke v. Baza'r*, 293 Or 239, 248-49, 646 P2d 1330 (1982).

In *Runft*, the Supreme Court said:

> "The claimant is required to prove only that the disease was caused by employment-related exposure; the claimant is not required to prove that exposure at a particular employer's workplace caused the disease. *Whether employment at any one workplace was the actual cause of the disease is irrelevant under the rule.*" 303 Or at 500, 739 P2d 12. (Emphasis supplied.)

Thus, it is immaterial for purposes of establishing the compensability of the claim, that the employers here, because of the latency period of mesothelioma, were not the actual cause of claimant's disease. All claimant must show to establish a compensable claim is that conditions at the Oregon employer were of the type that could have caused the disease. *Accord Bracke*, 293 Or at 248-49, 646 P2d 1330; *Fossum v. SAIF*, 293 Or 252, 646 P2d 1337 (1982); *Meyer v. SAIF*, 71 Or App 371, 692 P2d 656 (1984), *rev den* 299 Or 203, 700 P2d 251 (1985); *but see FMC Corp. v. Liberty Mutual Ins. Co.*, 70 Or App. 370, 689 P2d 1046 (1984), *on recon* 73 Or App 223, 698 P2d 551, *rev den* 299 Or 203, 700 P2d 252 (1985).

Employers next contend that, because of the latency period of mesothelioma, conditions of employment at their workplaces could not have contributed to claimant's disease. Therefore, they argue, and the dissent[3] agrees, they cannot be found responsible for claimant's occupational disease. The **<135 Or App 71/72>** Supreme Court rejected this very argument in *Fossum*. *Fossum* also involved a claimant with mesothelioma. The claimant had worked for three shipbuilders from the early 1940's to 1948, for W.R. Grasle from 1948 to 1967 and for Willamette Western from 1969 to 1976. In 1977 the claimant died and his widow filed a claim against all the employers. The Board found that the claimant had not proved actual causation against any one employer and held that the claim was not compensable. We reversed, holding that:

> "This particular form of cancer does not generally develop until 20 to 40 years after exposure. While it is clear that the deceased was exposed to asbestos at Willamette Western, we are satisfied from the medical evidence that this exposure did not contribute to the cause of his disease in this case and could not have done so."

Fossum v. SAIF, 52 Or App 769, 774, 629 P2d 857 (1981), *aff'd* 293 Or 252, 646 P2d 1337 (1982). The Supreme Court affirmed this court, "but on different reasoning." It first noted that conditions at Willamette Western did not involve exposure to asbestos, then stated:

> "*The Court of Appeals apparently excluded the [Willamette Western] employment because it was not an actual cause. The correct analysis under the last injurious exposure rule, however, is that [Willamette Western] is not liable because there is no evidence of exposure at [Willamette Western] to conditions which could have caused the disease.*" 293 Or at 256, 646 P2d 1337 (emphasis supplied).

At that point, the Supreme Court included the following footnote:

> "The employment at Willamette Western could not have been an actual cause of the disease because it was during the 20-year period before which actual causation must have occurred. *Had it been proved and found that the conditions of exposure at Willamette Western were of a kind which could have caused the disease, then under the last injurious exposure rule as described by Larson, Willamette Western would be liable even though that employment could not have been the actual cause.*" 293 Or at 256 n 1, 646 P2d 1337 (emphasis supplied).

The present case is almost identical to the hypothetical posed by the court in the footnote in *Fossum*.

135 Or App 73> We demonstrated our understanding of *Fossum's* rejection of employer's and the dissent's analysis in *Meyer*. In *Meyer*, the claimant sought review of a Board order upholding SAIF's denial of his claim for asbestosis. SAIF had denied responsibility in *Meyer* for the same reason that SAIF denies it here: the medical evidence indicated that the exposure did not cause the disease. The doctor in *Meyer* testified that "[i]n my opinion, that particular exposure would have nothing to do with his current condition." We stated:

> "That the 1978 exposure was not the actual cause of claimant's present condition does not absolve SAIF from responsibility, for the appropriate inquiry under the last injurious exposure rule is not whether the conditions of the last employment actually caused the disease, but whether those conditions were of a kind which could have caused the disease over some indefinite period of time. *Mathis v. SAIF*, 10 Or App 139, 499 P2d 1331 (1972); *see Fossum v. SAIF*, 293 Or 252, 256, n 1, 646 P2d 1337 (1982)."

The dissent attempts to distinguish *Meyer* by saying '[h]ere, decedent died before any potentially hazardous work conditions with employer could have caused other tumors.' 135 Or App at 83. The

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[3] There are two dissents to this opinion. Judge Deits dissents for the same reasons she dissented in Silveira v. Larch Enterprises, 133 Or.App. 297, 891 P.2d 697 (1995). Judge Edmonds dissents for fundamentally different reasons that were not at issue in Silveira. Judge Deits' concerns were answered in the majority's opinion in Silveira. Thus, when we refer to the dissent in this opinion, we are referring solely to Judge Edmonds' dissent.

dissent is correct, but that does not distinguish *Meyer*. In *Meyer*, there was no doubt that the work conditions at the employer did not and could not have caused the claimant's disease. The issue was whether the conditions, if exposure was continued over some time, could cause the disease. Here, as in *Meyer*, the testimony clearly indicates that the conditions could cause the diseases from which claimant suffers. In this case, Dr. Dobrow, plaintiff's oncologist, testified as follows:

> "Q. I want you to assume, and this is probably something that will never happen, but assume that [claimant] doesn't die from the tumor that he has now, this mesothelioma tumor that he has now.
>
> "You're not telling us that the exposure that he's had in April, May, June and July of 1989 could not cause a tumor in the future?
>
> "A. *No, I'm not saying that--that--that they could not cause a future tumor.*
>
> " * * * * *
>
> "Q. Assuming that there was exposure then those, in your opinion, are potentially harmful exposures to [claimant]?
>
> Beneficiaries of Estate of Strametz v. Spectrum Motorwerks, Inc.
>
> **135 Or App 74>** "A. *After a sufficient incubation period, yes.*
>
> " * * * * *
>
> "Q. You can tell us that potentially this exposure, if it's--if it occurred between April and June or July of 1989, was at least potentially causative, potentially harmful to [claimant]?
>
> "A. *Potentially at some future date,* but not dealing with this present tumor." (Emphasis supplied.)

Dr. Dobrow's testimony clearly indicates his belief that, given "a sufficient incubation period," or, as the dissent might put it, "an indefinite period of time," claimant's exposure could, in fact, have caused his disease.

If a claimant proves that there was Oregon employment with "conditions of exposure * * * of a kind which could have caused the disease," then the last employer with those conditions will be assigned responsibility under the last injurious exposure rule. Neither the Board nor the referee reached that question in this case, because they mistakenly determined that, because of the latency period, neither SML nor SMI could have been the actual cause of claimant's disease.

We recognize that our application of the last injurious exposure rule in this fashion leads to an arbitrary and counter-intuitive result. Nevertheless, since the rule's inception, the courts, for appropriate policy reasons, have accepted its arbitrary nature. *See Inkley v. Forest Fiber Products Co.*, 288 Or 337, 345, 605 P2d 1175 (1980); *Bracke*, 293 Or at 248, 646 P2d 1330; 4 Larson, *Worker's Compensation Law* 17-173, s 95.24 (1994). As the Supreme Court has said:

> "[T]he rule can be extremely arbitrary in a particular case, but this arbitrariness is mitigated in the long run as responsibility is spread proportionately among employers by operation of the law of averages." *Runft*, 303 Or at 500, 739 P2d 12.

The reason for the rule lies not in the achievement of individualized justice, but rather in its utility in spreading liability fairly among employers by the law of averages and in reducing litigation. *Bracke*, 293 Or at 248, 646 P2d 1330.

The legislature generally has accepted the arbitrary nature of the last injurious exposure rule, except where it has **<135 Or App 74\75>** decided to change it. As the dissent correctly notes, the legislature recently amended ORS 656.308(1) to read as follows:

> "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." ORS 656.308(1).

The new language "makes it more difficult to transfer responsibility for a condition or disability to a subsequent employer." *SAIF v. Drews*, 318 Or 1, 860 P2d 254 (1993). The effect of that amendment was to overturn some aspects of the last injurious exposure rule as developed in *Runft*, *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 675 P2d 1044 (1984) and *Bracke*. *Drews* at 7 n 3, 860 P2d 254. However, the amendment had no effect on the last injurious exposure rule in an initial claim context. *Bennett*, 128 Or App at 75 n 1, 875 P2d 1176. The 1991 amendments modified one particular application of the last injurious exposure rule, but left most of the rule intact. The dissent does not claim that the amendments changed the last injurious exposure rule enunciated in *Meyer* and *Fossum*. Instead, it attempts to assess the legislature's general intent. 135 Or App at 84. A more plausible reading of the effect of the 1991 amendments is that the legislature had the opportunity to amend the operation of the rule in an initial claims context, but chose not to. *Cf. Fifth Avenue Corp. v. Washington County*, 282 Or 591, 597-98, 581 P2d 50 (1978) (amendatory acts do not change the meaning of preexisting language further than is expressly declared or necessarily implied).

The basic effect of the rule is to create a risk pool of all employers whose workplaces have conditions that could cause the disease. As the Supreme Court explained in *Bracke*:

> "[The last injurious exposure rule] is fair to employers only if it is applied consistently so that liability is spread proportionately among employers by operation of the law of averages. * * * [Employers may require consistent application of the rule] so as to assure that they are not assigned disproportionate shares of liability relative to other **<135 Or App 75/76>** employers who provide working conditions which generate similar risk." 293 Or at 249-50, 646 P2d 1330.

The dissent demonstrates a fundamental misunderstanding of the last injurious exposure rule when it speaks of the rule creating "a risk pool of those employers of the claimant who could have actually contributed to the cause of the claimant's disease." 135 Or App at 86. To speak of "the law of averages" spreading liability proportionately only "among the employers who exposed the claimant to similar risks" makes no sense. Under the last injurious exposure rule, only one of a particular claimant's employers is found liable and all other employers have no liability. Under the dissent's concept of the risk-pool, there is no "spreading of liability." The dissent apparently recognizes the weakness of its artificial "risk pool" construct and posits an alternative reason why the correct conception of the risk pool is still unfair. 135 Or App at 86, n 2. However, that argument is the same one that Judge Deits makes in her dissent here and in *Silveira*. We see no reason to revisit our earlier decision.

The dissent later castigates the majority for "empower[ing] the imposition of responsibility on an innocent employer" and says that the net result makes

> "an Oregon employer responsible for a disease that was like a time bomb in decedent before he ever came to work in Oregon and to which the Oregon employer did not contribute or cause. That's not fair!"

The dissent might have a point, if employers held liable under the last injurious exposure rule were truly innocent. However, the employers subject to liability under the rule are only those with harmful working conditions that could cause the disease. Liability attaches to an Oregon employer only if it is creating its own time bombs.

Finally, the dissent argues that:

> "There is nothing in the Workers' Compensation Act to suggest that the legislature ever envisioned that an Oregon employer could be responsible for out-of-state employment conditions based on the law of averages among employers world-wide." 135 Or App at 87.

135 Or App 77> The dissent is correct, but we note that there is also nothing in the Workers' Compensation Act to suggest that the legislature ever envisioned that an Oregon worker with an occupational disease caused entirely by his working conditions could go without compensation. In the light of the long-standing policy that the Workers' Compensation Act is to be liberally construed for the benefit of the worker, *Fossum v. SAIF*, 289 Or 787, 805, 619 P2d 233 (1980); *Liberty Northwest Ins. Corp. v. Short*, 102 Or App 495, 499, 795 P2d 118 (1990); *Holden v. Willamette Industries*, 28 Or App 613, 618, 560 P2d 298 (1977), and the fact that the legislature has not specifically addressed this question, we fail to understand the dissent's strained attempts to ignore controlling precedent. [4]

The last injurious exposure rule requires that this case be remanded to the Board for consideration of whether SMI or SML are responsible for the claim because conditions at those employments were of a kind that could have caused the disease.

Reversed and remanded for reconsideration.

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[4] We note that we are not the first state to come to this conclusion and also note what the Nebraska Supreme Court has said:

> "[E]ven though liability imposed under this rule can have a harsh result [in a particular case], there will be a spreading of the risk when the total picture of asbestos litigation is considered on a nationwide basis." *Osteen v. A.C. & S., Inc.*, 209 Neb 282, 307 NW2d 514 (1981).

DEITS, Presiding Judge, dissenting.

For the reasons I discuss in my dissenting opinion in *Silveira v. Larch Enterprises*, 133 Or App 297, 891 P2d 697 (1995), I believe that the inquiry into the compensability of claimant's disease in this case must be limited to his Oregon employment. Because the Board's finding that claimant's work exposure while employed by an Oregon employer could not have contributed to his disease is supported by substantial evidence, I would agree with the Board that claimant's condition is not compensable in Oregon. Accordingly, I dissent.

EDMONDS, Judge, dissenting.

On the basis of the judicially-created "last injurious exposure rule," the majority holds employer responsible for **<135 Or App 77/78>** the decedent's occupational disease when the medical evidence is uncontroverted that it was medically impossible for the exposure to asbestos at employer's workplace to have actually contributed to the cause of decedent's disease. The majority's application of the rule to the facts of this case is misplaced, and, for reasons that will become apparent, works an unjust result on employer.

I. It is medically impossible for employer's work environment to have contributed to the cause of the decedent's cancer.

The Board held that claimant's work exposure while employed by any Oregon employer could not have contributed to the causation of the mesothelioma tumor that resulted in the worker's death. The decedent worked as an auto mechanic for 24 years before his death. During that time, he was exposed to asbestos through his work on brake linings and clutch pads. He was also exposed to asbestos while in the Navy from 1963 to 1968. The Board found

> "Doctor Dobrow, oncologist, opined that claimant's lifetime exposure to asbestos caused the mesothelioma. Dr. Dobrow explained, however, that there is generally a latency period of 30 to 40 years between the time of asbestos exposure to the onset of mesothelioma. Based on his research and experience, Dr. Dobrow added that he knew of no cases in which the latency period was less than 10 years.
>
> "Based on claimant's history of chest pains, Dr. Dobrow opined that the mesothelioma was in place as early as March 1990. Therefore, based on Dr. Dobrow's opinion, we find that the asbestos exposure causing the mesothelioma must have occurred by March 1980, or 10 years prior to onset.

"The record shows that claimant was not employed by an Oregon employer on or before March 1980. Rather, prior to that time, claimant had been in the Navy and had been employed as a mechanic in California and Florida. Claimant was not employed in Oregon until 1984.

"Based on the medical record, each and every potentially causal Oregon employment has demonstrated that it was impossible for them, individually or as a group, to have contributed to the causation of this condition. * * *

"Based on Dr. Dobrow's opinion that there is a 10-year latency period prior to the onset of mesothelioma, we find **<135 Or App 78/79>** that claimant's work exposure while employed by any Oregon employer could not have contributed to the causation of the mesothelioma. Accordingly, claimant's condition is not compensable." (Citation omitted.)

There is substantial evidence to support the Board's findings. Strametz died in 1994, subsequent to the Board's order. Because, based on the medical evidence, there is a minimum period of 10 years that must elapse after the date of exposure before an employer's work environment could contribute to decedent's disease, it was medically impossible for the decedent's Oregon employment to have contributed to his disability. Nevertheless, the majority reverses the Board's decision and makes employer responsible for his occupational disease claim based on an application of the "last injurious exposure rule."

II. The cases relied on by the majority do not decide whether the application of the last injurious exposure rule is applicable to the facts of this case.

Under the last injurious exposure rule, "the last employer who materially contributes to a worker's disabling condition is liable for compensation for the entire cumulative disability." *Bracke v. Baza'r*, 293 Or 239, 244, 646 P2d 1330 (1982). The majority applies the rule to this case because of language in footnote 1 in *Fossum v. SAIF*, 293 Or 252, 646 P2d 1337 (1982), even though employer could not have contributed to the decedent's condition. The footnote in its entirety says:

"The employment at Willamette Western could not have been an actual cause of the disease because it was during the 20-year period before which actual causation must have occurred. Had it been proved and found that the conditions of exposure at Willamette Western were of a kind which could have caused the disease, then under the last injurious exposure rule as described by Larson, Willamette Western would be liable even though that employment could not have been the actual cause. *See* 4 Larson, Workmen's Compensation Law s 95.21, *but see Bracke*, [293 Or at 250 n 5, 646 P2d 1330]. Where, as here, claimant's interests are protected because all potentially causal employers are parties, it is arguable that a defense of actual impossibility should be allowed to reduce the otherwise arbitrary operation of the last injurious exposure rule. *Cf.* [*Id.*] Because there is no evidence of potentially **<135 Or App 79/80>** causative exposure at Willamette Western or Grasle, however, we need not decide this issue." 293 Or at 256 n 1, 646 P2d 1337.

To put the footnote on which the majority relies in proper context, it is necessary to understand the facts in Fossum. Like this case, *Fossum* was a workers' compensation claim brought by the widow of a worker who died from mesothelioma. *Fossum* was an electrical worker who had worked for three different shipbuilders in the early 1940's. From 1948 to 1967, he worked primarily for the W.R. Grasle Company. From 1969 to 1976, he worked for an employer named Willamette Western. Shortly after leaving Willamette Western, the decedent was diagnosed as having mesothelioma, and he died in 1977. According to the medical testimony in that case, mesothelioma does not develop until 20 to 40 years after the exposure to asbestos. *Fossum*, 293 Or at 255, 646 P2d 1337.

On review, the Supreme Court held that as a matter of law that the claimant failed to establish that Fossum was exposed to asbestos during his post-1945 employment under conditions that could have caused the mesothelioma. *Id.* at 256, 646 P2d 1337. Regarding Grasle, an electrical construction company, the nature and intensity of the claimant's exposure to asbestos was not established by the

evidence. *Id.* at 255-56, 646 P2d 1337. As to Willamette Western, where the claimant was exposed to asbestos in the course of making brake linings, one expert witness testified that that employment could not have caused the disease and the other said that, although there was no statistical evidence that brake lining manufacture caused mesothelioma, "it was possible only in the sense that it could not be ruled out." *Id.* at 256, 646 P2d 1337. The court said that the evidence was insufficient as a matter of law to establish that Willamette Western was responsible under the last injurious exposure rule. *Id.* at 256, 646 P2d 1337. Footnote 1, on which the majority relies, follows this language in the text:

> "In applying the last injurious exposure rule to claims for occupational disease, however, the issue is not which employment actually caused the disease but which employment involved conditions which could have caused it. If conditions of exposure at Grasle could have caused the disease, for example, the exposure would have been prior to the 20-year minimum period for disease development and Grasle would have been liable as potentially causative under the last **<135 Or App 80/81>** injurious exposure rule. The Court of Appeals apparently excluded the Grasle employment because it was not an actual cause. The correct analysis under the the last injurious exposure rule, however, is that Grasle is not liable because there is no evidence of exposure at Grasle to conditions which could have caused the disease. The same may be said of the employment at Willamette Western." 293 Or at 256-57, 646 P2d 1337.

The reference in footnote 1 to *Bracke* is significant. In *Bracke*, the claimant had demonstrated actual causation. The issue was whether an employer could use the "last injurious exposure rule" as a defense where the worker established that she contracted the disease and suffered disability while working for that employer, but that she also worked for subsequent employers under conditions which could have caused the disease. The court accepted the evidence believed by this court that claimant's subsequent employment only activated the symptoms of her preexisting disease, and held that a recurrence of symptoms that did not affect the extent of the continuing underlying disease did not shift liability from the initial employer to the subsequent employer. *Id.* at 250, 646 P2d 1330. The court noted:

> "[T]he employment subsequent to Baza'r did not contribute to the cause of, aggravate or exacerbate the underlying disease. Had that occurred, a later employer would be liable under the last injurious exposure rule of liability, *see* n 5." *Id.*

Footnote 5 in *Bracke* says, in relevant part:

> "There is no reason to apply the [last injurious exposure] rule with any greater arbitrariness than is required to achieve its purposes, but there is no basis in this case to recognize an exception or qualification of the rule." *Id.*

Clearly, the holding in *Fossum* does not answer the question before us today. There, the court expressly declined to apply the last injurious exposure rule to two employers when the evidence was insufficient to prove that their workplaces had conditions that could have caused the claimant's disease. Moreover, in the same footnote on which the majority relies, the court recognizes that a defense of actual impossibility may be available "arguably" to reduce the arbitrary operation of the last injurious exposure rule, but it expressly says that it does not decide the issue with which we are faced. At best, the majority relies on *dictum*. Finally, the reference **<135 Or App 81/82>** to Bracke indicates that the Fossum court was cognizant that a predicate to the application of the "last injurious exposure rule" is that the conditions of the workplace could have caused or contributed to the claimant's disability and that the defense of "actual impossibility" may be available under some circumstances.

The majority also relies on *Runft v. SAIF*, 303 Or 493, 739 P2d 12 (1987), and the statement made in that case that,

> "Whether employment at any one workplace was the actual cause of the disease is irrelevant under the rule." 303 Or at 500, 739 P2d 12.

The issue in *Runft* was whether an employer whose working conditions were the major contributing cause of the claimant's asbestosis could avoid responsibility for payment of compensation by showing that the working conditions at the claimant's later employment contributed to the claimant's disability. The claimant had made no claim against the subsequent employer and the first employer had not sought to join the subsequent employer in the administrative proceeding. The court held that the first employer could not avoid responsibility under those circumstances. The statement, "the actual cause of the disease is irrelevant under the rule," is made in the context of the pronouncement that the last injurious exposure rule relieves claimants of the burden of proving the degree to which, if any, exposure at a particular employer actually caused the disease. It does not necessarily follow from the fact that a claimant is relieved of the burden of proving actual causation, that all of his employers are potentially responsible.

Finally, the majority relies on *Meyer v. SAIF*, 71 Or App 371, 692 P2d 656 (1984), *rev den* 299 Or 203, 700 P2d 251 (1985). In *Meyer*, the claimant sought review of an order of the Board upholding SAIF's denial of benefits for the claimant's asbestosis. Throughout the claimant's career, he had been exposed to asbestos while working for different employers. His last employment-related exposure was in 1978 while employed by SAIF's insured. SAIF denied responsibility on the ground that the claimant's condition was caused by his earlier exposure. The only doctor to testify about the effect of the 1978 exposure on the claimant's condition said:

135 Or App 83> " 'In my opinion, that particular exposure would have nothing to do with his current condition. Exposure was brief, a mask was worn and the time course for the development of asbestosis is far too long to imagine any exposure in 1978 would have significantly altered his current condition.' " 71 Or App at 374, 692 P2d 656.

We held,

> "[t]hat the 1978 exposure was not the actual cause of claimant's present condition does not absolve SAIF from responsibility for the appropriate inquiry under the last injurious exposure rule is not whether the conditions of the last employment actually caused the disease but whether those conditions were of a kind which could have caused the disease over some indefinite period of time. *Mathis v. SAIF*, 10 Or App 139, 499 P2d 1331 (1972); *see Fossum v. SAIF*, 293 Or 252, 256, n 1, 646 P2d 1337 (1982). To that inquiry, Dr. Patterson testified as follows:
>
> " 'Q And would it be your opinion that the circumstances as described would constitute the type of exposure that, if continued over some period of time, could be significantly injurious to an individual's health?
>
> " 'A Yes, if these exposures were continued for a sufficient period of time, I think they could be injurious.' " *Meyer*, 71 Or App at 374, 692 P.2d 656.

We concluded,

> "Because the conditions in claimant's 1978 employment at Contractors, Inc. [SAIF's insured] were of a kind which could have caused asbestosis over some indefinite period of time, that employment is deemed to have caused the disease. *FMC Corp. v. Liberty Mutual Ins. Co.*, 70 Or App 370, 689 P2d 1046 (1984) [*adhered to on recon* 73 Or App 223, 698 P2d 551, *rev den* 299 Or. 203, 700 P.2d 252 (1985)]. SAIF is the responsible insurer." *Meyer*, 71 Or App at 375, 692 P2d 656. (Footnote omitted.)

Here, decedent died before any potentially hazardous work conditions with employer could have caused other tumors. Consequently, employer did not contribute, nor could it have contributed, to decedent's condition. Moreover, the legislature has changed the law of the responsibility of employers since the cases relied on by the majority were decided, the significance of which will be discussed below. In sum, the issue before us is one of first impression, and we **<135 Or App 83/84>** should consider the application of the rule to the facts of this case in the light of the policy underlying the rule.

III. The policy underlying the last injurious exposure rule should not apply to this case because it will result in an unjust imposition of responsibility on employer.

Any application of the "Last Injurious Exposure Rule" should coincide with legislative intent inasmuch as the Workers' Compensation Act is a product of political compromise, and not the common law. *McGarrah v. SAIF*, 296 Or 145, 160, 675 P2d 159 (1983). Under current law, a compensable occupational disease is:

> "[A]ny disease * * * arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death * * *." ORS 656.802(1).

In 1990, a special session of the legislature passed Senate Bill 1197, which provides, in relevant 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." ORS 656.308(1).

Accordingly, in ORS 656.308(1), the legislature has expressed its intention that only employers who have contributed to the cause of the claimant's disability are responsible employers. [1] *See also SAIF v. Drews*, 318 Or 1, 7 n 3, 860 P2d 254 (1993), where the court recognized that one of the purposes of the 1990 amendments was to overturn the line of cases adopting the "last injurious exposure" rule and to **<135 Or App 84/85>** "make it more difficult to transfer responsibility for a condition or disability to a subsequent employer." Moreover, as the Supreme Court in *Bracke* admonished, there is no reason to apply what is an arbitrary rule to those situations in which the purpose of the rule is not furthered.

Inherent in the policy underlying the rule is the concept that it is fair to impose liability on an employer who could have contributed to the claimant's disability, because the employer exposed the worker to disease-causing conditions.

> "The reason for the [last injurious exposure rule] lies not in [the] achievement of individualized justice, but rather in [the] utility in spreading liability fairly among employers by the law of averages and in reducing litigation.
>
> " * * * * *
>
> "The operation of the rule * * * provides certainty in a way which is 'somewhat arbitrary.' It operates generally for the benefit of the interests of claimants. *It is fair to employers only if it is applied consistently so that liability is spread proportionately among employers by the operation of the law of averages.* We hold that employers have and may assert an interest in the consistent application of the last injurious exposure rules, either as to proof or liability, so as to assure that they are not assigned disproportionate shares of liability relative to other employers who provide working conditions which generate similar risk." *Bracke*, 293 Or at 248-250, 646 P2d 1330. (Emphasis supplied.)

The application of the rule to factual contexts other than this one is fair because it permits the worker to establish that his disability was caused by a disease that could have resulted from conditions at two or more places of employment. Once the causation requirement of some contributing exposure has been met, the last employer of the claimant who could have contributed to the disability is responsible even though the worker has not proved that the last employment was the actual cause of the disease. *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 342-43, 605 P2d 1175 (1980). However, the rule "is not intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not," and it does not prevent "an employer from proving that the claimant's disability was caused by a different employment or that the disability **<135 Or App 85/86>** did not arise from any work-related injury." *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244, 675 P2d 1044 (1984). As we said in *FMC Corp. v. Liberty Mutual Ins. Co.*, 70 Or App 370, 689 P2d 1046 (1984).

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[1] In *Liberty Northwest Ins. Corp. v. Senters*, 119 Or App 314, 317, 850 P2d 403 (1993), we held that ORS 656.308 was intended to apply to occupational disease claims. That holding is contrary to a statement made by Representative Mannix before the House of Representatives during the process of the adoption of SB 497. See Tape Recording, House Special Session, May 7, 1990, Tape 2, Side A at 190. Nonetheless, our holding remains the law.

> "[I]n order for [employer], as the last employer where conditions existed that *could* have caused the disease, to shift responsibility to an earlier employer where working conditions could have caused the disease, it must establish that the conditions of the earlier employer were the *sole* cause or that it was *impossible* for conditions at [employer's] plant to have caused the disease." 70 Or App at 374, 689 P2d 1046. (Emphasis in original.)

Thus, the effect of the rule is to create a risk pool of those employers of the claimant who could have actually contributed to the cause of the claimant's disease and assess responsibility on the basis of the law of averages. Although application of the rule by placing responsibility on the last employer in the risk pool is arbitrary because it may have contributed little to the claimant's disability, generally that hardship is ameliorated by the operation of the law of averages among the employers who exposed the claimant to similar risks.[2] In contrast, for those employers who are not in the risk pool for whatever reason, the policy of spreading the risk among potentially causative employers has no application because there is no probability that their work environment contributed to the claimant's disease. In that event, the element of fairness inherent in the policy underlying the rule does not exist. Thus, in *Starbuck*, where the evidence showed that the claimant's disability was caused solely by an injury occurring during an earlier employment, the court held, "[T]here is no reason to apply the rule." 296 Or at 243, 675 P2d 1044.

Here, the estate of decedent properly relied on the rule to prove causation. However, that does not prevent any employer of the decedent from proving that it is not responsible for his disease. Employer offered evidence that it was medically impossible for employer's work conditions to have contributed to the condition that resulted in the decedent's **<135 Or App 86/87>** death. Based on that fact, the referee and the Board were correct in refusing to hold employer responsible because it could not have contributed to the causation of decedent's tumor. In the light of the legislature's expression that employers are only responsible for those conditions caused by them, the application of the rule to employer when the decedent's other employers could have caused the disease and when those employers are all out of state makes the majority's ruling particularly unfair to employer. Decedent's other employers are not in the risk pool and subject to the "law of averages" arbitrarily imposed on employer by the majority. The net result of the majority's decision is to enlarge the risk pool by making an Oregon employer responsible for a disease that was like a time bomb in decedent before he ever came to work in Oregon and to which the Oregon employer did not contribute or cause. That's not fair!

There is nothing in the Worker's Compensation Act to suggest that the legislature ever envisioned that an Oregon employer could be responsible for out-of-state employment conditions based on the law of averages among employers worldwide. The majority's empathy for the beneficiaries of decedent is understandable, but it should not empower the imposition of responsibility on an innocent employer. The last injurious exposure rule, a product of judicial fiat, should not be extended beyond the lines drawn by its purpose. Such social adventures should be left to the legislature, which can properly undertake the delicate balancing of the conflicting interest of labor, management and the insurance industry.

I dissent.

De MUNIZ, J., joins in this dissent.

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[2] Even if the language in the case law means that the law of averages is spread among all employers whose workplaces have conditions that could cause other claimants to become diseased rather than among those employers of a particular claimant, the efficacy of the rule is lost when other potentially responsible employers are out of state and not subject to the same risk as an Oregon employer.

Cite as 135 Or App 155, 897 P2d 1172 (1995) June 21, 1995

Court of Appeals of Oregon,
Argued and Submitted Dec. 23, 1994; Resubmitted in banc June 8, 1995.

In the Matter of the Compensation of Steven L. Cline, Claimant.

SAIF CORPORATION and Weaver Construction Co., Petitioners,
v.
Steven L. CLINE, Respondent.
WCB 93-00701; CA A83804.

In Banc

Michael O. Whitty, Sp. Asst. Atty. Gen., argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson & Jensen.

LANDAU, J.

Reversed and remanded for reconsideration.

Employer seeks review of an order of the Workers' Compensation Board that awarded claimant a penalty under ORS 656.268(4)(g). We reverse and remand for reconsideration.

Claimant suffered a compensable injury to his thumb. When that condition became medically stationary, employer issued a notice of closure, awarding 23 percent permanent scheduled disability for the thumb. Claimant requested reconsideration. He was examined by a medical arbiter. As a result of that examination, his award was increased to 42 percent permanent scheduled disability for the thumb and 6 percent for the hand.

Claimant requested a hearing, arguing that he was entitled to a penalty under ORS 656.268(4)(g), because his compensation had been increased by more than 25 percent, and he had been determined to be at least 20 percent disabled. Employer argued that a penalty was not appropriate, because, among other things, claimant had not been determined to be at least 20 percent disabled. According to employer, ORS 656.268(4)(g) permits an award of penalties only if the entire worker, not a body part, has been determined to be at least 20 percent disabled. Employer argued that OAR 436-30-050(13) provides a methodology for converting percentages of disability for body parts to percentages of disability of the whole worker, and that, under that rule, claimant is less than 20 percent disabled.

The Board refused to apply OAR 436-30-050(13) and awarded the penalty. It concluded that the statute does not require conversion of percentages of disability for body parts to percentages of disability for the whole worker. Employer seeks review, arguing that the Board erred in failing to apply OAR 436-30-050(13). [1] Claimant responds that we rejected **<135 Or App 157/158>** the same arguments in *Nero v. City of Tualatin*, 127 Or App 458, 873 P2d 390 (1994).

ORS 656.268(4)(g) provides:

> "If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

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[1] Employer also argues that the Board erred in imposing the penalty without some showing of wrongdoing or unreasonable conduct. We recently rejected that argument in *SAIF v. St. Clair*, 134 Or App 316, 894 P2d 1264 (1995). We also do not address whether a penalty under ORS 656.268(4)(g) may be assessed in the first instance by the Board, rather than by the department on reconsideration. That issue has not been raised.

To administer that statutory provision, the Department of Consumer and Business Services (the department) promulgated a series of regulations that require a percentage of unscheduled disability or a percentage of scheduled disability for a particular body part to be converted to "degrees," with 320 degrees comprising a whole worker. *See generally* OAR 436-35-001 *et seq.* OAR 436-30-050(13) then provides:

> "[A] worker who receives a total sum of 64 degrees of scheduled and/or unscheduled disability shall be found to be at least 20 percent disabled."

The issue in this case is the validity and applicability of OAR 436-30- 050(13).

Our review of the validity of an agency rule depends on the type of statutory term construed by the rule. *Springfield Education Assn. v. School Dist.*, 290 Or 217, 223, 621 P2d 547 (1980). In this case, the statutory reference to "the worker" being found "at least 20 percent permanently disabled," is an inexact term, because the legislature has expressed itself completely, but the meaning of its enactment is subject to agency interpretation. *Id.* at 224-28, 621 P2d 547. Accordingly, our task is to determine whether the agency has erroneously interpreted the law. *England v. Thunderbird*, 315 Or 633, 638, 848 P2d 100 (1993).

We begin with the text and context of the statute, which include provisions concerning the same or related matters. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 611-12, 859 P2d 1143 (1993). The text of ORS 656.268(4)(g) refers to the disability of "the worker," not a particular body **<135 Or App 158/159>** part. That strongly suggests that the percentage of disability should be construed accordingly, and that the percentage of disability of a particular body part must be converted to a percentage of the whole worker before the statute may apply.

That construction is borne out by the statutory context. The extent of disability is determined first by whether the worker's disability is scheduled or unscheduled. Scheduled disabilities are those involving the loss of use or function of any of a series of organs or body parts specifically enumerated by statute. ORS 656.214(2) through (4). If the worker suffers an injury to one of those organs or body parts, the worker is awarded a certain amount of money for each "degree" of disability, with 320 degrees comprising the whole worker. ORS 656.214(5). For example, the fourth finger is assigned six degrees of disability. If a worker loses 50 percent of the use or function of a fourth finger, the worker has suffered three degrees of disability. ORS 656.214(2)(k). It is important to note that the "percentage" reference only describes the extent of loss of use of the limb, not the disability of the whole worker. The statute uses "degrees" as the unit of measurement of the disability of the whole worker.

If the disability is not expressly scheduled in ORS 656.214(2) through (4), the disability is unscheduled. Disabilities resulting from injuries to the head, back or neck, for example, are unscheduled. A worker receives a specified sum of money depending on the worker's degrees of unscheduled disability, based on the percentage of loss of earning capacity due to the compensable injury. ORS 656.214(5). Thus, a worker who suffers a back injury that causes a loss in earning capacity of 50 percent has suffered 160 degrees of disability, once again with 320 degrees comprising the whole worker. ORS 656.214(5).

The statutory use of the degrees of disability, therefore, provides the common unit of measurement, and a worker with at least 20 percent permanent disability is one who has suffered 64 degrees of disability. That is, in fact, the way the Supreme Court has applied the statutes. In *Foster v. SAIF*, 259 Or 86, 91-92, 485 P2d 407 (1971), for example, the court combined percentages of scheduled and unscheduled disabilities by translating them both into their common unit of measurement, degrees, and then adding the degrees to **<135 Or App 159/160>** arrive at a total disability figure. Similarly, in *Olds v. Superior Fast Freight*, 36 Or App 673, 677, 585 P2d 709 (1978), we did the same thing. Although the statutes have been amended since both decisions were issued, those amendments have not affected the language at issue and, therefore, remain illustrative of the proper manner in which to read the law.

In short, the statutes define a worker in terms of 320 degrees, and further define disability of the worker in terms of a percentage of those degrees. Accordingly, when a worker suffers an impairment of a particular body part, to determine the extent of disability to the whole worker, the disability must be translated into the statutory unit of measurement: the degree. That is precisely what the department's rules accomplish. They convert various percentages of disability for various body parts into degrees of

the whole worker. Then, if the worker is determined to have suffered 64 degrees of permanent disability, the worker is considered to be at least 20 percent disabled within the meaning of the statute. OAR 436-30-050(13).

That the department's rules constitute the only reasonable construction of the statute is further borne out by the consequences of a contrary construction. Assuming for the sake of argument that claimant is correct, a worker who has suffered the entire loss of a little finger is 100 percent permanently disabled within the meaning of the statute, although the loss of that finger results in less than two percent disability of the worker. ORS 656.214(2)(k). Moreover, if claimant is correct that percentages of disability need not be translated to degrees of a whole worker, then percentages of scheduled and unscheduled disability could be directly added together. Thus, if a worker suffered a 10 percent scheduled disability of a forearm and a 10 percent unscheduled disability of the lower back, the worker would be considered 20 percent disabled for the purposes of ORS 656.268(4)(g), even though, as a review of the law makes clear, that would be akin to saying the sum of two inches and two feet is four feet.

We are aware of the fact that our decision in Nero may be read to support claimant's arguments. In that case, the Board determined that the claimant had suffered an 11 percent loss of a scheduled body part and a 12 percent unscheduled loss. Because the two losses translated to a sum **<135 Or App 160/161>** of only 55 degrees of disability, the Board concluded that the claimant was not entitled to a penalty under ORS 656.268(4)(g). We reversed. It bears noting that the parties in that case did not challenge the validity of OAR 436-30- 050(13), and we expressly declined to rule on that issue. Moreover, the only issue that the parties did raise was whether it was proper to combine awards for scheduled and unscheduled disability in determining whether the worker is at least 20 percent permanently disabled. We held that it is proper to do that, and our decision today is consistent with that construction of the law. Nevertheless, we did reverse the Board in *Nero*. That result cannot be squared with our opinion today and, in that respect, *Nero* should be regarded as overruled.

We conclude that OAR 436-30-050(13) is valid and that the Board erred in declining to apply it in this case.

Reversed and remanded for reconsideration.

Cite as 135 Or App 176 (1995) June 21, 1995

Court of Appeals of Oregon.
Argued and Submitted March 20, 1995.

Jasper OSBORN and Judy Osborn, Appellants,
v.
CRANE EQUIPMENT MANUFACTURING CORPORATION, Defendant,
and
Niedermeyer-Martin Company and Richard Walls, Respondents.
No. 9202-01217; CA A78833.

Appeal from Circuit Court, Multnomah County.
Lee Johnson, Circuit Judge.
James L. Edmunson, Eugene, argued the cause, for appellants. On the briefs was Peter O. Hansen, Portland.
Karen O'Kasey, Portland, argued the cause, for respondents. With her on the brief were Erich H. Hoffmann and Schwabe, Williamson, Wyatt.
Michael V. Phillips, Eugene, filed an amicus curiae brief, for Oregon Trial Lawyers Ass'n.
Before RIGGS, P.J., and LANDAU and LEESON, JJ.
LEESON, J.
Reversed and remanded.

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135 Or App 178> Plaintiff[1] appeals from an adverse judgment in his third-party tort action against defendant Niedermeyer-Martin Company (NMC) for personal injuries sustained during his employment with Pacific Wood Treating Corporation (PWTC). We reverse and remand.

NMC is an Oregon corporation that buys raw lumber, poles and piling and sells them to PWTC for treatment with creosote. PWTC then sells the treated product back to NMC, which in turn sells it to the customer. Plaintiff was employed by PWTC as a pilot car driver. He was severely injured when a pole fell on him while he was watching the loading of an NMC-owned truck that he had been assigned to pilot. The poles were being delivered to PWTC by NMC. The truck driver, defendant Richard Walls, was an NMC employee.

Plaintiff received workers' compensation benefits from PWTC for his injuries. He filed this third-party claim against NMC and Walls pursuant to ORS 656.154. NMC moved for summary judgment on the ground that the interrelationship between NMC and PWTC made NMC plaintiff's employer for purposes of workers' compensation. The trial court denied the motion, but bifurcated the trial, considering first the question of whether NMC was immune from plaintiff's claim under ORS 656.018. After a fact-finding hearing, the trial court found that, although there is no "direct" employment relationship between plaintiff and NMC, NMC and PWTC are the same entity, that plaintiff therefore is a subject worker of NMC, and that, accordingly, NMC is immune from liability pursuant to ORS 656.018. The court entered judgment for NMC.

ORS 656.018 provides, in part:

> "(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the **<135 Or App 178/179>** subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom * * *.
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> " * * * * *

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[1] Plaintiffs are Jasper Osborn, the injured worker, and his wife Judy. For the sake of convenience, we use the term "plaintiff" when referring either to Jasper or to Jasper and Judy. Defendant Crane Equipment Manufacturing Corporation is not a party to this appeal.

> "(3) The exemption from liability given *an employer* under this section is also extended to the employer's insurer, the self-insured employer's claims administrator, the department, and the contracted agents, employees, officers and directors of the employer, the employer's insurer, the self-insured employer's claims administrator and the department * * *[.]" (Emphasis supplied.)

An "employer," for purposes of ORS chapter 656, is defined in ORS 656.005(13) as

> "any person * * * who contracts to pay a remuneration for and secures the right to direct and control the services of any person."

The trial court expressly found that, although the NMC truck driver was responsible for directing plaintiff in such matters as route, speed and breaks during dispatch, that "modicum of supervisory authority" was not sufficient control by NMC to make plaintiff a subject worker of NMC for purposes of workers' compensation.

The trial court concluded, nonetheless, that the exemption of ORS 656.018 was available to NMC, because of "the intercorporate relationship between * * * PWTC and NMC." The court reasoned, essentially, that if PWTC had been unable to satisfy its obligations to plaintiff, then plaintiff could have successfully challenged the separate corporate identities of PWTC and NMC, "pierced the corporate veil," and made a claim against NMC. Accordingly, the court concluded that PWTC and NMC are one and the same for purposes of the immunity conferred by ORS 656.018.

Plaintiff assigns error to many of the trial court's findings in support of its conclusion that PWTC and NMC are one corporation. He contends that those findings are incomplete or that they are not supported by the record. In our view, however, the proper inquiry concerns NMC's relationship with plaintiff, not its relationship with PWTC. As the Supreme Court said in *Martelli v. R.A. Chambers and Associates*, 310 Or 529, 536, 800 P2d 766 (1990), the immunity **<135 Or App 179/180>** conferred by ORS 656.018 is available only to one who fills the role of the plaintiff's employer, by virtue of the direction and control of the worker's services. The record supports the trial court's determination that under that test, plaintiff was a subject worker of PWTC, not of NMC. Additionally, NMC does not fit within any of the other categories of persons entitled to immunity under ORS 656.018. That is the extent of our inquiry. We reject the contention that NMC should be treated as claimant's employer for the purpose of immunity because of the nature of its relationship with PWTC. The employment relationship exists for the purpose of immunity under ORS 656.018 only if there is an employment relationship between the plaintiff and the defendant as defined in the Workers' Compensation Law. We decline to inquire into whether the separate corporate identities of NMC and PWTC might be subject to challenge in a hypothetical claim against NMC for PWTC's misconduct. Here, plaintiff seeks to sue NMC for NMC's own negligence. As a legal matter, ORS 656.018 offers no protection to NMC in the absence of an employment relationship.

In a cross-assignment of error, defendants challenge the trial court's determination that plaintiff was not a subject worker of NMC for workers' compensation purposes. Our examination of the record reveals evidence supporting both parties' positions regarding the direction and control test for purposes of determining whether PWTC or NMC was plaintiff's employer. The evidence supports the trial court's determination that NMC's involvement with plaintiff did not give rise to an employment relationship with NMC.

Reversed and remanded.

Cite as 135 Or App 202, 897 P2d 347 (1995) June 21, 1995

Court of Appeals of Oregon.
Argued and Submitted March 27, 1995.

In the Matter of the Compensation of Mary C. Hurlburt, Claimant.
Mary C. HURLBURT, Petitioner,
v.
TECTON LAMINATES CORP., and Liberty Northwest Insurance Corporation, Respondents.
WCB 91-12466; CA A85967.

Judicial Review from Workers' Compensation Board.

Thomas O. Carter, argued the cause and filed the brief for petitioner.

Alexander D. Libmann, Senior Trial Counsel, Liberty Northwest Ins. Corp., argued the cause and filed the brief for respondents.

Before RIGGS, Presiding Judge, and LANDAU and LEESON, Judges.

PER CURIAM

Affirmed.

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135 Or App 203> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in affirming the referee's order that failed to award her permanent and total disability. We affirm.

Claimant, who was 53 years old at the time of the hearing, injured her back at work in March 1989. She was treated with surgery in November 1989 and is presently treated with medication. Although the parties agree that claimant is not completely disabled from a physical standpoint, claimant contends that when her medical restrictions are considered in combination with her age, limited education and extensive use of medication, the finding is required that she is not capable of regularly performing work at a gainful and suitable employment. *See Wilson v. Weyerhaeuser*, 30 Or App 403, 567 P2d 567 (1977) (a combination of medical and nonmedical factors together may lead to the finding that the claimant is permanently and totally disabled under the "odd lot" doctrine); *Welch v. Banister Pipeline*, 70 Or App 699, 690 P2d 1080 (1984) (same).

The referee found, and claimant concedes, that claimant's physical disability does not preclude her employment. Additionally, the referee found that claimant is vocationally able to perform work within her physical limitations. Those findings are supported by substantial evidence. Claimant asks us to look at the evidence and, essentially, to make new findings. That is beyond the scope of our review. ORS 656.298; ORS 183.482.

Affirmed.

Cite as 135 Or App 209, 897 P2d 348 (1995) June 28, 1995

Court of Appeals of Oregon.
Argued and Submitted April 28, 1995.

In the Matter of the Compensation of John Q. Emmert, Claimant.
John Q. EMMERT, Petitioner,
v.
CITY OF KLAMATH FALLS and SAIF Corporation, Respondents.
WCB 91-14932, 91-07717; CA A84563.

Judicial Review from Workers' Compensation Board.

James L. Edmunson argued the cause and filed the brief for petitioner.

Michael O. Whitty, Sp. Asst. Atty. Gen., argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen.

Before WARREN, P.J., and EDMONDS and ARMSTRONG, JJ.

WARREN, P.J.

Reversed and remanded.

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135 Or App 211> Claimant seeks review of an order of the Workers' Compensation Board, which upheld employer's denial of claimant's coronary artery disease, arrhythmia condition and hypertension. We reverse.

Claimant was employed by employer as a firefighter. In 1981, he was performing work duties when he suffered chest pain. He filed a claim for "severe chest pains." The next day he was hospitalized, where he was diagnosed with acute myocardial infarction. Three months later, a cardiologist reported that the infarction was caused in material part by work-related stress superimposed on a preexisting coronary artery disease. Two weeks after the cardiologist's report, employer sent claimant a notice of claim acceptance in which it accepted the claim as disabling. The notice did not indicate what specific condition was accepted; it used codes to classify the injury. The codes stood for "unclassified" and "chest, including ribs, breast bone, and internal organs of the chest." There is no evidence that claimant was informed of the meaning of the codes.

Claimant returned to work and worked until August 1988. In 1989, his chest pain worsened. By 1991, he suffered from the conditions for which he now seeks compensation. Employer denied claims for coronary artery disease, vascular disease, arrhythmia, hypertension and related problems, on the ground that the 1981 injury was not the major contributing cause of the conditions.

The referee and then the Board affirmed. The Board found that employer had accepted myocardial infarction in 1981 and had not accepted coronary artery disease, which was the cause of claimant's current condition. It also found that claimant's current condition was not sufficiently related to the myocardial infarction to be compensable. Finally, it concluded that the condition was not compensable as an occupational disease.

Claimant challenges each of the Board's conclusions. Only the first challenge, that the Board erred in concluding that employer did not accept claimant's coronary artery disease in 1981, merits discussion. In *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), the Supreme Court held that, once **<135 Or App 211/212>** an employer accepts a claim, it generally may not thereafter deny that claim. Claimant argues that employer's denial in this case is an improper back up denial under *Bauman*, because employer accepted a claim for coronary artery disease in 1981. Claimant relies on *Georgia Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988), in which the court held that, if an employer accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms, and the employer may not go back and deny the conditions that cause the symptoms. Claimant argues that, here, employer accepted symptoms, severe chest pain, and that one of the causes of the pain was coronary artery disease. Therefore, according to claimant, employer accepted coronary artery disease. Employer responds that *Piwowar* does not apply, because employer accepted myocardial infarction, which is a different condition than coronary artery disease.

We conclude that employer accepted severe chest pain. The notice of acceptance in this case did not specify that a particular *condition* was accepted. Instead, it notified claimant that his *claim* had been accepted. His claim was for "severe chest pains." The codes that were used on the form did not limit that acceptance in any way; they merely specified a certain area of the body where the injury had occurred. Therefore, the notice of acceptance must be read as constituting an acceptance of the claim as filed, which was for severe chest pain.

When an employer accepts a claim for symptoms of a disease or injury, the acceptance constitutes an acceptance of the medical cause or causes of the symptoms. *Piwowar*, 305 Or at 501, 753 P2d 948. In this case, therefore, employer accepted the condition or conditions that caused the severe chest pain. In its order, the Board did not make a determination about what caused claimant's severe chest pain. On remand, the Board should make that determination.

Reversed and remanded for reconsideration.

Cite as 135 Or App 293, 897 P2d 1200 (1995) June 28, 1995

Court of Appeals of Oregon.
Argued and Submitted Feb. 2, 1995.

In the Matter of the Compensation of Gaylynn Grant, Claimant.
SAIF CORPORATION and Dammasch State Hospital, Petitioners,
v.
Gaylynn GRANT, Respondent.
93-03010; CA A83802.

Judicial Review from Workers' Compensation Board.

James W. Moller, Sp. Asst. Atty. Gen., argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen.

Robert Wollheim, Portland, argued the cause for respondent. With him on the brief was Welch, Bruun, Green & Wollheim.

Before DEITS, P.J., and RIGGS * and De MUNIZ, JJ.

De MUNIZ, J.

Reversed and remanded for reconsideration.

* Riggs, J., *vice* Haselton, J.

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135 Or App 295> Employer seeks review of a Workers' Compensation Board order setting aside its denial of claimant's left elbow claim. We reverse and remand for reconsideration.

On February 7, 1991, claimant, a mental health therapist, was attacked by a patient and suffered compensable injuries to her ribs, chest, left shoulder and neck. Employer accepted the claim. After returning to work, she was again injured while subduing another combative patient. On April 6, 1991, claimant had an emergency appendectomy. On September 16, 1991, claimant changed her attending physician to Dr. Takacs. Takacs diagnosed cervical, thoracic and rib strain and developing chronic pain syndrome. In January 1992, claimant was awarded permanent partial disability based on the February attack.

Claimant subsequently entered a vocational program to train as a medical assistant. In September 1992, claimant returned to Takacs complaining of a gradual onset of left hand numbness and pain while performing typing and computer work in the training program. Takacs diagnosed a left ulnar nerve lesion of the left elbow, and reported that claimant's condition was caused by her vocational training rather than by her previous injury.

Takacs referred claimant to Dr. Baum for surgical consultation. On February 25, 1993, Baum diagnosed ulnar nerve compression at the left elbow. Employer denied the claim for surgery on claimant's left elbow. After a hearing, the referee accepted Takacs' opinion that claimant's left elbow condition was not related to her original injury.

The Board reversed the referee's order. It explained that the medical evidence indicated that claimant's original injury included left elbow symptoms. The Board reasoned:

> "We are more persuaded by Dr. Baum's opinion than that of Dr. Takacs, because Dr. Takacs did not have claimant's complete medical history. Based on Dr. Baum's opinion, we conclude that claimant's left ulnar nerve lesion is directly related to the industrial accident."

The Board concluded that, because claimant's left elbow condition was directly related to her original injury, the **<135 Or App 295/296>** material contributing cause standard applied and claimant's condition was compensable.

On review, employer asserts that substantial evidence does not support the Board's finding that Takacs did not have claimant's complete medical history. Employer points to a September 16, 1991, report that the Board did not address, in which Takacs states:

"Patient is a 38-year old white female who was seen today complaining of neck, upper back, left rib and left arm pain. Patient reports she had a Workmens' Comp injury on 2/7/91 while working as a mental health therapist tech at Dammasch. She had to take down a combative patient. She cracked some ribs and had a shoulder and neck injury. She was seen at Meridian Park Emergency Room. X-rays were taken which showed rib fractures. There was some question of a ruptured spleen. She had a scan and it was unremarkable. She began seeing Dr. Erde in February who referred her to PT with S. Solonick, R.P.T. at the TMJ Clinic. He treated her with modality sprain and stretch; it was not help [sic] and in fact she would be very sore the day after she was seen. She returned to work for a couple of days, was injured again taking down another patient and, before she had healed from that, on 4/6/91 had an emergency appendectomy. * * * She has responded to Flexeril, Orudis and Skeletor. * * * She tried TENS unit for the last three weeks, perhaps it helped some, she is not sure."

Employer is correct. Takacs' letter, which was included in the record for the Board's review, is inconsistent with the Board's explanation that Takacs did not have claimant's complete medical history.

The only evidence that arguably supports the Board's finding that Takacs did not have claimant's complete medical history is a "Change of Attending Physician" form, which was completed by claimant and Takacs. The Board is correct that the form did not contain any language concerning claimant's history. However, the form does not contain a section that permits an explanation of the patient's medical history or the cause of a patient's condition. We agree with employer's argument that the "Change of Attending Physician" form was not intended to provide for a patient's complete medical history. The Board erred when it relied on the **<135 Or App 296/297>** form to find that Takacs lacked claimant's complete medical history.

Nonetheless, claimant points out that Baum's opinion, which the Board found persuasive, constitutes substantial evidence in support of the Board's decision that her left elbow condition was directly related to her compensable claim. That argument ignores the defect in the Board's order. We review the Board's order for, among other things, the existence and soundness of its rationale to determine whether it is supported by substantial reason. *Furnish v. Montavilla Lumber Co.*, 124 Or App 622, 625, 863 P2d 524 (1993).

The Board's conclusion that Takacs lacked claimant's complete medical history, based on its incorrect evaluation of the "Change of Attending Physician" form, deprives the order of substantial reason and requires reversal. *See Skochenko v. Weyerhaeuser Co.*, 118 Or App 241, 245, 846 P2d 1212 (1993). We cannot speculate whether, had the Board correctly evaluated Takacs' opinion, it still would have found Baum's opinion more persuasive.

We do not address employer's other contentions, because, on remand, the Board may adopt different findings or conclusions that resolve them.

Reversed and remanded for reconsideration.

Cite as 135 Or App 298, 897 P2d 1202 (1995) June 28, 1995

Court of Appeals of Oregon.
Argued and Submitted Feb. 2, 1995.

In the Matter of the Compensation of David A. McIntyre, Claimant.
David A. McINTYRE, Petitioner,
v.
STANDARD UTILITY CONTRACTORS, INC., and SAIF Corporation, Respondents.
93-10350; CA A85067.

Judicial Review from Workers' Compensation Board.
Pamela A. Schultz, Portland, argued the cause and filed the brief for petitioner.
Steven R. Cotton, Sp. Asst. Atty. Gen., argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Atty. Gen., and Virginia L. Linder, Sol. Gen.
Before DEITS, P.J., and De MUNIZ and HASELTON, JJ.
De MUNIZ, J.
Affirmed.

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135 Or App 300> Claimant seeks review of an order of the Workers' Compensation Board upholding employer's denial of his claim for back and neck pain. We review for substantial evidence, ORS 183.482(8)(c), and affirm.

On June 24, 1993, claimant suffered an electric shock while working on a power line. He sought treatment at Albany General Hospital for tingling in his hand. He filed a claim, which employer denied on July 20, 1993, on the ground that there were no objective findings to substantiate the injury. Claimant subsequently obtained employment driving a combine for a farmer. On August 31, 1993, claimant sought treatment for back and neck pain from Dr. McGill. On September 13, 1993, McGill diagnosed "cervico-dorsal (neck and back) strain, secondary to muscle spasm resulting from electrocution." [1]

Claimant requested a hearing. On November 29, 1993, the referee set aside the denial of claimant's hand injury claim, but held that claimant's back and neck strain was not related to the compensable injury. The referee held:

> "I do not find that claimant has established that the neck and back complaints and the attendant objective findings were related to the June 24, 1993 injury. Dr. McGill 'assumed' that claimant's neck and back condition was related because it was the most traumatic event claimant reported to him. An attribution based on ruling out other causes is not sufficient under ORS 656.266. Thus, those findings, even if considered objective, are not related to the June 24, 1993 injury[.]"

The Board affirmed.

In his first assignment, claimant argues that the Board erred when it required expert medical evidence to establish the causal link between the shock and claimant's back and neck pain. Claimant asserts that expert medical evidence is not required when the cause of the injury is readily apparent. *Barnett v. SAIF*, 122 Or App 279, 283, 857 P2d 228 **<135 Or App 300/301>** (1993). Although the cause of claimant's hand injury was readily apparent, the cause of his back and neck pain was not. After the shock, claimant's injury was limited to pain in his hand. There is no evidence, medical or otherwise, that claimant suffered back and neck pain at the time he visited Albany General Hospital. Although claimant asserts that the back and neck pain developed soon after the hospital visit, he did not seek medical treatment until two months after the shock. Under these circumstances, expert medical evidence was required.

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[1] McGill also reported:

"Since [claimant] can relate no other incidents, etc., that would account for his current symptoms, I must assume that his current condition is the result of the most traumatic event that has happened to him thus far: the electrocution on 6-24-94."

In claimant's second assignment, he argues that the Board erred when it held that McGill's opinion on causation was insufficient because it was established by disproving other possible causes. See ORS 656.266.[2] Claimant asserts that, even assuming that ORS 656.266 applies, McGill's analysis was not limited to disproving other possible causes. He points to Dr. McGill's findings on the muscle spasms and emotional shock.

We disagree with claimant for two reasons. The Board did not rely solely on ORS 656.266 in making its findings. It found that "Dr. McGill's assumption of a causal relationship is [not] sufficient to establish that it is medically probable that the electrical shock caused the strain." To prove medical causation, a medical opinion must be based on medical probability. *Lenox v. SAIF*, 54 Or App 551, 554, 635 P2d 406 (1981). Here, the Board reviewed that standard and found that McGill's opinion was not based on a medical probability.

However, even if the Board's finding dealt solely with the issue of whether McGill's report satisfied the requirements of ORS 656.266, its findings are supported by substantial evidence. Claimant's interpretation of McGill's report is one possible interpretation. However, the Board did not accept claimant's interpretation of that report. When it interpreted the report, it found that "Dr. McGill's assumption of a causal relationship is [not] sufficient to establish that it is **<135 Or App 301/302>** medically probable that the electrical shock caused the strain. McGill merely stated that, 'Since [claimant] can relate no other incidents, etc., that would account for his current symptoms, *I must assume* that his current condition is the result of the most traumatic event that has happened to him thus far: the electrocution of 6-24-93.' " (Emphasis supplied.) The Board's interpretation of that report is reasonable and is supported by substantial evidence.

In his final assignment, claimant argues that, because there was no medical evidence to the contrary, the Board erred in rejecting McGill's conclusion. Claimant contends that, absent persuasive reasons not to do so, we generally defer to the treating physician's opinion. *Weiland v. SAIF*, 64 Or App 810, 814, 669 P2d 1163 (1983). A treating physician's opinion, however, is less persuasive when the physician did not examine the claimant immediately after the injury. *Kienow's Food Stores, Inc. v. Lyster*, 79 Or App 416, 421, 719 P2d 890 (1986). Here, because McGill did not observe claimant until two months after the injury, the Board chose not to accord much weight to his conclusion. There was no error.

Affirmed.

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[2] ORS 656.266 provides, in part:

"The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other explanations of how the injury or disease occurred."

Cite as 135 Or App 524 (1995) July 19, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Arlene J. Koitzsch, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION
and Agripac Incorporated, *Petitioners*
v.
Arlene J. KOITZSCH, *Respondent.*
(90-13984; CA A86659)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 21, 1995.
Barbara Woodford argued the cause and filed the brief for petitioners.
James L. Edmunson argued the cause for respondent. With him on the brief was Linda C. Love.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Reversed and remanded for reconsideration.

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135 Or App 526> Employer seeks review of an order of the Workers' Compensation Board awarding claimant attorney fees to be paid by the carrier and not out of compensation. We reverse.

The facts relevant to our review are uncontested. Claimant petitioned for judicial review of an order of the Board that rejected her claim for additional disability compensation. We reversed and remanded for reconsideration. *Koitzsch v. Liberty Northwest Ins.Corp.*, 125 Or App 666, 866 P2d 514 (1994). On remand, the Board ultimately increased claimant's award of permanent partial disability. It awarded claimant's attorney 25 percent of the increased compensation award and, in addition, awarded an attorney fee to be paid by the carrier and not out of compensation. The Board relied on ORS 656.388(l) and its own cases construing that statute to permit an award of carrier-paid attorney fees. Employer appeals, assigning error to that award. Employer argues that ORS 656.388(l), as we have previously construed it, permits only an award of fees out of compensation. Claimant argues that we should defer to the Board's construction of the statute as reasonable.

Our review of an agency's construction of a statutory provision depends on the type of statutory terms involved. *Springfield Education Assn. v. School Dist.*, 290 Or 217, 223, 621 P2d 547 (1980). In this case, it is undisputed that the terms are "inexact." Accordingly, our task is to determine whether the agency has erroneously interpreted the law. *England v. Thunderbird,* 315 Or 633, 638, 848 P2d 100 (1993).

We begin with the text and context of the statute, which includes both prior versions of the statute and prior judicial construction of it. *Mathel v. Josephine County, 319* Or 235, 239-40, 875 P2d 455 (1994). ORS 656.388(l) provides:

> "No claim or payment for legal services by an attorney representing the worker or for any other services rendered before a referee or the board, as the case may be, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the referee or board, or if proceedings on appeal from the order of the board with respect to such claim or award are had before any court, <**135 Or App 526/527**> unless approved by such court. In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum."

In Greenslitt v. City of Lake Oswego, 88 Or App 94, 744 P2d 577 (1987), affd 305 Or 530, 754 P2d 570 (1988), we reviewed the current and former versions of that statute. We noted that under the prior versions of ORS 656.388(l), attorney fees could be paid only from a claimant's compensation award. We further noted that "intervening amendments have not made any relevant changes." Id. at 97.

The legislature has recently amended ORS 656.388(l), Oregon Laws 1995, chapter ___ , section 44, and claimant concedes that the amended statute expressly prohibits carrier-paid attorney fees. It is not necessary, however, for us to determine whether those amendments apply to this case, because we hold that, even before the 1995 amendments, the statute did not allow an award of carrier-paid fees.

Reversed and remanded for reconsideration.

Cite as 135 Or App 551 (1995) July 26, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kerment C. Verner, DCD, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and Glenbrook Nickel Co., *Petitioners,*

v.

Barcy VERNER, Beneficiary of Kerment C. Verner, Deceased, *Respondent.*

(WCB 93-10270; CA A85511)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 21, 1995.

E. Jay Perry argued the cause for petitioners. With him on the brief was Employers Defense Counsel.

James L. Edmunson argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson & Jensen.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

WARREN, P. J.

Reversed.

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135 Or App 553> WARREN, P. J.

Employer seeks review of an order of the Workers' Compensation Board that awarded death benefits to claimant's beneficiary. We reverse.

Claimant worked at an ore processing plant. In March 1993, he died at work and his beneficiary requested workers' compensation benefits. On the day he died, claimant and other workers were required to remove heavy equipment from a large ore dryer. The area in which claimant worked was approximately 80 to 85 degrees. A leaky propane hose caused an unpleasant odor in the dryer.

After claimant had worked for awhile, he complained about having indigestion, nausea and chest pains. He and the other workers took a 30-minute break and then resumed working. About 45 minutes later, claimant's supervisor left the plant to purchase beverages for the crew. At that time, he noticed that claimant appeared weak and that his face was sweating. After the supervisor returned, he gave claimant and the other workers a sports drink.

Shortly after claimant consumed his beverage, he became ill and asked to leave the ore dryer. A few minutes later, claimant vomited. The supervisor told his superintendent about claimant's illness. The superintendent told claimant that he should go home or seek medical help. Claimant refused. He then took his lunch break. A few minutes later, the superintendent observed him vomiting again. When claimant's break ended, at about 10:30 a.m., the superintendent again asked him whether he would like to go home. Claimant declined. The superintendent then assigned him to light duty work, which required claimant to note the time ore trucks arrived at and departed from the plant. Claimant was last seen alive at about 12:30 p.m. A short while later, a worker found him seated, partially reclined, in a stairwell. Medics pronounced him dead at the scene. The Coos County Coroner briefly examined claimant's body, but did not perform an autopsy. He listed the cause of death as "undetermined."

Claimant's beneficiary filed a claim for compensation, which employer denied. At the hearing, the principal issue was medical causation. The evidence at the hearing on <**135 Or App 553/554**> that issue consisted of two written reports and the testimony of claimant's expert witness, a pathologist. There was evidence that the coroner, after reviewing the death investigation reports and other records, could not determine the cause of death to a degree of medical probability. Similarly, a cardiologist who reviewed all of the records could not establish a cause of death with reasonable medical probability. However, the pathologist opined that claimant had died from cardiovascular collapse. His hypothesis was that the combination of excessive heat, physical exertion and the odor from the hose caused claimant to become nauseous, which lead to vomiting, fluid loss, electrolyte imbalance and, ultimately, death. Later, the referee awarded death benefits to claimant's beneficiary and the Board affirmed.

On appeal, we address only employer's assignment that the Board erred in concluding that the claim was compensable, because it is dispositive. The referee concluded that the pathologist's opinion about claimant's death being workrelated was "well-reasoned and based on a correct history" and awarded benefits to claimant's beneficiary. The Board adopted the referee's findings and conclusions. Employer argues that there is insufficient evidence to support a finding of compensability, because the pathologist's opinion about causation was based on assi;mptions that were contrary to facts adduced at the hearing.

The pathologist testified that he reached his opinion about the cause of claimant's death before the hearing[1] He based that opinion on numerous assumptions.[2] One of those assumptions was that claimant had been working in temperatures of 110 degrees or greater. In the pathologists's opinion, that was a factor that led to claimant's nausea and, ultimately, caused him to die. The pathologist testified that, standing alone, neither odors, exertion nor excessive heat caused claimant's death. His opinion about the cause of claimant's death was predicated on the combination of all three factors.

135 Or App 555> There is no evidence, however, that claimant worked in temperatures of 110 degrees or greater. The evidence is that the portion of the ore-dryer in which claimant worked was between 80 and 85 degrees. The pathologist testified that those temperatures were not excessive. Therefore, in the absence of any evidence that claimant worked in excessive heat, one of the factors on which the pathologist based his opinion about claimant's death did not exist.

The pathologist did not suggest, nor is there any evidence from which the Board could infer, that the combination of odors and exertion alone caused claimant to become ill and die. The pathologist's testimony is dependent on assumptions that are not supported by the record. Accordingly, the Board's determination that claimant's death was caused by work conditions is not supported by substantial evidence.

Reversed.

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[1] The fact that the workers were briefly exposed to an odor of propane was elicited for the first time at the hearing.

[2] For example, the pathologist assumed that claimant did not or could not consume any fluids from the last time that he was observed vomiting, which was about 10:00 a.m., until the time he was found dead. more than three hours later.

Cite as 135 Or App 556 (1995) July 26, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

INDEPENDENT CONTRACTORS OF OREGON, *Petitioner*,
v.
CONSTRUCTION CONTRACTORS BOARD, *Respondent*.
(CA A82576)

Judicial Review of Administrative Rule.
Argued and submitted March 28, 1995.
Brian L. Pocock argued the cause and filed the brief for petitioner.
John T. Bagg, Assistant Attorney General, argued the cause for respondent. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Rule held invalid.

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135 Or App 558> Petitioner Independent Contractors of Oregon challenges the validity of OAR 812-03-002(l), a rule of the Construction Contractors Board (CCB). ORS 183.400. It raises numerous challenges to the process by which the rule was adopted, as well as challenging the validity of the rule as being beyond the agency's statutory authority. We address only the argument that the rule violates ORS 701.035 and hold that the rule is invalid.

The CCB is charged with enforcing ORS chapter 701, relating to the regulation of construction contractors. ORS 701.205; ORS 701.235. Construction contractors are required to be registered with the Board. ORS 701.055(l); ORS 701.065. ORS 701.035 provides, in part:

> "(1) An applicant must qualify as an independent contractor, under ORS 670.600, to register with the board.
>
> "(2) The board shall establish two classes of independent contractor registration:
>
> "(a) The nonexempt class is a sole proprietor, partnership or corporation with employees or a partnership without employees.
>
> "(b) The exempt class is a sole proprietor without employees or a corporation whose officers have selected the option described in ORS 656.027."

OAR 812-03-002 provides that "[clontractors shall register as either nonexempt (employer with employees) or exempt (no employees) as provided in ORS 701.035[.]" On July 27, 1993, the CCB adopted the amendments to OAR 812-03-002(l), which petitioner challenges in this review. OAR 812-03-002(l) now provides:

> "If the agency discovers any registered contractor working together with one or more registered contractors at the same construction tasks at the same location at the same time; and
>
> "(a) If the agency determines that one or more of the following conditions exist, then the partnership or person is not an exempt contractor and must be registered nonexempt unless otherwise exempt from workers'compensation insurance coverage under ORS 656.027:

135 Or App 559> "(A) The individuals are working together as a partnership;

"(B) *One of the individuals is the lead person who directs and controls the other individuals; or*

"(C) *The individuals working together were brought there by a third person who directs and controls the individuals.*

"(b) However, an exempt contractor may work with the assistance of individuals who are employees of a nonexempt contractor so long as the nonexempt contractor:

"(A) Is in compliance with ORS Chapters 316, 656 and 657 and is providing the employee(s) with worker's compensation insurance; and

"(B) Does the payroll and pays all its employees, including those employees who assist an exempt contractor." (Emphasis supplied.)

Petitioner argues that the rule is invalid, because it exceeds the statutory authority of the agency. We address only its argument that the rule is invalid because it requires contractors who are defined as exempt under ORS 701.035(2)(b) to register as nonexempt.

ORS 701.035(2)(a) provides that all contractors with employees are nonexempt, as are all partnerships. The only contractors who qualify for exempt status are sole proprietors without employees, or corporations without employees "whose officers have selected the option described in ORS 656.027."[1] ORS 701.035(2)(b). Petitioner argues that the rule, specifically OAR 812-03-002(l)(a)(B) and (C), requires some sole proprietors and corporations without employees to register as nonexempt despite the fact that they are classified as exempt by the statute. If that is the effect of the rule, it is invalid, because it alters the terms of the legislative enactment. *U. of 0. Co-Oper. v. Dept. of Rev.*, 273 Or 539, 550, 542 P2d 900 (1975).

135 Or App 560> CCB submits, and we agree, that the word "employee" in ORS 702.035 means the same things as does the word "worker" in ORS chapter 656, the workers' compensation law. ORS 656.005(28) provides that a worker is

"any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *."

Under that definition, two elements must exist before a person is considered a worker: the person must engage to furnish services for a remuneration, and the person must be subject to the direction and control of an employer. An "employer" is "any person * * * who contracts to pay a remuneration for and secures the right to direct and control the services of any person." ORS 656.005(13).

Petitioner argues that the rule requires a contractor to register as nonexempt even if the contractor has not contracted to pay the other contractor remuneration. Because a contractor is not an "employee" unless the contractor has engaged to provide services for remuneration, petitioner argues that the rule expands the class of nonexempt contractors beyond that provided in ORS 701.035. We agree. OAR 812-03-002(l) requires a contractor to register as nonexempt on the basis of direction and control alone. However, simply being under someone's direction and control without remuneration does not make a person an employee within the meaning of ORS 701.035. Accordingly, it appears that the rule is inconsistent with the statute, in that it would require a contractor without employees to register as nonexempt when the statute would allow it to register as exempt.

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[1] ORS 656.027(9) allows officers of a corporation engaged in building and construction "who are directors of the corporation and who have a substantial ownership interest in the corporation" to elect to be nonsubject workers, if "all officers of the corporation are members of the same family and are parents, daughters or sons, daughters-in-law or sons-in-law or grandchildren[.]"

CCB's only response to the apparent inconsistency is to argue that the element of remuneration is implicit in the rule, because the rule as a whole "addresses employer and employee relationships[.]" We are not persuaded. The rule does not expressly require that a contractor be engaged for remuneration, nor is it possible to read into the rule a requirement that is not there.

Because OAR 812-03-002(l) requires a contractor without employees to register as nonexempt when ORS 701.035(2) would allow the contractor to register as exempt, the rule violates the statute and is invalid.

Rule held invalid.

Cite as 135 Or App 565 (1995) July 26, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jane A. Volk, Claimant.

Jane A. VOLK, *Petitioner*,
v.
AMERICA WEST AIRLINES and Travelers Insurance Co., *Respondents*.
(WCB 92-06678; CA A84509)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 15, 1995.
Donald M. Hooton argued the cause and filed the brief for petitioner.
Craig A. Staples argued the cause for respondents. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DEITS, P. *J.*
Affirmed.

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135 Or App 567> Claimant seeks review of an order of the Workers' Compensation Board (Board) holding that claimant's counsel is entitled to an attorney fee, but refusing to order insurer to pay the fees directly to the attorney. We affirm.

Claimant was awarded 20 percent unscheduled permanent disability by an October 23, 1991, determination order. Insurer paid the full amount of the award to claimant. Claimant subsequently requested reconsideration of the award. On June 9, 1992, an order on reconsideration was issued and claimant's award was reduced to 11 percent. Claimant then requested a hearing on the reconsideration order. Insurer sought to offset the overpaid compensation. Before a hearing was held on the matter, the parties entered into a stipulation that reinstated the award of 20 percent unscheduled disability. The parties also agreed to submit to the referee the question of claimant's counsel's entitlement to an attorney fee.

The referee concluded that because increased compensation was not awarded by the stipulation, claimant was not entitled to an out-of-compensation attorney fee. The Board disagreed with the referee's holding and concluded that claimant's attorney was instrumental in obtaining a "substantive increase" in her compensation and that her counsel was entitled to an out-of-compensation attorney fee pursuant to ORS 656.386(2).

The Board went on to conclude, relying on our decisions in *Johnson v. Capitol Car Wash*, 127 Or App 49,871 P2d 473 (1994), and *Lebanon Plywood v. Seiber*, 113 Or App 651, 833 P2d 1367 (1992), that it was without statutory authority to order the insurer to pay claimant's attorney a fee in addition to the amounts that it had already paid to claimant. The Board reasoned that requiring insurer to pay the attorney fee to claimant's attorney, when the full amount of compensation due had already been paid to claimant, would essentially be

ordering the insurer to pay additional compensation to which the claimant was not entitled. The Board then outlined a procedure for a claimant's attorney to recover a fee award in circumstances such as this. Under the Board's procedure, the attorney must first seek recovery of the fee <**135 Or App 567/568**> directly from the claimant. In the event that the attorney's efforts to recover the fee directly from claimant are unsuccessful, the Board concluded that the fee is a lien upon claimant's compensation under ORS 656.388(2) and OAR 438-15-010(3) and may be recovered from any future permanent disability awards granted on the claim. On May 24, 1994, the Board issued an order on reconsideration affirming its earlier decision.

Claimant assigns error to the Board's conclusion that it lacked authority to issue an order directing insurer to pay the approved attorney fees directly to claimant's counsel. Claimant argues that the Board's reliance on *Lebanon Plywood v. Seiber* and *Johnson v. Capitol Car Wash* was misplaced and that the Board abused its discretion in failing to apply the provisions of OAR 438-15-085(2).

Before turning to the merits, we must first consider the effect on this case of the adoption of Senate Bill 369 in the 1995 legislative session. ORS 656.386(2), which governs the award of attorney fees in this case, was amended to provide:

> "In all other cases, attorney fees shall be paid from the increase in the claimant's compensation, if any, *except as otherwise expressly provided in this chapter."* Or Laws 1995, ch ___, § ___ (SB 369, § 43) (emphasis supplied).[1] "

The first question that we must address is whether the above change in the law applies retroactively to this case. We conclude that it does. Section 66 of SB 369 provides, in part:

> "(1) Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

There are a number of exceptions to the retroactive effect of SB 369. However, the only one that has potential application to this matter is subsection (5)(a) of section 66, which provides:

135 Or App 569> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which an *order or decision has become final* on or before the effective date of this Act." (Emphasis supplied.)

The pertinent terms in the above subsection are "an order or decision [that] has become final." In interpreting a statute, our task is to discern the intent of the legislature. The critical question here is whether the legislature intended the new law to apply in a case such as this where the Board has taken its final action and the matter has been appealed to, but not finally resolved by, the courts.

Under *PGE v. Bureau of Labor and Industries,* 317 Or 606, 610, 859 P2d 1143 (1993), in determining what the legislature meant, we must first examine the statute's text and context. The text of the new law does not provide an answer as to when an order or decision becomes final. However, the context does provide guidance. ORS 656.295(8) provides:

> "An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298. The order shall contain a statement explaining the rights of the parties under this, subsection and ORS 656.298."

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[1] Before the 1995 amendment, ORS 656.386(2) read:

> "In all other cases attorney fees shall continue to be paid from the claimant's award of compensation except as otherwise provided in ORS 656.382."

Considered in the context of the above statute, we conclude that the legislature intended the changes in the law to apply to Board orders for which the time to appeal had not yet expired on the effective date of the Act or, if the case had been appealed, to any case that was still pending before the court on the effective date of the legislation.

Even if it could be said that the text and context of ORS 656.386(2) are not conclusive, the legislative history supports the same interpretation. *See PGE*, 317 Or at 612. As originally submitted, SB 369 did not include retroactivity language. However, before the Senate Committee on Labor and Government Operations, amendments making some portions of the bill retroactive were proposed as follows:

> "*Section 66.* (1) Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, **<135 Or App 569/570>** regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act.
>
> "(2) The amendments to ORS 656.126, 656.204 and 656.265 by sections 10, 13 and 29 of this Act and the amendments to ORS 656.210(2)(a) by section 15 of this Act apply only to injuries occurring on or after the effective date of this Act.
>
> "(3) Sections 8 and 9 of this Act and the amendments to ORS 656.054, 656.232 and 656.248 by sections 7, 23 and 26 of this Act become operative January 1, 1996.
>
> "(4) The amendments to ORS 656.268(4), (5), (6) and (9), 656.319(4) and 656.726(2)(f) by sections 30, 39 and 55 of this Act shall apply only to claims that become medically stationary on or after the effective date of this Act." Senate Bill File, Senate Committee on Labor and Government Operations, SB 369, February 21, 1995, SB 369-13 (LC 1477), pp 54-55. *See also* Minutes, Senate Committee on Labor and Government Operations, SB 369, February 17,1995, p 1 and Exs F & G.

In discussing the proposed amendments before the committee, Representative Mannix, a sponsor of the legislation, stated:

> "And the other section that needs to be discussed, I think, in terms of changes, is what is the effective date clause; we had an emergency clause but we weren't clear about when things were becoming effective. This is now section 66 in the LC amendments. This specifies the effective date plus operative dates for different provisions. It's been gone over pretty carefully to make sure that new things that require appeals processes as to claim closure don't go into effect except for claims that are medically stationary after July lst. A lot of the requirements imposed on the Department are delayed until January lst of '96 so they'll have time to promulgate the rules. [We] tried to build in some time frames for implementation, but the rest of it's fairly clear. There's only one part of the implementation dates, I think, probably needs a real flat statement on the record and that is that the *retroactivity also applies to cases in which a /inal order has not yet issued in litigation. There's a bunch of cases in the system right now that have been decided by different factfinders under two or three different versions of the law depending on whether the Board interpretation or the Court of Appeal's interpretatiòn or the Supreme Court interpretation was in* **<135 Or App 570/571>** *effect at that time and this says 'this law applies to everything no matter where it is unless you have already been to court, had it decided and there's a decision been rendered and the decision is not subject to being appealed anymore.' Otherwise, except with the exceptions here, this is the law for everybody and we'll go out and apply it* whether it's pro-worker or pro-employer." Tape recording, Senate Committee on Labor and Government Operations, SB 369, February 17, 1995, Tape 49, Side B at 187 (emphasis supplied).

The amendments were passed out of committee and eventually approved by the Senate in substantially the same form.

A number of amendments relating to the retroactivity language were proposed before the House Committee on Labor as it considered SB 369. On March 22, 1995, the following amendments to section 66 of the A-Engrossed version of SB 369, along with other "technical" amendments, were proposed:

> "(5) The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which an order or decision has become final on or before the effective date of this Act.
>
> "(6) The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not extend or shorten the procedural time limitations with regard to any action on a claim taken prior to the effective date of this Act.
>
> "(7) The amendments to ORS 656.506 by sections 63 of this Act first become operative October 1, 1995. " Testimony, House Committee on Labor, SB 369, March 22, 1995, Ex A, pp 67-68.

Representative Mannix discussed the proposed changes during a work session of the Committee. He stated:

> "[Tlhe amendment sub-5 will be 'the amendments to this chapter do not apply to any matter for which an order or decision has become final as of the date of passage of this Act' - *the old concept of res judicata; you litigate it, it's over, we're not going back and reopening litigation.*
>
> " * * * * *
>
> "We did make a change at line 14, this is effective upon passage, not July 1, 1995. It's operative as to certain provisions on July 1, '95 and it's operative as to other provisions <**135 Or App 571/572**> on January 1, '96, but it's effective on passage." Tape recording, House Committee on Labor, SB 369, March 22, 1995, Tape 62, Side B at 383 (emphasis supplied).

The House Committee adopted the proposed amendments, Minutes, House Committee on Labor, SB 369, February 22, 1995, pp 7-8, and the bill, as amended, was approved by the House.

The Senate refused to concur in the House amendments. In conference committee, the following amendments relating to retroactivity were proposed and added to section 66:

> "[(5)](b) Notwithstanding paragraph (a) of this subsection, the amendments to ORS 656.262(6) creating new paragraph (c) and the amendments to the subsection designated (10) by section 28 of this Act apply to all claims without regard to any previous order or closure.
>
> " * * * * *
>
> "(8) The amendments to ORS 656.313 by section 38a of this Act apply to orders issued on or after January 1, 2001.
>
> "(9) The amendments to ORS 656.340 by section 42a of this Act apply to claims for injuries or aggravations made on or after January 1, 2001.
>
> '(10) The amendments to ORS 656.212 by section 16a of this Act apply to all claims regardless of the date of injury for benefits payable on or after January 1, 2001.
>
> "(11) The amendments to ORS 656.726 by section 55a of this Act apply to claims that become medically stationary on or after January 1, 2001.

"(12) The amendments to ORS 656.012 and 656.018 by sections 4a and 5a of this Act apply to all claims or causes of action arising on or after January 1, 2001.

"(13) The amendments to ORS 656.245 and 656.260 by sections 25a and 27a of this Act apply to medical services provided on or after January 1, 2001." Senate Bill File, Conference Committee, SB 369, May 30, 1995, SB 369-B33 (LC 1477), pp 166-68.

The Senate and House then repassed the bill as amended.

Based on the text and context of the statute and the above legislative history, we conclude that the legislature's intent in subsection (5) (a) of section 66 was to make the new <**135 Or App 572/573**> law applicable to matters for which the time to appeal the Board's decision had not expired or, if appealed, had not been finally resolved by the courts. In this case, because review of the Board's order was sought, but was not finally resolved by the courts at the time of the effective date of the Act, the amended version of the statutes is applicable.

As noted above, ORS 656.386(2) now provides that attorney fees "shall be paid from the increase in the claimant's compensation, if any, *except as otherwise expressly provided in this chapter*." (Emphasis supplied.) This amended language makes it clear that it is not permissible to require that "out-of-compensation" attorney fees be paid from any other source than the claimant's compensation, unless the statutes expressly provide otherwise. Accordingly, the Board was correct in refusing to order insurer to pay claimant's attorney directly where the full amount of compensation due had already been paid to claimant, because the statutes do not provide special authority to do so. As a result of that change in the law, it is not necessary to consider whether the Board's reliance on *Johnson v. Capitol Car Wash* and *Lebanon Plywood v. Seiber* was correct. Similarly, it is unnecessary to consider claimant's argument relating to the application of OAR 438-15-085(2).

Affirmed.

Cite as 135 Or App 583 (1995) July 26, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Marilyn K. McMasters, Claimant.

MOTEL 6 and CIGNA Insurance Companies, *Petitioners,*
v.
Marilyn McMASTERS and Motel 6, *Respondents.*
(WCB 92-09365, 92-05850; CA A84163)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 13, 1994.
Rodger M. Hepburn argued the cause for petitioners. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C.
W. D. Bates, Jr., argued the cause and filed the brief for respondent Marilyn MeMasters.
Cynthia A. Wiens argued the cause for respondent Motel 6. On the brief were Adam T. Stamper and Cowling, Heysell, Plouse, Ingalls & Moore.
Before Deits, Presiding Judge, and Riggs and Haselton, Judges.
DEITS, P. **J.**
Affirmed.

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135 Or App 585> CIGNA Insurance Company (CIGNA) seeks review of an order of the Workers' Compensation Board (Board) upholding claimant's aggravation claim. We affirm.

Claimant worked as a housekeeper for Motel 6 beginning in July 1989. In August 1989, she suffered a compensable injury to her right shoulder and low back. The claim was accepted by CIGNA, which was employer's insurer at the time. It was closed in October 1989 by a notice of closure that awarded claimant temporary disability. Claimant returned to her regularj ob. She continued to have back pain and the claim was reopened in November 1989. A second notice of closure was issued in January 1990, and claimant was awarded additional temporary disability.

In March 1991, claimant filed a claim against employer for strained muscles in her right shoulder and left chest. Alexsis, which was then employer's insurer, denied the claim on the ground that CIGNA was the responsible insurer under the 1989 accepted claim. Claimant did not seek a hearing, nor did she file a claim with CIGNA at that time. Claimant continued to work, but, in December 1991, she sought treatment from Dr. Marie for her shoulder problem. In February 1992, she was moving a bed when she felt a sharp pain in both of her shoulders. She sought treatment from Dr. Abraham, who diagnosed her condition to be acute thoracic muscle strain. Marie diagnosed a thoracic muscle spasm and took claimant off work.

On February 20, 1992, claimant filed a new injury claim with employer for that condition. On March 10, 1992, Alexsis, on behalf of employer, issued a denial of compensability and responsibility. Pursuant to ORS 656.802(2) and OAR 438-05-053(4), Alexsis advised claimant that it was denying the claim and that " [y] our current problems are due to a continuation of pre-existing conditions and your injury of August 19, 1989 processed by CIGNA." The notice stated:

> "THIS IS A DENIAL OF YOUR CLAIM FOR BENEFITS. IF YOU THINK THIS DENIAL IS NOT RIGHT, YOU MUST DO TWO THINGS TO PROTECT YOUR RIGHTS:
>
> "(1) WITHIN 60 DAYS OF THE DATE OF THIS LETTER, YOU MUST REQUEST A HEARING. - - -
>
> **135 Or App 586>** "(2) WITHIN 60 DAYS MAKE A WRITTEN CLAIM WITH THE EMPLOYER(S) OR INSURERS(S) LISTED IN THIS LETTER. IF IN 60 DAYS YOU DO NOT MAKE A CLAIM WITH AN EMPLOYER OR INSURER WHO IS LATER FOUND RESPONSIBLE FOR YOUR CONDITION, YOU WILL LOSE YOUR BENEFITS."

On April 28, 1992, claimant requested a hearing on the denial. However, claimant did not file an aggravation claim against CIGNA until June 3, 1992, 85 days after Alexsis's denial of the claim. CIGNA denied the aggravation claim on July 9, 1992.

Claimant sought review of both the denial of a new injury by Alexsis and the denial of the aggravation by CIGNA. A hearing on both claims was held on March 17, 1993. The rbferee found that the injury was an aggravation of claimant's 1989 injury and that CIGNA was responsible for the claim. However, the referee further concluded that because claimant had not filed her claim against CIGNA within 60 days of the notice from Alexsis, it was untimely and, therefore, barred under ORS 656.308(2). The Board reversed the referee on the issue of the timeliness of the aggravation claim, concluding that, under these circumstances, ORS 656.308(2) did not bar the aggravation claim. The Board held that claimant had established an aggravation claim against CIGNA and set aside the insurer's denial.

CIGNA assigns error to the Board's conclusion that claimant's aggravation claim against it was not time-barred by ORS 656.308(2). Before turning to the merits of that issue, however, we must first consider the effect on this case of the adoption of Senate Bill 369 in the 1995 legislative session. ORS 656.308(2), on which the Board relied in making its decision, was repealed by Section 37 of Senate Bill 369, and new language relating to the same subject was adopted.[1]

135 Or App 587> As we held in *Volk v. America West Airlines*, 135 Or App 565, ___ P2d ___ (1995), generally, the changes to the Workers' Compensation law made by SB 369 apply to cases in which the Board had not issued a final order or for which the time to appeal the Board's order had not expired on the effective date of the Act. If the case had been appealed, the new law would apply if the case was pending before the court on the effective date of the Act. This case was appealed and was pending before this court on the effective date of the Act.

As we said in *Volk*, however, there are exceptions to the retroactive effect of SB 369. One of those exceptions is pertinent here. Subsection (6) of section 66 of SB 369 provides:

> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not extend or shorten the procedural time limitations with regard to any action on a claim taken prior to the effective date of this Act. "

Because this case involves a procedural time limit, the changes made by SB 369 are not applicable here.

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[1] ORS 656.308(2), as amended, provides, in part:

"(2)(a) Any insurer or self-insured employer who disputes responsibility for a claim shall so indicate in or as part of a denial otherwise meeting the requirements of ORS 656.262 issued in the 90 days allowed for processing of the claim. *The denial shall advise the worker to file separate, timely claims against otherpotentially responsible insurers or self-insured employers, including other insurers for the same employer, in order to protect the right to obtain benefits on* the claim. The denial may list the names and addresses of other insurers or self-insured employers. Such denials shall be final unless the worker files a timely request for hearing pursuant to ORS 656.319. All such requests for hearing shall be consolidated into one proceeding.

"(b) No insurer or self-insured employer, including other insurers for the same employer, shall bejoined to any workers' compensation hearing unless the worker has first filed a timely, written claim against that insurer or self-insured employer, or the insurer or self-insured employer has consented to issuance of an order designating a paying agent pursuant to ORS 656.307. An insurer or selfinsured employer against whom a claim is filed may contend that responsibility lies with another insurer or self-insured employer, including another insurer for the same employer, regardless of whether the worker has filed a claim against that insurer or self-insured employer.

"(c) Upon written notice by an insurer or self-insured employer filed not more than 28 days or less than 14 days before the hearing, the Administrative Law Judge shall dismiss that party from the proceeding if the record does not contain substantial evidence to support a finding of responsibility against that party. The Administrative Law Judge shall decide such motions and inform the parties not less than seven days prior to the hearing, or postpone the hearing.

"(d) 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." (Emphasis supplied.)

Accordingly, we review the Board's order under the version of the law in effect at the time of its decision. ORS 656.308(2) provided:

> **135 Or App 588>** "(2) No employer or insurer shall be joined in any workers' compensation proceeding unless the worker has first filed a timely written claim for benefits against that employer or insurer, or the employer or insurer has consented to the issuance of an order designating a paying agent under ORS 656.307. Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. *The worker shall have 60 days from the date of mailing of the notice to file* a claim *with such other employer or insurer.* Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection." (Emphasis supplied.)

CIGNA argues that the Board erred in concluding that claimant's claim against it was not time-barred under ORS 656.308(2). CIGNA contends that the claim was timebarred, because it was not filed within 60 days of Alexsis's notice to claimant, issued pursuant to ORS 656.308(2), that Alexsis was disclaiming responsibility for claimant's condition based on its determination that CIGNA was the responsible insurer.

The Board disagreed with CIGNA's reading of the statute. It explained:

> "Subsequent to the Referee's order, we issued our decision in *Jon F. Wilson,* 45 Van Natta 2362 (1993). In *Wilson,* we held that failure to follow the requirements of ORS 656.308(2) precludes a *carrier* from arguing that another employment exposure caused a claimant's need for medical services. *See Byron E. Bayer,* 44 Van Natta 1686, 1687 (1992). However, we further concluded that the claimant's failure to file a claim against a carrier within 60 days of the second carrier's responsibility disclaimer did not preclude the claimant from asserting compensability against the first carrier. We concluded that ORS 656.308(2) addresses responsibility for a claim and does not pertain to compensability. Therefore, we held that the claimant in Wilson was not precluded from filing an occupational disease claim **<135 Or App 588/589>** against the first carrier, provided that the claimant timely complied with the requirements set forth in ORS 656.807(l) for the filing of such a claim. *Wilson, supra.*
>
> "Although the present case does not involve an issue of an improper disclaimer by an insurer, we nonetheless extend the rationale expressed in *Wilson* to this case. As explained in Wilson, because ORS 656.308(2) pertains to responsibility, rather than compensability, we find no reason to preclude claimant from attempting to establish an aggravation claim with Cigna. Accordingly, we conclude that claimant's failure to comply with the 60 day time limit of the responsibility disclaimer statute does not bar claimant from proving compensability of her claim." (Emphasis in original.)

We begin our analysis of the meaning of the statute with its text and context. *PGE v. Bureau of Labor & Industries,* 317 Or 606, 610, 859 P2d 1 143 (1993). CIGNA relies on what it characterizes as the plain language of the statute. Specifically, it refers to the language of ORS 656.308(2) that provides that the worker shall have 60 days from the date of the mailing of the first insurer's disclaimer notice to file a claim against the second insurer. CIGNA reads that language to mean that a claimant who does not file a claim against the second insurer within 60 days is barred from bringing a claim against that insurer.

The problem with CIGNA's argument, however, is that the statute does not explicitly state that a failure to file against the second insurer in 60 days bars a claimant from filing a claim against that insurer. CIGNA's reading of the statute would have a substantial impact on a claimant's ability to file a claim for compensation. This case provides a good example of that. Under ORS 656.273(4), a claimant has five years after the first determination or first notice of closure to file an aggravation claim. CIGNA's reading of the statute would have

the effect of substantially reducing the time period for filing an aggravation claim solely because one insurer has asserted that another insurer is the responsible party. If the legislature had intended to so drastically reduce the time for filing such a claim based on such an occurrence, we believe that it would have explicitly said so.

Reading the statute as a whole also supports the conclusion that failure to file a claim against the second insurer within 60 days of the notice does not bar the claim. **<135 Or App 589/590>** The language that follows the imposition of the 60-day requirement in ORS 656.308(2) reads:

> "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."

It would appear from this language that the purpose of ORS 656.308(2) was to allow an insurer to defend itself by contending that another insurer is responsible, regardless of whether the other insurer has been joined in the present proceeding.

We agree with the Board's conclusion that the 60-day time limit was not intended to bar a claim that is otherwise timely filed. Because there is no indication here that the aggravation claim against CIGNA was not otherwise timely, the Board correctly concluded that the claim was not time-barred.

Affirmed.

Cite as 135 Or App 692 (1995) July 26, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation Kim D. Wood, Claimant.

BILLS KWIK MARKETand Grocers Insurance, *Petitioners,*
v.
Kim D. WOOD and Consolidated Freightways, *Respondents.*
(WCB 92-16294: CA A85830)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 14, 1995.
Karen O'Kasey argued the cause for petitioners. With him on the brief was Schwabe, Williamson & Wyatt.
Alan M. Scott argued the cause for respondent Kim Wood. With him
No appearance by respondent Consolidated Freightway
Before Warren, Presiding Judge, and Edmonds and Arstron , Judges.
PER CURIAM
Reversed and remanded for reconsideration.

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135 Or App 693> Employer seeks review of a Workers' Compensatio Board order holding that claimant's aggravation claim is compensable. At oral argument, both parties agreed that th new revisions to Oregon Laws 1995, chapter ___, (SB 369) which became effective June 7, 1995, apply to this case an ask that we remand to the Board to reconsider in light of the new law. We agree that is the proper disposition. *Volk u America West Airlines* 135 Or 565, ___ P2d ___ (1995).

Reversed and remanded for reconsideration.

Cite as 136 Or App 75 (1995) August 9, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ronald Zimbelman, Deceased, Claimant.

ROSEBURG FOREST PRODUCTS, *Petitioner - Cross-Respondent,*
v.
Cheri ZIMBELMAN, Beneficiary of Ronald R. Zimbelman, Deceased,
Respondent - Cross-Petitioner.
(WCB 93-02973, 93-02972; CA A86167)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 26, 1995.
Richard D. Barber, Jr., argued the cause for petitioner cross-respondent. With him on the briefs was Bostwick, Sheridan & Bronstein.
James L. Edmunson argued the cause and filed the brief for respondent - cross-petitioner.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
On petition, reversed and remanded for reconsideration; affirmed on cross-petition.

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136 Or App 77> WARREN, P. J.

Employer seeks review of an order of the Workers' Compensation Board that held that the deceased worker's (claimant) myocardial infarction, from which claimant died, is compensable. We reverse.

Claimant worked for employer for 20 years. He developed bilateral carpal tunnel syndrome and employer accepted his compensation claim for that condition. He had carpal tunnel release surgery on both wrists. After the surgery, he was released and returned to modified work. Soon thereafter, claimant developed a cervical condition. Employer denied that claim. Claimant had surgery for the cervical condition on July 27, 1992. As a result, he was temporarily totally disabled from that date until the date of his death on August 15, 1992.

After the cervical surgery, claimant became focused on his disability, the pain he had experienced when he had attempted to return to work and the denial of his cervical condition. In the two weeks preceding his death, his emotional and physical condition deteriorated, and he often stared out the window, did not sleep well and experienced indigestion and diarrhea. On August 15, he became extremely worried that he would not receive the amount of compensation to which he believed he was entitled. His compensation check arrived in the mail that day and he believed the amount of the check was not the full amount that was due. He became extremely agitated and upset. He suffered a myocardial infarction, which resulted in his death. After a hearing that was conducted after claimant died, employer accepted the claim for the cervical condition.

Claimant's beneficiary sought compensation for the myocardial infarction, claiming that it was compensable as a consequence of his compensable injuries. Employer denied the claim. The referee set aside the denial, concluding that the heart attack was a compensable consequential condition, and the Board affirmed. It held "that claimant's myocardial infarction was caused, in major part, by his emotional upset over his inability to work, his pain, and his reaction to the employer's processing of his claim, including the disputed <**136 Or App 77/78**> temporary disability check. All of these factors are sequelae of claimant's compensable injuries."

Employer seeks review, asserting that the Board erred in its application of ORS 656.005(7)(a)(A), which provides that "[n]o 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." [1] It argues that the Board failed to consider whether claimant's compensable injuries, i.e., the carpel tunnel syndrome and cervical condition, were the major contributing cause of claimant's heart attack. It asserts that claimant's emotional condition, which the Board found was the major contributing cause of the heart attack, was not the compensable injury, but instead was a circumstance surrounding the injury. Accordingly, employer argues that a finding that the emotional condition was the major contributing cause of the heart attack does not establish that the heart attack is compensable as a consequential condition.

Claimant's beneficiary responds that the Board correctly considered the circumstances surrounding the compensable injuries. She relies on *Barrett Business Services v. Hames,* 130 Or App 190, 881 P2d 816, *rev den* 320 Or 492 (1994), in which we held that a nerve injury that was caused by physical therapy necessitated by a compensable shoulder injury was compensable as a consequential condition. In that case, the Board had found that the original shoulder injury was the major contributing cause of the nerve injury. We affirmed, explaining that the nerve injury "flowed directly and inexorably from the shoulder injury." Id. at 195. Claimant's beneficiary asserts that that case stands for the proposition that the circumstances surrounding the compensable injury can be considered part of the compensable injury for purposes of determining the major contributing cause of a consequential condition.

We begin with the pertinent statutory language. ORS 656.005(7)(a)(A) provides that an injury or disease that is a consequence of a compensable condition is compensable if "the compensable injury is the major contributing cause of **<136 Or App 78/79>** the consequential condition." The question is whether the Board erred in considering sequelae of the compensable injury as part of the compensable injury for purposes of determining whether conditions caused by the sequelae are compensable.

"Compensable injury" is defined by statute as "an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death * * *." ORS 656.005(7)(a). Under that definition, the compensable injury is the medical condition that results from the accidental injury and is not the aftereffects of that condition. *See Albany General Hospital v. Gasperino,* 113 Or App 411, 833 P2d 1292 (1992) (distinguishing between compensable injury, which is a condition that is caused by the industrial accident, and a consequential condition, which is caused in turn by the compensable injury). Accordingly, the Board erred in treating claimant's emotional condition as part of the original compensable injuries.

Although claimant's emotional condition is not a part of the original compensable injuries, that does not necessarily preclude consideration of the emotional condition's contribution to claimant's heart attack. According to the Board's findings, the emotional condition had a relationship to the original compensable injuries: it was caused in part by claimant's emotional reaction to the pain caused by the injuries and the disability that resulted from the injuries.[2] If that emotional condition was caused in major part by the carpal tunnel syndrome and the cervical condition, the emotional condition constitutes a compensable consequential condition. Under ORS 656.005(7)(a), a compensable consequential condition is itself a compensable injury. Therefore, if the emotional condition is a compensable injury in its own right, i.e., because it is a compensable consequence of the original compensable injuries, then a condition that is caused **<136 Or App 79/80>** in major part by the compensate emotional condition may also be compensate as a consequential condition.

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[1] Oregon Laws 1995, chapter - (SB 369), did not change the language of ORS 656.005(7)(a)(A), nor do we see that any of the definitional changes affect this case.

[2] The Board found that claimant's emotional state was also caused in part by claimant's reaction to the processing of his claim and his belief that the amount of compensation was incorrect. A claimant's reaction to the amount of compensation and to claims processing is not caused by the compensable injury; it is caused instead by the process by which the claimant is compensated for the injury. Because those causes are collateral to the injury, they cannot be considered as caused by the compensable injury.

This case differs from *Barrett Business Services,* on which claimant relies. In that case, the Board found that the claimant's nerve damage was caused in major part by the original compensate injury, because it was a result of medical treatment necessitated by the compensate shoulder injury. The Board found that the medical treatment was caused solely by the compensate injury, and that the medical treatment was the major contributing cause of the nerve condition. Here, the Board never found that the original compensate injury was the major contributing cause of the heart attack; it instead found that the emotional condition was the major cause. Contrary to the facts in *Barrett Business Services,* here there is no argument that the sole causes of claimant's emotional condition were the compensate injuries.

In this case, if the emotional condition is a compensable injury because it is a compensate consequence of the carpal tunnel syndrome and the cervical condition, and if the heart attack was caused in major part by the emotional condition, then the heart attack is compensate under ORS 656.005(7)(a)(A). Because the Board failed to consider whether the emotional condition was caused in major part by the carpal tunnel syndrome and the cervical condition, we remand for reconsideration.

Because of our disposition of employer's petition, we need not address claimant's beneficiary's cross-petition.

On petition, reversed and remanded for reconsideration; affirmed on cross-petition.

Cite as 136 Or App 91 (1995) August 9, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

S-M MOTOR COMPANY and Argonaut Insurance Company, *Petitioners,*

v.

Howard R. MATHER and Department of Consumer and Business Services, *Respondents.*

(H92-159; CA A85413)

Judicial Review from Department of Consumer and Business Services.

Argued and submitted May 19, 1995.

Vera Langer argued the cause for petitioners. On the brief were Darren L. Otto and Scheminske & Lyons.

Max Rae argued the cause and filed the brief for respondent Howard R. Mather.

John T. Bagg, Assistant Attorney General, argued the cause for respondent Department of Consumer and Business Services. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

EDMONDS, J.

Reversed and remanded for reconsideration of penalty for unreasonable delay in paying medical expenses; otherwise affirmed.

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136 Or App 93> EDMONDS, J.

Employer[1] seeks reversal of an order of the Department of Consumer and Business Services (DCBS) assessing a 25 percent penalty based on employer's failure to pay temporary disability benefits to claimant and an additional 25 percent penalty for employer's unreasonable delay in paying him medical expenses. ORS 656.262(10)(a). We reverse in part and affirm in part.

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[1] Petitioners, S-M Motor Company and Argonaut Insurance Company will be referred to as "employer" throughout this opinion.

In December 1984, claimant injured his neck at work when he slipped on ice and fell. Claimant filed a claim that was eventually closed in August 1985. In August 1990, claimant filed an aggravation claim. Employer denied that claim, but after a hearing in January 1991, the referee held that the aggravation claim was compensable. Employer requested review of the referee's order. On March 19, 1991, claimant's physician reported that claimant was unable to work until further notice. Claimant was released to return to his regular work in July 1991.

In November 1991, the Workers' Compensation Board (Board) affirmed and adopted the referee's earlier order that had found the aggravation claim compensable. Employer sought review of the Board's order in this court. While review of that order was pending before this court, claimant filed a petition with DCBS seeking an award of penalties and attorney fees against employer pursuant to ORS 656.262(10)(a).[2] In June 1992, DCBS issued a proposed <**136 Or App 94**> amended order that assessed a 25 percent penalty against employer based on employer's failure to pay temporary disability payments due claimant between March 1991 and July 1991. Petitioners and claimant requested a hearing with DCBS on that order. Meanwhile, we issued an opinion, concluding that claimant's aggravation claim was compensable. *S-M Motor Co. v. Mather*, 117 Or App 176, 843 P2d 998 (1992).

In July 1993, a hearings officer for DCBS issued an amended preliminary order affirming the 25 percent penalty based on the failure to pay temporary disability benefits. He also assessed an additional 25 percent penalty against petitioner for an unreasonable delay in the payment of medical expenses. Employer requested reconsideration of that order, but DCBS denied reconsideration and affirmed the assessment of both penalties against employer.

On review, employer first argues that DCBS erred in awarding claimant a penalty under ORS 656.262(10)(a) for its alleged unreasonable delay in paying medical expenses. Employer contends that claimant's petition for penalties and attorney fees was filed prematurely because payment of all medical bills had been stayed pursuant to ORS 656.313 pending review of claimant's aggravation claim. ORS 656.313 provides, in part:

> "(1)(a) Filing by an employer or the insurer of a request for hearing on a reconsideration order or a request for board review or court appeal stays payment of the compensation appealed, except for:
>
> "(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs; and
>
> "(B) Permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed."[3]

136 Or App 95> ORS 656.005(8) defines "compensation" as

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[2] ORS 656.262(10)(a) provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection. The entire additional amount shall be paid to the worker if the worker is not represented by an attorney. If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee. The director's action and review thereof shall be subject to ORS 183.310 to 183.550 and such other procedural rules as the director may prescribe."

The 1995 Legislature renumbered ORS 656.262(10) as ORS 656.262(11). The text of the subsection was not changed. Or Laws 1995, ch __ (SB 369).

[3] The 1995 amendments to ORS 656.313 do not affect the disposition of this issue. Or Laws 1995, ch __ (SB 369).

"all benefits, including medical services, provided for a compensable injury to a subject worker * * *. "

Employer contends that, because ORS 656.313 provides that payment of compensation is stayed on review except for permanent and temporary disability payments, and because medical bius are compensation, its obligation to pay claimant's medical expenses was stayed during the pendency of the review. Therefore, no sanction could be assessed for an unreasonable delay. [4] Claimant argues that medical bills were related to claimant's original injury in 1984, not to the aggravation claim, and that the claim for the bills is not subject to ORS 656.313.

We conclude that DCBS's order is not adequate for our review. It does not resolve the factual dispute regarding whether the unpaid medical expenses relate to the original injury or the aggravation claim. If the medical expenses stemmed from the aggravation claim, ORS 656.313 expressly provides that they were stayed during the pendency of review. Thus, employer could not be penalized for a delay in paying medical expenses during that time. If, however, the medical expenses arose from the original injury, then the stay provisions of ORS 656.313 would be inapplicable. Consequently, we cannot review the issue framed by the parties without findings setting forth whether the medical expenses were attributable to the original injury or the aggravation claim. *See Campos v. Hood River Care Center,* 104 Or App 261, 799 <**136 Or App 95/96**> P2d 1152 (1990). On remand, if DCBS finds that the medical bills were related to the original injury, it should also make findings about whether any bills were submitted to employer and whether they were timely paid.

In its next assignment of error, employer argues that claimant did not timely file his petition for penalties and attorney fees for employer's alleged unreasonable failure to pay temporary disability benefits. The parties agree that the timeliness of claimant's petition is governed by OAR 436-60-155 (1990), which provided, in part:

> "(1) Pursuant to ORS 656.262(10), the director may require the insurer to pay an additional amount to the worker as a penalty when the insurer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim. Penalties for unreasonable delay in payment of medical bills shall be processed in accordance with OAR 436-10.
>
> "(2) For the purpose of administering this rule, violations occurring prior to January 1, 1991 will only be acted upon if presented by July 1, 1991. *Complaints on or after* January 1, *1991 must be presented within 180 days of the alleged violation.*" (Emphasis supplied.)[5]

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[4] Employer cites *Wacker Siltronic Corp. v. Satcher,* 103 Or App 513, 515-16, 798 P2d 264 (1990), for the proposition that "medical services cannot be considered compensation while review of compensability of the injury is pending." Wacker was decided before the 1990 amendments to the Workers' Compensation Law. Or Laws 1990, ch 1197 (Special Session). We specifically noted in Wacker that the amendments were not applicable to that case. Id. at 515 n 2. Before the 1990 amendments, ORS 656.313 provided, in part:

> "(1) Filing by an employer or the insurer of a request for review or court appeal *shall not* stay payment of compensation to a claimant.
>
> " * * * * *
>
> "(4) Notwithstanding ORS 656.005, for the purpose of this section, 'compensation'means benefits payable pursuant to the provisions of ORS 656.204 to 656.208, 656.210 and 656.213 and *does not include the payment of medical services."* (Emphasis supplied.)

The 1990 amendments changed section (1) and eliminated section (4). Thus, *Wacker* is inapplicable to the facts of this case.

[5] OAR 436-60-155 was amended in 1994. Subsection (1) remains the same, although subsections (2) and (3) now read:

> "(2) Requests for penalties under this section must be in writing, stating what benefits have been delayed or remain unpaid, and received by the Division within 180 days of alleged violation.
>
> "(3) For the purpose of this section, 'violation' is either:
>
> "(a) A late payment or the nonpayment of any single payment due, in which case a request for penalty must be received by the Director within 180 days of the date payment was due; or
>
> "(b) A continuous nonpayment or underpayment such as with yearly cost of living increases for temporary disability compensation. In these instances, a request for penalty must be received by the Director within 180 days of the date of the last underpayment. All prior underpayment will be considered as one violation, regardless of when the first underpayment occurred."

Under the rule, a petition for a penalty must be filed within 180 days of the alleged "violation."

Employer argues that, pursuant to OAR 436-60- 150(5),[6] temporary disability payments were required to be **<136 Or App 96/97>** paid **every** 14 days following the March 19, 1991, date when claimant's physician released him from work. Therefore, the 180-day period started to run on that date. Consequently, claimant's petition filed on December 4, 1992, or 246 days after the alleged violation, was untimely. Claimant argues that, because the violations occurred every 14 days, the 180day time limit did not begin to run until the last payment was due.

The Director determined that the commencement of the 180-day time limit does not begin so long as the violation is ongoing. [7] We will not disturb an agency's interpretation of its own rule where the agency's interpretation "cannot be shown either to be inconsistent with the wording of the rule itself, or with the rule's context, or with any other source of law. " *Don't Waste Oregon Com. v. Energy Facility Siting, 320* Or 132, 142, 881 P2d 119 (1994). In this case, the agency interpreted the term "violation" to include a continuing violation. This interpretation is plausible and consistent with the wording of the rule as well as with the statutory context and other sources of law. Accordingly, we hold that although claimant did not challenge the initial nonpayments of temporary disability benefits, OAR 436-60-155 does not preclude him from asserting a claim for penalties based on amounts of temporary disability due, so long as the petition was filed within 180 days from the time the final payment was due. The penalty under ORS 656.262(10)(a) is calculated on the **<136 Or App 97/98>** amounts then due. Thus, the total unpaid temporary disability benefits would constitute the amounts due and therefore the amount subject to the penalty, regardless of when the temporary disability benefits first became due.

Employer's remaining assignments of error and arguments do not merit discussion.

Reversed and remanded for reconsideration of penalty for unreasonable delay in paying medical expenses; otherwise affirmed.

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[6] OAR 436-60-150(5) says,

"Temporary disability shall be paid to within seven (7) days of payment at least once each 14 days. When making payments as provided in OAR 436-60-020(l), the employer may make subsequent payments of temporary disability concurrently with the payroll schedule of the employer, rather than at 14-day intervals."

[7] The Director reasoned:

"[Tlhe insurer's argument fails to address when the 180-day time limit properly commences.

"It is claimant's assertion that the insurer failed to make timely TTD payments. This violation is alleged to have occurred over a period of time. We simply submit that the commencement of the 180-day time limit in the rule does not accrue so long as the violation is ongoing. * * *

"At the very least, claimant's right to assert a claim for penalties based on the last TTD payment alleged to have been untimely should not be precluded by claimant's possible failure to have challenged earlier nonpayments. * * * Penalties assessed on either calculation of the OAR 436-60-155(2) deadline essentially will yield the same penalty because the amount of penalty relates to the total amount of compensation still outstanding. * * * "

Cite as 136 Or App 120 (1995) August 9, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John L. Willhite, Claimant.

John L. WILLHITE, *Petitioner,*
v.
ASPLUNDH TREE EXPERTS and Travelers Insurance Company, *Respondents.*
(WCB 91-01116; CA A75536)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs July 11, 1995.
Anita C. Smith and Estell & Bewley filed the brief for petitioner.
Jerald P. Keene filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
PER CURIAM
Reversed and remanded for reconsideration.

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136 Or App 121> Claimant seeks review of an order of the Workers' Compensation Board. At oral argument, both parties agreed that the new revisions to the Workers' Compensation Law, Oregon Laws 1995, chapter ___ (SB 369), which became effective June 7, 1995, apply to this case. They ask that we remand to the Board for reconsideration in light of the new law. We agree that a remand is appropriate. See Volk v. America West Airlines, 135 Or App 565, ___ P2d ___ (1995).

Reversed and remanded for reconsideration.

Cite as 136 Or App 200 (1995) August 23, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jennifer Kammerer, Claimant.

Jennifer KAMMERER, *Petitioner,*
v.
UNITED PARCEL SERVICE and Liberty Northwest Insurance, *Respondents.*
(93-05996; CA A84768)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 1, 1995.
Patrick K. Mackin argued the cause and filed the brief for petitioner.
Mark P. Bronstein argued the cause for respondents. With him on the brief was Bostwick, Sheridan & Bronstein.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Reversed and remanded for reconsideration.

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136 Or App 202> ARMSTRONG, J.

Claimant seeks review of an order of the Workers' Compensation Board that held that an injury to her eye was not compensable. The issue is whether the Board erred in its determination that claimant's injury, which was caused by horseplay, did not arise out of her employment. We reverse and remand.

The facts are not in dispute. Claimant was required by her employer to park her car in a lot across the street from employer's main facility. In order to reach her car at the end of her shift, she had to walk past a guard shack and through a parking lot reserved for certain employees.

On March 19, 1993, claimant was walkng through the designated parking lot with several coworkers, one of whom was in the habit of "flicking" plastic tags at other coworkers. The plastic tags were about two inches by three inches in size and resembled the tags used to close a plastic bag around a loaf of bread. The tags are used by employees to close large bags that contain small parcels.

As claimant walked through the lot, claimant's coworker flicked a tag at claimant and the tag struck her in the right eye. Claimant suffered "traumatic microhyphema and mydriases of the right eye" as well as "conjunctival abrasions at the limbus." Claimant submitted a claim to employer for her injury. Employer denied the claim on the basis that the injury did not arise out of or in the course of claimant's employment. Claimant requested a hearing.

At the hearing, the referee found that it was a common practice for employees to flick the tags at each other, and it was not unusual for an employee to be hit by the tags. The coworker who flicked the tag that hit claimant had received a prior reprimand for engaging in that behavior on employer's property.

The referee concluded that claimant proved her injury without question. The referee also concluded that

> "[tlhe case law presently supports the conclusion that there was sufficient work connection between claimant's walking through one company parking lot to another where she was told to park to support a finding of compensability. "

136 Or App 203> The referee went on, however, to affirm employer's denial of the claim:

> "An employer is not liable for any and all injuries to its employees regardless of the cause. There must be a causal link between the occurrence of the injury and a risk connected with the employment. * * * In the present case, the source of claimant's injury bears no relationship to her employment. There is no evidence that the co-worker tossing the tab was motivated by anything related to his or claimant's job. *[Alt]hough there was some testimony to the effect that tab flicking had occurred on the employer's property prior to the date of claimant's injury, there is insufficient evidence in the record to permit the conclusion that the employer had acquiesced in the behavior.* The employer apparently had an unwritten policy against the flicking. The causal link between employment and the harm to claimant in this case is too tenuous to support a workers' compensation claim. * * * Claimant is unfortunately the innocent victim of her co-worker's misbehavior."

(Citations omitted; emphasis supplied.) Claimant appealed the referee's decision to the Board, which affirmed and adopted the referee's order.

On judicial review, claimant argues that the Board erred as a matter of law when it concluded that her injury was not work related. An injury is compensable if it "aris[es] out of and in the course of employment." ORS 656.005(7)(a); *Henderson v. S.D. Deacon Corp.*, 127 Or App 333, 335, 874 P2d 76 (1994). " '[A]rising out of' and 'in the course of' are two elements of a single inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable." *Norpac Foods, Inc. u. Gilmore,* 318 Or 363, 366, 867 P2d 1373 (1994); *Henderson,* 127 Or App at 335.

The requirement that the injury occur in the course of employment concerns "the time, place and circumstances of the injury." *Henderson,* 127 Or App at 336. Both parties agree that the injury occurred in the course of claimant's employment. The issue, then, is whether the injury arose out of her employment. That element of the inquiry evaluates the "causal connection between the injury and the employment." *Henderson,* 127 Or App at 337-38.

136 Or App 204> Employer contends that injuries caused by horseplay are not compensable unless the employer knows of and acquiesces in the behavior. Employer asserts that it had a policy against flicking tags, and that claimant's coworker violated that policy when he hit her with the tag. Employer's and the Board's analyses are flawed.

Injuries caused by horseplay may or may not be compensable. *Brown v. Liberty Northwest Ins. Co.,* 105 Or App 92, 95, 803 P2d 780 (1990), *rev* den 311 Or 261 (1991). Under Oregon case law, an active participant or instigator in horseplay who is injured may not receive compensation unless the employer knew or should have known of and acquiesced in the behavior. *See Stark v. State Industrial Acc.* Com., 103 Or 80, 98, 204 P 151 (1922) (employee killed when he engaged in horseplay with air hose entitled to compensation because employer knew of horseplay and had no policy prohibiting it); *Brown,* 105 Or App at 95 (injuries resulting from horseplay not "always" compensable).

The theory behind excluding active participants in horseplay from coverage is that, in engaging in the horseplay, the employee may have engaged in a "voluntary steppingaside from the employment." See Arthur Larson, 1A Larson's *Workmen's Compensation Law* § 23.30, at 5-183 (1990). If a participant in horseplay is hurt and files a claim, then the employer's knowledge of and acquiescence in the horseplay become relevant. Where horseplay is common and the employer knows or should know of it and does nothing actively to discourage it, then an active participant in horseplay may recover. That is because an employer's decision to acquiesce in horseplay can reasonably be understood to make that activity an aspect of the work environment, such that an employee who engages in horseplay will not be understood to have voluntarily stepped aside from employment. Brown, *105* Or App at 95 (citing *Stark,* 103 Or at 98).

Oregon courts have not directly addressed whether a nonparticipant in horseplay may recover workers' compensation. Professor Larson has stated that "[ilt is now clearly established that the non-participating victim of horseplay **<136 Or App 204/205>** may recover compensation." Larson, 1A *Workmen's Compensation Law* § 23. 10, at 5-178[1] Indeed, a majority of states allow recovery by an innocent bystander without a showing of knowledge or acquiescence by the employer. *See id.* at 5-178 n 1. The reason for the difference in treatment between a participant and a nonparticipant is that there is no voluntary deviation from employment on the part of an innocent bystander. Generally, if an employee's conduct does not amount to a substantial deviation from the course of employment, an injury suffered on the job is compensable. Larson, 1A *Workmen's Compensation Law* § 23.00.

Oregon law has recognized a distinction between participants and nonparticipants in an equivalent context. ORS 656.005(7)(b)(A) bars compensation for an "[ilnjury 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[.]"* (Emphasis supplied.) We have held that the reason for denying compensation to participants in fights is that thosle workers have stepped away from their job assignments and deviated from their customary duties. *Kessen v. Boise Cascade Corp.*, 71 Or App 545, 548, 693 P2d 52 (1984). That is the same reasoning that we and other jurisdictions have used to deny compensation in horseplay cases. *See, e.g.*, Larson, 1A *Workmen's Compensation Law* § 23.00.

On the other hand, a claimant who is not the initiator nor an active participant in an assault or combat may recover compensation. *See Irvington Transfer v. Jasenosky,* 116 Or App 635, 639-40, 842 P2d 454 (1992) (claimant assaulted by coworker entitled to compensation). An innocent bystander engaged in normal work activities cannot be understood to have "stepped aside" from employment, and may recover when assaulted on the job. Similar reasoning applies to an innocent victim of horseplay. Thus, employer acquiescence in the horseplay should have no bearing on whether such a bystander is entitled to compensation.

136 Or App 206> In this case, claimant was not a participant in the horseplay. She was, as the Board said, "an innocent victim." Thus, the cases cited by employer are inapposite, because they address situations in which an active participant in the horseplay is injured and seeks compensation.

The Board erroneously determined that claimant's injury did not arise from her employment because the employee who hit her with the tag was engaging in horseplay and had deviated from his employment. Because claimant was not a participant in the horseplay, she was not precluded from receiving compensation on the ground that her injury arose from horseplay.

Reversed and remanded for reconsideration.

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[1] Oregon case law is not to the contrary. *Cf. Davis v. Weyerhaeuser Co.*, 231 Or 596,610,373 P2d 985 (1962) (dictum) (worker who was innocent victim of horseplay would have been entitled to compensation under Workers' Compensation Law).

Cite as 136 Or App 222 (1995) September 6, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Warren N. Bowen, Claimant.

SAIF CORPORATION and University of Oregon, *Petitioners*
v.
Warren N. BOWEN, *Respondent.*
(WCB 91-15616; CA A77263)

On remand from the Oregon Supreme Court. *SAIF v. Bowen,* 320 Or 501, 887 P2d 787 (1995).
Judicial Review from Workers' Compensation Board.
Submitted on remand March 3, 1995.
David L. Runner, Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Edward J. Harri argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson, Jensen & Correll.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DEITS, P. J.
Reversed and remanded with instructions to dismiss petition.

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136 Or App 224> This case is on remand from the Supreme Court for reconsideration in the light of *Martin v. City of Albany,* 320 Or 175, 880 P2d 926 (1994), and *Niccum v. South Coast Lumber Co.,* 320 Or 189, 880 P2d 923 (1994). *SAIF v. Bowen,* 320 Or 501, 887 P2d 787 (1995).

The issue in this case is whether the Workers' Compensation Board had jurisdiction to determine the appropriateness of proposed medical treatment for claimant.[1] The Supreme Court's decisions in *Martin* and *Niccum* held that the Board did have jurisdiction. However, the amendments to the workers' compensation law made by Oregon Laws 1995, chapter 332, are applicable here because this case was pending before the courts on the effective date of the petition. *Volk v. America West Airlines,* 135 Or App 565, ___ P2d ___ (1995). Those amendments give the Director of the Department of Consumer and Business Services exclusive authority to decide whether proposed medical treatment is excessive, inappropriate, ineffectual or in violation of applicable rules. Oregon Laws 1995, chapter 332, sections 41 and 50; *Newell v. SAIF,* 136 Or App 280, __ P2d __ (1995). Accordingly, the Board lacked jurisdiction to consider this question. We remand to the Board with instructions to dismiss claimant's petition to it.

Reversed and remanded with instructions to dismiss petition.

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[1] SAIF also assigns error to the Board's award of attorney fees under ORS 656.386(1). In light of our conclusion that the Board lacked jurisdiction, it is unnecessary to address this question.

Cite as 136 Or App 247 (1995) September 6, 1995

IN THE.COURT OF APPEALS OF THE STATE OF OREGON

Karl J. TADSEN, *Respondent,*
v.
PRAEGITZER INDUSTRIES, INC., a corporation, *Appellant.*
(93-1208-L-2; CA A85428)

Appeal from Circuit Court, Jackson County.
L. L. Sawyer, Judge.
Argued and submitted July 13, 1995.
Charles R. Markley argued the cause for appellant. With him on the briefs was Greene & Markley, P.C.
Joseph M. Charter argued the cause for respondent. With him on the brief was Werdell, Charter & Hanson.
Elizabeth McKanna and Bennett & Hartman filed the brief amicus *curiae* for Oregon Trial Lawyers Association.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DEITS, P. J.
Affirmed.

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136 Or App 249> Defendant employer appeals from the judgment for plaintiff, its former employee, in this action under ORS 659.121 for a wrongful discharge based on plaintiff's physical impairment resulting from an on-the-job injury. Plaintiff also alleged other related unlawful employment practices. We affirm.

Plaintiff began working for defendant as an electrician in 1989. He was promoted to a supervisory position the following year. In 1991, plaintiff suffered an on-the-job back injury and took a two-week medical leave of absence. In his absence, defendant filled plaintiff's supervisory position, and it assigned him to perform as a non-supervisory electrician upon his return. However, it did not formally change his job classification at that time.

Plaintiff suffered aggravations of his injury while performing his new assignment, which necessitated further medical leaves between May and October 1991. In late October, defendant formally removed him from his supervisory position, and assigned him to be a "senior electrician," which entailed more physically strenuous work than the supervisory job. According to defendant, plaintiff "felt his back injury prevented him from performing the duties of senior electrician." Plaintiff took sick leave and, in early November, defendant fired him. Plaintiff was in his early 50's at that time.

Plaintiff then brought this action, alleging the discriminatory firing decision and other unlawful employment practices. He sought economic and noneconomic damages of various kinds, including damages for loss of future earnings and benefits. Such damages, generally referred to as "front pay" damages, are designed to compensate a wrongfully discharged employee for the wages and benefits that he would ultimately have received from his employer if the employer had not wrongfully discharged him.

The case was tried to ajury, which found that defendant had wrongfully discharged plaintiff because of his physical impairment and also, earlier, had failed to reinstate him to his own or another suitable position on his return to work. *See* ORS 659.415 and ORS 659.425 (proscribing the conduct **<136 Or App 249/250>**that the jury found). The jury awarded damages in the total amount of $423,450. Although the verdict form called for a general award of damages, the form as returned by the jury contained handwritten interlineations, indicating that the jury had included two components in its overall award: "$70,000 non-economic (stress)" and "$353,450 economic. The latter figure accorded exactly with the amount of earnings and benefits,that plaintiff's

expert testified that he would have received had he remained defendant's employee until reaching the age of 63.[1] Axiomatically, an award of that amount under that and the other evidence necessarily would have consisted largely of front pay damages.

For reasons we will discuss, our disposition of defendant's last assignment of error depends on whether we may consider only the general award for which the verdict form asked, or may also consider the component figures shown by the interlineations: if we are restricted to the former approach, the assignment may succeed, but if we may follow the latter approach, it fails.[2]

Generally, we could not properly take the jury's interlineations into account when, as here, the record does not definitively disclose the source or the circumstances under which they were made. However, in its opening brief, defendant cites the verdict form and recites as fact:

> "The jury awarded plaintiff economic damages in the amount of $353,450 (the exact future estimated by [plaintiffs expert] to be plaintiff's lost past and future wages and benefits to retirement age 63) and non-economic damages in the, amount of $70,000, for a total award of $423,450."

Accordingly, the differentiated figures are accepted and presented to us as the facts of the case by defendant[3] the appealing party and the one that stands to lose by our viewing the facts in that manner. Quite apart from the verdict form itself, we may accept as true any representation of adverse facts that a party to an appeal presents to us. We do so here, in **<136 Or App 250/251>** the interest of avoiding a reversal that is not warranted under the facts that the parties agree on and inform us to be.true.

All of defendant's arguments on appeal relate to the claim for front pay damages. In its first assignment of error, defendant asserts that the trial court erred by denying its motibn to strike the claim for those damages. Defendant argues initially that plaintiff was an "at will" employee and that, as such, he should not be entitled to damages for front pay as a matter of law. Defendant reasons that plaintiff "had no right to future employment" with defendant. Because defendant could discharge plaintiff at any time on any basis that would not constitute an unlawful reason, defendant maintains that plaintiff "cannot say that 'but for' the wrongful termination he would continue to be employed by [defendant]." Defendant hypothesizes that, had the trial court ordered plaintiff's reinstatement as a remedy in this case, defendant "could have terminated [plaintiff] the day after his reinstatement so long as the discharge" - unlike the one that actually occurred - "did not constitute an unlawful employment practice. Defendant concludes, on the basis of those propositions, t hat front pay damages can never be itcompensatory" in the case of an at-will employee, and therefore cannot be recoverable under ORS 659.121.[4]

We rejected a materially identical argument by the employer in *Wooton v. Viking Distributing Co., Inc.*, 136 Or App 56, ___ P2d ___ (1995). The thrust of defendant's argument is that, notwithstanding a discriminatory discharge and its actual causal relationship to a loss of future earnings, damages for that loss cannot be recovered because, independently of the unlawful firing, the employee had no "right" to or assurance of any future employment with the employer. The premise that necessarily underlies that argument is that an employer should enjoy a conclusive presumption that, had it not discharged the employee illegally, it would have discharged him lawfully at exactly the same time that it in fact did so unlawfully. We find that premise unconvincing and, accordingly, are not persuaded by the argument.

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[1] The expert also computed a higher alternative figure, based on the assumption that plaintiff would work for defendant until turning 65. The jury found the lesser of the two amounts.

[2] Defendant's other assignments are not *dispositively* affected.

[3] We note that plaintiff does not suggest otherwise.

[4] We imply no view about the correctness or incorrectness of any of defendant's propositions that we do not expressly reject.

136 Or App 252> Defendant also argues, in support of its first assignment:

> "When the terms of employment are indefinite, as in an at-will employment situation, neither the existence nor the amount of future wages can be proved with reasonable certainty. It follows, as a matter of law, that an at-will employee cannot recover future wages."

To the extent that that argument presents the same *per se* argument as the first, except that it is cast in terms of "proof," we reject it for the reasons we rejected a similar argument by the employer in Wooton. 136 Or App at 65-66. We decline to hold that an at-will employee can never prove the requisite facts for an award of front pay damages. The fact that the employment does not have a set term does not mean that its likely duration is incapable of proof to the degree of certainty that is required to establish damages for lost earnings. *Owens v. Haug, 61* Or App 513, 517, 658 P2d 523, *rev* den 294 Or 792 (1983); *see also Welch v. U.S. Bancorp,* 286 Or 673, 704-05, 596 P2d 947 (1979) (sufficiency of proof of lost profits).

In its second assignment, defendant asserts that, in this case, "plaintiff failed to present any evidence from which to determine a reasonable period that plaintiff's employment would have continued, but for the wrongful termination." Defendant therefore maintains that the court erred in denying its motion to strike the front pay claim.

The threshold task under this assignment is to define the requirements for proving the likely duration of future employment in circumstances such as these, when there is no fixed term of employment to serve as a reference point. Defendant relies on *Beal v. Gilchrist Timber Co.,* 64 Or App 300, 667 P2d 575, *rev den* 295 Or 840 (1983). In that case, the plaintiff was hired as a temporary employee, for a minimum of two weeks, and was told that her "employment might or might not develop into a permanent job." *Id.* at 302. She was fired after one day's work, as the result of sex discrimination. We said, in discussing the plaintiff's claim for back pay:

> "[T]he record does not contain any evidence that all employes, or that any substantial number of employes, were hired initially on a temporary basis; nor is there any evidence that employes hired on a temporary basis, as a matter of **<136 Or App 252/253>** practice, became permanent employes. We find no substantial evidence that plaintiff s temporary position, in particular, would have evolved into a permanent position. Plaintiff *hoped* she might work permanently.[1] The supervisor testified that he had said that plaintiff s employment might or might not become permanent, depending on whether another opening were to appear while she was working. No one, however, testified that a permanent position ever became available in the weeks immediately following plaintiff's employment, and no one in any way suggested that plaintiff probably would have continued on a permanent basis. Plaintiff s employment in a temporary 'entry-level position' or a 'laborer position,' without more, does not necessarily indicate permanency. We hold that, when a term of employment is temporary or for a fixed term, back pay may only extend to the end of the period that the factfinder determines the plaintiff would have been employed but for the discrimination.
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> ---
>
> "[1] Another employe testified that employes generally had a couple of weeks to *learn* their jobs and become oriented. He did not testify that plaintiff's position would typically evolve into a permanent one. Plaintiff testified that her supervisor said her job was temporary; she added, '[But I believe there is also a thirty-day temporary thing for every new employee.' Plaintiff's apparent reference to a *probationary* period must be distinguished from *temporary* employment. Her testimony does not establish that temporary employes always or even usually become permanent." Id. at 303 (emphasis in original; citation omitted.)

Other Oregon cases, dealing with analogous issues, make clear that lost earnings and analogous damages and facts relevant to them, such as the duration of future employment, do not have to be established with complete certainty; proof of a likelihood or probability suffices. *Wilson v. B.F. Goodrich,* 292 Or 626, 633, 642 P2d 644 (1982); *see also Welch,* 286 Or at 704-05.

We conclude that the same ultimate question - the period that the plaintiff would likely have been employed by the defendant but for the discrimination - is the proper one in connection with front pay claims as well as claims for back pay. It is also the proper ultimate question in claims by at-will **<136 Or App 253/254>** employees, as well as claims by temporary and fixed term employees.

In *Lords v. Northern Automotive Corp.*, 75 Wash App 589, 881 P2d 256 (1994), the Washington court included a helpful discussion of the issue:

> "Front pay should be awarded 'for a reasonably certain period of time that does not exceed the likely duration of the terminated employment.'Hayes *[v. Trulock],* 51 Wash. App. [795,] 802, 755 P2d 830 (quoting Smith *v. Atlas Offshore Boat Serv., Inc.,* 552 F. Supp. 128, 130 (S.D. Miss. 1982)). Although front pay was not at issue, *Xieng [v. Peoples Nat'l* Bank, 120 Wash 2d 512, 531-32, 844 P2d 389 (1993)] held a back pay award should not be cut off when the employee's position was eliminated, unless the employer shows the employee would not have been retained in some other capac*ity. Xieng,* 120 Wash.2d at 531-32, 844 P.2d 389. In arriving at this conclusion, Xieng noted its reasoning was consistent with *MacDissi v.* Valmont *Indus., Inc.,* 856 P.2d 1054, 1060 (8th Cir. 1988) ('courts will presume for the purposes of awarding relief that an illegally discharged employee would have continued working for the employer until he or she reaches normal retirement age, unless the employer provides evidence to the contrary') and with *Sims v. Mme. Paulette Dry Cleaners,* 638 F.Supp. 224,233 (S.D.N.Y. 1986) (general reduction in work force not a valid defense to front pay). Otherwise, the employee bears the burden of proving lost future wages for a reasonable period of time." 75 Wash App at 605-06.

Although we agree generally with that statement in other particulars, Oregon law is inconsistent with the suggestions in it that the likely duration of employment - to retirement age or otherwise - can be established presumptively, or that a burden of disproof shifts to the employer. See *Beal; Callan v. Confed. of Oreg. Sch.* Adm., 79 Or App 73, 717 P2d 1252 (1986) (implicitly or explicitly contrary to respective suggestions). However, that does not mean that the employee in a particular case cannot prove as a fact that the likely duration of employment would have been until retirement age or the earlier end of the employee's working years. *Tyler v. Bethlehem Steel Corp.*, 958 F2d 1176 (2d Cir 1992).

In this case, plaintiff's proof was sufficient to enable the jury to make either of those findings. He was 52 at the **<136 Or App 254/255>** time of trial, and, of course, had back problems. There was evidence that the market for supervisory personnel in the geographical area was small, and that plaintiff had no intention or incentive to enter it. His job satisfaction was high. There was also evidence that, before plaintiff's physical difficulties, defendant was quite satisfied with plaintiff and his work. His performance evaluations were excellent and his merit salary increases made him the highest paid person in a comparable position whom defendant employed. The inference was available that both parties wanted the arrangement to continue indefinitely,

There was also statistical evidence, in the form of government "work life expectancy tables" presented by plaintiff's expert, that, together with the direct evidence, would enable the jury to infer that plaintiff would have continued working until the age of 63 or 65. (Presumably but somewhat inconsequentially given what the jury in fact found - the jury could also have determined from the evidence that plaintiff would have worked until some lesser age that it could have considered was more reflective of plaintiff's personal circumstances ' than the statistical evidence might indicate.) In sum, there was sufficient evidence to support the jury's finding of the likely period that plaintiff would have remained in his position with defendant, but for the latter's wrongful action, and there was sufficient evidence to support the resulting damages that it awarded.

Defendant's remaining assignment challenges the court's refusal to give its requested instruction: .

> "Economic damages are objectively verifiable, monetary losses incurred by the plaintiff. In determining the amount of economic damages, if any, consider:

"(1) The amount of loss of income sustained by the plaintiff since the termination from employment throughout the period determined by you to be a reasonable period that plaintiff's employment would have been continued, but for the termination of the plaintiff, less any compensation actually earned or which reasonably could be earned by the plaintiff during that period. I instruct you that claims for lost income must be proven with reasonable certainty and cannot be based on guess work, conjecture or speculation."

136 Or App 256> Based on what we have already said, we conclude that the requested instruction is an essentially correct statement of the law.

The instruction on the subject that the court gave instead apprised the jury:

"Now, economic damages are objectively verifiable monetary losses incurred by the plaintiff. To determine the amount of economic damage, if any, you may consider the amount of loss of income sustained by the plaintiff since the termination to date. The amount may not exceed the sum of $403,550."

Defendant offers the following explanation of how it was prejudiced by the combination of the giving of the latter instruction and the refusal to give the requested one:

"The court merely instructed the jury to consider plaintiff's loss of income from the date of termination *to the date of trial* in an amount not to exceed $403,550. This was the amount plaintiff's expert testified that plaintiff could expect to lose *until retirement* because of his physical inability to earn $16.00 an hour. The jury, therefore, inferred from the court's instruction that plaintiff was entitled to receive lost wages until his retirement, even though there was no evidence that plaintiff could reasonably have expected to work [for defendant] until retirement. The jury then awarded plaintiff $353,450, which was the exact amount calculated by [the expert] to be plaintiff's lost wages if he had retired at age 63 rather than at age 65.

"The court's instruction was an improper statement of the law regarding the appropriate measure of economic damages in this case and unfairly prejudiced [defendant]. If the court had given defendant's requested instruction, the jury would have been notified that they *[sic]* had to consider the reasonable period that plaintiff's employment would have been continued rather than simply assuming plaintiff could recover lost wages until retirement. " (Emphasis defendant's; citation to record omitted.)

We have already rejected the aspects of defendant's argument that presuppose that there was a failure of proof by plaintiff. Further, contrary to defendant's assertion, there is no basis for concluding that the jury *assumed* that plaintiff could recover wages until retirement; the *evidence supported* the finding that he would work for defendant until he ended **<136 Or App 256/257>** his working years at age 63. Beyond that, it is not at all apparent how the jury *could* have reasoned in the way defendant surmises. Defendant is correct that the jury *in fact* found that, had he not been unlawfully fired, plaintiff would have ended his employment for defendant at the age of 63. Defendant is also correct that the instruction that the court gave placed a $403,550 cap on plaintiff's economic damages, the amount that the expert testified plaintiff would have accrued if he had worked for defendant until he was 65. Defendant is not correct, however, in its understanding that the jury reasonably could have been induced by the reference to the $403,550 figure in the instruction to believe that it must find that plaintiff would have worked for defendant until he"retired" at 65 or any other age. Two readily distinguishable questions are involved: how long plaintiff would in fact have worked, and how much in earnings he could have lost if he had worked to the latest possible time contemplated by the evidence. Moreover, the lesser damages that the jury awarded, and the proof that it accepted and reasoning it necessarily followed in order to award those damages, are compelling evidence that it inferred nothing from the court's reference to the $403,550 cap on the damages recoverable for a period of future employment that it did not find.

Comparing the instruction that was given and the one that was requested and refused, as they bear on what the jury could have found concerning the likely duration of plaintiff's future employment, the former was more favorable to defendant than the latter. *See Winnett v. City of Portland, 118* Or App 437, 847 P2d 902 (1993) (error in instruction that benefits party challenging it is not reversible error). The instruction that was given allowed the jury to find damages only to the date of trial - a period of roughly one and one half years from the date of his discharge; the requested instruction, to the extent that it correctly states the law, permitted the jury to find damages for a period of likely continued employment of at least the approximate 13 years that it did find[5]

That does not quite end the inquiry. Defendant maintains that the requested instruction, viewed alone **<136 Or App 257/258>** rather than in comparison with the one that was given, would have apprised the jury that it *could* also have found a lesser period of future employment instead of the period it in fact found. As an abstraction, defendant is correct, but the facts of the case do not compel us to deal with abstractions. We reiterate that we know the specifics of what the jury found and how it found them. The jury accepted the retirement at age 63 variation offered by plaintiff's expert. The linchpin of the work duration factor in the expert's equation was the "work life expectancy table" evidence that he presented, together with the opinion that he based on it.

Defendant points to no direct evidence from which the jury could have arrived at a conclusion that plaintiff would have ceased working for defendant before the age 63 or age 65 alternatives that the expert derived. We might agree with defendant's apparent premise that, even in the absence of direct evidence, the jury was *free* to infer from the evidence as a whole that plaintiff's future employment would have had a duration shorter than the age 65 or age 63 variations presented by the expert. However, given that the expert's evidence was the source of both the underyling statistical data and the derivative opinion testimony that led to the age 63 work-duration finding that was actually made, the following instruction that was given by the court seems to us to have told the jury everything of consequence that the ungiven requested instruction might have added to assure that the jury knew it could consider a finding of a shorter period of future employment:

> "There's been expert witnesses testifying in this case, and an expert may give an opinion on any matter which they have special knowledge, skill, experience, training, or education. You should consider the qualifications and credibility of an expert witness and the reasons given for the expert's opinion. You're not bound by the opinion. Give it what weight, if any, to which you consider it to be entitled, and you can totally disregard it if you wish."

Given the circumstances of the case, we see no likelihood that the requested instruction, if given, could have led to a more favorable outcome for defendant. It is clear what the jury found, and it is also clear that the jury was informed that it could have rejected the evidentiary predicate for that finding in whole or in part. The refusal to give the instruction had **<136 Or App 258/259>** no probable affect on the outcome of the case. *Waterway Terminals v. P.S. Lord,* 256 Or 361, 474 P2d 309 (1970). If it was error not to give the instruction, the error was harmless.

Affirmed.

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5 Defendant does not assign as error that the jury's verdict was inconsistent with the instruction that was given, in that it awarded greater damages than that instruction would have permitted.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Lori A. Newell, Claimant.

Lori A. NEWELL, *Petitioner,*
v.
SAIF CORPORATION and Benton County, *Respondents.*
(WCB 92-09328; CA A81960)

Judicial Review from Workers' Compensation Board.
Defendant does not assign as error that the jury's verdict was inconsistent with the instruction that was given, in that it awarded greater damages than that instruction would have permitted.
On respondents' motion for reconsideration filed June 1 1995. Opinion filed May 31, 1995. 134 Or App 625, 896 P2 16.
Theodore R. Kulongoski, Attorney General, Virginia Linder, Solicitor General, and Michael 0. Whitty, Special Assistant Attorney General, for motion.
Before Deits, Presiding Judge, and De Muniz and Leeson, Judges.
DEITS, P. J.

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136 Or App 282> SAIF moves for reconsideration of our earlier decision in this case. *Newell v. SAIF,* 134 Or App 625, 896 P2d 16 (1995). SAIF contends that Oregon Laws 1995, chapter 332, amended the statutory provisions at issue here and, accordingly, the case must be reconsidered. We allow SAIF's motion for reconsideration.

SAIF is correct that the amendments to the Workers' Compensation Law made by Qregon Laws 1995, chapter 332, are applicable to this case, because it was pending before the courts at the time of the effective date of the legislation, June 7, 1995. *Volk v. America West Airlines,* 135 Or App 565, ___ P2d ___ (1995). Although our earlier decision was issued on May 31, 1995, the time for seeking reconsideration or Supreme Court review of our decision had not expired on June 7, 1995. ORAP 9.05.

In our opinion, we relied on the Supreme Court's decision in *Niccum v. Southcoast Lumber Co.,* 320 Or 189, 880 P2d 923 (1994), and reversed and remanded the Workers' Compensation Board's order that held that, under ORS 656.327(l) and ORS 656.704(3), it lacked jurisdiction[1] to consider whether proposed medical treatment for claimant was appropriate. However, as SAIF points out, these statutes have now been Amended to provide that the Director of the Department of Business and Consumer Affairs has exclusive jurisdiction to review whether proposed medical treatment is excessive, inappropriate, ineffectual or in violation of applicable rules. Oregon Laws 1995, chapter 332.

ORS 656.704(3) was amended as follows:

> "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. However, <**136 Or App 282/283**> such matters do not include any *[proceeding for resolving a dispute regarding* medical treatment *or fees for which a procedure is otherwise provided in this chapter]* **disputes arising under ORS 656.245, 656.248, 656.260, 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under ORS 656.340 except as those provisions may otherwise provide.**" Oregon Laws 1995, chapter 332, section 50.

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[1] Contrary to SAIF's assertions, we did not hold that SAIF had waived any issues relatingto the board's jurisdiction. We simply stated that SAIFconceded that under the Supreme Court's decision in *Niccum,* the Board did not have jurisdiction to consider the appropriateness of proposed medical treatment.

ORS 656.327(l)(a) was amended as follows:

"If an injured worker, an insurer or self-insured employer or the Director **of the Department of Consumer and Business Services** believes that [an *injured worker is receiving]* **the** medical treatment, **not subject to ORS 656.260,** that **the injured worker has received, is receiving, will receive or is proposed to receive** is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services [and *wishes reuiew of the treatment by the director],* the injured worker, insurer or self-insured employer shall **request review of the treatment by the diieector and** so notify the parties *[and the director]."* Oregon Laws 1995, chapter 332, section 41.[2]

As can be seen, the above statutes now clearly provide that the director has exclusive jurisdiction to review proposed medical treatment. Accordingly, the Board's holding that it lacked jurisdiction to review the proposed surgery for claimant is consistent with the statutes now in effect. We vacate our earlier opinion and affirm the Board's order.

Reconsideration allowed; opinion vacated; affirmed.

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[2] In keeping with Legislative Counsel's format, we bracket and italicize the material deleted form the statutes by the amendments and print the new material in bold face.

Cite as 136 Or App 284 (1995) September 6, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON OCCUPATIONAL SAFETY & HEALTH DIVISION, *Petitioner,*
v.
Daren Richard OSTLIE, *Respondent.*
(SH-92165; CA A84285)

Judicial Review from the Workers' Compensation Board.
Argued and submitted February 13, 1995.
Richard D. Wasserman, Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Elliott Cummins argued the cause for respondent. On the brief were George W. Goodman and Cummins, Brown, Goodman, Fish & Peterson, P.C.
Before Riggs, Presiding Judge, and Richardson, Chief Judge, and Leeson, Judge.
RIGGS, P. J.
Reversed and remanded for reconsideration.

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136 Or App 286> The Oregon Occupational Safety and Health Division (OR-OSHA) seeks review of an order of a referee of the Workers' Compensation Board in this proceeding under the Oregon Safe Employment Act, ORS 654.001 *et seq.* The referee dismissed all seven citations against employer for the reason that OR-OSHA's Safety Compliance Officer (SCO) violated procedural requirements.

The referee made these uncontested findings:

"[Employer] was awarded a contract by the U.S. Department of Agriculture Forest Service [USFS] to blast the tops of live conifer trees located solely within the Mt. Hood National Forest on public lands owned by the United States. The purpose of this contracted service was to create wildlife habitat. The employer's performance of this service was overseen by the [USFS] contracting officer's representative. The contract specified certain safety obligations of the employer. The [USFS] had the right to inspect employer's work and camp-site at any time and did so.

"[Employer] hired his younger brother, Jason Ostlie, to work as his employee. During operations on December 16, 1991, Jason Ostlie was accidentally injured due to a premature detonation of dynamite he had prepared in a tree located within the Mt. Hood National Forest. The employer was the first one on the scene and immediately used a cellular telephone to send for an ambulance. An ambulance from Estacada, Oregon, responded and stabilized employee Jason Ostlie. A 'life flight' was then called for and soon the employee was flown to Emanual Hospital in Portland, Oregon. By that time [USFS] personnel were on the scene so the employer asked one Forest Service employee to 'secure' the dynamite and other blasting materials, which was done promptly. The employer left the premises by private vehicle and traveled to the hospital.

"[OR-OSHA] was notified of the accident on December 17, 1991 and [SCO] Bruce Lawson arrived at the Estacada Ranger Station at 2:30 p.m. that afternoon. Guy Price, Contract Office Representative for [USFS], and William Cortain, Head Blaster for the Mt. Hood National Forest, [USFS] were present. Neither [employer] nor anyone employed by (employer], was present at the Ranger Station. [USFS] knew the injured worker had been flown to Emanual Hospital in Portland. [USFS] also knew the employer's <**136 Or App 286/287**> address and phone number and had frequently communicated with him during the course of the contract, and knew the employer was probably at his brother's side in the hospital. No one made any effort to locate the employer.

"SCO Lawson presented his 'credentials' and conducted an 'opening conference' with those individuals who were present at the ranger station. At approximately 3:00 p.m. that same day SCO Lawson went to the accident site before attempting contact with, or presenting credentials to, the employer. Guy Price and William Cortain accompanied SCO Lawson to the site. SCO Lawson first arrived at the accident site at approximately 3:30 p.m. Neither [the employer] nor anyone employed by [the employer] was at the accident site at that time. SCO Lawson took photographs and interviewed Price and Cortain. The artifacts of the accident and the accident site were not disturbed. SCO Lawson, Price and Cortain left the accident site around 4:00 p.m. as night was falling. They returned to the Estacada Ranger Station. SCO Lawson then inquired about the best way to contact [the employer.] Price contacted [the employer], and arranged a meeting at the Estacada Ranger Station for the next day, (December 18, 1991) at 1:00 p.m. * * *

"On the morning of December 18, 1991, SCO Lawson, together with fellow SCO Fritz Schukar, returned to the Estacada Ranger Station, reviewed the [USFS] contract folder, and then returned to the accident site to take measurement. SCOs Lawson and Schukar were again accompanied to the site by Price and Cortain. No representatives of the employer had been invited to go to the site with SCO Lawson. No representative of the employer was present. On this second visit to the site, the wires and other evidence which related to the blast were moved from their positions, thereby obscuring whatever might have been the original condition of those wires and items.

"Returning to the Estacada Ranger Station at 1:00 p.m. on December 18, 1991, SCOs Lawson and Schukar met with [the employer] for the first time. They presented their credentials, conducted an opening conference, and interviewed (the employer].

"Following the investigation by SCOs Lawson and Schukar, OR-OSHA issued a citation to the employer for seven violations of the Oregon Safe Employment act for alleged activities of the employer arising out of the employer's contract with [USFS]. "

136 Or App 288> Employer sought dismissal of the citations on the grounds that OR-OSHA had violated the statutes and rules with regard to the presentation of credentials, ORS 654.067(l); OAR 437-01-065(2); the conduct of the opening conference, OAR-437-01-075; and the inspection of the employment premises, ORS 654.067(4); OAR 437-01-080(3). The referee concluded that OR-OSHA had acted improperly in each instance and held that the citations must be dismissed.

ORS 654.067 provides:

> "(1) In order to carry out the purposes of ORS 654.001 to 654.295 and 654.750 to 654.780, the director, *upon presenting appropriate credentials to the owner, employer or agent in charge, is authorized:*
>
> *"(a) To enter without delay and at reasonable times any place of* employment; and
>
> "(b) To inspect and investigate during regular working hours and at other reasonable times, and within reasonable limits and in a reasonable manner, any such place of employment and all pertinent conditions, structures, machines, apparatus, devices, equipment and materials therein, and to question privately the owner, employer, agents or employees.
>
> "(c) No person shall give an owner, employer, agent or employee advance notice of any inspection to be conducted under ORS 654.001 to 654.295 and 654.750 to 654.780 of any place of employment without authority from the director.
>
> "(3) Except in the case of an emergency, or of a place of employment open to the public, if the director is denied access to any place of employment for the purpose of an inspection or investigation, such inspection or investigation shall not be conducted without an inspection warrant obtained pursuant to ORS 654.202 to 654.216, or without such other authority as a court may grant in an appropriate civil proceeding. Nothing contained herein, however, is intended to affect the validity of a constitutionally authorized inspection conducted without an inspection warrant.
>
> "(4) Arepresentativeoftheemployerandarepresentative authorized by the employees of the employer shall be given an opportunity to accompany the director during the inspection of any place of employment for the purpose of aiding such inspection. Where there is no employee representative, or the employee representative is not an employee of the employer, the director should consult with a reasonable <**136 Or App 288/289**> number of employees concerning matters of safety and health in the place of employment." (Emphasis supplied.)

The referee held that SCO Lawson violated ORS 654.067(l) in failing to present his credentials to employer. OR-OSHA contends that when the property to be inspected is public property, the provisions of ORS 654.067 are inapplicable and there is no. need for the SCO to present credentials. That argument was not made to the referee and we decline to consider it on review.

OR-OSHA also argues that because ORS 654.067 permits an inspection upon the showing of credentials to the "owner," the SCO complied with the statute by showing his credentials to the USFS official. It is agreed that USFS is the owner of the land on which employer's blasting operations took place.

ORS 654.005 provides:

> "As used in this chapter, unless the context requires otherwise
>
> " * * * * *

> *"(6) 'Owner' means and includes every person having ownership, control or custody of any place of employment* or of the construction, repair or maintenance of any place of employment." (Emphasis supplied.)

ORS 654.005(8) defines "place of employment" as

> "every place, whether fixed or movable or moving, whether indoors or out or under ground, and the premises and structures appurtenant thereto, where either temporarily or permanently an employee works or is intended to work and every place where there is carried on any process, operation or activity related, either directly or indirectly, to an employer's industry, trade, business or occupation, including an labor camp provided by an employer for employees or by another person engaged in providing living quarters or shelters for employees, but 'place of employment' does not include any place where the only employment involves nonsubject workers employed in or about a private home."

On their face, the words of the statutes permit the presentation of credentials to the owner of the "place" on which an employee is working or a business is operating, whether or not that person has an ownership interest in the business <**136 Or App 289/290**> itself. Employer reasons, nonetheless, that when it is considered in its context, the requirement regarding the presentation of credentials evidences the legislature's intention to provide notice to the person responsible for the business operations and potentially subject to citation for violations. Employer argues that it is not sufficient to serve the owner of the "place" on which the work site is located, if that person is not also connected to the business operations beyond providing the premises.

Even assuming, without deciding, that the statutes require that the owner of the place of employment have some. interest in the employment operations beyond mere ownership of the premises, we conclude that the connection is present here. Although USFS had no ownership interest in the business operations, it had contracted for employer's services and had an interest, by virtue of its contractural agreement and federal safety standards, in seeing that those services were accomplished safely. We conclude that, as owner of the place of employment, USFS could receive credentials for the purpose of an OR-OSHA inspection. There is no contention that the USFS personnel to whom the credentials were presented were not authorized to represent USFS in that capacity. We hold that the referee erred in concluding that OR-OSHA violated ORS 654.067(l).

The referee also held that the SCO failed to comply with OAR 437-01-065 by presenting his credentials to the employer or the employer's representative. OAR 437-01065(2) provides:

> "A Compliance Officer, if possible, shall present his/her credentials to an employer or employer's representative to establish the Compliance Officer's right of entry."

OR-OSHA concedes that USFS was not the employer for the purpose of the administrative rule. It contends, however, that USFS was "employer's representative," as defined in OAR 437-01-015(24), which includes "the person in charge of the place of employment at the time of inspection."

OR-OSHA contends that when employer asked the USFS official to secure the explosives on the employment premises, that person became employer's representative "in charge of the place of employment." However, employer's <**136 Or App 290/291**> request did not include authorization to take responsibility for the place of employment. The referee found that USFS officials were not in charge of the place of employment at the time of the inspection. That finding is supported by substantial evidence.

OAR 437-01-075 requires that "if possible," an SCO ..conduct a joint opening conference with the employer or a representative, and a representative of the employees, if any." For the reasons discussed above, we agree with the referee that USFS personnel were not representatives of employer for the purpose of thejoint opening conference, and we affirm the referee's holding that OR-OSHA violated the administrative rule.

With exceptions not relevant here, OAR 437-01080(3) provides:

> "No inspection will be made if neither the employer, employer representative, nor employees are present at the place of employment."

The referee held that OR-OSHA's inspection, which took place only in the presence of USFS personnel, violated that rule, for the reason that no employer or employer's representative was present. For the reasons previously discussed, we conclude that USFS was not employer's representative and agree with the referee's holding that the rule was violated.

OR-OSHA does not challenge the referee's conclusion that the SCO violated the requirement of ORS 654.067(4) that the employer or a representative of the employer be given an opportunity to accompany the director during an inspection.

Having held that the evidence against employer was obtained as a result of an improper presentation of credentials and an improper inspection, the referee struggled to fashion an appropriate remedy. He first considered only excluding the improperly obtained evidence, but then reasoned that the improper inspection had tainted the entire investigation and that it was impossible to segregate the properly obtained evidence. He ruled that because the entire investigation was unlawful, there was no statutory basis for the issuance of the citations, and he dismissed them all.

136 Or App 292> There is no express statutory authorization for the dismissal of citations or the exclusion of evidence obtained as a result of invalid procedures; nor are those consequences expressly foreclosed by the statutes. ORS 654.071(1) provides:

> "If the director or an authorized representative of the director has *reason to believe, after inspection or investigation of the place of employment,* that an employer has violated any state occupational safety or health law, regulation, standard, rule or order, the director or the authorized representative *shall* with reasonable promptness issue to such employer a citation, and notice of proposed civil penalty, if any, to be assessed under this chapter, and fix a reasonable time for correction of the alleged violation." (Emphasis supplied.)

The parties appear to agree that that statute requires a *valid* inspection or investigation as a prerequisite to the issuance of a citation. We accept that interpretation of the statute for the purpose of this case. OR-OSHA contends that, even assuming that its *inspection* was invalid, its *investigation* beyond the inspection was proper and provides an adequate basis for the issuance of the citations.

We held in *Oregon Occupational Safety v. Don Whitaker Logging,* 124 Or App 246, 249, 862 P2d 526 (1993), *rev den* 318 Or 458 (1994), that OR-OSHA's off-premises investigations are not subject to the requirements of ORS 654.067, and that that statute "addresses only that aspect of the inspection or investigation that is made on the employer's premises." On these facts, contrary to the referee's conclusion, it is not apparent that evidence obtained from the offpremise investigation is tainted by the procedural defects associated with the inspection of the premises. The record does not show that the only evidence against employer was discovered in the course of the inspection of the employment premises, and, thus as a result of the tainted inspection. Several of the alleged violations relate to matters not involving the premises itself, such as the training and credentials of employees and the safety equipment worn by them. The referee should consider in the first instance, whether the alleged violations were established by evidence other than that derived from the invalid inspection of the premises.

136 Or App 293> Because the question may arise on remand, we consider OR-OSHA's contention that, when the director has reason to believe that a violation has occurred, dismissal of the citation is not an appropriate remedy for improper procedures unless the failure to comply with the statutory requirements resulted in substantial prejudice to the employer. For guidance, we have examined the federal OSHA case law

on which OR-OSHA relies. As we understand the cases, the existence of prejudice to the employer is relevant only when the agency has demonstrated that it has substantially complied with the procedural requirements. *Hartwell Excavating Co. v. Dunlop,* 537 F2d 1071 (9th Cir 1976); *Marshall v. C.F. & I. Steel Corp.,* 576 F2d 809,813-814 (10th Cir 1978). In the absence of substantial compliance, no showing of prejudice to the employer is required. Here, OR-OSHA has made no attempt to show that, if did not fully comply with the administrative requirements. for the presentation of credentials and the holding of a joint opening conference and the statutory requirement permitting the employer to accompany OROSHA on the inspection, then it substantially complied. There has been no justification offered here to adopt for OROSHA a standard for compliance with procedural safeguards that is less rigorous than the federal standard. We will not restrict the referee's authority to dismiss citations to cases involving prejudice to the employer when there has been no showing of substantial compliance by OR-OSHA.

Reversed and remanded for reconsideration.

Cite as 136 Or App 302 (1996) September 6, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kelly 0. Sullivan, Claimant.

Kelly 0. SULLIVAN, *Petitioner,*
v.
SEARS, ROEBUCK & CO. and Kemper Insurance Co., *Respondents.*
(WCB 93-02652; CA A86267)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 10, 1995.
Robert F. Webber argued the cause for petitioner. With him on the brief was Black, Chapman, Webber & Stevens.
Mariie G. Masters argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Edmonds and Leeson, Judges.
RIGGS, P. J.
Reversed and remanded for reconsideration.

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136 Or App 304> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in affirming the referee's order upholding employer's denial of his aggravation claim.

Claimant injured his low back in 1986 while working for employer as an appliance repairman. He was treated conservatively without much benefit and continued to suffer left low back and leg pain. The claim was closed on September 14, 1987, by a determination order. At the time of closure, claimant's range of motion was reported to be more or less normal, and the determination order awarded no permanent partial disability.

Claimant continued to experience flare-ups of pain above his pain base line over the next several years. On August 6, 1992, claimant was seen by Dr. Purtzer, a neurosurgeon. Purtzer reported that claimant had a 50 percent reduction of normal range of motion in his low back. Claimant contends that Purtzer's comments concerning range of motion show that his condition had worsened and that Purtzer's report is an aggravation claim. Employer denied the aggravation claim; the Board upheld the denial on the ground that Purtzer's report did not establish a "prima facie case" for aggravation.

Thereafter the legislature amended ORS 656.273(3). Or Laws 1995, ch 332, § 31. That section now provides:

"A claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or the worker's representative. The claim for aggravation must be accompanied by the 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." (Emphasis supplied.)

The amendment is applicable to this case. *Volk u. America West Airlines,* 135 Or App 565, - P2d - (1995). Accordingly, we remand the case to the Board for reconsideration in light of ORS 656.273 as amended.

Reversed and remanded for reconsideration.

Cite as 136 Or App 351 (1995) September 6, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James E. Bogle, Claimant.

James E. BOGLE, *Petitioner,*
v.
DEPARTMENT OF GENERAL SERVICES and SAIF Corporation, *Respondents.*
(WCB 93-04776; CA A86129)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 10, 1995.
Pamela A. Schultz argued the cause and filed the brief for petitioner.
Michael 0. Whitty, Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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136 Or App 353> Claimant seeks review of an order of the Workers' Compensation Board holding that his psychological condition is not compensable. We affirm the Board, but write to address claimant's contention that the Board erroneously discounted the opinion of his treating physician.

Claimant worked for the Telecommunications Division of the General Services Department of the State of Oregon as Chief Switchboard Services Operator. His primary job was to answer and route incoming calls to state government. In March 1993, claimant was aware that his position would be eliminated in June 1993, when a new automated system became operational. Claimant knew that it was likely that he would be transferred to a different position in state government, but apparently, according to his physician, he also had concerns about the possibility of being laid off.

In March 1993, calls to state government increased dramatically as a result of public response to a legislative proposal to cut education funding. To claimant, the work became difficult and stressful, and on March 4, 1993, claimant felt unable to continue and went home at the end of the morning. Before leaving, he called the Department Safety Officer to advise her that the working conditions were unsafe and that everyone was feeling very stressed. His supervisor advised him that he could return to work when he had been released by his physician.

Claimant has been under treatment for depression since 1987. When he left work in March 1993, he went to his family physician, Dr. Paulissen, who had been treating him for depression since 1991. In Paulisson's opinion, claimant's preexisting depression had become worse. Additionally, he attributed the change in claimant's condition to his employment:

"[I]t appears that his work situation was indeed of increased stress with increased work load as well as a *possibility of being laid off or having to change jobs.* Increasing work load is an obvious stressor, but probably more so *uncertainty about one's job and work situation would be* an *extreme stressor* to most people. This certainly could relate to an exacerbation of his existing condition." (Emphasis supplied.)

136 Or App 354> The Board did not find Paulissen's opinion persuasive of compensability:

"Paulissen * * * never indicates that the increased calls alone is the cause. The other cause which comprises the 'work situation,'according to Dr. Paulissen, is uncertainty of claimant's employment picture. Because the uncertainty of the employment would be equated with cessation of employment, the statute excludes this factor as a cause of a compensable condition. Dr. Paulissen's opinion is therefore not persuasive.'

"The statute" to which the Board referred is ORS 656.802(3), which provides, in part:

"Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:

" * * * * *

"(b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment."

The Board reasoned that claimant's employment uncertainty, i.e., his concern about being laid off or transferred to a new job, was the equivalent of "cessation of employment" under ORS 656.802(3)(b), and could not properly be considered as a cause of a compensable condition.

Despite claimant's arguments to the contrary, there is substantial evidence to support a finding that claimant was concerned about his impendingjob transfer or that he might be laid off. The first question here is whether the statutory term "cessation of employment" includes uncertainty of employment or a concern about the possibility of being laid off.

In *Elwood v. SAIF,* 298 Or 429, 693 P2d 641 (1985), the Supreme Court held that, although illness resulting from the circumstances and manner of discharge can be considered work related, the stress of actual discharge or loss of the job cannot be treated as a condition of the employment. The court said that the occupational disease law did not make illness from *losing* a job a compensable risk of the job. Id. at 433.

136 Or App 355> SAIF contends that the legislative history of ORS 656.802 shows that the enactment of paragraph (3)(b) was an attempt to codify *Elwood.* It may be that the legislature intended to encompass the holding of *Elwood* within the scope of ORS 656.802(3). Tape Recording, House Task Force on Occupational Disease, October 8, 1986, Tape 21-31 at 081. However, "cessation of employment," the term that the legislature chose to describe the circumstance that would not be treated as a condition of employment, is quite narrow and specific. It means that one's employment has ended or will end. The circumstances described in Paulissen's report, claimant's concern over the *possibility* of being laid off or changing jobs, or "uncertainty in employment," are not cessation of employment, or even, in the language used by the Supreme Court in *Elwood,* 298 Or at 433, anticipated unemployment. We conclude that neither the statute nor the Supreme Court's opinion in *Elwood expressly* excludes the possibility of being laid off or transferred as a condition of the employment.

Nonetheless, we affirm the Board, because we conclude that concern over the status of one's employment in and of itself is not a condition of the employment for which one can be compensated. The

Supreme Court's opinion in *Elwood* distinguished between the circumstances and mdnner of discharge, which are regarded as events intrinsic to the employment relationship, and the discharge itself, which, because it brings the person outside of the employment relationship, cannot be regarded as a condition of the employment. Similarly, the circumstances or manner of possible lay off or job transfer are events intrinsic to the employment relationship; however, no such circumstances have been described here. Following the Supreme Court's reasoning in *Elwood, we* conclude that the mere fact of transfer or possible lay off is not a condition of the employment; it is a shifting or possible interruption of the employment relationship and is not work related. Because Paulissen's opinion concludes that claimant's concern over being laid off or transferred was a significant cause of the worsening of his preexisting condition, the Board correctly reasoned that Paulissen's opinion does not support the compensability of the claim.

Affirmed.

Cite as 136 Or App 426 (1995) September 6, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Gregory A. WHITLEY, *Respondent,*
v.
SOUTHERN PACIFIC TRANSPORTATION COMPANY, a Delaware corporation, *Appellant.*
(9105-03193; CA A80632)

Appeal from Circuit Court, Multnomah County.
Stephen S. Walker, Judge.
Argued and submitted January 30, 1995.
Roger K. Stroup argued the cause for appellant. With him on the briefs was Bodyfelt Mount Stroup & Chamberlain.
Lawrence Baron argued the cause for respondent. With him on the brief were Kimberley Chaput and Pozzi Wilson Atchison.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed.

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136 Or App 428> Plaintiff filed this action under the Federal Employer's Liability Act (FELA), 45 USC § 51, claiming that he was injured as a result of defendant's negligence. The jury returned a verdict for plaintiff. Defendant appeals, assigning error to the trial court's rulings regarding the admission of evidence and instructions to the jury. We affirm.

The underlying facts are not in dispute. Plaintiff worked for defendant, a railroad company, as a switchman. On June 10, 1988, plaintiff climbed down a ladder on the side . of a railroad car. As he stepped from the ladder to the walkway, he twisted his ankle on a rock. Plaintiff reported his injury to defendant and did not return to work the next day. He obtained a doctor's authorization to stop working.

Defendant conducted an investigation of the accident, and on July 26, 1988, it fired plaintiff for failure to follow the company's safety rules. Plaintiff appealed the dismissal, seeking reinstatement and back pay. Before the conclusion of the appeal, plaintiff's doctor released him to work, and defendant allowed plaintiff to return without prejudice to his appeal. Subsequently, the appellate board held that plaintiff had violated company rules and was, therefore, not entitled to back pay. The board did, however, conclude that dismissal was unwarranted and ordered that defendant be reinstated, and he was.

Plaintiff then filed this action under the FELA, alleging that defendant was negligent " [il n failing to provide plaintiff with a safe place to work" in that the walkway was not properly maintained, contained large rocks and contained a rock that exceeded the "maximum allowable. " Plaintiff also alleged that defendant was negligent in failing to comply with four specific administrative rules, promulgated by the Public Utility Commission (PUC): OAR 860-44-300(l), which requires that railroad walkways have a regular surface and be "maintained in a safe condition"; OAR 860-44-300(2)(b), which specifies the type of surface materials that are to be used on walkways and the manner of their application; OAR 860-44-305(l), which specifies the maximum "grade and slope" allowed for walkways; and OAR 300-44-315, which <**136 Or App 428/429**> describes the necessary width and elevation of railroad walkways. Plaintiff requested both general damages and lost wages.

Before trial, defendant moved to exclude evidence of wages that plaintiff lost after he was physically able to return to work and evidence of plaintiff's embarrassment and humiliation regarding his discharge. Defendant argued that, because that evidence was related solely to plaintiff's discharge, and not his injury, those damages were not recoverable under the FELA and the evidence was, therefore, irrelevant. The trial court denied the motion.

At trial, plaintiff introduced evidence showing that the walkway on which he was injured did not comply with the state administrative rules. Plaintiff also testified that he had twisted his ankle when climbing off a railroad car and that, because of that injury, he was physically unable to return to work for about four months. Plaintiff testified that, despite his subsequent medical release, he remained unable to return to work because he had been discharged.

Plaintiff then testified that he felt " [a] nger and hurt, not just physical pain that I was in, but hurt that I was being treated this way," and that he found it "humiliating that they dismissed me over this." Plaintiff was concerned, because he "didn't really know if [he] would be allowed to come back to a career that [he] had put so much time in." Plaintiff's fiance testified that plaintiff was concerned that she would not marry him because he had lost his job and that plaintiff was embarrassed, humiliated and devastated by the discharge.

After all of the evidence was submitted, and before closing arguments were made, plaintiff withdrew his allegations regarding defendant's failure to provide a safe place to work. Instead, plaintiff relied solely on his allegation that defendant was negligent in its failure to adhere to the four specified administrative rules.

Following closing argument, the parties addressed the issue of jury instructions. Plaintiff requested that the trial court instruct the jury that defendant was under a duty to provide a "reasonably safe place to work." Defendant objected to that instruction, insisting that it would improperly allow the jury to find against defendant on an allegation <**136 Or App 429/430**> that had been withdrawn. Defendant requested an instruction informing the jury that it should consider plaintiff's contributory negligence. The trial court denied that request. The jury returned a special verdict in plaintiff's favor.

On appeal, defendant first assigns error to the admission of evidence of wages that plaintiff lost after he was able to return to work and to the admission of evidence of plaintiff's mental suffering. Defendant argues that the evidence of lost wages and mental suffering relates to plaintiff's discharge, and that damages resulting from an allegedly wrongful discharge may not be sought in an FELA claim, but must instead be sought exclusively under the arbitration procedures set forth in the federal Railway Labor Act (RLA). 45 USC § 151 *et* seq. Plaintiff counters that the scope of the compulsory arbitration provisions of the RLA is narrow and is limited to disputes arising out of the interpretation or application of collective bargaining agreements concerning rates of pay, rules or working conditions.

Although this matter was tried in state court, it is governed by federal substantive law. *St. Louis Southwestern Railway Co. v. Dickerson,* 470 US 409, 411, 105 S Ct 1347, 84 L Ed 2d 303 (1985); *Staples v. Union Pacific R.R. Co.,* 265 Or 153, 155, 508 P2d 426 (1973). Under the FELA,

> " [e]very common carrier by railroad * * * shall be liable in damages to [employees] * * * for such injury or death resulting in whole or in part from the negligence of any of the officers, agents, or employees of such carrier."

45 USC § 51. That provision allows recovery for negligence, occupational injuries and diseases, intentional torts and some mental injury. *Lewy v. Southern Pacific Transp. Co.,* 799 F2d 1281, 1288 (9th Cir 1986). The RLA provides a framework for the arbitration of certain labor disputes in the railroad industry. Specifically, 45 USC § 153(i) provides that all

> "disputes between [railroad] employees and * * * carriers growing out of grievances or out of the interpretation of agreements concerning rates of pay, rules, or working conditions"

are subject to compulsory arbitration.

The relationship between the FELA and the RLA was extensively reviewed by the United States Supreme <**136 Or App 430/431**> Court in *Atchison, T. & S. F. R. Co. v. Buell,* 480 US 557, 1413-16, 107 S Ct 1410, 94 L Ed 2d 563 (1987):

"In 1906, Congress enacted the FELA to provide a federal remedy for railroad workers who suffer personal injuries as a result of the negligence of their employer or their fellow employees. A primary purpose of the Act was to eliminate a number of traditional defenses to tort liability and to facilitate recovery in meritorious cases. * * * The coverage of the statute is defined in broad language, which has been construed even more broadly. We have recognized generally that the FELA is a broad remedial statute, and have adopted a ,standard of liberal construction in order to accomplish [Congress's] objects.'

"The RLA, by contrast, provides a comprehensive framework for the resolution of labor disputes in the railroad industry. Enacted in 1926, the text of the RLA does not mention the FELA or otherwise deal with the subject of tort liability.

" * * * * *

"The [defendant] asserts first that employees have the right to have defects in the workplace corrected by resorting to the grievance machinery that is in place pursuant to the RLA, and that the RLA is the exclusive remedy for such minor disputes. Indeed, in this case, preliminary though abortive steps in that direction were actually taken. Thus, the [defendant] argues that an FELA action for damages is barred. We find no merit in this argument. *The fact that an injury otherwise compensable under the FELA was caused by conduct that may have been subject to arbitration under the RLA does not deprive an employee of his opportunity to bring* an *FELA action for damages.*

"This Court has, on numerous occasions, declined to hold that individual employees are, because of the availability of arbitration, barred from bringing claims under federal statutes. Although the analysis of the question under each statute is quite distinct, the theory running through these cases is that notwithstandingthe strongpolicies encouraging arbitration, 'different considerations apply where the employee's claim is based on rights arising out of a statute designed to provide minimum substantive guarantees to individual workers.'

"This principle is instructive on the question before us. The FELA not only provides railroad workers with substantive protection against negligent conduct that is independent **<136 Or App 431/432>** of the employer's obligations under its collective-bargaining agreement, but also affords injured workers a remedy suited to their needs, unlike the limited relief that seems to be available through the Adjustment Board. *It is inconceivable that Congress intended that a worker who suffered a disabling injury would be denied recovery under the FELA simply because he might also be able to process* a *narrow labor grievance under the RLA to a successful conclusion. * * * '[T]he Railway Labor Act * * * has no application to a* claim *for damages to the employee resulting from the negligence of an employer railroad.'*

" * * * * *

"As far as a worker's right to damages under the FELA is concerned, Congress[s] enactment of the RLA has had no effect. "

(Footnotes and citations omitted; emphasis supplied.)

In the light of the Supreme Court's discussion in *Buell,* it is clear that defendant is simply incorrect in asserting that the RIA preempts an award of damages to plaintiff for lost wages and emotional distress in his FELA action. The decisions relied upon by defendant for the contrary proposition are distinguishable in that they were decided before the Supreme Court's decision in *Buell, see Lewy,* 799 F2d at 1288 n 6; *Jackson v. Consolidated Rail Corp.,* 717 F2d 1045, 1045 (7th Cir 1983), *cert den* 465 US 1007 (1984); *Beanland v.*

Chicago, Rock Island & Pacific Railroad Co., 480 F2d 109 (8th Cir 1973), or were based on the preemption of non-FELA claims, *see Lewy,* 799 F2d 1281; *Jackson,* 717 F2d at 1045; *Magnuson v. Burlington Northern, Inc.,* 576 F2d 1367 (9th Cir), *cert den* 439 US 930 (1978).

Defendant argues that even if plaintiff's claims for lost wages and emotional distress need not be brought under the RLA, they are still not recoverable under the FELA, because those injuries were not caused by defendant's negligence, but instead were solely caused by plaintiff's discharge. Plaintiff does not dispute that his loss of wages and emotional distress were a consequence of his discharge. He argues that they are nevertheless recoverable under the FELA, because there was evidence that the discharge was a direct result of defendant's negligence in causing his injury and that that is a sufficient causal link to permit recovery <**136 Or App 432/433**> under the liberal causation requirement of the FELA. Furthermore, he argues, traditional concepts of tort law, such as proximate cause, do not apply under the FELA. *Oglesby v. Southern Pacific Transp. Co.,* 6 F3d 603, 607 (9th Cir 1993); *Lies v. Farrell Lines, Inc.,* 641 F2d 765, 769-80 (9th Cir 198 1).

In an action brought under the FELA, "the quantum of evidence sufficient to present a jury question of causation is less than it is in a common law tort action." *Claar v. Burlington Northern R. Co.,* 29 F3d 499, 503 (9th Cir 1994). All that is required is that the jury be able to determine that the "employer['s] negligence played any part, even the slightest, in producing the injury." *Rogers v. Missouri Pacific R. Co.,* 352 US 500, 506, 77 S Ct 443, 1 L Ed 2d 493 (1957). The negligence of the employer need not be either "the sole or whole cause of the injury," nor the "direct or proximate cause" of the injury, *Oglesby,* 6 F3d at 608-09. Rather, FELA plaintiffs need only demonstrate "some causal connection between a defendant's negligence and their injuries." Claar, 29 F3d at 503.

In this case, there is evidence that plaintiff was injured in a fall occasioned by defendant's negligence. There also is evidence that defendant terminated plaintiff's employment because of that fall, and that plaintiff suffered lost wages and emotional distress as a result. Thus, there is a direct chain of events from defendant's negligence to plaintiff's damages. There is ample evidence that defendant's negligence played the requisite "slightest part" in producing plaintiff's injuries. We conclude that the trial court did not err in admitting evidence of plaintiff's lost wages and emotional distress.

Defendant next assigns error to the trial court's instruction to the jury that a common carrier has a " continuing nondelegable duty and obligation to furnish a reasonably safe place for its employees to work. " According to defendant, the trial court's instruction exceeded the scope of plaintiff's pleadings, which alleged only that defendant was negligent in failing to comply with specific administrative rules. Plaintiff responds that, when the instructions are read as a whole, they did not create an erroneous impression in the minds of the jurors that likely affected the outcome of the trial. We agree with plaintiff.

136 Or App 434> We review the trial court's instructions

> "as a whole, in the context of the entire trial, to determine whether they were 'misleading or * * * inadequate to guide the jury's deliberations.' "

Lewy, 799 F2d at 1287 (quoting *United States v. Shorrt Accountancy Corp.,* 785 F2d 1448, 1454 (9th Cir), *cert den* 478 US 1007 (1986)). We may reverse only for an abuse of discretion, giving the trial court "substantial latitude" in tailoring the instructions. Lewy, 799 F2d at 1287.

In this case, the trial court's instruction, viewed in isolation, does go beyond the scope of the pleadings, which were limited to plaintiff's allegation that defendant had failed to comply with four specific administrative regulations. However, after making the general statement that a common carrier is obligated to provide a reasonably safe workplace, the trial court proceeded to detail precisely how plaintiff had alleged that defendant had failed to comply with that duty, namely, by failing to comply with the four enumerated regulations. The trial court then read, verbatim, from plaintiff's complaint the specifications of negligence alleged, referring to each of the four regulations. The trial court then instructed the jury to determine whether plaintiff had

established, by a preponderance of the evidence, the claims set forth in the pleadings. The trial court then gave the jury a special verdict form, which required the jury to determine whether defendant was "negligent in one or more of the respects claimed in plaintiff's complaint." Given the fact that plaintiff's complaint was predicated solely on defendant's failure to comply with four specific regulations, and given the fact that the trial court's instructions and the special verdict form specifically referred to those pleadings, we cannot say that the trial court's instruction concerning a common carrier's general duty to provide a reasonably safe workplace was misleading or inadequate to guide the jury's deliberations.

In its third assignment of error, defendant argues that the trial court erred in instructing the jury that it must find that defendant was negligent if it finds that defendant violated any of the specified Oregon administrative rules. According to defendant, the Oregon administrative rules are not the type of regulations on which an FELA claim may be based. In its fourth assignment, defendant argues that the **<136 App 434/435>** trial court erred in failing to deliver a requested instruction on contributory negligence. Although defendant concedes that the FELA prohibits the assertion of comparative negligence in cases in which injury was caused by a violation of safety laws, it asserts that the Oregon administrative rules that form the basis for plaintiff's case are not "laws" that have such preclusive effect. Because the two assignments concern the same legal issues, we consider them together. Once again, we review the instructions as a whole to determine whether they were misleading or inadequate. *Lewy,* 799 F2d at 1287.

The FELA provides that

> "no such employee who may be injured or killed shall be held to have been guilty of contributory negligence in any case where the violation by such common carrier of any statute enacted for the safety of employees contributed to the'injury or death of such employee."

45 USC § 53. Although that provision refers to violation of a 4 4 statute," a related federal law effectively elevates certain administrative rules to the level of a statute for purposes of the FELA. The Federal Railroad Safety Act (FRSA) of 1970 provides:

> "[a]ll orders, rules, regulations, standards and requirements in force, or prescribed or issued by the Secretary under this subchapter, or by any State agency which is participating in investigative and surveillance activities [in connection with federal railroad safety standards] shall have the same force and effect as a statute for purposes of the application of sections 53 and 54 of this title, relating to the liability of common carriers by railroad for injuries to their employees."

45 USC § 437(c)[1] In this case, the rules on which plaintiff relies were promulgated by the PUC, which is a state agency participating in the "investigation and surveillance activities" described in the FRSA. No one contests that the PUC is such a participating state agency.[2] Defendant's sole argument is that, under the FRSA, only federal regulations and **<136 Or App 435/436>** state regulations relating to investigation and surveillance activities concerning those federal regulations are considered safety "statutes" for FELA purposes.

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[1] The provision was repealed after the initiation of these proceedings. Act of July 5, 1994, Pub L 103-272, § 7(b), 108 Stat 1379. That repeal, however, has no effect on "proceedings that were begun before the date of [its] enactment," id., and, thus, has no bearing on our decision.

[2] ORS 760.070 provides:

"(1) The commission shall employ at least three full-time railroad inspectors to assist the commission as the commission may prescribe in:

"* * * * *

"(c) Conducting any investigative, surveillance and enforcement activities that the commission is authorized to conduct under federal law in connection with any federal law, rule, regulation, order or standard relating to railroad safety."

That, however, is not what the statute says, and the language of the FRSA cannot reasonably be read to obtain the result defendant suggests. The FRSA says that all orders, rules, regulations, standards and requirements "prescribed by * * * any State agency which is participating" in certain cooperative enforcement efforts with the federal government shall have the effect of a statute for FELA purposes. 45 USC § 437(c). The statute does not say that only federal regulations have such statutory effect. It specifically includes regulations "prescribed by * * * any State agency." 45 USC § 437(c). Nor does it say that only state rules that relate to investigation and surveillance activities concerning those federal regulations have that effect. The reference to investigation and surveillance activities describes only the type of agency to which the provision applies.[3]

Defendant argues that such a construction of the FRSA is at odds with decisions in which courts have held that the type of state railroad safety regulations at issue in this case are preempted by federal law. *See Missouri Pacific R. Co. v. Railroad Com'n of Texas,* 948 F2d 179, 184 (5th Cir 199 1); Union *Pacific R. v. Pub. Util. Com'n of Oregon,* 723 F Supp 526, 529-30 (D Or 1989); *Norfolk and Western Ry. Co. v. Burns,* 587 F Supp 161, 169-71 (ED Mich 1984). Plaintiff responds that the nature of the FRSA's preemption provisions necessitates factual inquiry into the nature and effect of the challenged state regulation, and that defendant made no <**136 Or App 436/437**> such record in this case. In any event, plaintiff asserts, other courts have held that state regulations similar to those at issue in this case have not been preempted by the FRSA. *See Southern Pacific Transp. v. Pub. Utilities* Com'n, 647 F Supp 1220 (ND Cal 1986), *affd* 820 F2d 1111 (9th Cir 1987); Ill. *Cen. Gulf R. v. Tenn. Pub. Serv.*, 736 SW2d 112, 116 (Tenn App 1987). Defendant offers no reply to those assertions.

The FRSA declares that railroad safety regulations "shall be nationally uniform'to the extent practicable." 45 USC § 434.[4] The act, however, permits continued state regulation of railroad safety in certain circumstances:

> "A state may adopt or continue in force any law, rule, regulation, order, or standard relating to railroad safety until such time as the Secretary has adopted a rule, regulation, order or standard covering the subject matter of such State requirement. A State may adopt or continue in force an additional or more stringent law, rule, regulation, order, or standard relating to railroad safety when necessary to eliminate or reduce an essentially local safety hazard, and when not incompatible with any Federal law, rule, regulation, order, or standard, and when not creating an undue burden on interstate commerce."

Id. Accordingly, a determination of whether a particular state railroad safety regulation is preempted by the FRSA depends on the nature of the regulation at issue and the factual record concerning its necessity and effect. In that regard, we note that each of the decisions cited by both defendant and plaintiff was based on the factual record before the court as to the necessity and effect of the regulations at issue, and that the different results in those cases simply reflect the different factual records developed in them.

In this case, there is no record at all about the necessity or effect of the regulations on which plaintiff relies. Indeed, aside from the citation to the decisions of other courts, defendant asserts no basis on which we could determine whether the Oregon railroad safety regulations at issue have been preempted by the FRSA.

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[3] Indeed, defendant's construction of the statute would require us to read the same statutory words to mean two different things at the same time. If defendant correctly reads section 437(c), then "all" railroad safety regulations means "all" in reference to federal regulations, but something substantially less than "all" in reference to state regulations. That construction cannot be reconciled with the statutory language: "All orders * * * prescribed or issued by the Secretary * * * or by any state agency." 45 USC § 437(c).

[4] Although that provision has been repealed, it is nevertheless controlling, because these proceedings were begun before that repeal. Act of July 5, 1994, Pub L 103-272, § 7(b), 108 Stat 1379.

136 Or App 438> We conclude that the Oregon railroad safety regulations on which plaintiff relied are "orders, rules, regulations, standards and requirements" within the meaning of the FRSA. Accordingly, the violation of those rules may give rise to FELA liability and FELA precludes the introduction of a contributory negligence defense. The trial court did not err in so instructing the jury.

Affirmed.

Cite as 136 Or App 487 (1995) September 6, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Pablo Villafuerte, Claimant.

Pablo VILLAFUERTE, Petitioner,
v.
UNGER FARMS and SAIF Corporation, Respondents.
(93-10195; CA A86491)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 10, 1995.
Steven M. Schoenfeld argued the cause for petitioner. With him on the brief were Schoenfeld & Schoenfeld, P.C., and Lynn-Marie Crider.
Michael 0. Whitty, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Affirmed.

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136 Or App 489> Claimant seeks review of a Workers' Compensation Board (Board) order holding that his injury is not compensable. The issue is whether claimant was in the course of his employment when he was injured. We affirm.

Claimant, a farm worker, was employed by Unger Farms (employer) in Cornelius. Employer contracts with Echeverria to supply workers and supervise strawberry picking. On any given day during the picking season employer has a crew of approximately 100 workers at the farm. Workers either drive to the farm in private cars or ride in van pools organized by Echeverria. Van drivers are also farm workers and are paid by Echeverria. Employer does not own the vans, does not pay the drivers and does not provide transportation for the workers.

Employer abuts a county road. When the fields are dry, workers park their cars or vans on employer's property. When the fields are muddy, they park along the shoulder of the road. The road and the shoulder of the road are owned by the county.

On June 2, 1993, claimant rode to work in one of the vans. The fields were muddy, so the driver parked on the shoulder of the road across from employer's field. When claimant finished his shift he went to stand next to the van to wait for the ride home. While he was waiting, an oncoming car struck another van, then swerved across the center line and hit claimant, who was running to avoid being hit.

SAIF denied that the injuries claimant suffered were a result of his employment. The referee set aside that denial and the Board reversed. Relying on Adamson *v. The Dalles Cherry Growers, Inc.*, 54 Or App 52, 633 P2d 1316 (1981), it concluded that claimant's injury is not compensable under the "parking lot" exception to the going and coming rule, because employer did not control the public road where claimant was injured.

We address only claimant's argument that his injury was compensable because it was caused by an employer-created hazard. He contends that the Board's reliance on Adamson is misplaced and that this case is factually similar to <**136 Or App 489/490**> *Kiewit Pacific v. Ennis,* 119 Or App 123, 849 P2d 541 (1993). In that case, the Board found that the employer's requirement that the claimant use a specific parking lot exposed him to a greater hazard than that faced by the general public and that, therefore, the claimant's injury was connected to his employment. Claimant contends that employer's practice of requiring employees to park on the shoulder of the road when the fields are muddy supports a finding that employer exposed him to a hazard to which the general public was not exposed. Employer responds that there was no finding that it exposed claimant to a hazard of errant drivers any different from that to which members of the general public are exposed, that the injury occurred on a county road that employer did not control or maintain and that claimant's use of the road was no different from that of any member of the general public.

Injuries sustained by an employee who is going to or coming from work generally are not compensable, because they do not arise out of and in the course of employment. *SAIF v. Reel,* 303 Or 210, 216, 735 P2d 364 (1987). One exception involves employer-created hazards.

> "[W]hen an employee traveling to or from work sustains an injury on or near the employer's premises, there is a 'sufficient work relationship'between the injury and the employment only if the employer exercises some 'control' over the place where the injury is sustained. Whether the requisite control is evinced by increased, employer-created hazards * * * or by the employer's property rights to the area where the injury is sustained * * * is immaterial." *Cope v. West American Ins. Co.*, 309 Or 232, 239, 785 P2d 1050 (1990) (citations omitted).

In *Adamson,* the claimant was prevented from parking in the employer's parking lot because it was filled with snow. She parked on the street and was injured when she slipped on the icy surface and fell while on her way to the building in which she worked. In affirming the Board's order denying compensability, we noted that the street was not part of the employer's premises and that the employer did not exercise control over the use or maintenance of the street. 54 Or App at 59.

136 Or App 491> In *Kiewit Pacific,* by contrast, the claimant was injured when his car was struck from the rear by a log truck as he was slowing to a near stop to turn from Highway 42 into the employer's parking area. Relying on *Nelson v. Douglas Fir Plywood Co.,* 260 Or 53, 488 P2d 795 (1971), we affirmed the Board's finding of an employer-created hazard and its conclusion that the injury was, therefore, compensable. The claimant was required to use the employer's parking lot and the entrance to that lot was constructed in a way that exposed the claimant to greater risks than those faced by the general public.

The facts in this case make it analogous to *Adamson*, not to *Kiewit Pacific*. Substantial evidence supports the Board's finding that employer created no hazard for claimant that did not exist for members of the general public. The Board did not err in upholding the denial of compensation.

Affirmed.

Cite as 136 Or App 536 (1995) September 6, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joseph Parry, Claimant.

Joseph PARRY, *Petitioner,*
v.
MARVIN WOOD PRODUCTS, INC., *Respondent.*
(WCB 93-14867; CA A86603)

Judicial Review from. Workers' Compensation Board.

Argued and submitted June 23, 1995.

Alan J. Schmeits argued the cause for petitioner. With him on the brief was Silven, Schmeits & Vaughan.

Vera Langer argued the cause for respondent. With her on the brief was Scheminske, Lyons & Bussman.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

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136 Or App 537> Claimant seeks review of a Workers' Compensation Board order upholding employer's denial of his current low back condition. The statutes pertinent to this review have been amended by Oregon Laws 1995, chapter 332. Because the amended version of the statutes is applicable here, we remand for reconsideration in the light of the new law. *Volk v. America West Airlines,* 135 Or App 565, ___ P2d ___ (1995).

Reversed and remanded for reconsideration.

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