# VAN NATTA'S
# WORKERS' COMPENSATION REPORTER

VOLUME 47

(Pages 1913-END)



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.

OCTOBER-DECEMBER 1995

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

PRINTED ON RECYCLED PAPER

# CONTENTS



## CITE AS

47 Van Natta ____ (1995)

In the Matter of the Compensation of
**DARIO RODRIGUEZ, Claimant**
Own Motion No. 95-0283M
OWN MOTION ORDER
Willner & Heiling, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable low back injury. Claimant's aggravation rights expired on February 21, 1989. SAIF opposes authorization of temporary disability compensation, contending that: (1) surgery or hospitalization is not reasonable and necessary for the compensable injury; (2) claimant has not sustained a worsening of the compensable injury; and (3) claimant was not in the work force when the current condition worsened.

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

On March 10, 1995, the Managed Care Organization (MCO) disapproved spinal canal exploration recommended by Dr.Pollard, claimant's attending physician. That letter advised Dr. Pollard that it had been 30 days since the request for the medical service was disapproved. Further, the letter advised that there had been no appeal, and therefore, the MCO concluded that the provider was withdrawing his request. Finally, the letter advised claimant that if he disagreed with the decision and if the provider did not elect to appeal the disapproval, "the employee may request a review by the Workers' Compensation Division Medical Director." There is no indication that Dr. Pollard appealed the MCO's decision, or that claimant requested Director review.

Inasmuch as the dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1983 injury claim for the payment of temporary disability benefits. See ORS 656.278(1)(a). Should claimant's circumstances change, and the medical services subsequently be determined to be reasonable and necessary, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
**CORINNE M. ESPERANZA, Claimant**
WCB Case No. 94-14932
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order that: (1) awarded a penalty pursuant to ORS 656.268(4)(g) equal to 25 percent of the permanent disability awarded by the Order on Reconsideration for claimant's right forearm; and (2) declined to address whether SAIF could offset its overpayment of permanent disability benefits against further awards of compensation. Claimant cross-requests review of that portion of the order that reduced claimant's scheduled permanent disability for loss of strength of the left forearm from 9 percent (13.5 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issues are extent of permanent disability, offset and penalties. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Extent of Disability - Left Forearm

The ALJ found that claimant failed to prove injury to the nerve, muscle loss or disruption of a musculotendinous unit in the left forearm which would support an impairment rating for loss of strength. On review, claimant contends that "the evidence as a whole with reasonable inferences therefrom" establishes that the median nerve is the source of claimant's loss of strength in the left wrist.[1] We disagree.

OAR 436-35-007(14) provides that "[a] preponderance of medical opinion shall be used" to identify the nerve or plexus responsible for loss of strength. Here, neither claimant's treating physician, Dr. Dreyer, nor Dr. Fry, the medical arbiter, reported that claimant had an injured left median nerve.

Dr. Dryer's report identified an injury to the right median nerve as the cause of claimant's right hand condition, but did not identify the left medial nerve as the cause of claimant's left hand condition. Similarly, although Dr. Fry diagnosed "possible" left carpal tunnel syndrome and reported some loss of grip strength, he did not indicate any nerve injury or disruption on the left which would support an impairment rating.

As the ALJ found, the absence of the requisite medical evidence constitutes a failure of proof under the applicable standards. Contrary to claimant's contention, on this record, the Board is without the expertise to "infer" an injury to the left median nerve. See Ram Narayan, 47 Van Natta 1593 (1995) (Board is without expertise to infer physical restrictions in the absence of medical evidence that the claimant is precluded from performing certain activities). We therefore affirm that portion of the ALJ's order that reduced claimant's permanent disability award for the left forearm to zero.

### Penalty Under ORS 656.268(4)(g)

The ALJ found that claimant was entitled to a penalty under former ORS 656.268(4)(g)[2] since that portion of the Order on Reconsideration awarding claimant 11 percent scheduled permanent

---

[1] In the alternative, claimant argues that the case should be remanded to the Department to obtain supplemental information from the medical arbiter regarding claimant's left median nerve. We deny the request. We have previously found no basis to remand a claim for a supplemental arbiter's examination where the Department has accepted the medical arbiter's report and relied on it to determine the extent of the claimant's disability. See, e.g. Steven K. Rule, 47 Van Natta 83 (1995); Beverly L. Cardin, 46 Van Natta 770 (1994); see also Daniel L. Bourgo, 46 Van Natta 2505 (1994).

[2] ORS 656.268(4)(g) has been amended by SB 369, although the amendments are not applicable in this case. See Or Laws 1995, ch 332 §§ 30(4)(g) and 66(4) (SB 369, §§ 30(4)(g) and 66(4)).

disability for loss of strength of the right forearm was not modified. On review, SAIF contends that claimant is not entitled to a penalty under this section because the disability award is less that 64 degrees. We agree.

Subsequent to the ALJ's order, the Court of Appeals held in SAIF v. Cline, 135 Or App 155 (1995), that former ORS 656.268(4)(g) permits an award of penalties only if the entire worker, not just a body part, has been determined to be at least 20 percent disabled. Thus, only a worker who receives a total sum of 64 degrees of permanent scheduled and/or unscheduled disability is considered to be "at least 20 percent permanently disabled."

Because claimant's total award is less than 64 degrees, she is not entitled to a penalty under former ORS 656.268(4)(g).[3] Consequently, we reverse that portion of the ALJ's order.

Offset

SAIF's Notice of Closure, issued July 7, 1994, awarded temporary disability only. Claimant requested reconsideration and, pursuant to an October 12, 1994 Order on Reconsideration, was awarded 9 percent scheduled permanent disability for the left forearm and 11 percent scheduled permanent disability for the right forearm. SAIF paid the permanent disability awards and requested a hearing, challenging both of claimant's awards. The ALJ affirmed the 11 percent award, and reversed the 9 percent award.

At hearing, SAIF also sought authorization to offset its overpayment of permanent disability paid in accordance with the Order on Reconsideration.[4] The ALJ found the question of overpayment moot, and declined to address it. On review, SAIF contends that the ALJ was authorized to consider that the disallowance of the permanent disability award for the left wrist created an overpayment. We agree.

Because it is undisputed that claimant received the scheduled permanent disability for the left wrist/forearm awarded by the Order on Reconsideration, we find that SAIF is entitled to recover the overpayment. Consequently, SAIF is entitled to offset the overpayment of these benefits in the manner prescribed in ORS 656.268(15). See Or Laws 1995, ch 332 § 30(15) (SB 369, § 30(15)).

ORDER

The ALJ's order dated April 20, 1995 is affirmed in part and reversed in part. That part of the order awarding a penalty under ORS 656.268(4)(g) is reversed. SAIF is authorized to offset the 9 percent scheduled permanent disability paid in accordance with the Order on Reconsideration in the manner prescribed by ORS 656.268(15). The remainder of the order is affirmed.

---

[3] As SAIF also points out, once the ALJ disallowed the 9 percent award for the left wrist, the total award fell below 20 percent in any event. Thus, even prior to SAIF v. Cline, the penalty was improper. See Mast v. Cardinal Services, Inc., 132 Or App 108 (1994) (subsequent reduction of permanent partial disability award below minimum level required for assessment of penalty eliminates the claimant's entitlement to the penalty).

[4] In Lee I. Foster, 47 Van Natta 1361 (1995), we confirmed that ORS 656.313(2), which provides that a claimant shall not be required to repay overpayments of compensation "paid pending the review or appeal," applies only to compensation paid pending Board review or court appeal; it does not apply to compensation paid pending a hearing. Since SAIF's overpayment in this case was paid pending review by the Hearings Division, ORS 656.313(2) does not preclude authorization of an offset.

In the Matter of the Compensation of
**JANICE E. HENSLEY, Claimant**
WCB Case No. 94-07090
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
James Edmunson, Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of her occupational disease claim for a bilateral plantar fasciitis condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated April 20, 1995 is affirmed.

**Board Member Gunn dissenting.**

The majority adopts and affirms the ALJ's finding that claimant failed to sustain her burden of proving that her occupational disease claim for a bilateral plantar fasciitis condition was compensable. Because I would find that, when read together, the medical opinions of claimant's primary care physician , Dr. Taggart, and examining podiatrist, Dr. Goldstein, are sufficient to establish that claimant's employment activities were the major contributing cause of her foot condition, I respectfully dissent.

Claimant is a grocery checker who developed pain in her heels and the sole of her feet. The pain began in her right foot and subsequently developed in her left foot. She was diagnosed as having bilateral plantar fasciitis by her primary care physician, Dr. Taggart. Dr. Taggart opined that the predominant cause of claimant's plantar fasciitis is her work activity, i.e., prolonged standing on a hard surface, lifting groceries and using a foot pedal to operate the belt at the check-stand.

Dr. Goldstein, who examined claimant at the insurer's request, identified claimant's work activities as a contributing factor, although he did not expressly indicate that her work was the major contributing factor. Dr. Goldstein reported that "there is no single cause of plantar fasciitis. It is likely a combination of the patient's foot and leg structure, her weight [which is not necessarily inappropriate for someone of claimant's height], and the fact that she stands long hours during the day." (Ex. 13).

The ALJ discounted Dr. Taggart's opinion mainly because he is not a podiatrist. The ALJ found Dr. Goldstein's report the most persuasive in terms of reasoning and explanation, but deemed it insufficient to support the compensability of claimant's condition because he does not identify work activities as the major cause.

Unlike the majority, I would find that Dr. Goldstein's medical opinion, when read in conjunction with Dr. Taggart's opinion, satisfies claimant's burden of proof.

It is well-settled that a physician need not mimic statutory language in rendering a medical opinion. A physician need only provide an opinion from which it can reasonably be concluded that claimant's burden of proving medical causation has been satisfied. See McClendon v. Nabisco Brands, 77 Or App 412, 417 (1986). Dr. Goldstein opines that claimant's condition likely results from three factors: her work activity, her foot structure and her weight. He then proceeds to discount the contribution of the latter two factors, since claimant's feet cannot be appropriately classified as flat and her weight is not necessarily inappropriate. Based on this, I conclude that a fair reading of Dr. Goldstein's opinion indicates that claimant's work is probably the major contributory factor of the three, which is consistent with Dr. Taggart's assessment.

Because I would find that claimant has satisfied her burden of proving by a preponderance of the evidence that her occupational disease claim is compensable, I would reverse the ALJ's decision and set aside the insurer's denial. For this reason, I must respectfully dissent.

In the Matter of the Compensation of
**HARRIET OLSON, Claimant**
WCB Case No. 94-11583
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
David L. Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) awarded 20 percent (64 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration had awarded none; and (2) awarded an "out-of-compensation" attorney fee based on the increased compensation created by his order. On review, the issues are extent of unscheduled permanent disability and attorney fees. We reverse.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

The ALJ reinstated the Determination Order award of 20 percent unscheduled permanent disability, which was based on a chronic condition impairment finding. SAIF argues that claimant is not entitled to an award for permanent disability because she has not established any impairment due to her compensable injury. We agree with SAIF.

We apply the disability standards in effect on the date of the Determination Order 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 June 17, 1994. Accordingly, those standards contained in WCD Admin. Orders 6-1992, 17-1992, and 93-056 apply to claimant's claim.

Claimant has the burden of proving the extent of disability resulting from her compensable injury. ORS 656.266. Claimant is not entitled to an award of unscheduled permanent disability if there is no measurable impairment under the standards. OAR 436-35-270(2). Impairment must be measured by a physician. OAR 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991).

The medical evidence concerning the extent of claimant's unscheduled permanent impairment comes from Dr. Eusterman, claimant's attending physician, and Drs. Dineen, orthopedist, Case, orthopedist, and Bobker, neurologist, who comprised the medical arbiter panel.

Claimant was 61 years old at the time of her examination by the medical arbiter panel. (Ex. 41-1). Drs. Dineen, Case, and Bobker diagnosed "[b]y history, low back sprain superimposed on pre-existing degenerative changes." (Ex. 41-2). They also measured some reduced ranges of motion in claimant's lumbar spine. Id. However, they opined that claimant had "no objective evidence of any measurable permanent impairment that can be attributed to the incident, i.e., no decreased ability to repetitively use any body part which can be attributed to the incident." Id.

On May 2, 1994, Dr. Eusterman declared claimant medically stationary. (Ex. 21). That same month, he opined that the work injury had resolved and claimant had returned to pre-injury status, with normal ranges of motion and no permanent impairment. (Exs. 21, 24). He also checked a box indicating that the work injury was the reason for claimant's current work restrictions. (Ex. 24). However, in explaining these current work restrictions, Dr. Eusterman referred to his March 9, 1994 progress note, wherein he stated that, in order to reduce the risk of reinjury, he recommended a permanent work modification of no lifting over 50 pounds. (Exs. 20, 24). Regarding this work restriction, he also noted that it was "unlikely that at [claimant's] age she can improve her trunk strength and flexibility enough through a conditioning program to reduce her risk of re-injury with that approach." (Ex. 20).

Claimant argues that Dr. Eusterman's work restriction against lifting over 50 pounds establishes that she has a chronic condition impairment due to the work injury. We disagree.

OAR 436-35-320(5) provides that a "worker may be entitled to unscheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition." The rule requires medical evidence of at least a partial loss of ability to repetitively use the body area due to the compensable injury. Donald E. Lowry, 45 Van Natta 1452 (1993). Furthermore, work limitations imposed to avoid the likelihood of reinjury do not establish an inability (or partial inability) to repetitively use a body area due to the compensable injury. David A. Kamp, 46 Van Natta 389, 390 (1994); Mark A. Roberts, 46 Van Natta 1168 (1994).

Dr. Eusterman restricted claimant from lifting more than 50 pounds to reduce the risk of reinjury. (Ex. 20). Such a restriction does not establish that claimant has lost (or partially lost) her ability to repetitively use her low back. David A. Kamp, supra; Mark A. Roberts, supra. Claimant argues that David A. Kamp, supra, is inapplicable because, there, we found no opinion by the treating physician that the claimant's restrictions were related to the work injury. We disagree that Kamp in inapplicable. Here, although checking a box indicating that the work injury was the reason for claimant's current work restrictions, Dr. Eusterman explained that the restrictions were imposed to reduce the risk of reinjury. (Exs. 20, 24). Thus, in both the present case and Kamp, the purpose of the restrictions was to reduce the risk of reinjury. We find Kamp to be directly on point.

Furthermore, the remaining medical evidence does not establish that claimant has a chronic condition impairment or that she has other injury-related unscheduled permanent impairment under the standards. In this regard, both the medical arbiter panel and Dr. Eusterman opine that claimant has no impairment due to the injury.[1] Consequently, claimant has not established entitlement to an unscheduled permanent disability award under the standards. See OAR 436-35-270(2).

Accordingly, we reverse the ALJ's award of unscheduled permanent disability and the related "out-of-compensation" attorney fee.

ORDER

The ALJ's order dated January 19, 1995 is reversed. The Order on Reconsideration is reinstated and affirmed.

---

[1] Claimant argues that the medical arbiter panel's opinion that claimant's impairment is related to preexisting degenerative disc disease is not persuasive. In this regard, claimant argues that the panel did not explain their opinion and had no evidence supporting the existence of degenerative disc disease. However, even if we accepted claimant's argument and found the medical arbiter opinion unpersuasive, that would not help claimant's position. We cannot rewrite the medical arbiter opinion to state that claimant has impairment due to the work injury when that opinion explicitly states she does not have such impairment. (Ex. 41-2).

**Board Member Gunn dissenting.**

I agree with the ALJ's reasoning that Dr. Eusterman's opinion establishes a chronic condition impairment and that the Determination Order award of 20 percent unscheduled permanent disability should be reinstated. Therefore, I respectfully dissent.

The majority is mistaken in its conclusion that David A. Kamp, supra, is directly on point. I find Kamp distinguishable. In Kamp, the Board held that restrictions imposed to avoid the likelihood of reinjury do not establish a chronic condition due to a compensable injury.

Here, because of the compensable injury, claimant's treating physician imposed restrictions to avoid reinjury. However, as the ALJ found, these restrictions were also imposed because at claimant's age she was unable to recover the conditioning that she lost due to the injury and the subsequent lack of activity. (Exs. 20, 24). Thus, unlike Kamp, claimant's restrictions were not solely imposed to avoid the likelihood of reinjury. Those restrictions were also imposed due to claimant's permanent inability to recover her conditioning due to the work injury. I find that such restrictions establish an unscheduled chronic condition impairment in that claimant is unable to repetitively use her low back to lift over 50 pounds due to the compensable injury. Donald E. Lowry, supra. Accordingly, I would affirm the ALJ.

In the Matter of the Compensation of
**DAVID E. THOMPSON, Claimant**
WCB Case No. 94-11505
ORDER ON RECONSIDERATION
Hollander & Lebenbaum, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Claimant requests reconsideration of our September 7, 1995 Order on Review that adopted, with supplementation, Administrative Law Judge (ALJ) Crumme's order upholding the SAIF Corporation's denial of claimant's low back injury claim. In that order, we agreed with the ALJ that SAIF was prejudiced by claimant's late notice of a work injury because it was unable to obtain a contemporaneous medical examination to determine whether claimant's eventual disability and need for treatment were due to a work injury or a subsequent nonwork activity. This "subsequent nonwork activity" consisted of claimant's attempt to play basketball with his children. In adopting the ALJ's order, we considered claimant's argument that there was no basketball "incident" or "injury."

With his request for reconsideration, claimant again raises the argument that there was no basketball "incident" or "injury." We continue to reject this argument. The record establishes that claimant sought medical treatment after attempting to play basketball with his children. Prior to that incident, claimant had not reported a work injury and had not sought medical treatment. Furthermore, at the time claimant reported to his supervisor that he needed to go to a doctor, he did not report a work injury but, instead, reported that his back was sore after attempting to play basketball with his children. (Tr. 7, 10, 14, 15). It was not until after seeking treatment following his attempt to play basketball that claimant reported that a work injury occurred earlier. We continue to find that an off-work basketball "incident" occurred. Furthermore, for the reasons stated in our order, we continue to find that SAIF was prejudiced by claimant's late notice of a work injury.

Accordingly, our September 7, 1995 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 7, 1995 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---



In the Matter of the Compensation of
**CHARLENE L. VINCI, Claimant**
WCB Case No. 95-01968
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Members Neidig and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order which reduced claimant's scheduled permanent disability award from 9 percent (12.15 degrees) for loss of use or function of her left foot (ankle) and 7 percent (9.45 degrees) for loss of use or function of her right foot (ankle), as awarded 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

Claimant slipped and fell at work on March 31, 1993, fracturing her left ankle and severely spraining her right ankle. The SAIF Corporation accepted the claim on April 14, 1993 as a left ankle fracture and right ankle sprain.

Claimant came under the care of Dr. Lawton, who performed surgery on claimant's left ankle on April 5, 1993. On September 27, 1994, Dr. Lawton declared claimant medically stationary, reporting that she demonstrated full range of motion in the left ankle. On October 21, 1994, Dr. Lawton reported to SAIF that claimant had no residual disability in the right ankle and that her left ankle range of motion was "normal for her." (Ex. 16). Dr. Lawton concluded that claimant had no permanent impairment of range of motion as a result of her injuries.

SAIF issued a Notice of Closure on November 21, 1994, closing the claim without an award of permanent disability. Claimant requested reconsideration and a medical arbiter, Dr. Strum, was appointed. In his January 9, 1995 arbiter's report, Dr. Strum reported reduced range of motion in both of claimant's ankles. (Ex. 18-4). However, Dr. Strum also was asked to determine whether claimant had a chronic and permanent medical condition limiting her ability to repetitively use either injured ankle. In response to that inquiry, Dr. Strum not only confirmed that claimant did not demonstrate substantive objective findings which would establish a chronic and permanent medical condition, but also stated that there were no objective findings which would establish permanent disability. (Ex. 18-5). Dr. Strum wrote that claimant's limitations were "self-imposed" and that she was not precluded from repetitively using her feet and ankles.

Relying on the range of motion findings that Dr. Strum reported, the Appellate Unit nevertheless awarded claimant 9 percent scheduled disability for her left foot and 7 percent scheduled disability for her right foot in its January 18, 1995 Order on Reconsideration. SAIF then requested a hearing, challenging the reconsideration order.

The ALJ reduced claimant's scheduled awards to zero, reasoning that the medical evidence from both the attending physician and the medical arbiter indicated that claimant had no objective permanent disability.

On review, claimant contends that we should reinstate the permanent disability awarded in the reconsideration order based on Dr. Strum's range of motion findings. Although we reject claimant's contention and conclude that the ALJ properly reduced claimant's permanent disability awards to zero, we offer the following reasoning.

In evaluating claimant's permanent disability, we do not automatically rely on a medical arbiter's opinion in evaluating permanent impairment. See Raymond L. Owen, 45 Van Natta 1528 (1993) (Impairment is established by a preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings); aff'd Roseburg Forest Products v. Owen 129 Or App 442 (1995). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. See Carlos S. Cobian, 45 Van Natta 1582 (1993). In addition, we generally rely on the medical opinion of the attending physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

In this case, we find no persuasive reason not to rely on the opinion of Dr. Lawton, claimant's attending physician. Moreover, we find Dr. Lawton's closing examination to constitute the most thorough and complete evaluation of claimant's permanent impairment.

Dr. Lawton has been claimant's attending physician throughout the course of this claim. Dr. Lawton has consistently reported on claimant's ankle range of motion and concluded in his closing examination that claimant has no permanent impairment of range of motion . (Exs. 12, 15, 16). Given his familiarity with claimant's medical condition and his long-term reporting on claimant's range of motion, we find his assessment of claimant's permanent impairment to be persuasive.

Although Dr. Strum, the medical arbiter, examined claimant closer in time to the reconsideration order and reported reduced range of bilateral ankle motion, we do not find his report to be persuasive evidence that claimant has permanent impairment in her ankles. First, the fact that Dr. Strum examined claimant closer in time to the reconsideration order is not always decisive. See David J. Rowe, 47 Van Natta 1295, 1297 (1995) (attending physician more persuasive than medical arbiter). Second, we do not consider Dr. Strum's one-time evaluation to be more persuasive than Dr. Lawton's opinion based on his lengthy observation of claimant's bilateral ankle condition. Moreover, it is unclear from Dr. Strum's report whether claimant's range of motion findings are the result of her compensable injury or whether they are due to self-imposed limitations. Given the ambiguity in Dr. Strum's medical report, we do not find it to be a well-reasoned evaluation of claimant's permanent impairment. Carlos S. Cobian, supra. Therefore, we accord Dr. Strum's arbiter's report less weight than Dr. Lawton's evaluation of claimant's permanent impairment .

Accordingly, based on Dr. Lawton's closing examination, we agree with the ALJ that SAIF has established that claimant does not have permanent impairment due to her compensable injury. Therefore, we affirm the ALJ's decision to reduce claimant's scheduled permanent disability awards to zero.

ORDER

The ALJ's order dated April 26, 1995 is affirmed.

---

October 4, 1995 Cite as 47 Van Natta 1921 (1995)

In the Matter of the Compensation of
**GEORGE B. BAILEY, Claimant**
WCB Case No. 93-15331
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Kevin Mannix, Defense Attorney
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The noncomplying employer requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside the SAIF Corporation's denial on its behalf of decedent's claim for low back and right knee injuries; (2) set aside a February 15, 1994 Determination Order and subsequent Order on Reconsideration as premature; (3) declined to authorize recovery of an alleged overpayment; and (4) awarded an assessed attorney fee. Decedent's beneficiary cross-requests review of that portion of the ALJ's order which determined that the issue of temporary disability was prematurely raised. On review, the issues are compensability, premature closure, overpayment, jurisdiction and attorney fees.

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

Compensability

SAIF accepted, on behalf of the noncomplying employer, a disabling right forearm strain and right knee contusion that resulted from decedent's[1] eight-foot fall from a ladder on May 13, 1993.[2] On July 6, 1993, Dr. Lee, claimant's attending physician, diagnosed right knee and low back strains. On November 30, 1993, the same day it accepted the right forearm strain and right knee contusion, SAIF issued a partial denial of claimant's "degenerative lumbar strain" and "right knee arthritis" on the ground that the compensable injury was not the major contributing cause of these conditions. (Ex. 12).

On December 28, 1993, claimant requested a hearing contesting the denial. Present at the December 29, 1994 hearing were claimant's beneficiary, the noncomplying employer and SAIF. The ALJ set aside SAIF's denial to the extent that it denied a lumbar strain and right knee strain.[3] In concluding that claimant's accepted injury was both the major and a material contributing cause of claimant's strain conditions, the ALJ relied on the opinion of Dr. Lee. Dr. Lee had related claimant's strain conditions to his fall on May 13, 1993 in a July 6, 1993 medical report. Dr. Lee subsequently agreed in a March 17, 1994 response to an inquiry from claimant's counsel that the May 1993 injury was the major contributing cause of claimant's right knee strain and need for treatment for both the right knee strain and claimant's low back condition. (Ex. 14-2).

---

[1] For ease of reference, the decedent will be referred to as "claimant" from this point forward.

[2] Claimant died from causes unrelated to the compensable injury on April 19, 1994.

[3] No party objected to claimant's characterization of the issue at hearing as compensability of a lumbar strain and right knee strain. (Tr. 2).

On review, the employer contends that the ALJ erred in finding the right knee and lumbar strains compensable because Dr. Lee relied on inadmissible hearsay statements from claimant in his medical reports in concluding that claimant's right knee and lumbar conditions resulted from the May 13, 1993 fall. The employer cites Froylan L. Zurita, 43 Van Natta 1382 (1991), aff'd Zurita v. Canby Nursery, 115 Or App 330 (1992); Ciriacio Sosa, 43 Van Natta 1713 (1991); and Javier Carrasco, 42 Van Natta 1133 (1990).

In Zurita, supra, we held that a claimant's statements to a physician for purposes of medical diagnosis or treatment are admissible to the extent that they are reasonably pertinent to diagnosis or treatment, even though they are hearsay and the claimant is not available at hearing for cross-examination. We also held that, while there may be a strong indicia of reliability in a hearsay report of how injuries occurred, there is no such indicia of reliability in hearsay reports of where injuries occurred. In accordance with that rationale, we concluded in Zurita that the claimant's statements in the medical reports that the mechanism of injury (lifting and twisting) happened at work were not reasonably pertinent to diagnosis or treatment. Inasmuch as they were not prima facie evidence of the fact asserted, we accorded those statements little weight in concluding that the claimant, who did not attend the hearing, had failed to establish by a preponderance of the evidence that he injured his back in the course and scope of his employment.

In contrast to Zurita, claimant, here, was deceased at the time of hearing and obviously unavailable to testify at the hearing. More importantly, claimant in this case had an accepted claim, unlike the claimant in Zurita, who was attempting to establish compensability in the first instance. By virtue of its acceptance of a right forearm strain and right knee contusion, SAIF has conceded that claimant suffered an injury when he fell eight feet on May 13, 1993, as claimant reported on his form 801. Thus, the concerns about the indicia of reliability concerning hearsay reports of where an injury has occurred are not present in this case, as they were in Zurita.[4] Therefore, we find the cases on which the employer relies distinguishable and conclude that the ALJ did not err in relying on Dr. Lee's medical reports in finding claimant sustained compensable lumbar and right knee strains.

Premature Closure

The ALJ set aside the February 1994 Determination Order and subsequent Order on Reconsideration. The ALJ reasoned that, because claimant's right knee and lumbar strain conditions were compensable, the Determination Order and resulting reconsideration order must be set aside as premature since they did not "rate" all compensable components of claimant's claim.

On review, the employer contends that the claim closure was proper because it was an administrative closure based on claimant's failure to seek medical treatment after September 21, 1993. See OAR 436-30-035(7). The employer's contention notwithstanding, we conclude that the ALJ properly determined that the claim closure was premature.

A claimant must be medically stationary from all compensable conditions before the claim is properly closed. Rogers v. Tri-Met, 75 Or App 470 (1985); Mary J. McKenzie, 44 Van Natta 2301, 2303 (1992). Since there is no evidence that either of these conditions was medically stationary prior to the February 1994 closure, we agree with the ALJ that the claim was prematurely closed. See Kenneth A. Hinkley, 45 Van Natta 1123, 1126 (1993), aff'd mem 126 Or App 543 (1994).[5]

---

[4] Sosa and Carrasco also did not involve accepted claims and concerned compensability in the first instance.

[5] Effective June 7, 1995, amended ORS 656.268(1)(b) allows closure of a claim based on a claimant's failure to continue medical treatment. Or Laws 1995, ch 332, § 30 (SB 369, § 30). However, we need not determine the applicability of that amendment, given our finding that claimant's right knee and lumbar strain conditions are compensable. Inasmuch as those conditions have not yet been processed to closure, it would be inappropriate to affirm the administrative claim closure issued on the basis of claimant's failure to seek treatment when the right knee and lumbar strain conditions were in denied status.

Temporary Disability/Overpayment

Claimant's claim was administratively closed by Determination Order on February 15, 1994 pursuant to OAR 436-30-035(7) because of claimant's failure to seek further medical treatment with Dr. Lee after September 21, 1993. Claimant was presumed medically stationary on January 24, 1994 and awarded temporary disability through that date. (Ex. 13). SAIF's records reveal that temporary disability was paid, however, through February 22, 1994. (Ex. 17-2).

Reconsideration was requested on claimant's behalf in August 1994. This resulted in an October 26, 1994 Order on Reconsideration which reduced claimant's temporary disability award to zero. At hearing, SAIF sought recovery of an overpayment of temporary disability. Claimant sought reinstatement of the award of temporary disability in the Determination Order, as well as an additional award of temporary disability through April 19, 1994.

Reasoning that both issues of temporary disability and overpayment were premature in light of his finding that claimant's claim had been prematurely closed, the ALJ concluded that these issues should be resolved at claim closure. On review, the employer contends that the ALJ erred in not reaching the overpayment issue. Claimant's beneficiary asserts in her cross-request for review that she is entitled to "procedural" temporary disability after the date SAIF ceased payment of temporary disability to April 19, 1994, the date of claimant's death.

We agree with the ALJ's reasoning that it would be premature to address the temporary disability and overpayment issues until the claim was properly closed. As a result of our finding that the claim was prematurely closed, the claim remains open. Thus, additional temporary disability benefits may well be payable prior to the closure of the claim. As with any open claim, the employer is required to administer and process the claim according to law. Under such circumstances, we consider it appropriate to defer a determination concerning temporary disability and the offset request until claim closure. See Joel O. Sandoval, 45 Van Natta 1261 (1993). Thus, we affirm the ALJ's decision to defer resolution of these issues until reclosure of the prematurely closed claim.

Attorney Fees

The ALJ awarded claimant's counsel an assessed attorney fee of $2,500 for prevailing against SAIF's denial. The employer contends that the ALJ awarded an excessive fee. We disagree.

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 compensability issue is $2,500, payable by SAIF on behalf of the noncomplying 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.

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 and premature claim closure issues is $1,000, payable by SAIF on behalf of the noncomplying 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated January 26, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by SAIF on behalf of the noncomplying employer.

In the Matter of the Compensation of
**WILLIAM R. ENGLESTADTER, Claimant**
WCB Case No. 94-14109
ORDER OF ABATEMENT
Brothers, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The insurer requests reconsideration of our September 8, 1995 Order on Review which concluded that claimant had established that his unscheduled permanent disability for a skin disorder should be increased from 3 percent to 54 percent, and his scheduled permanent disability for a skin disorder of the left forearm should be increased from 3 percent to 38 percent. The insurer argues that, pursuant to ORS 656.268(2), claimant must be medically stationary and the claim closed before permanent impairment may be rated. The insurer further argues that, because we relied on medical reports that issued before claimant was medically stationary, the impairment findings in those reports are not persuasive.

In order to allow us sufficient time to consider the insurer's motion, we withdraw our September 8, 1995 order. Claimant is requested to submit a response to the motion 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
**JOHN R. NYE, Claimant**
WCB Case No. 94-13518
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Schultz' order which set aside the employer's partial denial of claimant's claim for a current cellulitis condition. On review, the issue is compensability. We reverse.

## 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

On December 1, 1992, claimant suffered a compensable puncture wound to his left shin. As a result of the puncture wound, claimant developed cellulitis (inflammation of cellular tissue) in his left shin and leg. At the time of his injury, claimant had a preexisting condition known as venous stasis. This condition impairs the flow of blood in the claimant's veins and makes him more susceptible to the development of cellulitis. On November 11, 1993, the employer accepted claimant's condition for puncture wound coupled with cellulitis. On July 22, 1994, claimant developed another case of cellulitis in his left shin. This new case of cellulitis was in claimant's left calf near the area where claimant's initial cellulitis developed.

The ALJ found that a material cause of claimant's "current" cellulitis condition was his compensable injury.[1] In so doing, the ALJ found the opinion of Dr. Imatani, treating physician, persuasive.

---

[1] Because the employer issued a formal denial of the compensability of the underlying claim, i.e., claimant's current cellulitis condition (Ex. 33), we retain jurisdiction to review this dispute even though it involves a claim for medical services. See amended ORS 656.245(6), Or Laws 1995, ch 332 § 25 (Senate Bill 369, § 25).

On review, the employer contends that Dr. Imatani initially opined that claimant's preexisting venous stasis condition was the cause of his current cellulitis. However, in a concurrence letter sent by claimant's attorney, Dr. Imatani changed his opinion to support the compensability of claimant's claim. Therefore, according to the employer, the medical opinion of Dr. Imatani is too inconsistent to support compensability. We agree.

Dr. Imatani is the only physician who has advanced a medical opinion in regard to the cause of claimant's current cellulitis. On August 1, 1994, claimant was examined by Dr. Imatani for cellulitis of the left lower leg. (Ex. 28A). At that time, Dr. Imatani opined that claimant's cellulitis "is clearly related to his" preexisting underlying venous stasis condition. Id.

On September 20, 1994, Dr. Imatani reiterated his initial opinion stating that claimant's preexisting condition played a major role in his current cellulitis. (Ex. 30). Additionally, Dr. Imatani explained that, because claimant's current cellulitis and his original injury were located in different locations on claimant's left shin, the original compensable injury was probably not an implicating factor. Id.

However, on January 13, 1995, Dr. Imatani changed his opinion in a concurrence letter sent by claimant's attorney. According to the concurrence letter, Dr. Imatani believed that claimant's "on-the-job" injury was a material cause of his current cellulitis and need for medical care and treatment. (Ex. 36). In the concurrence letter, Dr. Imatani offered no explanation for the change in his opinion. Because Dr. Imatani changed his opinion in the concurrence letter without explanation, we afford that opinion no probative weight. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Therefore, we conclude that claimant has failed to prove by a preponderance of the evidence that his current cellulitis condition is causally related to his compensable injury.[2] Consequently, the employer is not responsible for claimant's need for medical services for his current cellulitis condition.

The ALJ awarded an attorney fee for prevailing upon an injury denial. Because we have reversed the ALJ's order on the issue of medical services, there was no basis upon which to award an attorney fee.

ORDER

The ALJ's order dated February 9, 1995 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[2] Inasmuch as the evidence does not satisfy either a material or major contributing cause standard, we need not determine which theory is applicable.

---

October 4, 1995 Cite as 47 Van Natta 1925 (1995)

In the Matter of the Compensation of
**JODI G. PALMER, Claimant**
WCB Case No. 95-00439
ORDER OF DISMISSAL
Coons, Cole & Cary, Claimant Attorneys
Breathouwer, et al, Defense Attorneys

The self-insured employer requested review of Administrative Law Judge (ALJ) Baker's order that set aside its denial of claimant's psychological condition. The parties have submitted a proposed "Disputed Claim Settlement, Stipulation, and Order of Approval," which is designed to resolve this denied and disputed claim, in lieu of the ALJ's order.

Pursuant to the settlement, the parties agree that the insurer's denial "shall become final." The parties further stipulate that this matter "is dismissed with prejudice."

We have approved the parties' amended settlement, thereby fully and finally resolving this dispute, in lieu of the ALJ's order. Accordingly, this matter is dismissed with prejudice.

In granting this approval, we acknowledge that the settlement does not include a list of medical service providers who will receive reimbursement from the settlement proceeds. See OAR 438-09-010(2)(g). Instead, the settlement provides that, in addition to the settlement proceeds, the employer will pay claimant's outstanding medical bills as of the "settlement date" in amounts required by ORS 656.248. To the extent that such a proposed distribution exceeds the formula set forth under ORS 656.313(4)(d), claimant consents to a distribution which exceeds the "40 percent" statutory distribution scheme.

We have previously ruled that it is unnecessary to provide a list and acknowledgment when all medical bills have been paid at the time of the "settlement date." Robert Wolford, 46 Van Natta 522 (1994). We have further held that claimant may consent to a distribution in excess of the statutory distribution scheme. Charles E. Munger, 46 Van Natta 462 (1994).

The current settlement presents a hybrid of the agreements approved in Wolford and Munger. Rather than agreeing that no outstanding medical bills exist on the settlement date, the DCS stipulates that all such bills will be paid in accordance with ORS 656.248, as of the "settlement date." Thus, although no "list" has been included, the DCS contains an acknowledgment that the proposed payment schedule for medical bills exceeds the employer's obligation under the statutory scheme. In light of the insurer's express representation that such bills will be honored and satisfied, we find such a provision similar to that contained in the Wolford settlement.[1] Consistent with the Wolford ruling, we find the provision approvable.

Furthermore, as in Munger, the settlement includes claimant's express consent to a distribution which exceeds the statutory "40 percent" distribution scheme. Considering that the proposed distribution has been expressly defined (if not precisely quantified) and since the settlement confirms that claimant is aware of the existence of these outstanding medical bills which will be reimbursed by the employer in addition to the settlement proceeds, we find claimant's express and voluntary acknowledgment of an "excess 40 percent" distribution schedule to likewise be acceptable. See Munger, supra.

In conclusion, based on the aforementioned reasoning, we have approved the parties' proposed settlement.

IT IS SO ORDERED.

---

[1] We would reach the same conclusion had the settlement provided that the employer would honor any medical service provider billings incurred through the date of our approval of the settlement. In such a situation, as in the present case, the key factors are the parties' mutual acknowledgment that the proposed distribution to medical service providers might exceed the statutory scheme and the claimant's knowing and voluntary consent to such a distribution.

---

October 4, 1995 Cite as 47 Van Natta 1926 (1995)

In the Matter of the Compensation of
**LYNDA J. ZELLER, Claimant**
WCB Case No. 94-15664
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that affirmed an Order on Reconsideration which set aside a Notice of Closure as premature. On review, the insurer contends that the Appellate Review Unit of the Department erroneously considered two "denied conditions," the compensability of which the insurer was challenging on Board review. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant injured her upper back and right arm after a fall at work on August 4, 1990. The insurer accepted right carpal tunnel syndrome on October 26, 1990. (Ex. 5). She underwent right carpal tunnel release surgery on November 15, 1990. (Ex. 58A).

Claimant subsequently developed right de Quervain's syndrome and underwent a surgical release of the first dorsal compartment of the right wrist on March 11, 1991. (Id.) The insurer asserts that it accepted a claim for trigger thumbs and de Quervain's syndrome.

Claimant continued to have problems with her right forearm. Dr. Layman diagnosed neuroma and reflex sympathetic dystrophy and he proposed surgery. On August 12, 1994, the insurer denied compensability of the neuroma and reflex sympathetic dystrophy conditions on the basis that those conditions did not exist, and if they did exist, they were not a consequence of claimant's August 4, 1990 industrial injury. (Ex. 50). The insurer also denied claimant's proposed surgery. On November 23, 1994, ALJ Peterson set aside the insurer's denial of claimant's neuroma and reflex sympathetic dystrophy conditions and also set aside the denial of the proposed surgery. (Ex. 58A).[1]

In the meantime, the insurer had issued a Notice of Closure on November 4, 1994 that awarded no permanent disability. (Ex. 58). Claimant requested reconsideration of that Notice of Closure, contending that her claim had been prematurely closed and pointing out that the neuroma and reflex sympathetic dystrophy conditions had been found compensable. (Ex. 59). The insurer objected to the request, arguing that those conditions had not been "accepted" and that it had appealed the November 23, 1994 Opinion and Order. (Ex. 60). The insurer contended, among other things, that the Department did not have jurisdiction to consider the neuroma and reflex sympathetic dystrophy conditions in its appellate review.

The December 19, 1994 Order on Reconsideration rescinded the November 4, 1994 Notice of Closure. (Ex. 62). The worksheet attached to the Order on Reconsideration referred to the November 23, 1994 Opinion and Order and indicated that the medical record did not establish whether the "newly accepted conditions" of neuroma and reflex sympathetic dystrophy conditions were medically stationary. (Ex. 61).

According to the insurer, the statutes and rules state that "accepted" conditions, rather than "compensable" conditions are to be used for closure and rating of permanent disability. The insurer argues that, since the denied conditions were not "accepted," they may not be considered in closure or reconsideration. We disagree.

A claimant must be medically stationary from all compensable conditions before the claim may be properly closed. See Nordstrom, Inc. v. Gaul, 108 Or App 237 (1991); Rogers v. Tri-Met, 75 Or App 470 (1985). Whether or not claimant was medically stationary is primarily a medical question. Harmon v. SAIF, 54 Or App 121, 125, rev den 292 Or 232 (1981).

An injured worker is considered medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claims shall not be closed if the worker's "condition" has not become medically stationary, with certain exceptions that do not apply in this case. Amended ORS 656.268(1). ORS 656.268(4)(a) provides in part:

> "When the worker's condition resulting from an accepted disabling injury has become medically stationary, and the worker has returned to work or the worker's attending physician releases the worker to return to regular or modified employment, * * * the

---

[1] On September 6, 1995, the Board affirmed ALJ Peterson's order insofar as the denied conditions were found compensable. That portion of ALJ Peterson's order which pertained to the propriety of the proposed surgery was vacated for lack of jurisdiction. Lynda J. Zeller, 47 Van Natta 1581 (1995).

> claim may be closed by the insurer or self-insured employer, without the issuance of a determination order by the Department of Consumer and Business Services."[2] (Emphasis added).

See also ORS 656.268(2)(a) (referring to whether the worker's "condition resulting from an accepted disabling injury" has become medically stationary).

Before we can decide whether claimant is medically stationary, we must determine the "condition [that] result[ed] from an accepted disabling injury." See ORS 656.268(4)(a).

Here, claimant's accepted disabling injury is a right carpal tunnel condition. The insurer also accepted a claim for trigger thumbs and de Quervain's syndrome. On November 23, 1994, ALJ Peterson concluded that claimant's neuroma and reflex sympathetic dystrophy conditions resulted from her accepted injury claim. The Order on Reconsideration concluded that claim closure was premature because there was no evidence that claimant's neuroma and reflex sympathetic dystrophy conditions were medically stationary.

In light of the November 23, 1994 Opinion and Order, claimant's neuroma and reflex sympathetic dystrophy conditions are "condition[s] [that] result[ed] from an accepted disabling injury" pursuant to ORS 656.268(4)(a). Since the medical evidence does not establish that those conditions are medically stationary, the Order on Reconsideration properly concluded that claim closure was premature. See also Elmer F. Knauss, 47 Van Natta 826, on recon 47 Van Natta 1064 (1995) (for reasons of administrative efficiency, an order may be given precedential effect, even though adjudication of the initial claim is not final due to an appeal); Michael S. Barlow, 46 Van Natta 1627 (1994).

The insurer argues that the Appellate Review Unit had no authority to consider ALJ Peterson's November 23, 1994 Opinion and Order in the reconsideration process. The insurer contends that the November 23, 1994 Opinion and Order does not correct any information in the record.[3] We disagree.

ORS 656.268(6)(a) provides:

> "At the reconsideration proceeding the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure."[4]

See also former OAR 436-30-050(2) (WCD Admin. Order 5-1992) ("[a]ll information to correct the record * * * must be presented during the reconsideration proceeding").[5]

---

[2] After the ALJ's order, the legislature enacted Senate Bill 369. Generally, the changes 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. Volk v. America West Airlines, 135 Or App 565 (1995). Here, however, the amendments to ORS 656.268(4) apply only to claims that become medically stationary on or after the effective date of the Act. Or Laws 1995, ch 332, § 66(4) (SB 369, § 66(4)). Since claimant's claim was not medically stationary on the effective date of the Act, we do not apply the amendments to ORS 656.268(4)(a). See Motel 6 v. McMasters, 135 Or App 583 (1995).

[3] We agree with the insurer's assertion that the November 23, 1994 Opinion and Order does not qualify as "medical evidence that should have been but was not submitted * * * at the time of claim closure" under ORS 656.268(6)(a). See ORS 656.268( 7); Daniel L. Bourgo, 46 Van Natta 2505 (1994) (holding that "supplemental" medical arbiter reports are not admissible except where the Department or the arbiter indicate that the initial report was incomplete).

[4] We note that ORS 656.268(6)(a) was formerly included in ORS 656.268(5). In Senate Bill 369, the legislature added ORS 656.268(6)(b). Since the amendments to ORS 656.386(6) apply only to claims that become medically stationary on or after the effective date of the Act, and claimant's claim was not medically stationary on the effective date of the Act, we do not apply the amendments to ORS 656.268(6)(b). Or Laws 1995, ch 332, §§ 30(6), 66(4) (SB 369, §§ 30(6), 66(4)).

[5] Former OAR 436-30-050(2) was amended and renumbered to OAR 436-30-115(2) (WCD Admin Order No. 94-059). OAR 436-30-115(2) provides, in part that "[a]ll information to correct or clarify the record * * * must be presented during the reconsideration proceeding.

In her request for reconsideration of the November 4, 1994 Notice of Closure, claimant referred to the November 23, 1994 Opinion and Order which found the denied conditions of neuroma and reflex sympathetic dystrophy compensable. Under ORS 656.268(6)(a), claimant is allowed to "correct information in the record that is erroneous." In Dr. Layman's August 26, 1994 report, he expressly considered claimant medically stationary as of October 1992 only if the conditions of neuroma and reflex sympathetic dystrophy were denied. (Ex. 51). Since the November 23, 1994 Opinion and Order set aside the insurer's denial, it corrected the erroneous information that the conditions of neuroma and reflex sympathetic dystrophy were denied. Consequently, such information may be considered pursuant to ORS 656.268(6)(a) and OAR 436-30-050(2).

At the time the claim was closed, Dr. Layman had proposed surgery for claimant's neuroma and reflex sympathetic dystrophy conditions. Since there is no evidence in the record that claimant's neuroma and reflex sympathetic dystrophy conditions were medically stationary, we agree with the ALJ's conclusion that the claim was prematurely closed.

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 $1,230, 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 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 March 31, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,230, payable by the insurer.

---



In the Matter of the Compensation of
**DAN J. ANDERSON, Claimant**
WCB Case Nos. 93-15302, 93-15301 & 93-15300
ORDER ON REVIEW
Allen, Stortz, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys
Williams, Zografos, et al, Defense Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by the Board en banc.

St. Paul Fire and Marine Insurance Company (St. Paul) requests review of Administrative Law Judge (ALJ)[1] Nichols' order that: (1) set aside its responsibility denial of claimant's bilateral carpal tunnel syndrome (CTS) occupational disease claim; (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) and Reliance Insurance's (Reliance's) responsibility denials of claimant's aggravation and occupational disease claims for the same condition; and (3) awarded claimant's attorney a $2,000 under former ORS 656.307(5). On review the issues are responsibility and attorney fees. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Standard of Review

This case arose under former ORS 656.307. Under former ORS 656.307(2), our review was limited to questions of law. Under amended 656.307(2), "307" proceedings "shall be conducted in the

---

[1] Under former ORS 656.307, the factfinder was called an arbitrator. Under amended ORS 656.307, they are called Administrative Law Judges. Or Laws 1995, ch 332, § 36.

same manner as any other hearing and any further appeal shall be conducted pursuant to ORS 656.295 and 656.298." Or Laws 1995, ch 332, § 36 (SB 369, § 36). Under ORS 656.295, we review de novo. E.g., Destael v. Nicolai Co., 80 Or App 596, 600 (1986).[2] Accordingly, under amended ORS 656.307(2), our review is de novo. The remaining question is whether amended ORS 656.307 applies here. It does.

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). Amended ORS 656.307 is not among the exceptions to that general rule. See SB 369, § 66 (enumerating exceptions to general retroactivity provision). Consequently, because this matter has not been finally resolved on appeal, amended ORS 656.307 applies here. Accordingly, under amended ORS 656.307(2), we review this matter de novo.

Responsibility

Claimant has made claims for right and left CTS. We analyze each condition separately.

Claimant is a construction worker. He worked for Liberty's insured from July 1991 to January 1992, and for St. Paul's insured from August 1992 to March 1993. He worked for Reliance's insured in April 1993, and again for St. Paul's insured from May to July 1993.

Claimant first complained of right arm symptoms in 1991; thereafter, he developed bilateral wrist symptoms. In February 1993, claimant filed a claim with Liberty for bilateral CTS. Liberty accepted the right CTS in May 1993. In July 1993, claimant filed a claim with Liberty for bilateral carpal tunnel release. Liberty denied the claim, naming Reliance and St. Paul as potentially responsible carriers. Claimant filed claims with those two carriers, both of which subsequently denied responsibility. Thereafter, a "307" order issued, naming Liberty as the paying agent.

The ALJ concluded that, because claimant's right CTS worsened after he left employment with Liberty's insured and while he was employed with St. Paul's insured, claimant had established a "new occupational disease" for which St. Paul is responsible. St. Paul asserts that the ALJ erred in finding it responsible for claimant's right CTS because, inter alia, Liberty did not establish that claimant's right CTS had pathologically worsened. We agree.

Because claimant's right CTS is an accepted condition, ORS 656.308[3] applies. Smurfit Newsprint v. DeRossett, 118 Or App 368, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993). Under that statute, Liberty can shift responsibility for the right CTS to another carrier only by showing that subsequent work exposure was the major contributing cause of a pathological worsening of that condition. E.g., Shelly K. Funkhouser, 47 Van Natta 126 (1995); see Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314, 317 (1993) (carrier with accepted condition has burden of establishing that subsequent work activities were major contributing cause of claimant's disease or its worsening). Liberty has not met that burden.[4]

Dr. Buza, treating physician, opined that claimant's CTS symptoms were more severe in July 1993. (Ex. 14). Drs. Wilson and Neufeld examined claimant on Liberty's behalf. They noted a recurrence of claimant's right CTS symptoms, but did not address the underlying pathology of that condition. (Ex. 17-5). Buza concurred with that report. (Ex. 19).

Thereafter, Dr. Buza agreed that claimant's bilateral CTS had "worsened clinically." (Ex. 28). In deposition, Dr. Wilson was unable to say whether claimant's CTS has worsened pathologically. (Ex. 37-14, -15). Dr. Rosenbaum, who examined claimant on Reliance's behalf, reached the same conclusion. (Ex. 38-6). Buza concurred with Rosenbaum's findings. (Ex. 39). Thereafter, Buza agreed that claimant's bilateral median neuropathy had worsened. (Ex. 40).

---

[2] SB 369 did not amend ORS 656.295.

[3] SB 369 amended ORS 656.308. SB 369, § 37. Those amendments are not relevant here.

[4] St. Paul refers us to amended ORS 656.802(2)(b) (SB 369, § 56), which now includes express language regarding the pathological worsening issue. We need not address that language, because our decision would be the same under either version of the statute.

On this record, we find insufficient evidence that claimant's right CTS pathologically worsened during his employment after he left Liberty's insured. Most of the medical evidence refers to claimant's symptoms, not the underlying pathology. Dr. Buza came the closest to addressing the pathological worsening issue when he agreed that claimant's CTS has "worsened clinically." Buza also agreed that claimant's bilateral median neuropathy had worsened, suggesting a worsening of claimant's underlying condition. However, in view of Buza's subsequent agreement with Dr. Rosenbaum, who was unable to determine whether claimant's condition had pathologically worsened, we find Dr. Buza's opinion insufficient to meet Liberty's burden of proof. Therefore, Liberty cannot shift responsibility for that condition to any other carrier. Consequently, we reverse the ALJ's decision to assign responsibility for claimant's right CTS to St. Paul; Liberty remains responsible for that condition.

We turn to the left CTS claim. St. Paul asserts that, because the preponderance of the evidence establishes that claimant's work with Reliance's insured actually caused the left CTS, the ALJ erred by assigning responsibility for that condition to St. Paul under the last injurious exposure rule. We disagree.

No one has accepted claimant's left CTS. Therefore, ORS 656.308 does not apply. SAIF v. Yokum, 132 Or App 18, 23 (1994). Instead, we analyze this case under the last injurious exposure rule, unless actual causation is proved with respect to a particular carrier. E.g., Eva R. Billings, 45 Van Natta 2142 (1993).

Claimant relies on Dr. Wilson's deposition testimony as proof of actual causation. Dr. Wilson testified that claimant's bilateral CTS was caused, in major part, by his employment with Reliance's insured. (Ex. 37-23). However, Wilson later testified that claimant's work with Reliance's and St. Paul's insureds was the major cause of claimant's current condition. (Id. at 31-32). That evidence is insufficient to establish which employment actually caused claimant's left CTS.

Consequently, we resort to the last injurious exposure rule. Under that rule, the potentially causal employer at the onset of disability is assigned initial responsibility for the disease. Bracke v. Baza'r, 292 Or 239, 248 (1992). The onset of disability is the date on which the claimant first became disabled as a result of the compensable condition, or the date on which he or she first sought medical treatment for the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, claimant first sought treatment for left CTS on June 8, 1993, while he was working for St. Paul's insured. (Ex. 11-2; see Tr. 14, 28). Therefore, claimant's onset of disability date is June 8, 1993. Because claimant was employed by St. Paul's insured at the time, responsibility for the left CTS is initially assigned to St. Paul.

St. Paul can shift responsibility to a prior carrier by showing that claimant's work exposure while a prior carrier was on the risk was the sole cause of claimant's left CTS, or that it was impossible for conditions while St. Paul was on the risk to have caused that disease. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985).

St. Paul has not met that burden. Although none of the treating or examining physicians was ultimately able to identify a particular employment as the major cause of claimant's left CTS, all implicated St. Paul's insured as a potential contributor to that condition. (Exs. 17-5, 19, 37-23, -31, -32, 38-7, 39). Under the circumstances, we conclude that St. Paul has not satisfied the sole cause/impossibility standard. Therefore, it remains responsible for claimant's left CTS.

In sum, Liberty is responsible for claimant's right CTS and St. Paul is responsible for claimant's left CTS.

Attorney Fees

For services at hearing, the ALJ awarded claimant's attorney a $2,000 assessed fee, payable by St. Paul. St. Paul and Liberty assert that, in view of the intervening enactment of ORS 656.308(2)(d), the maximum fee to which claimant is entitled is $1,000. We disagree.[5]

[5] Claimant asserts that, because no one appealed the amount of the ALJ's attorney fee until after SB 369 went into effect, that award has become final. We disagree. Pursuant to our de novo review, we have authority to consider all issues considered at hearing, including the amount of the attorney fee.

ORS 656.308(2)(d) provides that, "[n]otwithstanding 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." SB 369, § 37 (emphasis added). That statute is not among the exceptions to the general retroactivity provisions of SB 369. See SB 369, § 66. Therefore, it applies to cases arising under the former and present versions of ORS 656.308. See Volk v. America West Airlines, supra.

Amended ORS 656.307(5) provides:

> "The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at such proceeding and actively and meaningfully participates through an attorney, the Administrative Law Judge may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the Administrative Law Judge to be the party responsible for paying the claim."

That is essentially the same as the former version of the statute. See former ORS 656.307(5).[6]

Amended ORS 656.307(5) is not among the exceptions to the general retroactivity provisions of SB 369. See SB 369, § 66. Therefore, it applies to cases arising under the former and present versions of ORS 656.307. See Volk v. America West Airlines, supra.

This case arose under former ORS 656.307. Therefore, amended ORS 656.307(5) applies, and 656.308(2)(d) does not. Amended ORS 656.307(5) contains no limit on the amount an ALJ may award a claimant for his or her counsel's services in a "307" proceeding. Consequently, we reject St. Paul's and Liberty's argument that the ALJ awarded an excessive attorney fee.

In so holding, we recognize the incongruity between amended ORS 656.307(5) and 656.308(2)(d). However, because this clearly is a "307" proceeding, we decline to address that incongruity and leave that issue for future cases.[7]

Notwithstanding our conclusion that the ALJ was authorized to award a $2,000 fee, we nevertheless modify the ALJ's fee award. Because we have found Liberty responsible for claimant's right CTS and St. Paul responsible for claimant's left CTS, we award claimant's attorney a $2,000 fee for services at hearing, $1,000 payable by Liberty and $1,000 payable by St. Paul.

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 St. Paul, the carrier that sought Board review. Cigna Insurance Companies v. Crawford & Company, 104 Or App 329, 331 (1990). In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's and supplemental briefs), the complexity of the issues, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services related to the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

## ORDER

The ALJ's order dated September 21, 1994, and reconsidered October 31, 1994, is affirmed in part, reversed in part and modified in part. The ALJ's decision assigning responsibility for claimant's right CTS to St. Paul Fire and Marine Insurance Company and upholding Liberty Northwest Insurance

---

[6] The amendments merely clarified that Referees are now called Administrative Law Judges.

[7] We note, however, that amended ORS 656.308(2)(d) begins with the clause, "Notwithstanding ORS 656.382(2), 656.386 and 656.388[.]" It does not mention ORS 656.307, which suggests that the Legislature intended that only "308" proceedings have an attorney fee cap.

Corporation's denial of the same condition is reversed. Liberty's denial of claimant's left CTS is set aside and the claim is remanded to Liberty for processing according to law. St. Paul's denial of claimant's left CTS is reinstated and upheld in its entirety. The ALJ's attorney fee award is modified. In lieu of a $2,000 fee for services at hearing, payable by St. Paul, claimant is awarded $2,000, $1,000 payable by Liberty and $1,000 payable by St. Paul. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded $1,000, payable by St. Paul.

---

October 5, 1995 Cite as 47 Van Natta 1933 (1995)

In the Matter of the Compensation of
**WILLIAM C. BECKER, Claimant**
WCB Case No. 94-10386
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that awarded a $2,400 assessed attorney fee under former ORS 656.386(1) for prevailing over SAIF's "premature" denial of claimant's "withdrawn" occupational disease claim for mental stress. On review, the issues are the validity of SAIF's denial and attorney fees. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the word "prematurely" in the "Findings of Ultimate Fact" and briefly summarize the pertinent facts as follows:

On August 16, 1994, claimant signed an 801 Form asserting a claim for "occupational stress" on the basis of a "series of physical injuries in a short period of time." The 801 was countersigned by claimant's employer and forwarded to SAIF for processing.

On August 22, 1994, SAIF received a fax from claimant indicating that he did "not want to pursue the occupational stress claim at this time." A SAIF claims adjuster also contacted the employer, who also reported that claimant did not wish to pursue a stress claim at the time. On August 26, 1994, SAIF issued a denial of the claim, on the grounds claimant's work activity was not the major contributing cause of his stress.

Claimant requested a hearing after SAIF refused to rescind the denial. On September 26, 1994, SAIF issued an amended denial stating, in part, "[e]ven though you've withdrawn your claim, we must still deny the claim on the basis of your denial."

## CONCLUSIONS OF LAW AND OPINION

The ALJ set aside as premature SAIF's denials of claimant's claim. The ALJ reasoned that because claimant had withdrawn his claim before it was processed, there was no "claim" in existence at the time SAIF issued its denial and therefore any denial would be premature. The ALJ further found that because claimant had prevailed against the denial, he was entitled to an assessed attorney fee pursuant to former ORS 656.386(1).[1]

On review, SAIF argues that its August 26, 1994 denial, as amended September 26, 1994, is not premature and, even if it was, an assessed fee cannot be awarded because claimant did not obtain compensation. Claimant appears to concede that he is not entitled to an assessed attorney fee under former ORS 656.386(1), but contends he is entitled to a fee under former ORS 656.382(1) for SAIF's allegedly unreasonable resistance to the payment of compensation.

---

[1] Subsequent to the ALJ's order and the parties briefing on review, Senate Bill 369 was enacted, which amended ORS 656.386(1). Or Laws 1995, ch 332, § 43 (SB 369, § 43). The new law applies in this case. SB 369, § 66(1); Volk v. America West Airlines, 135 Or App 565 (1995).

Premature Denial

SAIF argues that a claim cannot be "withdrawn."[2] We disagree. We have previously acknowledged that a claim may be withdrawn and that a carrier has no duty to process that claim if it is withdrawn before the statutory period for investigating the claim has run. See Michael A. Dipolito, 44 Van Natta 981 (1992), as discussed in Allen B. Miller, 44 Van Natta 2122 (1992).[3]

SAIF also argues that its denial should not be designated "premature," but should be reinstated because claimant is no longer making a claim for compensation. We generally designate a denial as premature when the carrier denies a condition before a "claim" for that condition is filed.[4] See Larry J. Bergquist, 46 Van Natta 2397 (1994); Cindy L. Smith, 44 Van Natta 1660 (1992). Technically, SAIF's denial in this case is not "premature" because it did not predate the filing of a claim. However, since claimant withdrew his claim prior to expiration of the statutory 90-day "acceptance/denial" period under former ORS 656.262(6) and before issuance of SAIF's denial, there was no claim outstanding when SAIF issued the denial. We have held that a denial issued in the absence of a claim is a nullity and has no effect. Larry J. Bergquist, supra; William F. Hamilton, 41 Van Natta 2195, 2198 (1989). In this case, then, regardless of the term we use to describe it, i.e., "repudiated" or "invalid," SAIF's denial of the "withdrawn" claim is null and void and has no legal effect.

Michael C. Holt, 44 Van Natta 962 (1992), relied on by SAIF, is distinguishable. There, we declined to set aside the carrier's denial because we found that the claimant's treating physician had made a claim on the claimant's behalf, even though the claimant denied the existence of the claim. In this case, on the contrary, no physician had advanced claimant's claim. Moreover, as a result of claimant's "pre-denial" withdrawal of his claim, it is clear that no claim for compensation was being pursued at the time of SAIF's denial.

Attorney Fee

The ALJ awarded an assessed attorney fee, payable by SAIF, because claimant prevailed against the denial. We reverse.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 ( 1984). We have construed the term "prevail" in former ORS 656.386(1) to mean that the claimant must "obtain compensation" to be entitled to an assessed attorney fee. Patricia E. McGrath, 45 Van Natta 1256 (1993).

Amended ORS 656.386(1) now provides that claimant must prevail over a "denied claim" to be entitled to attorney fees. Here, claimant withdrew his claim. Further, claimant will not receive benefits as a result of our decision that SAIF's denial of a "withdrawn" claim is a nullity. Since claimant has not prevailed over a denied claim, he is not entitled to an attorney fee award under amended 656.386(1). Accordingly, we have no authority to award an attorney fee under this section in this case.[5]

---

[2] We note that in its reply brief, SAIF apparently abandons this contention and concedes that claimant had a right to withdraw his claim. However, it continues to object to the designation of its denial as "premature" when it was made in response to a claim that had been formally submitted and then withdrawn.

[3] In Miller, we held that a carrier's duty to respond to the claim was not absolved where the claim had not been withdrawn during the statutory period.

[4] A "claim" is defined as "a written request for compensation from a subject worker * * * or any compensable injury of which the subject employer has notice or knowledge." ORS 656.005(6).

[5] Alternately, to the extent that claimant "prevailed" in that we are invalidating SAIF's denial, he was not seeking, nor did he obtain, compensation. Claimant therefore was not entitled to an assessed attorney fee under the former version of this statute either. See Cindy L. Smith, supra. Finally, we disagree with the dissent's interpretation of amended ORS 656.386(1) as it pertains to this case. Noting that the denial has been rescinded, Member Hall reasons that claimant is entitled to a carrier-paid attorney fee regardless of whether that rescission results in compensation. Yet, the statute is premised on "cases involving a denied claim." Here, we have found, and Member Hall agrees, that claimant withdrew his claim. Since the underlying basis for the denial has been withdrawn, it follows that the foundation for an attorney fee award (i.e., a denied claim) has likewise evaporated.

Finally, because claimant did not raise the issue of unreasonable resistance to the payment of compensation at hearing, we will not consider the issue for the first time on appeal. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Moreover, even if we could consider the issue, we cannot assess an attorney fee under amended ORS 656.382(1) where, as here, claimant is seeking only to avoid the preclusive effect of SAIF's denial. Absent a compensable claim, we cannot award a penalty for unreasonable resistance to the payment of compensation. See SAIF v. Condon, 119 Or App 194 (1993); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

ORDER

The ALJ's order dated December 28, 1994 is affirmed in part and reversed in part. That portion of the order that awarded an assessed attorney fee is reversed. In lieu of the ALJ's "premature" finding, SAIF's denial remains set aside as invalid and is null and void. The remainder of the order is affirmed.

**Board Member Hall, concurring in part and dissenting in part:**

I concur with the majority in holding that claimant may "withdraw" a claim. For the following reasons, however, I respectfully dissent on the issue of attorney fees.

Applying amended ORS 656.386(1), the majority concludes that claimant is not entitled to an assessed attorney fee because he has not "prevailed" over a denied claim. I dissent for two reasons, one procedural and one substantive. Procedurally, this case was litigated under former ORS 656.386(1). Without the benefit of briefs and argument from the parties, the majority interprets and then applies amended ORS 656.386(1) to this case. While the amended statute may well apply retroactively, the parties to the litigation should have the opportunity to express their respective positions and offer analysis concerning the amendment. The forum and the appellate process would be better served with supplemental briefing, for without such input from the parties, the Board is deciding a significant issue sua sponte.

Since the majority is interpreting amended ORS 656.386(1), I will, despite the above noted procedural concern, also offer my interpretation of the amended statute.

Former ORS 656.386(1) provided, in pertinent part, as follows:

> "In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing is not held, a reasonable attorney fee shall be allowed. . . ." (Emphasis added).

We held in Patricia E. McGrath, 45 Van Natta 1256 (1993), that the term "prevail" as used in this section meant that claimant must "obtain compensation."[1] Our reasoning in McGrath was based on the statutory language emphasized above. We found that no attorney fee was authorized when the carrier agreed to void its aggravation denial, because the claimant's attorney was not instrumental in "obtaining compensation" for the claimant. There, the parties stipulated that claimant had not made a claim for aggravation, thus there was no need for the denial.

The SB 369 amendments to ORS 656.386(1) changed the language we relied upon to decide McGrath. The amended statute now provides, in pertinent part:

> "In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable 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, a reasonable attorney fee shall be allowed. . . ." (Emphasis added).

---

[1] Prior to the enactment of SB 369, the Court of Appeals held in SAIF v. Blackwell, 131 Or App 519 (1994), that the phrase "instrumental in obtaining compensation" in former ORS 656.386(1) is not limited to cases involving unpaid bills. There, the court found that claimant's attorney was entitled to an insurer-paid attorney fee for gaining an express acceptance of the denied condition by the insurer, even though the claimant's bills had already been paid.

I read the amended statute as no longer requiring that the claimant "obtain compensation" to be entitled to an attorney fee. Rather, the plain language of the amended statute requires only that claimant obtain a rescission of the denial. Consequently, based on our reasoning in McGrath, it appears the term "prevail" in amended ORS 656.386(1) has a different meaning than it did in former ORS 656.386(1). The term "prevail" in the context of amended ORS 656.386(1) means simply that the claimant "obtain a rescission" of the insurer's denial, which is exactly what occurred in this case.

I acknowledge that, in this case, the claimant's attorney was instrumental in obtaining a rescission of the denial after a hearing and decision of the ALJ, yet the sentence containing the phrase "instrumental in obtaining a rescission of the denial" in amended ORS 656.386(1) deals with the situation in which the matter is resolved prior to an ALJ decision. However, given our construction of former ORS 656.386(1) and reasoning in McGrath, I see no reason why the presence or absence of an ALJ decision should make a difference.[2] In McGrath, the "obtaining compensation" language we relied upon to construe the term "prevail" in the phrase "prevails finally in a hearing before the referee" was similarly situated in that portion of the statute directed toward allowing an attorney fee when a hearing was not held. Accordingly, I would construe the term "prevail" in amended ORS 656.386(1) to mean "obtain a rescission of the denial" rather than "obtain compensation," and conclude that where, as here, a claimant is successful in invalidating the carrier's denial in a hearing before the ALJ and/or on review by the Board, that claimant is entitled to an assessed attorney fee, whether or not the claimant actually obtains compensation.

The majority suggests that since the claim has been withdrawn, the foundation for an attorney fee award, i.e., a denied claim, has been eliminated. (Majority opinion, n. 5). Under the facts of this case, I disagree with this assessment. Here, a claim was made. Several days later, claimant tried to withdraw it and SAIF would not let him do so. SAIF refused to acknowledge the attempted withdrawal and forced claimant to litigate its denial of the claim. Throughout the litigation (including this request for review), SAIF maintained its denial of the claim.[3] As a result of litigation, claimant has succeeded in having the denial set aside (rescinded). I would therefore find that this case comes within the statutory requirement of "cases involving a denied claim." Amended ORS 656.386(1).

---

[2] See, e.g., Safeway Stores, Inc. v. Hayes, 119 Or App 319, 322 (1993), where the court, interpreting former ORS 656.386(1), held that the where the statute provides for an attorney fee when a hearing is not held, the legislature certainly intended that an attorney fee be available when a hearing is held but the matter was resolved by stipulation of the parties before the referee had issued an opinion. See also, Gates v. Liberty Northwest Ins. Corp., 131 Or App 164, 169 (1994) (attorney fee under former ORS 656.386(1) allowed where insurer withdrew its compensability denial before the hearing, leaving responsibility as the sole issue at hearing, since the claimant's attorney was instrumental in obtaining that withdrawal).

[3] SAIF initially issued a denial on the grounds that claimant's work activity was not the major contributing cause of his condition. A month later, after claimant requested hearing on the denial, SAIF issued an amended denial stating, in part, "[e]ven though you have withdrawn your claim, we still must deny the claim on the basis of your withdrawal." (Ex. 4).

---



In the Matter of the Compensation of
**UGO E. BRABO, Claimant**
WCB Case No. 94-12192
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that declined to award an assessed fee based on the employer's alleged failure to assist claimant in obtaining medical treatment. The SAIF Corporation challenges that portion of the order that set aside its denial of reimbursement for liaison and interpreter services. On review, the issues are jurisdiction, medical services and attorney fees. We affirm in part and vacate in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Medical Services

The ALJ determined that the liaison and interpreter services provided to claimant by Eye on U investigations were compensable as "other related services" for claimant's accepted finger injury claim under former ORS 656.245(1)(c) (now renumbered ORS 656.245(1)(b)).

Subsequent to the ALJ's order, the legislature enacted Senate Bill 369 and amended ORS 656.245 and ORS 656.327, effective June 7, 1995. Amended ORS 656.327(1) now provides that if an injured worker or a carrier believes that the medical services are 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." (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). SB 369, § 25(6).

In Walter L. Keeney, 47 Van Natta 1387 (1995), we concluded, among other things, that the amendments to ORS 656.327(1) and new 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. Accord Newell v. SAIF, 136 Or App 280 (1995) (amended ORS 656.704(3) and 656.327(1) place exclusive jurisdiction with the Director to review the appropriateness of proposed medical treatment).

Here, the medical services dispute does not pertain to the compensability of claimant's underlying claim for his accepted finger condition. Rather, the issue is whether claimant is entitled to reimbursement for the liaison and interpreter services provided by Eye On U investigations. Because jurisdiction over this matter rests with the Director, rather than the Hearings Division, we vacate this portion of the ALJ's order.[1]

### Attorney Fees

Finding no statute, rule or decision that places an affirmative duty on an employer to ensure that an injured worker receives immediate medical treatment for an injury, the ALJ declined to assess an attorney fee against the employer. On review, claimant contends he is entitled to a fee under ORS 656.382(1) due to the employer's unreasonable conduct.[2]

Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). ORS 656.382(1) authorizes an attorney fee when a carrier unreasonably resists the payment of compensation. Here, even if we were to find that the employer acted unreasonably in not advising claimant he could seek medical treatment, this conduct did not result in the resistance of any payment. Claimant's claim was timely accepted and benefits were paid. We, therefore, have no authority to award an attorney fee under this section.

---

[1] Although a signatory to this order, Member Hall directs the parties to his dissent in Keeney.

[2] As part of SB 369, the legislature also enacted section 42d, which provides that the Hearings Division and the Board may not award penalties or attorney fees for matters arising under the review jurisdiction of the Director. To the extent claimant maintains he is entitled to a fee in connection with the insurer's failure to pay for the liaison and interpreter services, we lack jurisdiction.

ORDER

The ALJ's order dated January 31, 1995 is affirmed in part and vacated in part. That part of the order disapproving SAIF's denial of liaison services is vacated and claimant's request for hearing on the issue of medical services is dismissed for lack of jurisdiction. The remainder of the order is affirmed.

---



In the Matter of the Compensation of
**ROGER ELI, Claimant**
WCB Case No. 94-14302
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian & Gunn.

EBI Companies (EBI) requests review of Administrative Law Judge (ALJ) McCullough's order that set aside its denial of claimant's right upper extremity injury claim. On review, the issues are "validity" of EBI's denial, timeliness of the hearing request, and, potentially, compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the last two paragraphs.

CONCLUSIONS OF LAW AND OPINION

Claimant was employed by Selectemp, a temporary employment contractor, in early August 1994. Prior to August 15, 1994, claimant worked at Kerr Concentrates (Kerr) as Selectemp's employee. Claimant injured his right hand and elbow at work on August 3, 1994. Claimant's symptoms continued during the next two weeks and he sought medical treatment on August 17, 1994. Claimant was diagnosed with right lateral epicondylitis.

In the meantime, claimant's employment with Selectemp ended on August 15, 1994, and he became a permanent employee with Kerr. On August 18, 1994, claimant filed an "801" form concerning his August 3, 1994 injury. (Ex. 2A).

EBI, Selectemp's insurer, sent claimant a letter on August 24, 1994, denying responsibility for an injury on August 17, 1994. (Ex. 5). EBI advised claimant that it believed his injury arose out of his employment with Kerr.

Claimant subsequently filed a claim with Kerr. Kerr's insurer, AIAC, denied the claim on November 9, 1994. (Ex. 15A). Claimant filed a request for hearing on EBI's August 24, 1994 denial, which was received by the Hearings Division on November 25, 1994. In late November 1994, claimant also filed a request for hearing regarding Kerr's November 9, 1994 denial.

At hearing, the parties agreed to dismiss Kerr from the proceeding because claimant was injured before his employment with Kerr. (Tr. 2-3). The ALJ found that EBI's August 24, 1994 denial was not a valid denial of claimant's August 3, 1994 injury because the denial referred only to an injury on August 17, 1994. Consequently, the ALJ concluded that claimant's November 1994 request for hearing was not untimely.

Alternatively, the ALJ found that claimant's request for hearing was not barred because claimant had good cause for the delay. The ALJ found that claimant had not challenged EBI's denial earlier because he believed the injury would be covered by Kerr. The ALJ concluded that claimant's reason for not appealing EBI's denial until late November 1994 constituted mistake and excusable neglect. In addition, the ALJ held that claimant's right upper extremity claim was compensable.

EBI argues that the ALJ exceeded the scope of review by concluding that EBI's August 24, 1994 was not a valid denial. EBI asserts that claimant did not raise any such issue or argument at hearing and that any arguments about the alleged defects of the denial were waived.

An ALJ's scope of review is limited to issues raised by the parties. Saedeh K. Bashi, 46 Van Natta 2253 (1994). At hearing, claimant's attorney said: "We agree that the Request for Hearing was not filed within the 60 days after the date of the Denial, but we feel there [are] reasonable grounds for the failure to file within that period of time." (Tr. 5). Inasmuch as claimant did not raise the issue of the validity of EBI's August 24, 1994 denial at hearing, we are not inclined to address that issue on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

In any event, we are not persuaded that EBI's August 24, 1994 letter was an invalid denial. Claimant argues on review that EBI's denial ignored its "statutory duty" and ignored the correct date of injury. Although EBI's August 24, 1994 denial referred to an injury on August 17, 1994, rather than August 3, 1994, claimant cites no statute or rule that requires a carrier to include the date of injury on the denial. ORS 656.262(6)(a) provides, in part, that "[w]ritten notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim."[1] Although ORS 656.262(6) requires particular information in the notice of acceptance, there are no similar statutory requirements for a denial. Likewise, although OAR 438-05-055 requires a notice of denial to specify the factual and legal reasons for the denial, it does not require a carrier to specify the date of injury.

There is no evidence that claimant suffered more than one injury in August 1994 involving his right upper extremity. Furthermore, since claimant's request for hearing on EBI's August 24, 1994 denial referred to the date of injury as August 3, 1994, it does not appear that claimant was confused about the injury date in EBI's denial. We conclude that claimant's failure to object to an alleged "defect" in EBI's August 24, 1994 denial constituted a "valid waiver of all procedural errors relating to litigation of the claim." See Thomas v. SAIF, 64 Or App 193 (1983); Lawrence Runninghawk, 47 Van Natta 114, on recon 47 Van Natta 287 (1995).

Claimant argues on review that EBI did not issue a proper notice required by ORS 656.308 and it denied only responsibility, not compensability, in violation of statute. Since claimant did not raise this issue at hearing, we do not address the issue on review. See Stevenson v. Blue Cross of Oregon, supra.

EBI argues that claimant did not establish good cause for his failure to file a timely request for hearing. A request for a hearing must be filed not later than the 60th day after claimant was notified of the denial.[2] A hearing request that is filed after 60 days, but within 180 days after notification, confers jurisdiction if claimant had good cause for the late filing. ORS 656.319(1)(b). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B. Hempel v. SAIF, 100 Or App 68 (1990).

---

[1] We note that this portion of ORS 656.262(6)(a) was not amended by Senate Bill 369. Or Laws, ch 332, § 28(6)(a) (SB 369, § 28(6)(a)).

[2] After the ALJ's order, the legislature enacted Senate Bill 369. Amended ORS 656.319(1)(a) provides that a request for hearing must be filed not later than the 60th day after the mailing of the denial to claimant. Or Laws 1995, ch 332, § 39 (SB 369; § 39). A hearing request that is filed after 60 days, but within 180 days after mailing of the denial, confers jurisdiction if claimant had good cause for the late filing. Amended ORS 656.319(1)(b).

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). However, one exception to the retroactive effect of SB 369 applies 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 the issue of the timeliness of claimant's request for hearing involves a procedural time limit, the changes made by SB 369 do not apply to this case. See Motel 6 v. McMasters, 135 Or App 583 (1995). We note that, in any event, application of the amendments to ORS 656.319(1) would not affect the outcome in this case.

The ALJ relied on William P. Stultz, 34 Van Natta 170 (1982), in concluding that claimant had established good cause. In Stultz, we found that the claimant was caught in a "cross-fire" between two carriers which gave him a sense of security about the claim. We noted that the carrier which paid temporary disability benefits had "deferred" action on the claim and we found that the claimant could not be expected to conclude that such an action provided the possibility that the claim ultimately would be denied. Since the claimant was receiving temporary disability benefits from one carrier and there was no reason for the claimant to take action on the other carrier's denial, we held that the claimant had established good cause for his failure to timely request a hearing from that other carrier's denial.

We find Stultz factually distinguishable from the present case. Unlike Stultz, claimant testified that he did not receive any temporary disability payments from either carrier and he did not know whether or not the medical bills were being paid. (Tr. 16). Claimant said that he did not know that Kerr/AIAC had paid his medical bills until they sent the denial. (Tr. 21).

Furthermore, unlike Stultz, the facts in this case do not support a conclusion that claimant had an objective reason for feeling "secure" about his claim. The fact that claimant erroneously believed that his claim would be covered by Kerr does not establish good cause, particularly since the record does not indicate that either carrier misled claimant.

Kerr's employee in charge of worker's compensation matters testified that she told claimant that she would file a claim with Kerr's insurer. (Tr. 8). She testified that she did not discuss whether either EBI or Kerr would accept the claim. (Tr. 10). Claimant agreed that the employee told him that she would file the claim through the company's insurer. (Tr. 15). Claimant testified: "She said, 'Well, we'll file through our insurance company,' so I didn't worry about it because I figured their insurance would pick it up." (Tr. 16). Claimant acknowledged that the employee did not indicate whether or not Kerr would accept the claim. (Tr. 20).

In addition, claimant was informed on more than one occasion that his claim with EBI had been denied. Claimant remembered receiving a letter from Salem Immediate Care regarding medical bills. (Tr. 21). The October 21, 1994 letter informed claimant that EBI had denied his claim and he was responsible for payment of the medical bills. (Ex. 14A). The letter also informed claimant that if he did not file a request for hearing on the denial within 60 days, he would lose any right to compensation unless he could show good cause for delay beyond 60 days. (Id.) Claimant testified that he read the letter, but he "kind of ignored it" because he felt that Kerr was going to take care of the claim. (Tr. 22).

In previous cases, we have held that confusion about the status of a claim does not constitute "good cause." In Wayne A. Moltrum, 47 Van Natta 955 (1995), the reason for the claimant's former attorney's failure to timely request a hearing on the carrier's denial was because he mistakenly believed that the carrier had already been ordered to accept the claim. We held that such a reason would not constitute excusable neglect if attributed to the claimant and we concluded that the claimant had failed to established good cause for his failure to file a timely hearing request on the denial. See also Joan C. Gillander, 47 Van Natta 391 (1995) (the claimant's belief, due to the receipt of temporary disability benefits, that her Washington claim had been accepted did not constitute good cause for her failure to timely request a hearing on the Oregon carrier's denial), order denying recon, 47 Van Natta 789 (1995); Mary M. Schultz, 45 Van Natta 393, on recon 45 Van Natta 571 (1993) (receipt of interim compensation and any confusion created by that action did not constitute good cause).

We conclude that claimant has not established good cause for his failure to timely request a hearing on EBI's denial. In light of our conclusion, we do not address claimant's request for a penalty against EBI for "persisting" in this request for review.

## ORDER

The ALJ's order dated March 28, 1995 is reversed. Claimant's hearing request is dismissed as untimely. EBI's denial is reinstated. The ALJ's attorney fee award is reversed.

**Board Member Gunn dissenting.**

Because I believe that the ALJ correctly found that claimant established "good cause" to justify his failure to timely file his request for hearing, I respectfully dissent.

I agree with the ALJ that this case is similar to William P. Stultz, 34 Van Natta 170 (1982). In that case, good cause was found to exist where a claimant was caught in a cross-fire between two carriers which gave him a sense of security about his claim. The claimant in Stultz was receiving temporary total disability benefits from one insurer and there was no reason to take any action on the other carrier's denial. Within a reasonable time after the claimant's benefits ceased, he requested a hearing. Under those circumstances, the Board found that good cause had been established.

In this case, claimant was also caught in a cross-fire between two carriers. Claimant did not realize that he needed to take action concerning EBI's denial until Kerr/AIAC issued its denial in November 1994. Claimant subsequently obtained legal counsel and appealed EBI's denial shortly thereafter. The reason claimant did not appeal EBI's denial sooner was because he erroneously believed that his claim would be covered by Kerr/AIAC. Under these circumstances, claimant's confusion is understandable. An unrepresented claimant cannot be expected to understand the legal consequences of his or her actions.

I agree with the ALJ that claimant's reason for not appealing EBI's denial until late November 1994 constitutes mistake and excusable neglect. I would conclude that claimant established "good cause" for the untimely filing of his request for hearing. Accordingly, I would affirm the ALJ on this issue and address the merits of the claim. For these reasons, I dissent.

---

October 5, 1995 Cite as 47 Van Natta 1941 (1995)

In the Matter of the Compensation of
**GLORIA MITCHELL, Claimant**
WCB Case No. 94-02715
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) McCullough's order which set aside its denial of claimant's low back injury claim. On review, the issue is whether claimant's injury arose out of and occurred in the course of her employment. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exceptions of the last sentence of the last full paragraph on page two, and the first full paragraph on page three.

## CONCLUSIONS OF LAW AND OPINION

Claimant experienced low back pain while running from her classroom in a daycare facility to her car in the employer's parking lot to turn off her headlights. The employer's policy specifies that a teacher is not supposed to leave the children unsupervised or in a situation where the child/adult ratio in the classroom is higher than a certain specified ratio.

Here, when claimant left her classroom, she asked an adult from another classroom to cover her classroom so that the ratio in claimant's classroom remained within the employer's requirements. The other classroom, however, was left short one adult. The ALJ reasoned that, by running to her car, thereby leaving the classroom understaffed for a shorter period of time than if she had walked, claimant's activity was a benefit to the employer. Therefore, the ALJ concluded that the running was a "risk" sufficiently connected with claimant's employment to establish that claimant's back injury arose out of her employment. We do not agree.

To establish the compensability of an injury, claimant must show that the injury: (1) occurred in "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. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). We consider all the circumstances to determine if the claimant has satisfied the work-connection test. Id. at 366, 369. Further, we no

longer rely on the Mellis factors as an independent and dispositive test of work connection; rather, we consider those factors that remain helpful under the Norpac Foods' analysis. First Interstate Bank of Oregon v. Clark, 133 Or App 712, 717 (1995); Mark Hoyt, 47 Van Natta 1046, 1047 (1995).

Here, we conclude that claimant has failed to prove that her injury "arose out of" her employment because the conditions of her employment did not put her in a position to be injured. See Henderson v. S.D. Deacon Corp., 127 Or App 333, 338-39 (1994).

Claimant's work duties included doing lesson plans, cleaning children's bathrooms, sweeping the floors, playing with the children, and reading stories. (Tr. 10, 11). Claimant was injured when she left her classroom and ran to the parking lot, and back, in order to turn off her car lights. Turning off her car lights was not within the scope of activities of claimant's job. (Tr. 22). At the time of her injury, claimant was involved in a personal mission.

Furthermore, we are not persuaded that, by running, claimant provided a benefit to her employer. Rather, claimant appears to have provided some benefit to herself by running to turn off the car lights. That is, by running, claimant reduced the time she was gone from her classroom, thereby minimizing the time that her activity resulted in a violation of the employer's adult/child ratio policy in the other classroom. In light of these circumstances, we are not persuaded that claimant's back injury arose from an risk connected to her employment. Accordingly, we conclude that claimant has failed to meet her burden of proving that she sustained a compensable back injury.

## ORDER

The ALJ's order dated March 3, 1995 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

---



In the Matter of the Compensation of
**KENNETH L. MORRIS, Claimant**
WCB Case Nos. 94-01247, 93-13675 & 93-10226
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Lumbermen's Underwriting Alliance and its insured, Marlette Homes (Marlette), request review of those portions of Administrative Law Judge (ALJ) Hazelett's order which: (1) set aside its compensability and responsibility denials of claimant's "new injury" claim for a low back condition; (2) upheld the aggravation denial issued by the self-insured employer, U&I Fresh Pack, Inc.(U&I), and its processing agent, Johnston and Culbertson; and (3) awarded an assessed attorney fee of $8,500 against Marlette. In his brief, claimant contends that the ALJ erred in declining to assess penalties for Lumbermen's alleged discovery violation. On review, the issues are compensability, responsibility and penalties. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the first paragraph of his "ultimate findings of fact."

## CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back injury on March 30, 1981, while working for U & I. Dr. Grewe and Dr. Smith treated claimant for a low back strain and L5 nerve root impingement. Dr. Grewe eventually performed a laminectomy at the L4-5 level in May of 1983. Claimant received a total of 30 percent unscheduled permanent disability for the 1981 injury.

In June 1989, claimant began working for Ross Machine & Iron Works (Ross), insured by Liberty Northwest Insurance Corporation. Claimant was struck on the upper back by an object, an incident for which he sought treatment for neck, back and left leg symptoms. Although the claim was initially diagnosed and accepted as a back contusion, the diagnosis eventually became lumbosacral strain with left sciatica. The claim was closed with an award of temporary disability but no permanent disability in October 1990.

Claimant began working for Marlette as a laborer in March 1993. On or about May 19, 1993, claimant was unloading refrigerators and felt a sudden onset of back and left leg pain. Claimant advised a coworker about the incident, but kept working his regular job. Claimant eventually sought medical treatment in June 1993 from Dr. Fulper, who referred claimant to Dr. Gehling. Dr. Gehling suspected L4-5 radiculopathy at first, but diagnostic testing did not reveal any significant pathology. Dr. Gehling stated that, although the May 1993 incident "may" have caused a lumbosacral strain, claimant's complaints were a continuation of his preexisting back injuries. (Ex. 117). In February 1994, claimant's counsel referred claimant back to Dr. Grewe for a neurosurgical consultation. (Ex. 123).

Marlette, Ross and U & I denied both compensability and responsibility for claimant's low back condition. Reasoning that claimant's condition in June and July 1993 was related to at least one of the previously accepted injuries, as well as the work incident in May 1993, the ALJ determined that claimant's low back condition was compensable. Finding, however, that claimant had not timely appealed Ross' denial and had failed to establish good cause for his failure to do so, the ALJ dismissed claimant's request for hearing as to Ross.

The ALJ then determined that Marlette was responsible for claimant's low back condition, concluding that Dr. Gehling's and Dr. Grewe's opinions established that the major contributing cause of claimant's need for medical treatment in June and July 1993 was the May 1993 incident. Finally, the ALJ rejected claimant's request for penalties for Marlette's allegedly unreasonable failure to provide discovery documents to claimant's counsel.

On review, Marlette contends that the ALJ incorrectly determined that claimant's current low back condition is compensable and, further, that the ALJ erroneously assigned responsibility. Marlette also contests the ALJ's attorney fee award, asserting that claimant is not entitled to an assessed fee and, even if he is, the ALJ' s award was excessive. Claimant contends that the ALJ erred in not assessing penalties for Marlette's alleged discovery violation.[1]

Compensability

We adopt and affirm the ALJ's reasoning and conclusion that claimant's current low back condition is compensable. However, for the reasons discussed below, we conclude that claimant is not entitled to benefits and that claimant's counsel is not entitled to an attorney fee.

Penalties

We adopt and affirm the ALJ's conclusion.

Responsibility

As previously noted, claimant sustained two compensable injuries involving his low back in 1981 and 1989. Claimant also experienced an exacerbation of his low back condition in May 1993. The relevant statute pertaining to the responsibility issue is ORS 656.308(1). ORS 656.308(1) provides, in part: "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition."

---

[1] Claimant does not contest the ALJ's finding that his request for hearing regarding Ross' denial of compensability and responsibility was time-barred.

To establish a new injury under the statute, claimant's employment activity in May 1993 must have been the major contributing cause of claimant's disability or need for medical treatment of the "combined condition." Amended ORS 656.308(1); SAIF v. Drews, 318 Or 1 (1993).[2] However, ORS 656.308 applies only if claimant's current condition is the "same condition" as that previously accepted by Ross in 1989. Smurfit Newsprint v. DeRosset, 118 Or app 371-72, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).

If we assume that claimant's last accepted injury in 1989 involved the same body part (low back), but not the same condition as that for which he now seeks compensation, then the analysis of Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), 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, Ross would be presumptively responsible for claimant's condition unless the medical evidence established that claimant's 1989 industrial injury did not independently contribute to a worsening of the low back condition. Kearns, supra, 70 Or App at 587.

We need not definitively decide whether claimant's current low back involves the "same condition" as previously accepted by Ross, thereby triggering application of ORS 656.308, or whether, under Kearns, claimant's current condition involves the same body part, but not the "same condition." We find that responsibility for claimant's current low back condition would not shift forward to Marlette under either ORS 656.308 or Kearns.

The ALJ determined that claimant's work incident in May 1993 constituted the major contributing cause of his current low back condition. Having reached that conclusion, the ALJ then found Marlette responsible for claimant's current low back condition. Marlette argues that the ALJ did not correctly analyze the medical evidence from Dr. Gehling and Dr. Grewe and should not have found it responsible. We agree.

Dr. Gehling, although he only examined claimant one time, provided an in-depth analysis of claimant's current low back condition, both in his November 19, 1993 medical report and in his deposition. (Exs. 117, 127). In his November 1993 response to an inquiry from counsel for Marlette, Dr. Gehling opined that, although the May 1993 incident may have caused a low back strain, claimant's current complaints were a continuation of his two prior injuries. (Ex. 117). Dr. Gehling explained that claimant's current symptoms were similar to those he had previously experienced and noted that his examination was no different than that conducted by Dr. Rosenbaum in 1987. (Id. at 3). Dr. Gehling, accordingly, concluded that claimant had not experienced a new injury in 1993 that independently contributed to or worsened his preexisting low back condition, and that the 1981 U&I injury was the major contributing cause of claimant's current low back condition. (Id.)

In his deposition, Dr. Gehling again conceded that claimant's work in May 1993 may have caused a low back strain and precipitated his need for treatment in June and July 1993. (Ex. 127-29). Dr. Gehling, however, emphasized that the major factor in claimant's current condition was his preexisting low back condition. (Ex. 127-26). Dr. Gehling testified that the opinion expressed in his November 1993 letter to Marlette's counsel had not changed significantly. Id.

Dr. Grewe reached the opposite conclusion from Dr. Gehling. Dr. Grewe opined that the May 1993 work incident was the "predominant cause" of claimant's symptoms based on the description he received of claimant's injury. (Ex. 125). We do not find Dr. Grewe's opinion to be persuasive, however. Dr. Grewe does not provide the detailed explanation that Dr. Gehling gave both in his medical report and at his deposition. Inasmuch as it is not thoroughly explained, we do not give Dr. Grewe's opinion as much weight. See Somers v. SAIF, 77 Or App 259 (1986).

---

[2] After the ALJ's order, the legislature enacted Senate Bill 369 which amended ORS 656.308(1). Or Laws 1995, ch 332, § 37 (SB 369, § 37). Amended ORS 656.308(1) now specifically provides that the standards for determining the compensability of a "combined condition" under ORS 656.005(7) shall be used to determine the occurrence of a new compensable injury or disease.

Therefore, we find that, even if claimant's current low back condition is the "same condition" accepted by Ross in 1989, the medical evidence does not establish that claimant's May 1993 work incident is the major contributing cause of claimant's need for medical treatment in June and July 1993.[3] Thus, we would conclude that responsibility for claimant's current low back condition would not shift forward to Marlette under ORS 656.308.[4]

Even assuming that Kearns, supra, was applicable, we would still conclude that Marlette was not responsible for claimant's current low back condition. Kearns created a rebuttable presumption that, in the context of successive accepted injuries involving the same body part, the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. The carrier with the last accepted injury can rebut the Kearns presumption by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. Id. at 588.

The circumstances are unusual in this case, inasmuch as claimant's request for hearing against Ross, the employer with the last accepted injury, was dismissed for claimant's failure to timely appeal Ross' denial. Claimant does not challenge the ALJ's dismissal on review. However, even if claimant had timely appealed Ross' denial, the record supports a causal connection between claimant's current low back condition and his 1989 injury at Ross. We base this conclusion on the following reasoning.

Dr. Gehling, whose medical opinion we have already found persuasive, opined that claimant's current low back condition is a continuation of both the 1981 and 1989 injuries. (Ex. 117-3). Although Dr. Gehling considers the 1981 injury to be the major contributing cause of claimant's current condition, he did not rule out that claimant's 1989 injury independently contributed to claimant's current low back condition. See Raymond H. Timmel, supra. Because of this, and the fact that Dr. Gehling related claimant's current condition, at least in part, to the 1989 injury, we conclude that responsibility would remain with Ross, even had claimant timely appealed its denial. Accordingly, we conclude that Marlette would not be responsible for claimant's current low back condition, even if the Kearns presumption were applicable.

In conclusion, the denials issued by U&I and Marlette are upheld. Although we would find under ordinary circumstances that Ross is responsible for claimant's medical treatment for his current low back condition, claimant did not timely appeal Ross' denial. Therefore, we are without authority to disturb that denial.

Attorney Fees

The ALJ awarded an assessed attorney fee of $8,500, payable by Marlette, for claimant's counsel's efforts overturning Marlette's denials. Since we have concluded that the ALJ erroneously assigned responsibility to Marlette, we reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated March 13, 1995 is reversed in part and affirmed in part. Those portions of the ALJ's order which set aside the responsibility denial of Marlette and awarded an assessed attorney fee are reversed. Marlette's denials of responsibility are reinstated and upheld. The remainder of the ALJ's order is affirmed.

---

[3] We note that Dr. Fulper indicated in a February 28, 1994 "check-the-box" response to an inquiry from counsel that the "June 1993" injury was not the major contributing cause of claimant's back condition. (Ex. 122).

[4] To the extent that claimant seeks a finding that Marlette is responsible for a low back "strain," we are still unable to assign responsibility to Marlette. Although Dr. Gehling stated that the May 1993 incident "may" have caused a low back strain, expressions of medical possibility are insufficient to establish medical causation. See Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

**Board Member Hall specially concurring.**

While I agree that, based on this record, assessment of a penalty against Marlette is not justified because there are no amounts then due on which to assess a penalty, I write separately to express my view that a carrier or employer has a duty to provide all documents, regardless of whether the claimant may have a document in his possession.

The document at issue is a copy of Ross' disclaimer of responsibility, which Ross apparently provided to claimant, himself, but not to his attorney. The ALJ reasoned that there is no requirement that one insurer or employer provide the claims documents of another employer or insurer. In addition, because there was no evidence that Marlette failed to provide claims documents related to its claim, and, further, because claimant, himself, had a copy of Ross' disclaimer, the ALJ concluded that Marlette did not act unreasonably and declined to assess a penalty.

The relevant discovery rules provide that all documents pertaining to a claim shall by disclosed within 15 days of a Request for Hearing or a written request for discovery. OAR 438-07-015(2). All documents acquired after the initial exchange shall be disclosed within 7 days after the disclosing party's receipt of the documents. OAR 438-07-015(4). Failure to comply with this rule shall, if found unreasonable, be considered delay or refusal under ORS 656.262(10) (since renumbered ORS 656.262(11)). OAR 438-07-015(5).

There is nothing in OAR 438-07-015 that relieves an employer or carrier of its duty to provide documents that are already in a claimant's possession or that pertain to the claim processing of another employer or carrier. Moreover, OAR 438-07-015(5) provides that "[i]t is the express policy of the Board to promote the full and complete disclosure of all facts and opinion pertaining to the claim being litigated before the Hearings Division." This Board has affirmed the policy underlying that administrative rule on numerous occasions. See e.g. Oswald F. Kuznik, 45 Van Natta 1194 (1993).

In light of the Board's express policy of encouraging full and open disclosure of claim documents, I conclude that Marlette had a duty to provide all claims documents "pertaining to the claim" to claimant's counsel, regardless of whether a document may have already been in the possession of claimant. This is also true if that document pertains to another employer's or carrier's claim processing.

---

October 5, 1995 Cite as 47 Van Natta 1946 (1995)

In the Matter of the Compensation of
**DONALD D. PAUL, Claimant**
WCB Case No. 94-04108
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Davis' order which: (1) modified a Director's order that found that claimant was not eligible for vocational assistance; and (2) awarded an attorney fee under ORS 656.382(1) for the insurer's allegedly unreasonable claim processing. On review, the issues are vocational assistance and attorney fees. We vacate the ALJ's order and dismiss claimant's hearing request.

## FINDINGS OF FACT

We adopt the ALJ's finding of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing regarding a Director's order which found that claimant was not entitled to vocational assistance. Finding that claimant was entitled to such assistance, the ALJ modified the Director's order. In addition, the ALJ awarded an attorney fee under ORS 656.382(1) for the insurer's unreasonable refusal to provide vocational assistance. The insurer sought Board review.

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 656.283(2), which now provides only for Director review of vocational assistance disputes. Or Laws 1995, ch 332, § 34(2) (SB 369, § 34(2)).

In Ross Enyart, 47 Van Natta 1540 (1995), relying on Volk v. America West Airlines, 135 Or App 565 (1995), we determined that, absent a specific exception, the amendments to the Workers' Compensation Law made by Senate Bill 369 are retroactively applicable to cases pending before us. Finding no such exception, we concluded that amended ORS 656.283(2) (which now provides for Director review of vocational assistance disputes) was applicable.

In reaching our decision in Enyart, we recognized that amended ORS 656.283(2)(d) allows 60 days within which to appeal a Director's administrative review order. However, noting that claimant had previously sought a contested case hearing with the Board's Hearings Division within 60 days of the Director's administrative order, we speculated that such a hearing request may serve to preserve claimant's appeal rights. In any event, because the authority over the vocational assistance dispute now rests with the Director, we concluded that resolution of the question was a matter for that forum.

This case is controlled by our holding in Enyart. Inasmuch as this pending dispute concerns claimant's entitlement to vocational assistance, jurisdiction over this matter rests with the Director. Consequently, we vacate the ALJ's order and dismiss claimant's hearing request.

Finally, we note that pursuant to section 42(d)(5) of Senate Bill 369 neither the ALJ nor the Board may award penalties or attorney fees for matters arising under the review jurisdiction of the Director. (SB 369 § 42(d). Because claimant sought penalties and attorney fees based on the insurer's processing of the vocational assistance claim and since jurisdiction over vocational assistance matters rests with the Director, it follows that neither we nor the ALJ are authorized to consider claimant's penalty/attorney fee request. Accordingly, we also vacate those portions of the ALJ's order which awarded an attorney fee under ORS 656.382(1).

## ORDER

The ALJ's order dated December 30, 1994 is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

**Board Member Gunn specially concurring.**

I acknowledge that this holding is compelled by the Board's holding in Ross M. Enyart, 47 Van Natta 1540 (1995), which was based on the decisions reached in Volk v. America West Airlines, 135 Or App 565 (1995), and Walter L. Keeney, 47 Van Natta 1387 (1995).

However, the holding in this case further exemplifies and substantiates my concerns expressed in Keeney and Enyart. In sum, those concerns were the egregious effects of retroactively altering the rights and obligations of the parties, who have litigated their dispute in reliance on the law in effect at the time of their actions; and the failure of the workers' compensation system to live up to providing a fair and just administrative system that, to the greatest extent practicable, reduces litigation. ORS 656.012(2)(b).

Here, the Director, relying on former OAR 436-120-025(1)(b), concluded that claimant was a "seasonal or temporary" employee. Basing claimant's wages for determining eligibility for vocational assistance on earnings for the 52 weeks preceding the injury, the Director concluded that a suitable wage was $4.75 per hour. Thus, the Director held that claimant did not have a substantial handicap to employment, and was not eligible for vocational assistance.

The ALJ found former OAR 436-120-025(1)(b) inapplicable because claimant had not collected unemployment benefits in the 52 weeks prior to his injury. Accordingly, the ALJ concluded that the Director should have applied former OAR 436-120-005(6)(a)(A) to determine claimant's eligibility for vocational assistance.

At the time of the ALJ's order the law was settled in regard to the issue presented in this case. See Keith D. Kilbourne, 46 Van Natta 1837 (1994). 656.283(2)(a)). In short, under OAR 436-120-005(6)(a)(A), the ALJ properly determined that claimant is entitled to vocational assistance because his injury has precluded him from obtaining employment within 20 percent of his regular employment wage ($12.00 per hour).

Given that SB 369 applies retroactively to this case, I document the absurd path this case must now follow. First, the Director has already ruled on whether claimant is entitled to vocational assistance. Second, now that this case must return to the Director, it is unclear what, if any, significance will be placed on the record already developed in this case. Third, considering further Director review will effectively involve modification of procedural limitations, I have serious doubts as to whether such a procedure is consistent with section 66(6) of Senate Bill 369. Fourth, even if the Director reverses his order, claimant will probably not receive his vocational assistance until another 2 years of additional litigation have passed.

As such, I am hard pressed to acknowledge that the legislative mandate, to provide "just" "fair" and expedient disposition of claims while reducing litigation is in any way furthered by the retroactive application of SB 369. Therefore, I concur with the decision, but do so with regret in that we have allowed the retroactive legislation to uproot the objectives upon which the workers' compensation law is founded.

---



In the Matter of the Compensation of
**DAVID J. ARONSON, Claimant**
WCB Case No. 94-10772
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

On July 25, 1995, we withdrew our June 27, 1995 Order on Review that affirmed the Administrative Law Judge's (ALJ) order that increased claimant's scheduled permanent disability award for loss of use and function of the right thumb from 12 percent (5.76 degrees), as awarded by an Order on Reconsideration, to 21 percent (10.08 degrees). We took this action to consider claimant's contention that, in light of the passage of Senate Bill 369, Or Laws 1995, ch 332 § 17 (SB 369, § 17), his award of permanent partial disability should be paid at the higher rate of $347.51 per degree, rather than $305 per degree, as set forth in former ORS 656.214(2). Since the SAIF Corporation has not responded within the time set forth in our July 25, 1995 order, we now proceed with our reconsideration.

The sole issue on review was the extent of scheduled permanent disability. On reconsideration, claimant raises an issue that pertains not to the extent of disability, but to SAIF's eventual actions in processing the claim, i.e., the rate at which the permanent partial disability award affirmed on review shall be paid.

Because SAIF has yet to process the claim in response to our order, any ruling regarding the applicable rate for claimant's permanent disability benefits would be premature and advisory in nature. See, e.g., James J. Sheets, 44 Van Natta 400 (1992). If claimant subsequently disagrees with SAIF's actions in paying the permanent disability award granted by our order, he may seek a hearing concerning that matter. See ORS 656.283(1). The issue will be ripe at that time.

Accordingly, on reconsideration, as supplemented herein, we republish our June 27, 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
**ALDA S. CARBAJAL, Claimant**
WCB Case No. 94-05806
ORDER ON RECONSIDERATION
Gatti, Gatti, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our September 8, 1995 Order on Review which directed the self-insured employer to pay temporary disability benefits from January 6, 1994, until termination is authorized by law. Claimant contends that we erred in failing to award temporary disability from August 10, 1993, based on an October 1992 release to light work from claimant's treating chiropractor, Dr. Bolin. In support of this contention, claimant asserts that Dr. Bolin served as claimant's attending physician under a Managed Care Organization (MCO) agreement. As such, claimant contends, Dr. Bolin could authorize time loss benefits beyond the normal statutory limitations on authorization of time loss by a chiropractor. Thus, claimant argues, she is entitled to temporary disability from August 10, 1993.

After review of the entire record, we find no evidence to support claimant's assertions that she was covered by an MCO agreement or that her referral from her initial treating chiropractor, Dr. Cummings, to Dr. Bolin occurred because Dr. Bolin was a member of an MCO. (Exs. 6-1, 7-4, 10-2, 15-1, 15-2, 19-2, 19-3, Tr. 10, 23-25, 29, 35-37). In other words, there is no evidence to support claimant's attorney's assertions that Dr. Bolin was authorized to continue serving as attending physician beyond the 30 day/12 treatment statutory limitation because he was a member of an MCO. In fact, the only evidence relating to Dr. Bolin's authority to serve as attending physician comes from a vocational rehabilitation consultant who stated that, as a chiropractor, Dr. Bolin was not qualified to serve as claimant's attending physician. (Exs. 19-2, 19-3).

Finally, claimant makes no showing that, with due diligence, she could not have obtained evidence at the time of the hearing as to whether she was covered by an MCO agreement or that Dr. Bolin served as her attending physician under a MCO agreement. Thus, to the extent that claimant's assertions could be interpreted as a motion to remand for the taking of additional evidence, such a request would be denied. See Kienow's Food Stoves v. Lyster, 79 Or App 416 (1986). Consequently, we adhere to our prior order.

Accordingly, we withdraw our September 8, 1995 order. On reconsideration, as supplemented herein, we adhere to and republish our September 8, 1995 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---



In the Matter of the Compensation of
**DEBORAH A. JOHNSTON, Claimant**
WCB Case No. 94-12071
ORDER ON REVIEW
Max Rae, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) increased claimant's unscheduled permanent disability award from 8 percent (25.6 degrees), as awarded by an Order on Reconsideration, to 20 percent (64 degrees); and (2) awarded claimant's attorney a $500 assessed attorney fee. Claimant cross-requests review, contending that she is entitled to additional unscheduled permanent disability benefits. 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 Disability

The only issue in dispute is claimant's adaptability factor. The parties contest both claimant's base and residual functional capacities. We begin with the base functional capacity (BFC).

The ALJ concluded that, based on one of claimant's pre-injury jobs as a stock clerk, her base functional capacity (BFC) was heavy. See DOT 22.367-042 (stock clerk is a heavy strength position). SAIF asserts that, because a stock clerk has a Specific Vocational Preparation (SVP) value of 4, which equates to a 3 to 6 month training time, and because claimant worked in that position for only two months, the ALJ should have relied on claimant's at-injury, light strength job as a cashier-checker to ascertain her BFC. We disagree.

Claimant's BFC is the highest strength category assigned to the DOT for the most physically demanding job she successfully performed in the five years before determination. 436-35-310(4)(a). If, however, claimant does not meet the requirements of OAR 436-35-300(3), her BFC is based on her job at injury. OAR 436-35-310(4)(c). Claimant can meet the requirements of OAR 436-35-300(3) only if she completed employment for a particular job for the maximum period specified in the SVP table in OAR 436-35-300(4). OAR 436-35-300(3)(b)(A).

The ALJ based claimant's BFC on her pre-injury stock clerk job. That position has an SVP of 4, for a maximum training period of 6 months. OAR 436-35-300(4); DOT 299.367-014. Claimant worked in a full-time stock clerk position in January and February 1991. From then, however, until her injury in March 1993, she intermittently performed stock clerk duties. (See Tr. 24). Because claimant performed stocking duties for more than six months, we find that, on this record, claimant has met the requirements of OAR 436-35-300(3) with respect to the stock clerk position.

That claimant performed the stock clerk duties on less than a full-time basis after February 1991 does not detract from this conclusion. See Lorene E. Yost, 43 Van Natta 2321 (1991) (claimant's part-time work held sufficient to meet SVP time required for that job). Therefore, we reject SAIF's argument under OAR 436-35-310(4)(c). Rather, we conclude that, because the stock clerk position was the most physically demanding job that claimant successfully performed in the five years before determination, OAR 436-35-310(4)(a), and because that is a heavy strength position, DOT 299.367-014, the ALJ correctly relied on that job to conclude that claimant's BFC was heavy.

We turn to the residual functional capacity (RFC) issue. The ALJ concluded that claimant's RFC was medium/light. SAIF asserts that claimant's RFC is indeterminable or light; claimant asserts that her RFC is light. We agree with the ALJ.

SAIF first asserts that, because neither the treating physician nor the medical arbiters restricted claimant's post-injury employment, she has failed to establish that she was not released to her regular work. We disagree.

Neither the treating physician nor the medical arbiters specifically addressed claimant's RFC. Therefore, we do not rely on their reports in evaluating claimant's RFC. Rather, we rely on a "pre-reconsideration order" work hardening program discharge summary indicating that claimant is capable of occasionally lifting and carrying 40 pounds. (Ex. 14B-1). That places her in the medium/light strength category. OAR 436-35-310(3)(g). Accordingly, we affirm the ALJ's conclusion to that effect.

SAIF asserts that, under Koitzsch v. Liberty Northwest Insurance Corp., 125 Or App 666, on remand Arlene J. Koitzsch, 46 Van Natta 1563, 46 Van Natta 2265 (1994), we are prohibited from considering the discharge summary "for the rating of claimant's impairment." SAIF's Appellant's Brief at 5. We disagree.

Koitzsch holds that ORS 656.245(3)(b)(B) prohibits the use of carrier-requested medical examinations to impeach an attending physician's impairment findings. The issue in this case is, however, adaptability. We consider impairment and adaptability separately when we evaluate a worker's disability. See ORS 656.726(3)(f)(A) ("[t]he criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment as modified by the factors of age, education and adaptability to perform a given job."); OAR 436-35-270(2) (same); see also Roseburg Forest Products v. Owen, 129 Or App 442, 445-46 (1994) (distinguishing adaptability from impairment). Because Koitzsch did not concern the admissibility of evidence regarding a worker's adaptability to perform a particular job, we reject SAIF's argument regarding that case.

SAIF also asserts that the ALJ erred by relying on claimant's testimony in evaluating her RFC. Because we find the discharge summary sufficient to establish claimant's RFC, we need not address that argument.

Claimant asserts that, based on her testimony,[1] the "pre-reconsideration order" work hardening program discharge summary, and the medical arbiters' report, her RFC is light. We disagree.

Claimant has an RFC established between two categories -- light and medium. She is entitled to use the "light" classification if she has "restrictions." OAR 436-35-310(7). "Restrictions" means that a worker is permanently limited "[f]rom frequently performing at least two of the following activities: stooping/bending, crouching, crawling, kneeling, twisting, climbing, balancing, reaching, or pushing/pulling." OAR 436-35-310(3)(l)(C).

Here, the medical arbiters found that claimant was "unable to repetitively use her right shoulder in an elevated position above the parallel level in a repetitive manner." (Ex. 21-3). We find that that constitutes a restriction on reaching. Because, however, that is the only activity restriction, claimant is not entitled to use the "light" classification in evaluating her RFC. Instead, as the ALJ correctly concluded, claimant's RFC is medium/light.

Claimant asserts that the work hardening discharge summary restricted her from frequent bending, kneeling, crawling, stairs, inclines, ladders and overhead work. We disagree. To the extent that the discharge summary addressed those activities, it reported claimant's "demonstrated ability" to perform them; it did not restrict claimant from performing any activities. (See Ex. 14B-1).

Claimant also asserts that her testimony establishes that her RFC is light. Although claimant's post-injury job involved lighter strength activities, claimant testified that her condition had not changed much since she left the work hardening program. (Tr. 19). In view of that testimony, and the fact that the medical arbiters examined claimant nearly a year after she left the work hardening program (see Exs. 14B and 21), we find claimant's testimony insufficient to alter our conclusion that her RFC is medium-light.

In reaching this conclusion, we note that claimant appears to argue that OAR 436-35-310(5) is invalid, because it requires medical, as opposed to lay, evidence regarding a worker's RFC, whereas, according to claimant, the Workers' Compensation Act imposes no such requirement.[2] Because we have declined to rely on claimant's lay testimony in assessing her RFC, we do not address that argument.

In sum, we agree with the ALJ's conclusion that claimant's adaptability value is 4 and that she is 20 percent disabled. Accordingly, we affirm the ALJ's award of 20 percent unscheduled permanent disability.

Attorney Fees

The ALJ awarded claimant's attorney a $500 assessed attorney fee pursuant to former ORS 656.386(1) for establishing an earlier injury date than that alleged in claimant's claim. We conclude that claimant is not entitled to a fee under ORS 656.386(1).

When 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 under ORS 656.386(1) is not

---

[1] Amended ORS 656.283(7) prohibits us from considering "[e]vidence on an issue regarding a notice of closure or determination order that was not considered at the reconsideration required by ORS 656.268 * * *." Or Laws 1995, ch 332, § 34 (SB 369, § 34). We need not consider the applicability of that amended statute because, even if we considered claimant's testimony at hearing, such evidence would not alter our ultimate decision.

[2] RFC is the greatest capacity evidenced by the attending physician's release or a preponderance of the medical opinion. OAR 436-35-310(5).

authorized. Short v. SAIF, 305 Or 541, 545 (1988); Glenn C. Smith, 47 Van Natta 1568 (1995).[3] Here, the dispute concerns SAIF's calculation of claimant's benefits based on an erroneous injury date. Consequently, we find that this dispute concerns the amount of extent of claimant's compensation and, therefore, that she is not entitled to an attorney fee under ORS 656.386(1). For these reasons, we reverse the ALJ's assessed attorney fee award.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the permanent disability issue is $1,000, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated March 17, 1995 is affirmed in part and reversed in part. The ALJ's assessed attorney fee is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the SAIF Corporation.

---

[3] The Legislature recently amended ORS 656.386(1). SB 369, § 43. Because we believe that Short applies to both the former and amended versions of that statute, we need not address the amendments.

---



In the Matter of the Compensation of
**MICHELLE T. NAGMAY, Claimant**
WCB Case No. 95-00286
ORDER ON REVIEW (REMANDING)
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of her aggravation claim for a left knee condition. Claimant also requests that the case be remanded to the ALJ for submission of further evidence. On review, the issues are remand and aggravation. We remand.

Claimant moves for remand alleging that, following the hearing, she underwent repeat arthroscopic surgery on her left knee. Claimant argues that a compelling reason exists for remanding because the Operative Report from this surgery, which was not in existence at the time of hearing, sheds additional light on whether claimant's need for surgery resulted from her 1988 compensable injury to the medical collateral ligament or from a 1981 noncompensable fracture of her tibial plateau. We agree.

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, e.g., Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

In this case, the record includes the (pre-surgery) opinion of Dr. Cook, claimant's treating doctor and surgeon, indicating that her current left knee condition and need for treatment relate to her 1988 compensable injury. (Ex. 32). The record also includes a contrary opinion by Dr. Gambee that claimant's noncompensable 1981 knee fracture is more "etiologically significant" to her present complaints than her 1988 compensable injury. (Ex. 27).

The ALJ was not persuaded by Dr. Cook's opinion because Dr. Cook did not explain why the 1988 injury would be more of a cause of claimant's current need for treatment than the 1981 fracture. Consequently, the ALJ determined, among other things, that claimant had failed to establish by a preponderance of the evidence that her compensable injury was the major cause of her current condition and need for treatment.

Given the facts of this case, we find a compelling reason to remand. Without the operative report, the record is incompletely developed. To the extent this "post-hearing" report addresses the nature and cause of claimant's current left knee condition and adds support to Dr. Cook's prior opinion, it is reasonably likely to affect the outcome of the case. See Parmer v. Plaid Pantry #54, 76 Or App 405 (1985) (Where the proffered evidence concerning the claimant's post-hearing surgery "vindicated" the treating physician's prior opinion that the work injury was merely a possible cause of the claimant's need for treatment, the Board abused its discretion by not remanding the case to the referee). See also Wanda Kelley, 47 Van Natta 146 (1995) (remand is appropriate where evidence of post-hearing surgery is relevant to the nature and cause of the claimant's left knee condition and reasonably likely to affect outcome of the case).

Accordingly, we find that the case should be remanded to the ALJ for the taking of additional evidence, including the post-hearing surgery report proffered by claimant. In addition, the ALJ shall allow the insurer an opportunity to cross-examine the authors of this additional evidence and/or present rebuttal evidence. The ALJ shall conduct further proceedings in any manner that will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

In light of our decision to remand, we do not address claimant's other contentions on review.

ORDER

The ALJ's order dated April 20, 1995 is vacated. This case is remanded to ALJ Podnar for further proceedings consistent with this order.

---

October 6, 1995 Cite as 47 Van Natta 1953 (1995)

In the Matter of the Compensation of
**DEBRA L. LAY, Claimant**
WCB Case No. 95-01137
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed the Order on Reconsideration's award of 19 percent (60.80 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of disability, scheduled and unscheduled.

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

A September 16, 1994 Determination Order awarded claimant temporary total disability and 19 percent unscheduled permanent disability for a disabling low back injury. The insurer (and not claimant) requested reconsideration of the Determination Order. The Order on Reconsideration affirmed the Determination Order in all respects. Claimant then requested a hearing on the Order on Reconsideration, alleging entitlement to additional unscheduled permanent disability and entitlement to scheduled permanent disability.

The ALJ determined that claimant was foreclosed from challenging the Order on Reconsideration based on Duncan v. Liberty Northwest Insurance Corp., 133 Or App 605 (1995). In Duncan, the Court of Appeals held:

> "When a party objects at 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 [former] ORS 656.268(5)[1] forecloses the objection if no request for reconsideration was made. Thus the determination order becomes the instrument that defines the maximum or minimum awards when a party fails to raise its objections through a request for reconsideration." Id. at 611.[2]

On review, claimant contends that Duncan is distinguishable because the issue in that case was compensability whereas the issue in this case is the extent of permanent disability. Claimant argues that while an insurer who fails to challenge the compensability of an injury on reconsideration may be precluded from raising the issue at hearing, a claimant is not precluded from seeking additional permanent disability at hearing based on the medical arbiter's report even though that claimant did not request reconsideration of the Determination Order. We disagree.

In Duncan, the court framed the issue as "what effect the failure to request reconsideration has on a party's right to subsequently raise issues" and determined that the failure of a party to request reconsideration of a Determination Order will bar that party's subsequent challenge to the Determination Order at hearing in those cases where the reconsideration order "affirms the determination order." Any question concerning the application of this rule in an "extent" case was resolved by Diane's Foods v. Stevens, 133 Or App 707 (1995). There, relying on Duncan, the court held that a party could not challenge a Determination Order award of permanent partial disability at hearing if it did not request reconsideration of that award under former ORS 656.268(5).

Based on Duncan and Stevens, claimant may not seek additional permanent disability at hearing because she did not request reconsideration of the Determination Order awarding 19 percent.

To the extent claimant contends that Leslie v. U.S. Bancorp, 129 Or App 1 (1994), holds to the contrary, she is incorrect. In Leslie, the employer issued a notice of closure on the claimant's claim awarding unscheduled permanent disability and time loss. Claimant requested reconsideration, and the Department increased claimant's unscheduled permanent disability and awarded additional temporary disability benefits. Claimant requested a hearing, asserting, among other things, that she was entitled to scheduled permanent disability, as well as additional unscheduled permanent disability. The court held that neither former ORS 656.268(4)(e) nor former ORS 656.283(7) precluded the claimant from raising her entitlement to scheduled permanent disability for the first time at hearing. Leslie is clearly distinguishable from the instant case because there, the claimant requested reconsideration. Moreover, Leslie involved ORS 656.268(4)(e) rather than ORS 656.268(5)(b).

## ORDER

The ALJ's order dated April 28, 1995 is affirmed.

---

[1] Former ORS 656.268(5)(b) provided: "If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order." This section has since been amended by Senate Bill 369, which added the phrase, "[t]he request for reconsideration must be made within 60 days of the date of the determination order." Or Laws 1995, ch 332, § 30(5)(b) (SB 369, § 30(5)(b). This particular provision is not retroactively applicable. SB 369, § 66(4).

[2] Moreover, subsequent to Duncan, ORS 656.268 was amended to provide 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, § 30(8).

In the Matter of the Compensation of
**LORRAINE L. RENARD, Claimant**
WCB Case No. 94-08706
ORDER ON REVIEW
Thomas Coleman, Claimant Attorney
Peter Davis (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that upheld the SAIF Corporation's denial of her occupational disease claim for a mental disorder. On review, the issue is compensability.

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

The ALJ determined that claimant failed to sustain her burden of proving a compensable mental disorder under former ORS 656.802(2) and (3). Specifically, the ALJ found that claimant's employment conditions were not the major contributing cause of her mental disorder, and that the employment conditions allegedly producing her mental disorder (the perceived sexual or offensive touching by her supervisor) did not exist in a real and objective sense. The ALJ also found that, although claimant's arm may have been inadvertently touched by some part of her supervisor's body as he leaned over her to assist her with a computer program, such inadvertent contact is a condition generally inherent in every working situation.

On this record, we conclude, as did the ALJ, that the contact that likely occurred between claimant and her supervisor was, like the contact at issue in Fuls v. SAIF, 129 Or 255 (1994), innocent and non-tortious. We distinguish innocent and truly unintentional contact from contact of a sexual nature, which is not to be tolerated and is not considered a condition generally inherent in every working situation.

Claimant's first contention on review is that we should remand the case to the Hearings Division in light of the Senate Bill 369 amendments to ORS 656.802 (Or Laws 1995, ch 332, § 56 (SB 369, § 56)). We disagree.

We may remand for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or some other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In this case, claimant does not indicate what, if any, additional evidence she could present which would alter our decision. Further, she does not contend, nor do we find, that the record is incompletely or insufficiently developed. Accordingly, we see no compelling reason to remand this case.

Claimant next argues that the retroactive application of SB 369 violates her rights under the Oregon and United States Constitutions.[1] Because we find that the legislative amendments to ORS 656.802 are not pertinent to the outcome of this case, and the result would be the same under either version of the statute, we decline to address this argument.

Former ORS 656.802(2), which was in effect when the ALJ decided this case, provided that the worker must show that the employment conditions were the major contributing cause of the disease or its worsening. Amended ORS 656.802(2)(a) retains this same standard. Although SB 369 added provisions to deal with the worsening of a preexisting disease and the contribution of a preexisting condition (see amended ORS 656.802(b) - (e)), these new provisions are not determinative in this case. Claimant has made a claim for a mental disorder arising out of her employment conditions. Her claim is not based on the worsening or combining of a preexisting disease or condition.

---

[1] See Volk v. America West Airlines, 135 Or App 565 (1995) (Unless specifically excepted from retroactive application by section 66, the provisions of Senate Bill 369 apply retroactively to all pending cases).

Moreover, the only substantive change to the "mental disorder" provisions of ORS 656.802 is the addition of the phrase "or employment decisions attendant upon ordinary business or financial cycles" to subparagraph (3)(b). See SB 369, § 56(3)(b). Since this case does not involve such an employment decision, the retroactive application amended ORS 656.802(3) does not alter our determination of the compensability of claimant's claim.

Claimant also argues that to the extent ORS 656.802(3) requires claimants with mental disorder claims to prove the additional element that the employment conditions causing the mental disorder are conditions not generally inherent in every working condition, the statute is discriminatory. Specifically, claimant contends that ORS 656.802(3)(b) violates the Americans With Disabilities Act ("ADA"), 42 U.S.C. § 12132, and is therefore preempted by federal law.

We decline to address this "preemption" argument because it is an issue being raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not raised at hearing). At hearing, claimant's counsel agreed that the only issue to be resolved was the compensability of claimant's occupational disease claim. (Tr. at 2). Since claimant had the burden of proving that the employment conditions causing her mental disorder were conditions other than those generally inherent in every working situation under former ORS 656.802(3), claimant's contention that this requirement is in violation of federal law could have been raised at hearing. Because claimant did not raise this argument until now, we do not consider it.

Claimant also argues on review that amended ORS 656.802(2)(e) (which was not yet enacted at the time of hearing) violates state and federal handicap discrimination law because it treats preexisting conditions as causative factors. Because this new provision is not determinative in this case, we also decline to address this argument on review.

Finally, claimant argues that the ALJ did not give due consideration to the opinion of claimant's treating physician, Dr. Paltrow. Dr. Paltrow's opinion that claimant has a psychiatric condition that is caused in major part by her work is based on the assumption that claimant was being sexually harassed by her supervisor. Because Dr. Paltrow's conclusion is not accompanied by a thorough explanation and is based on an inaccurate history, it is unpersuasive.[2] See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (medical opinion that is not based on a complete and accurate history is less persuasive).

ORDER

The ALJ's order dated May 4, 1995 is affirmed.

[2] This is especially true considering claimant's burden in this case. Under ORS 656.802(3)(d), a claimant must prove by clear and convincing evidence that her mental disorder arose out of and in the course of her employment.

---



In the Matter of the Compensation of
**STEPHEN M. SNYDER, Claimant**
WCB Case No. 93-02957
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 that portion of Administrative Law Judge (ALJ) Davis' order that awarded claimant temporary partial disability (TPD) benefits after March 30, 1993. Claimant cross-requests review of those portions of the order that: (1) declined to award interim compensation prior to January 14, 1993; and (2) declined to assess penalties or attorney fees for the employer's allegedly unreasonable claim processing. On review, the issues are interim compensation, temporary partial disability, penalties and attorney fees. We affirm in part, modify in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for his findings of ultimate fact. In addition, we offer the following summary of the pertinent findings and procedural history.

Claimant was compensably injured at work on December 2, 1992. At the time of injury, claimant was working part-time, earning $7.00 an hour.

Claimant left work at 11 a.m. on December 2, 1992. Dr. Matteri, orthopedic surgeon, began treating claimant on December 4, 1992. On that date, Dr. Matteri released claimant to "sit down work only." The employer first knew of claimant's injury claim on December 4, 1992.

On January 11, 1993, the employer wrote claimant and advised him to report for modified work before January 18, 1993. The employer did not submit a description of the proposed modified job to Dr. Matteri nor did Dr. Matteri provide claimant with a written release to return to modified work. Claimant began the modified job on January 14, 1993. He worked five hours a day, two days a week. Claimant was paid his at-injury wage of $7.00 an hour.

By letter dated March 4, 1993, the employer accepted the claim as disabling. The employer did not pay interim compensation pending claim acceptance. On March 30, 1993, the employer terminated claimant from the modified job for reasons unrelated to the work injury. Claimant remained released for modified work only. The employer did not pay TPD after claimant was terminated from modified work.

Claimant requested a hearing. Initially, the ALJ declined to award interim compensation. Further, citing Safeway v. Owsley, 91 Or App 475 (1988), the ALJ reasoned that claimant was entitled only to the amount of temporary disability compensation that he would have received if his employment had not been terminated. Because the modified work paid $7.00 an hour, the same hourly rate as the job at-injury, the ALJ concluded that that amount was zero.

Claimant appealed to the Board. Noting that subsequent to the ALJ's decision, the court issued Stone v. Whittier Wood Products, 124 Or App 117 (1993), we remanded to the ALJ. Stephen M. Snyder, 46 Van Natta 1201 (1994). In our original order, we instructed the ALJ to take evidence concerning claimant's proportionate loss of earning power at any kind of work, and to consider the effects, if any, of the Director's post-Stone rules on the interim compensation and TPD issues.

The ALJ convened a second hearing to receive written and testimonial evidence. On remand, the ALJ awarded claimant interim compensation effective January 14, 1993, the date claimant "ma[d]e himself available" for modified work.

The ALJ also found that, although the administrative rules in WCD Admin. Order No. 94-055 do not expressly apply, those rules nevertheless embody the court's directive in Stone v. Whittier Wood Products, supra, and thus serve as useful guidelines for resolving TPD disputes. On the supplemented record, the ALJ concluded therefore that claimant's post-injury earning power was diminished, entitling him to TPD after he was terminated from modified work on March 30, 1993. Finally, finding that, at the time claimant's disability arose, the employer was following established law, the ALJ declined to award penalties and attorney fees.

## CONCLUSIONS OF LAW AND OPINION

On review, the employer argues that claimant is not entitled to temporary partial disability benefits (TPD) after he was terminated from modified work because he failed to prove an actual loss of earning capacity as a result of the compensable injury. In his cross-request for review, claimant contends that he is entitled to interim compensation prior to January 14, 1993, and to penalties and attorney fees for the employer's failure to pay interim compensation.

Subsequent to the ALJ's order on remand, the legislature passed Senate Bill 369 (SB 369), which became effective June 7, 1995.[1] The bill, which is applicable in this case,[2] amended, *inter alia*, ORS 656.210(3), 656.212, and 656.262(4)(a). We first address claimant's entitlement to interim compensation.

Interim Compensation

The ALJ found claimant entitled to interim compensation from January 14, 1993 (the date claimant began modified work), through March 4, 1993 (the date of the employer's acceptance). For the reasons discussed below, we find that claimant's entitlement to interim compensation begins on December 5, 1992. We modify the ALJ's award accordingly.

"Interim compensation" is temporary disability payments made between the employer's notice of injury and the acceptance or denial of the claim. Bono v. SAIF, 298 Or 405, 407 n. 1 (1984). In the present case, the claim has been accepted. A claimant's entitlement to interim compensation is triggered by the carrier's notice or knowledge of the claim, if the attending physician verifies an injury-related inability to work. See amended ORS 656.262(4)(a).[3]

Although a claimant is entitled to interim compensation whether or not the claim is proven compensable, there is no duty to pay such compensation if the worker has not "left work" as a result of the injury pursuant to amended ORS 656.210(3). See Bono v. SAIF, supra, 298 Or at 408, 410. A worker may "leave work" by either being absent from work or by losing wages due to the work injury. See amended ORS 656.210(3). However, a claimant who is absent from work for reasons not related to the injury is not entitled to interim compensation. See Bono v. SAIF, supra, 298 Or at 408; Nix v. SAIF, 80 Or App 656 (1986).

Here, claimant left work due to the compensable injury on December 2, 1992. On December 4, 1992, Dr. Matteri released him to return to modified work and notified the employer of claimant's injury-related inability to work. On January 14, 1993, claimant returned to modified work. Thus, claimant was away from work due to the compensable injury for approximately six weeks. Claimant is therefore entitled to interim compensation during that period.

Pending issuance of its acceptance, the employer did not pay interim compensation. The employer contends that because claimant failed to begin modified work until January 14, 1993, claimant did not "leave work" due to his compensable injury until that date, thereby relieving the employer of its duty to pay interim compensation. We disagree. Claimant "left work" both by being absent from work and by suffering a loss of earnings as the result of the work restrictions placed on him by Dr. Matteri.[4]

Interim compensation is due and payable beginning 14 days after the date upon which the employer receives notice or knowledge of the claim and verification from the attending physician as to the worker's injury-related inability to work. Amended ORS 656.262(4). Since such notice was provided to the employer on December 4, 1992, interim compensation became due and payable 14 days later (December 18, 1992). Consequently, claimant is entitled to interim compensation (in the form of temporary disability) payable in the manner set forth in amended ORS 656.262(3) through March 4, 1993

---

[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).

[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. American West Airlines, 135 Or App 565 (1995).

[3] Amended ORS 656.262(4)(a) now provides, in pertinent part: "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."

[4] Because we reject the employer's contention that an unaccepted offer of modified work somehow excuses its failure to comply with the requirements of ORS 656.262(4) that an employer begin paying interim compensation within 14 days after the date it receives notice of a claim, we do not reach claimant's argument that the employer's offer of modified work was defective because it failed to strictly comport with the requirements of ORS 656.268(3) concerning termination of TTD.

(the date of the employer's acceptance). Claimant's attorney is awarded 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. ORS 656.386(2).

Penalties and Attorney Fees

On review, claimant argues that the ALJ should have imposed a penalty for the employer's failure to pay interim compensation. Applying the law in effect at the time the employer had notice of claimant's injury and verification of injury-related inability to work (which is consistent with the amended statutes), we agree.

As the Court has noted, ORS 656.262 gives the employer two choices: deny the claim or make interim payments. Jones v. Emanuel Hospital, 280 Or 147, 151 (1977). We find that it was unreasonable for the employer not to have addressed claimant's entitlement to interim compensation at any time prior to its March 4, 1993 acceptance. Moreover, as explained above, by December 4, 1992, the employer had notice that claimant had left work due to his injury (both by being absent from work and as a result of Dr. Matteri's restrictions from regular work). Given the clear requirements of the statute and established case law, we conclude that the employer's failure to pay interim compensation constitutes an unreasonable refusal to pay compensation. Amended ORS 656.262(11); Petronilo Lopez, 45 Van Natta 1136 (1993).

Accordingly, we assess a 25 percent penalty based on any interim compensation due and payable by this order, such penalty to be shared equally by claimant and his attorney. Amended ORS 656.262(11)(a).

Temporary Partial Disability After March 30, 1993

The employer contests the ALJ's award of temporary compensation after March 30, 1993, when claimant was terminated from modified work. A claimant is entitled to temporary disability compensation if he 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. Matteri, his attending physician, to his regular job. Because his disability was partial, claimant is entitled to temporary partial disability benefits during the period in question. Amended ORS 656.212; David L. Gooding, 47 Van Natta 1468 (1995); Ricardo Morales, 47 Van Natta 1394 (1995). Accordingly, we agree with the ALJ that claimant is entitled to TPD after March 30, 1993.[5] However, we note that claimant's rate of TPD may well be zero under the amended statute.

ORDER

The ALJ's order dated August 27, 1993, as modified October 31, 1994, is affirmed in part, modified in part and reversed in part. In lieu of the interim compensation awarded by the ALJ, claimant is awarded interim compensation payable in the manner set forth in amended ORS 656.262(3) through March 4, 1993. Claimant is also awarded a 25 percent penalty based on any interim compensation due and payable by this order, to be shared equally by claimant and his counsel. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly by the employer to claimant's attorney. The remainder of the ALJ's order is affirmed.

[5] Under amended ORS 656.212, TPD is calculated based on a comparison of claimant's wages at modified employment and his at-injury wages. 1995 Or Laws ch 332, § 16 (SB 369, § 16). We have determined herein that claimant is entitled to TPD after March 30, 1993. It is up to the self-insured employer to process the claim to closure under ORS 656.268 and to 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
**PATRICIA A. VOLDBAEK, Claimant**
WCB Case Nos. 94-07550 & 94-05662
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys
Robert J. Yanity (Saif), Defense Attorney

Reviewed by Board Members Christian, Neidig and Gunn.

Liberty Northwest Insurance Corporation requests review of Administrative Law Judge (ALJ) Mills' order which: (1) set aside Liberty's partial denial of claimant's current left wrist condition; and (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for the same condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Scope of Liberty's Acceptance

The ALJ determined that claimant's tenosynovitis was a symptom of claimant's preexisting psoriatic arthritis. As such, the ALJ, relying on Georgia-Pacific v. Piwowar, 305 Or 494 (1988), found that Liberty's acceptance of a symptom (tenosynovitis) was acceptance of the cause of the symptom (i.e., the psoriatic arthritis).

On review, Liberty asserts that Piwowar does not apply because claimant's tenosynovitis was not merely a symptom of her psoriatic arthritis. Therefore, according to Liberty, its acceptance of claimant's tenosynovitis was not also an acceptance of her preexisting psoriatic arthritis. We agree.

A carrier's acceptance of a claim includes injuries or conditions specifically accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). However, where a carrier has accepted a symptom of a disease, it is deemed to have also accepted the underlying disease causing that symptom. Georgia Pacific v. Piwowar, supra.

At first glance, Piwowar appears to be analogous to the present case. However, the evidence available to Liberty at the time it accepted claimant's claim shows that her tenosynovitis was not merely a symptom of her psoriatic arthritis.

Here, claimant filed an "801" claim form for "inflamed tendons-swollen with fluid." (Ex. 6). The employer indicated on its portion of the "801" form, that claimant had "inflamed tendons in hand." Id. Liberty initially deferred claimant's claim by checking the boxes labeled "deferred," "disabling," and "injury" on the "801" form.

Thereafter, Liberty received several reports from Dr. Hauge, claimant's treating physician. Dr. Hauge reported that he has treated claimant since November 1989 "for arthritic problems related to [her] psoriatic arthritis." (Ex. 8). Dr. Hauge diagnosed claimant's condition as "acute inflammatory synovitis." (Ex. 5D). He opined that claimant's work activities for Liberty's insured "played a major role in precipitating and exacerbating degenerative processes associated with [claimant's] arthritis." (Ex. 11). Dr. Hauge performed a tenosynovectomy on claimant's extensor tendons to treat claimant's tenosynovitis. Based on this medical information, Liberty accepted claimant's claim as "tenosynovitis left hand." (Ex. 7).

Considering these facts, we conclude that the scope of Liberty's acceptance was limited to tenosynovitis of the left hand, a specific condition diagnosed and treated by Dr. Hauge, which is separable from the psoriatic arthritis. Accordingly, we find that Liberty did not accept claimant's psoriatic arthritis.

Compensability/Responsibility

The ALJ found that claimant's current left wrist condition, diagnosed as left dorsal wrist ganglion, was the "same condition" which Liberty had previously accepted. The ALJ then determined that Liberty had failed to establish that the major contributing cause of claimant's disability was her work activities while working for SAIF's insured. Therefore, the ALJ concluded, that responsibility for claimant's current condition remained with Liberty. See former ORS 656.308(1).[1]

Liberty contends that claimant's current left wrist condition is not the "same condition" which it previously accepted. Therefore, according to Liberty, former ORS 656.308(1) is not applicable to the present case. Instead, Liberty asserts that responsibility should be assigned to SAIF under the "last injurious exposure rule."

Former 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). 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).

Here, Liberty accepted claimant's claim for "tenosynovitis left hand" in December 1990. (Ex. 7). Claimant's current condition was initially diagnosed by Dr. Busby as "recurrent left wrist dorsal ganglion cyst." (Ex. 24). The medical arbiters opined that claimant's tenosynovitis accepted by Liberty was medically stationary at the time of the October 1993 claim closure with no permanent impairment. (Ex. 34-2). The arbiters stated that they suspected Dr. Busby's diagnosis of left wrist ganglion would turn out to be "severe inflammatory tenosynovitis and not a ganglion." Id. The arbiters stated that claimant's current "inflammatory arthritis" was related to her psoriasis and not her work activity.

Dr. Button did not find any evidence of a "ganglion" on claimant's left wrist or hand during his examination. (Ex. 32-4). Dr. Button's diagnosis of claimant's current condition was psoriatic arthritis/synovitis of the left wrist. (Id at 6). Dr. Button opined that claimant's psoriatic arthritis was the major contributing cause of her current synovitis condition.

Dr. Duff diagnosed claimant's condition as chronic synovitis of the left wrist relating to her underlying psoriatic arthritis. (Ex. 29-3). Further, none of the doctors who examined or treated claimant have opined that her current left wrist condition is the same as the prior tenosynovitis accepted by Liberty in 1990.

Based on this medical evidence, we conclude that claimant's current condition is not the "same condition" as that which Liberty accepted in 1990. See Smurfit Newsprint v. DeRosset, supra. Accordingly, former ORS 656.308(1) does not apply.

Where former ORS 656.308(1) is not applicable, the last injurious exposure rule applies to assign responsibility. SAIF v. Yokum, supra; Jerald T. Kilby, 46 Van Natta 2487 (1994); Fred A. Nutter, 44 Van Natta 854 (1992). However, since the medical evidence supports a finding that claimant's current left wrist condition was caused by her preexisting psoriatic arthritis, not her employment activities, the issue of responsibility is moot.

Claimant asserts that her current condition is an occupational disease. Under such a theory, claimant must prove that the major contributing cause of her current condition was her work activities subsequent to her accepted compensable injury. See Stacy v. Corrections Division, 131 Or App 610, 614 (1994).

---

[1] After the ALJ's order, the legislature enacted Senate Bill 369, which amended ORS 656.308(1). Or Laws 1995, ch 332 § 37 (SB 369, § 37). We need not decide whether amended ORS 656.308(1) applies retroactively in this case because the outcome would be the same under either the former or amended version of ORS 656.308(1).

Only Dr. Busby opined that claimant's current condition was due to her work activities. (Ex. 39). However, Dr. Busby's opinion is unpersuasive because of its conclusory nature. Specifically, Dr. Busby offered no explanation as to why he believed that claimant's work was the major cause of her current condition in light of claimant's preexisting psoriatic arthritis. Moe v. Ceiling Systems, 44 Or App 429 (1980).

Dr. Button, opined that claimant's preexisting psoriatic arthritis was the major contributing cause of her on-going symptomatology. (Ex. 32-6). Dr. Button explained that when an arthritic wrist such as claimant's is placed under physical activity, it will result in swelling and pain. Dr. Button stated that these "symptoms" are the "visual manifestations" of claimant's underlying arthritis. He explained that claimant's arthritis has caused the bones in her wrist joint to become "ill-fitting." (Ex. 32-5). Thus, when claimant's wrist is placed under a work load, her body secretes excess synovial fluid in an attempt to keep the arthritic wrist well lubricated. Dr. Button stated that it is this secretion of excess synovial fluid which creates pressure within claimant's wrist joint, resulting in bulging, dorsal swelling and pain. Therefore, in Dr. Button's opinion, although claimant's work contributed to the onset of symptoms in her wrist, it was her underlying preexisting psoriatic arthritis which caused her condition. Because Dr. Button's opinion is well explained and based on an accurate history, we find it persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

Further, the medical arbiters stated that claimant's current tenosynovitis was not due to her work activity, but was due to her psoriatic arthritis. (Ex. 34-2). Dr. Duff diagnosed chronic synovitis relating to the underlying psoriatic arthritis. (Ex. 29-3). Dr. Duff opined that the major contributing cause of her tenosynovitis was the underlying arthritic process. (Id).

Based on this medical evidence, we are not persuaded that claimant's work activities were the major contributing cause of her current left wrist condition or its worsening. Instead, we conclude that the major contributing cause of claimant's current left wrist condition was her preexisting psoriatic arthritic disease. Consequently, claimant's current condition is not compensable, and Liberty's denial shall be upheld. Further, since claimant's current condition is not compensable, we also reverse that portion of the ALJ's order which assessed Liberty a penalty for unreasonable claim processing.

## ORDER

The ALJ's order dated November 3, 1994 is reversed in part and affirmed in part. Liberty Northwest's responsibility and compensability denials are reinstated and upheld. The ALJ's attorney fee and penalty awards are reversed. The remainder of the order is affirmed.

**Board member Gunn dissenting.**

Because Liberty is precluded from denying the compensability of claimant's psoriatic arthritis, I must respectfully dissent.

Liberty accepted claimant's claim for tenosynovitis in her left hand. Drs. Fuller, Duff, Button, Peterson and the medical arbiter all determined that claimant's tenosynovitis was a symptom/manifestation of claimant's "pre-existing psoriatic arthritis."

In Georgia-Pacific v. Piwowar, 305 Or 494 (1988), the Supreme Court held that a carrier cannot deny the compensability of an underlying disease process when that carrier accepts symptoms of that underlying disease.

Similarly, in this case claimant's tenosynovitis was a symptom of her psoriatic arthritis. Liberty accepted claimant's tenosynovitis. The medical evidence determined that claimant's psoriatic arthritis is the "underlying disease" which caused her accepted tenosynovitis condition. As such, I find that Liberty is precluded under Piwowar from denying the compensability of claimant's psoriatic arthritis. Consequently, I must respectfully dissent.

In the Matter of the Compensation of
**KATHRYN P. ENGLISH, Claimant**
WCB Case No. 94-10848
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Haynes and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Michael Johnson's order which set aside its denial of claimant's injury claim for a mid-back condition. On review, the issue is compensability. We reverse.

## 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

Claimant worked at a cherry processing plant. While claimant was sweeping the employer's parking lot, she went behind a stack of two totes (a heavy wooden box approximately two and one-half feet square) to work. As claimant was working behind the totes, a co-worker driving a forklift drove into position to lift the totes onto the forks of the forklift. The forklift driver was unaware that claimant was behind the totes. At the moment that the forks slid under the totes and began to lift them up, claimant was leaning up against the totes taking a break. Once the totes began to move, claimant was spun around and jumped out of the way.

The ALJ found that claimant sustained a compensable injury. In so doing, the ALJ relied on claimant's testimony to establish the compensability of her claim. On review, the insurer contends that claimant is not credible. Therefore, it asserts that claimant has not established the compensability of her claim

The ALJ's credibility finding was based on the substance of claimant's testimony, rather than on her demeanor and manner of testifying. When the issue of credibility concerns the substance of claimant's' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or app 282, 285 (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).

Because claimant is alleging that her current condition arose directly from an injury sustained at work, she must establish, by medical evidence, that her work activities were a material contributing cause of her disability or need for medical treatment. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Mark N. Wiedle, 43 Van Natta 855 (1991).

After our review of the record, we find material inconsistencies and unexplained discrepancies that cast doubt on claimant's reliability. For the following reasons, we conclude that claimant did not prove the compensability of her mid-back condition.

Claimant testified that she was injured when a forklift raised the totes that she was leaning up against. As the totes were being lifted, claimant stated that she was pushed which caused her to spin around and jump out of the way. (Tr. 32).

Beatrice Campoz, co-worker, testified that claimant said she was "fine" immediately after the fork lift incident. (Tr. 22). Raymond Leal, forklift driver, testified that claimant said that he "almost hit" her while he was attempting to move the totes. (Tr. 50).

Claimant reported to Dr. DeHamer that she was injured when a forklift ran into a stack of pallets which she was leaning up against, causing her to jump, whirl around and was "knocked out."

(Ex. 3-2). Dr. DeHamer's objective findings were a few superficial splinters in the left forearm and tenderness in the mid-back, with no visible bruising. (Exs. 2, 3). Dr. DeHamer's reports do not indicate that he removed (i.e. performed medical treatment) the "splinters" from claimant's forearm. Finding no signs of contusions and reporting full range of motion, Dr. DeHamer also released claimant to her regular work with no limitations. Agreeing with the insurer's attorney, Dr. DeHamer believed that claimant's pain complaints were "most unusual" in light of the absence of any significant signs of trauma. (Ex. 14-2). At claimant's request, Dr. DeHamer referred her to Dr. Gallagher.

Reporting pain throughout her body, claimant would not let Dr. Gallagher touch her because she would "jump with pain." (Ex. 1-10). However, Dr. Gallagher noted that claimant was able to move around the exam room with no difficulty, while showing him alleged skin cancers over her entire body. (Ex. 1-10). Dr. Gallagher's impression was that claimant had "at most" a muscle strain and contusions of the back, but stated that he really could not find anything wrong. (Ex. 1-11).

In light of the suspicions and inconsistencies mentioned in the reports authored by Drs. DeHamer and Gallagher, we find that claimant was not credible in reporting her medical history. See Marchia T. Galicia, 46 Van Natta 542, 5643 (1994) (a medical opinion is only as good as the medical history upon which it is based); Luella M. Best, 45 Van Natta 1638 (1993); Coastal Farm Supply v. Hultberg, supra. For instance, on July 26, 1994, (one day after her work incident) claimant treated with Dr. DeHamer, who found a few superficial splinters (which did not require medical treatment) in the left forearm, tenderness in the mid back with no visible bruising. (Ex. 3-2). On August 9, 1994, Dr. DeHamer reported that claimant's condition had significantly improved. (Ex. 3-3). Then, on August 16, 1994, claimant complained of pain from the top of her head, to the bottom of her ankles. (Ex. 3-4). Dr. DeHamer found full range of motion of claimant's back, no evidence of contusions, and recommended that claimant return to her usual work duties.

Dr. Gallagher examined claimant on August 23, 1994, at which time claimant reported pain throughout her entire body since the work incident. (Ex. 1-10). Unable to locate any source for claimant's complaints, Dr. Gallagher would not authorize a work release. (Ex. 1-11).

Finally, and of most importance, both Drs. Gallagher and DeHamer could not affirmatively relate claimant's condition to a work related incident. (Exs. 1-11, 3, 14). In light of these physician's concerns about the reliability of claimant's complaints, as well as their inability to relate claimant's condition to a work incident, we are not persuaded that claimant's need for medical treatment was materially caused by an industrial injury. See Somer v. SAIF, 77 Or App 259, 263 (1986); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Consequently, the medical evidence fails to support the compensability of claimant's claim.

## ORDER

The ALJ's order dated January 20, 1995 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

In the Matter of the Compensation of
**COLIN J. McINTOSH, Claimant**
WCB Case No. 94-08299
ORDER ON RECONSIDERATION
Coons, Cole & Cary, Claimant Attorneys
Roberts, et al, Defense Attorneys

The insurer requests reconsideration of our June 7, 1995 order which affirmed Administrative Law Judge (ALJ) McWilliams' order that: (1) set aside its denial of claimant's psychological condition; and (2) assessed a 25 percent penalty against the insurer for an allegedly untimely denial. On June 23, 1995, we withdrew our order. Having received claimant's response and the insurer's reply, we proceed with our reconsideration.

Claimant has preexisting post-traumatic stress disorder (PTSD) stemming from his Viet Nam experience and has participated in a support group for Viet Nam veterans to assist him in coping with his war experience. In addition, claimant also has a history of substance abuse that preexisted his compensable injury.

In February 1993, claimant sustained a compensable low back injury. That claim was later closed with a permanent disability award. During his participation in an injured worker's program, claimant exhibited symptoms of depression. In January 1994, claimant was referred to Dr. McDonald, a psychiatrist.

In February 1994, claimant was hospitalized for depression accompanied by suicidal ideation. At the hospital, claimant was believed to be suffering from major depression arising from the severe stress associated with his inability to secure work due to his disability.

The insurer partially denied claimant's "psychological/depression/stress." Claimant requested a hearing and the ALJ concluded that claimant established compensability of his depression under ORS 656.005(7)(a)(B). In our prior order, we affirmed the ALJ's order.

On reconsideration, the insurer contends that § 3 of SB 369 applies to this dispute and "mandates a reversal" of the ALJ's order.[1] On June 23, 1995, we withdrew our June 7, 1995 order for reconsideration and requested that the parties submit supplemental briefs concerning the effect on this case, if any, of § 3 of SB 369, as well as any other potentially applicable sections of the recently enacted law. Having received the parties' supplemental briefs, we proceed with our reconsideration.

Section 3 of SB 369 provides:

> "In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:
>
> "* * * * *
>
> "(2) In occupational disease or injury claims involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of an actual worsening of the preexisting condition and not just of its symptoms." (Emphasis added).

The insurer argues that this provision is an "additional proof 'filter' on benefits to be applied in a supplemental fashion after the initial compensability of the underlying claim had been proven." The insurer further asserts that the impact of claimant's injury was "symptomatic, reactive and transient at most, with no actual worsening of the preexisting condition itself." On the basis of this argument, the insurer contends that § 3 precludes it from being held liable. Claimant responds by arguing that § 3 does not apply since his disability is not solely caused by his preexisting PTSD condition and his medical treatment is not solely directed to his preexisting condition.

---

[1] On the same date our initial order was issued, Senate Bill 369 was signed by the Governor. The Act took effect on its passage. Or Laws 1995, ch 332, § 69 (SB 369, § 69). The Act applies retroactively to cases in which an order or decision has not become final, subject to the other exceptions listed in § 66. See Newell v. SAIF, 136 Or App. 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995). Having found no relevant exception, we retroactively apply the amendments to this case.

In order to determine the applicability of the aforementioned statute, we must decide what condition is being claimed and whether it is preexisting. Claimant's current mental condition has been diagnosed by Dr. McDonald as major depression. Dr. McDonald believed that, although claimant's preexisting problems relating to substance abuse and military service may have contributed to his present psychological condition, they were not the major contributing cause of his current depression.

Dr. McDonald does not specifically diagnose PTSD, but seems to refer to it when he speaks of claimant's preexisting problems relating to military service. Moreover, there was no diagnosis of depression prior to claimant's compensable injury. Thus, we read Dr. McDonald's opinion as separating claimant's current depression from his preexisting problems related to military service (PTSD).

Claimant was also examined on behalf of the insurer by Dr. Parvaresh, psychiatrist. Dr. Parvaresh diagnosed both dysthymic disorder and PTSD. After reviewing the records related to claimant's hospitalization for depression in February, 1994, (after the compensable injury), Dr. Parvaresh, opined that claimant's psychological problems were longstanding. Dr. Parvaresh further opined that the compensable back injury was a factor in claimant's psychological condition, but was not the major contributing cause of claimant's psychological problems. After noting that claimant's psychological condition had improved, Dr. Parvaresh reasoned that if the back condition was the major contributing cause of the psychological condition, he would not have expected claimant's psychological condition to have improved since there had been no change in the status of the back condition.

For the reasons given by the ALJ, we do not find Dr. Parvaresh's opinion persuasive. Dr. Parvaresh does not adequately explain the relationship between claimant's preexisting psychological problems, (diagnosed as PTSD), and his current depression. Moreover, given that claimant's depression was treated, we question Dr. Parvaresh's conclusion that the depression should not have improved.

Instead, we are more persuaded by the opinion of Dr. McDonald and find his opinion to be more logical and consistent with the record and the course of claimant's treatment for depression. Claimant did not become suicidal and was not treated or hospitalized for depression until after his compensable injury. Moreover, the records of his hospitalization for depression confirm that claimant was distressed over his compensable injury and its effects. These records are consistent with Dr. McDonald's opinion. Because we find Dr. McDonald's opinion to be better reasoned and based on complete information, we find it more persuasive than that of Dr. Parvaresh. Somers v. SAIF, 77 Or App 259 (1986).

Based on Dr. McDonald's persuasive opinion, we conclude that claimant's current psychological condition is major depression. Given that claimant's preexisting condition was identified as PTSD, we are not persuaded that claimant's disability is solely related to, or his need for medical services is solely directed to, his preexisting condition (PTSD). Consequently, we conclude that § 3 of SB 369 is not applicable to this case.

In our initial order, we analyzed claimant's claim as a resultant/combined condition under ORS 656.005(7)(a)(B).[2] Under this analysis, claimant's compensable back injury combined with his preexisting PTSD and resulted in his depression. Based on Dr. McDonald's persuasive opinion, the compensable injury is the major contributing cause of his disability and need for treatment for his depression. Therefore, claimant's claim is compensable under ORS 656.005(7)(a)(B). Similarly, even if claimant's claim is analyzed as a consequential condition under ORS 656.005(7)(a)(A), claimant's depression is compensable since the low back injury is the major contributing cause of the depression. SAIF v. Freeman, 130 Or App 81 (1994).

Claimant's attorney is entitled to an assessed fee, in addition to the attorney fee awarded by our June 7, 1995 order, for services expended in response to the insurer's request for reconsideration. 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 reconsideration is $800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's supplemental brief on reconsideration), the complexity of the issue, and the value of the interest involved.

---

[2] The amendments to ORS 656.005(7)(a)(B) do not change our conclusions regarding the compensability of claimant's psychological condition.

Accordingly, 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.

---



In the Matter of the Compensation of
**MARIA E. ROJO, Claimant**
WCB Case No. 94-11778
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
David E. Fowler (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

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

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated January 10, 1995 is affirmed.

**Board Member Gunn dissenting.**

The majority concludes that, based on claimant's purported lack of credibility, she has failed to establish the compensability of her back injury claim. I disagree and, therefore, dissent.

The Administrative Law Judge (ALJ) found that, at hearing, "claimant appeared excessively uneasy and failed to make eye contact, even when directly addressed by the [ALJ]." Opinion and Order at 3. The Board and the ALJ used that as a basis for finding claimant not credible.

I think both the ALJ and the Board misread the situation. Claimant is a Hispanic woman who speaks very little English. Many cultures, likely including that into which claimant was born, find direct eye contact with anyone, much less a government official, invasive, improper and downright rude. I find nothing unusual in a non-English-speaking person showing deference in a judicial setting by not making eye contact with the presiding officer. As to claimant's uneasiness at hearing, have we forgotten how frightening a hearing can be to claimants, especially to ones who don't speak English?

In my view, this case is yet another example of the increasing insensitivity that members of the dominant culture and government of this country often display towards members of other cultures. Unfortunately, when cases produce decisions like the majority's, the result is blatant institutional discrimination against minorities.

Cultural issues aside, I am not persuaded that there is a valid basis for concluding that claimant was not a credible witness. I do not find it unreasonable that a woman, who was used to heavy labor, injured herself and continued to work, and that her initial symptoms subsided, only to escalate to the point that she later required treatment. Therefore, even if I did not harbor grave concerns about the cultural issues in this case, I would find that claimant is a credible witness. The majority concludes otherwise. Consequently, I dissent.

---

In the Matter of the Compensation of
**SANDY K. THOMPSON, Claimant**
WCB Case No. 93-12620
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that set aside its denial of claimant's occupational disease claim for a low back condition to the extent it denied her nerve root inflammation and irritation at L5. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the last sentence of fact No. 8, and briefly summarize the pertinent facts as follows:

Claimant has worked as a custodian at a high school since 1991. In that position, she has engaged in repetitive heavy lifting during the summer months and holiday breaks, as that is when the custodial staff conducts a thorough cleaning of the classrooms and their furnishings.

In September 1992, about two weeks after she had last done repetitive heavy lifting in conjunction with her summer cleaning duties, claimant developed right leg symptoms, including pain and numbness. She did not seek treatment because she thought the problem would resolve on its own.

In May 1993, claimant first sought treatment, complaining of low back and right leg pain. The symptoms continued to worsen and she again sought treatment on July 15, 1993. An August 1993 MRI examination revealed grade I spondylolisthesis at L5-S1, with subarticular stenosis of the L5 roots bilaterally, worse on the right, as well as foramenal stenosis at L5-S1 bilaterally, also worse on the right.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that, although claimant's spondylolisthesis at L5-S1 was not compensable,[1] she had established the compensability of her nerve root condition at L5 as an occupational disease.[2] The ALJ's conclusion was based on a report of claimant's attending physician, Dr. Gallo, which identified claimant's work activity as the "cause" of her nerve root inflammation and irritation at the area of her subarticular stenosis at L5. (Ex. 20).

On review, the insurer contends that claimant has not established that her L5 nerve root pathology was caused in major part by her employment activities, as is required to prove an occupational disease. The insurer argues that, although claimant's work activity made her nerve root symptomatic, the record does not support a finding that her work activity was the major cause of a pathological worsening of her underlying disease, i.e., her stenosis at L5. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457-58 (1985); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979).

We need not determine whether claimant's nerve root inflammation and irritation constitutes a pathological worsening of her underlying stenosis to resolve this case. Rather, we conclude, given the medical evidence in this record (which is essentially limited to the report and testimony of Dr. Gallo), that claimant has failed to sustain her burden to proof. In other words, we are not persuaded that claimant's employment activity is the major contributing cause of her current low back condition.

In this case, it is undisputed that claimant's spondylolisthesis at L5-S1 and her stenosis at L5 and

---

[1] Claimant does not challenge this portion of the ALJ's order on review. Respondent's Brief at 1.

[2] Claimant testified to the gradual onset of her right leg symptoms in the fall of 1992, as well as a discrete event that caused a sharp low back pain during the summer of 1993. Claimant does not, however, challenge the ALJ's decision to analyze her condition as an occupational disease.

L5-S1 were preexisting conditions and not caused by claimant's work activities.[3] (Exs. 20, 21-9). Because we are unable, from the medical evidence in the record, to separate out claimant's nerve root inflammation and irritation at L5 (which Dr. Gallo relates to claimant's work activity) from the preexisting stenosis at the same area, we must analyze claimant's current nerve root condition as a worsening of a preexisting disease.[4] Claimant must therefore prove that her work activity was the major contributing cause of this worsening. See ORS 656.802(2).[5]

Dr. Gallo's opinion is insufficient to establish that claimant's work activity is the major contributing cause of a worsening of claimant's preexisting nerve root condition. Dr. Gallo's report does not establish that claimant's nerve root irritation and inflammation is itself a disease, nor does it discuss whether claimant's work activity caused a pathological worsening of the preexisting condition or merely a worsening of symptoms alone. For these reasons, we conclude that claimant has failed to prove that her nerve root condition at L5 is separate from the underlying stenosis or that it is compensable as an occupational disease. See ORS 656.266; ORS 656.802(2).

ORDER

The ALJ's order dated April 4, 1995 is affirmed in part and reversed in part. That portion of the order that set aside the insurer's denial as to claimant's nerve root inflammation and irritation at L5 is reversed, as is that portion assessing an attorney fee award. The denial is reinstated and upheld in its entirety. The remainder of the order is affirmed.

[3] In her report, Dr. Gallo indicated that claimant's subarticular stenosis of the L5 roots and the L5-S1 foramenal stenosis preexisted the development of claimant's symptoms at work. In her deposition, Dr. Gallo confirmed that claimant's stenosis was not caused by her work activities. (Ex. 21-9).

[4] Dr. Gallo was asked to provide a "biomechanical and physiological analysis of how the repetitive lifting either caused the spondylolisthesis and or stenosis and or need for treatment." (Ex. 19). She responded that: "The repetitive bending and lifting [at work] most likely caused nerve root inflammation and irritation at the area of the subarticular stenosis, thus resulting in radicular pain and subsequent need for treatment." (Ex. 20). Considered in the context of the request made, we do not find that Dr. Gallo's explanation treats claimant's nerve root condition as separate from and unrelated to the underlying stenosis at the same location.

[5] ORS 656.802(2) has been amended by Senate Bill 369, Or Laws 1995, ch 332 § 56 (SB 369, § 56). The new provision states that when the occupational disease claim is based on the worsening of a preexisting disease, the worker must prove that the employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. Amended ORS 656.802(2)(b). In addition, the new provision requires that preexisting conditions be deemed causes in determining major contributing cause under this section. Amended ORS 656.802(2)(e). We need not analyze the applicability of the amendments in this case, because we find the result, i.e., that claimant has failed to meet her burden of proof, would be the same under either version of the statute.



In the Matter of the Compensation of
**WESLEY D. BRENT, Claimant**
WCB Case Nos. 93-11317 & 93-07909
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

J & R Construction, an alleged noncomplying employer, requests review of Administrative Law Judge (ALJ) Black's order which: (1) found that J & R's request for hearing was untimely insofar as it pertained to an objection to the SAIF Corporation's acceptance of claimant's injury claim; and (2) affirmed a Department of Insurance and Finance[1] (Department) order of noncompliance. On review, the issues are jurisdiction and subjectivity.

[1] Now Department of Consumer and Business Services.

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

On April 12, 1993, claimant sustained a broken ankle while working for J & R. On June 17, 1993, as amended June 23, 1993, the Department issued an Order Declaring Noncompliance. (Exs. 5, 6A). On the same day, the Department referred claimant's claim to SAIF for processing, as required by former ORS 656.054. (Ex. 6). A copy of the referral letter to SAIF was sent to J & R, along with an "Important Notice to Alleged Noncomplying Employer." (Ex. 6-2).

On June 29, 1993, J & R sent a handwritten letter of appeal to the Compliance Section, stating that it did not have any employees. (Ex. 6B). J & R also sent a letter to Compliance stating that it wished to "exercise Right #1 [of the Important Notice to Alleged Noncomplying Employer] (NO SUBJECT WORKERS)." (Ex. 6AA). SAIF issued a claim acceptance on August 13, 1993. (Ex. 8). On September 24, 1993, J & R requested a hearing contesting the compensability of claimant's ankle injury. The ALJ dismissed J & R's hearing request as not timely under former ORS 656.054. J & R requested review.

J & R contends that its handwritten letter raises the issue of compensability of claimant's ankle injury claim. The ALJ found that the correspondence from J & R did not raise the issue of compensability but, rather, addressed only the issue of subjectivity. Therefore, the ALJ concluded that J & R's September 24, 1993 request for hearing on the compensability of claimant's claim was untimely. We agree with the ALJ's conclusion. See Thomas R. Lee, 46 Van Natta 2269, aff'd mem 135 Or App 697 (1994) (noncomplying employer must request hearing objecting to claim within the 90-day period in which SAIF has to accept or deny claim after "ORS 656.054" referral).

Alternatively, even if we addressed J & R's objection to SAIF's claim acceptance, we would find the claim compensable. We would base such a conclusion on the following reasoning.

J & R contends that claimant was outside the scope of his employment because he built a scaffold, against J & R's specific order not to, which caused claimant's injury. We disagree.

We have previously held that, when determining whether a claimant's misconduct takes the claimant out of the scope of employment, the focus is on whether the claimant's misconduct involved a violation of a regulation or prohibition relating to the method of accomplishing his work or whether the misconduct involved a prohibited overstepping of the boundaries defining the ultimate work to be done by the claimant. David Bottom, 46 Van Natta 1485 (1994), aff'd mem Liberty Northwest v. Bottom, 133 Or App 449 (1995). Here, claimant's activity of building a scaffold constituted a method of performing his work and, therefore, we would conclude that violation of J & R's policy did not take him out of the course and scope of employment.

J & R also contends that this case is "absolutely no different" from Frosty v. SAIF, 24 Or App 851 (1976), where the court held that a claimant was outside the scope of his employment because he had been forbidden to ski when his work as a charter bus driver required that he drive groups on ski trips. We find Frosty distinguishable. In Frosty, the claimant had entered in his log book that he was "off duty." Furthermore, he had turned over the keys of the bus to the head of the ski group who had chartered the bus for the day. 24 Or App at 854. Here, there is no dispute that claimant was working at the time of his 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 $900, payable by SAIF on behalf of J & R. 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 April 7, 1995, as amended May 3, 1995, is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $900, payable by the SAIF Corporation on behalf of J & R Construction.

In the Matter of the Compensation of
**MARIA S. CHAVEZ, Claimant**
WCB Case No. 94-03718
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Roberts, et al, Defense Attorneys

On May 5, 1995, we withdrew our April 19, 1995 Order on Review, which affirmed an Administrative Law Judge's (ALJ's) order which declined to authorize an offset of scheduled permanent disability against a subsequent award of unscheduled permanent disability. We took this action to consider the insurer's motion for reconsideration. Thereafter, the insurer announced that the parties had settled their dispute and would be submitting a proposed agreement for our consideration.

We have now received the parties' proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them. Pursuant to the settlement, claimant agrees that "her claim shall remain in its denied status and her Request for Hearing shall be dismissed with prejudice." The parties further stipulate that "all issues any party could raise are conclusively deemed either settled or waived by this settlement."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, on reconsideration, this matter is dismissed with prejudice.

IT IS SO ORDERED.

---



In the Matter of the Compensation
**THURMAN M. MITCHELL, Claimant**
WCB Case No. 91-14771
SECOND ORDER ON REMAND
Jon C. Correll, Claimant Attorney
Steve Cotton (Saif), Defense Attorney

On June 15 1995, we withdrew our May 19, 1995 Order on Remand which: (1) set aside the SAIF Corporation's partial denial of claimant's medical services claim for travel expenses; and (2) awarded a carrier-paid attorney fee for overturning the denial. We took this action in response to SAIF's motion to abate and reconsider in light of the recent Senate Bill 369 amendments to the workers' compensation laws. Specifically, SAIF contends that under the new law, jurisdiction to review this medical services dispute vests exclusively with the Director of the Department of Consumer and Business Services. SAIF therefore requests that we vacate our original Order on Remand and issue a new order holding that the Board and Hearings Division lack jurisdiction to consider this claim.

Subsequent to our June 15, 1995 Order of Abatement, we received claimant's response to SAIF's motion. We therefore proceed with reconsideration of the jurisdiction issue.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

This is a medical services travel expense case before the Board on remand from the Court of Appeals. In Mitchell v. Burnt Mountain Logging, 125 Or App 278 (1993), the court reversed our prior order which adopted and affirmed an Administrative Law Judge's (ALJ's) order that held the Hearings Division lacked jurisdiction to consider this matter. Specifically, the ALJ dismissed claimant's hearing request concerning SAIF's refusal to reimburse claimant for travel expenses associated with reasonable

and necessary medical services received for a compensable condition from an attending physician beyond claimant's geographic area.[1] On remand, we found SAIF responsible for full reimbursement.

On reconsideration, SAIF argues that the recent amendments to ORS 656.327(l)(a), 656.704(3) and 656.283(l) (Or Laws 1995, ch 332 §§ 41, 50, 34 (SB 369, §§ 41, 50, 34)), require that all medical services disputes be reviewed initially by the Director. SAIF further argues these new provisions, which are not excepted from the retroactivity provision of section 66 of SB-369, are applicable to this case. We agree.

Subsequent to our Order on Remand (but before it became final), the legislature amended ORS 656.327(l) to provide that if an injured worker, a carrier, or the director believes that an injured worker's medical services[2] are 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 (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 (SB 369, § 25(6)).

We have 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).[3] The Court of Appeals also has held that the provisions of Senate Bill 369 apply retroactively to all pending cases, unless specifically excepted from retroactive application by Section 66. Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995). The 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. Accordingly, in this case, since our Order on Remand had not become final by the date SB 369 was enacted and because we withdrew our order prior to its becoming final by operation of law, the amended versions of the statute are applicable to our analysis on reconsideration. Newell v. SAIF, supra.

Notwithstanding these recent decisions, claimant contends that the retroactive application of SB 369 is an unconstitutional ex post facto law. We disagree. The retroactive application of Senate Bill 369 does not raise any ex post facto concerns because the federal and state constitutional prohibitions against ex post facto laws apply only to criminal statutes. See, e.g., United States Trust Co. v. New Jersey, 431 US 1, 97 S Ct 1505, 52 L Ed 2d 92 (1977); Kilpatrick v. Snow Mountain Pine Co., 105 Or App 240, 243, rev den, 311 Or 426 (1991). Specifically, "[a] law implicates ex post facto concerns if it makes criminal an action that was innocent when done; aggravates a crime, or increases the punishment for a crime after it is committed; or 'alters the legal rules of evidence, and receives less, or different testimony, than the law required at the time of the commission of the offense, in order to convict the offender.' Calder v. Bull, 3 US 386, 390, 1 L Ed 648 (1798) (opinion of Chase, J.)." Dawson v. Board of Parole, 23 Or App 619, 621 (1993) (emphasis added).

---

[1] The court's remand was based on Meyers v. Darigold, Inc., 123 Or App 217 (1993), rev den 320 Or 453 (1994), which held that under former ORS 656.327, the Board had jurisdiction to consider a medical services dispute if no party had requested review by the Director.

[2] Medically-related travel expenses are "other related [medical] services" under amended ORS 656.245(l)(b) (formerly numbered ORS 656.245(l)(c)). See, e.g., Susan A. Lowly-Puls, 43 Van Natta 1106 (1991).

[3] In Keeney, we recognized a potential problem in the retroactive application of amended ORS 656.245(6) in that the current version of OAR 436-10-046 requires the insurer to issue notice of its intent to request Director review within 180 days of its receipt of the first billing in dispute. 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. In this regard, we note that, on August 18, 1995, the Director adopted OAR 436-01-015, which is designed to address several of these "medical services/jurisdictional" cases where a hearing request was initially filed with the Board's Hearings Division. WCD Admin. Order 95-061.

Accordingly, because SB 369 is civil legislation, its retroactive application does not raise ex post facto law concerns. See Carl M. Keeton, 44 Van Natta 664 (1992) (rejecting ex post facto challenge to the 1990 amendments).

Claimant also contends that the retroactive application of SB 369 would violate his substantive and procedural due process rights. Claimant does not, however, elaborate or explain this contention, nor does he specify the specific due process rights that would be violated. Because this constitutional argument is not adequately developed for our review, we decline to address the issue. See Ronald B. Olson, 44 Van Natta 100 (1992) (Board declined to address unspecified constitutional challenges to the 1990 amendments); Carl M. Keeton, supra, (same).

In conclusion, claimant's hearing request arises out of SAIF's refusal to reimburse him for travel expenses associated with reasonable and necessary medical services for a compensable condition received from an approved Coos Bay attending physician because he lives in Bend, a significant travel distance from Coos Bay. Because this case does not involve a dispute regarding the formal denial of claimant's underlying claim, the Director has exclusive jurisdiction over it. Amended ORS 656.245(6).

Accordingly, on reconsideration, we vacate our prior Order on Remand for lack of jurisdiction, and affirm the ALJ's June 8, 1992 order that dismissed claimant's request for hearing.[4]

IT IS SO ORDERED.

---

[4] Although a signatory to this order, Member Hall directs the parties to his dissent and that of Member Gunn in Walter L. Keeney, supra. Consistent with those positions, although not deciding the applicability of the Director's temporary rule, Member Hall notes that the rule's adoption raises serious questions regarding whether it contravenes Section 66(6) of SB 369.

---



In the Matter of the Compensation of
**ROBERT L. TEGGE, Claimant**
WCB Case No. 93-10914
ORDER ON REVIEW
David C. Force, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order which upheld the SAIF Corporation's partial denial of his bilateral leg and foot condition. On review, the issue is compensability.

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

Claimant argues that SAIF's September 9, 1993 partial denial of his foot condition is an improper "back-up" denial. Claimant's "back-up" denial argument was not raised at hearing, but rather was first asserted on Board review. We have consistently held that we will not consider an issue raised for the first time on appeal. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

We acknowledge that claimant's argument could also be characterized as merely a different theory of contesting SAIF's denial, rather than a separate issue. See Alan B. Cooper, 40 Van Natta 1915 (1988). However, if we were to find that SAIF's denial constituted a "back-up" denial, SAIF would be significantly prejudiced, based on this late-raised theory, since it would then have the burden to prove that claimant's bilateral leg and foot condition was not compensable under ORS 656.262(6). Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue. See Gunther H. Jacobi, 41 Van Natta 1031 (1989). SAIF would be denied that opportunity because it had no notice of the "back-up" denial issue. Larry L. Schutte, 45 Van Natta 2085 (1993). Accordingly, we decline to consider claimant's "back-up" denial issue.

ORDER

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

**Board Member Hall specially concurring.**

I agree with the majority that claimant cannot for the first time on review raise the back-up denial theory, viz., the denial is an attempt to encompass symptoms of the low back radiculopathy stemming from the accepted back condition. Thus, I write separately to point out for purposes of clarification that SAIF's denial is limited to the conditions specifically listed in the denial, i.e., diabetes, tarsal tunnel syndrome and pedal paresthesia. (At hearing and on Board review, claimant conceded the diabetes condition was not compensable.) The denial should not be construed as a denial of the radicular component of claimant's accepted low back claim. Therefore, we are affirming SAIF's denial to the extent it denies only the tarsal tunnel syndrome and the pedal paresthesia.

---



In the Matter of the Compensation of
**THOMAS TOBIN, Claimant**
WCB Case Nos. 94-05999 & 94-04190
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denials of claimant's aggravation and new injury/occupational disease claims for his low back condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant began working as a bundler for the employer, a cardboard company, in April 1992. On June 30, 1992, claimant experienced a compensable, nondisabling lumbar strain. He was on light duty for two weeks and then returned to full duty. On September 1, 1993, claimant experienced a compensable, disabling lumbar strain while working for the same employer as a flexo assistant. He returned to regular full duty work on October 29, 1993. The claim was closed January 10, 1994 by Notice of Closure.

Claimant continued to experience low back pain and developed right leg pain. In February 1994, claimant sought treatment with Dr. Campbell, whom he had seen for his prior back strains.

Dr. Campbell referred claimant to Dr. Nash, a neurosurgeon. On February 11, 1994, Dr. Nash examined claimant and reviewed x-rays taken September 2, 1993 (at the time of claimant's second lumbar strain). A lumbar scan taken February 21, 1994 identified Grade I L5-S1 spondylolisthesis secondary to L5 bilateral spondylolysis defects. By report dated March 3, 1994, Dr. Nash diagnosed "lumbar vertebral instability syndrome with spondylolysis and spondylolisthesis of L5 on S1." (Ex. 15).

Claimant went to see Dr. Duff, M.D., for an employer-arranged exam on March 23, 1994. Dr. Duff diagnosed lumbosacral strain and Grade I spondylolisthesis, but determined that claimant's condition was not materially worse than it had been in January 1994 when the second back strain claim had been closed.[1] (Ex. 16).

---

[1] In a supplemental report dated June 23, 1994, Dr. Duff opined that the current major contributing cause of claimant's disability and need for treatment was claimant's spondylolisthesis, and that claimant's most recent injury claim did not result in any objective worsening of the "pre-existing" spondylolisthesis. (Ex. 23A).

Dr. Nash referred claimant to Dr. Misko, a neurosurgeon, who examined claimant on May 20, 1994. Dr. Misko also diagnosed spondylolisthesis at L5-S1, and, like Dr. Nash, considered claimant's condition completely work related. He recommended surgery. (Ex. 23).

## CONCLUSIONS OF LAW AND OPINION

The ALJ analyzed the case under former ORS 656.005(7)(a)(B) and found that claimant's current low back condition was caused in major part by the compensable lumbar strains claimant had experienced in June 1992 and September 1993.

On review, the employer argues that claimant failed to establish that his low back condition is compensable as a new injury, occupational disease or a worsening of the prior accepted lumbar strains. Claimant, on the other hand, argues that his current condition and need for surgery is compensable as a new injury or occupational disease or, alternately, as an aggravation of the accepted lumbar strains.

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,[2] amended ORS 656.005(7)(a)(B)[3] (dealing with compensable injuries and combined conditions), 656.802(2) (dealing with occupational disease claims) and ORS 656.273(1) (dealing with aggravation claims).

Since claimant asserts alternate theories of recovery for his current condition, our first task is to determine which provisions of the Workers' Compensation Law are applicable. DiBrito v. SAIF, 319 Or 244 (1994); Daniel S. Field, 47 Van Natta 1457 (1995). Ordinarily, we would first determine whether this claim is properly analyzed as an aggravation or a new compensable condition. However, in this case, because of the nature of claimant's current condition[4] and the application of SB 369, we first determine whether claimant's current condition (spondylolisthesis) is properly characterized as an industrial injury or an occupational disease. This latter analysis requires a determination of whether the condition was unexpected or expected, and whether the onset was sudden or gradual. James v. SAIF, 290 Or 343 (1981); Valtinson v. SAIF, 56 Or App 184 (1982).

In prior cases, we have treated spondylolisthesis as both an injury and an occupational disease. For example, in Dennis G. Kitchen, 46 Van Natta 2326 (1994), where the medical evidence established that the claimant had preexisting asymptomatic spondylolisthesis which became symptomatic after working a 15 hour shift, we analyzed the claimant's condition as an injury and resultant condition under former ORS 656.005(7)(a)(B). Conversely, in Brian A. Bundy, 46 Van Natta 382 (1994), we analyzed the claimant's disabling unstable spondylolisthesis condition as an occupational disease under former ORS 656.802 because the condition was not unexpected (considering claimant's preexisting congenital spondylolisthesis and his repetitive work activities) and appeared to worsen gradually.

In this case, like Bundy, supra, we treat claimant's condition as an occupational disease rather than an accidental injury. The medical evidence shows that claimant's spondylolisthesis is not unexpected (in light of his preexisting pars interarticularis defect and his work activities) and also that the condition gradually worsened over time (beginning with his industrial injuries in July 1992 and September 1993 until diagnosed in early 1994).

---

[2] See Volk v. America West Airlines, 135 Or App 565 (1995) (changes to workers' compensation law made by SB 369 apply retroactively to all cases currently pending unless provision is specifically excepted in section 66).

[3] 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."

[4] As discussed infra, both Drs. Nash and Misko determined that claimant's low back condition progressively worsened subsequent to the September 1993 accepted strain, and both doctors attributed that worsening to claimant's continued work activity. (Exs. 23B, 24, 25).

In order to prevail on an occupational disease claim, claimant must establish that the employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that the employment conditions were the major contributing cause of the combined condition and the pathological worsening of the disease. ORS 656.802(2)(b)

The medical evidence does not establish that the disputed condition, spondylolisthesis, was preexisting. The spondylolisthesis was first diagnosed on February 21, 1994, well after the work injuries of 1992 and 1993. Dr. Nash determined that it developed as a result of claimant's industrial injuries and his continued work activities.[5] (Exs. 25, 28-16). Dr. Duff, on the other hand, assumes that claimant's spondylolisthesis was "preexisting" but does not explain why, other than to note that there was no specific event or intervening injury between the back strain in September 1993 and the diagnosis of the condition in 1994. (Exs. 23A, 26).

We give the most weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Conversely, we give little, if any weight, to conclusory, poorly reasoned opinions, such as unexplained "check-the-box" reports. Marta I. Gomez, 46 Van Natta 1654 (1994). Here, we find no persuasive reason not to rely on the medical evidence of Dr. Nash, claimant's treating physician. Weiland v. SAIF, 64 Or App 810 (1983). We find the opinion of Dr. Nash (that the spondylolisthesis developed after the September 1993 back strain) to be the most complete and well reasoned. Dr. Duff's disparate opinion is speculative and lacking in explanation and analysis.

Because we have found that claimant did not have preexisting spondylolisthesis, this matter is appropriately analyzed under ORS 656.802(2)(a).

In determining the major cause of claimant's current condition, we rely on the well-reasoned and persuasive opinions of treating neurosurgeon Nash and examining neurosurgeon Misko, who agree that claimant's spondylolisthesis is directly related to his work activities. Dr. Nash believes the major contributing cause of claimant's condition was the 1992 injury, exacerbated by the 1993 injury and claimant's continued day-to-day work activity. (Ex. 25). In his deposition, Dr. Nash explained that the industrial injuries caused the pars defect to become evident, and that the "slip" (i.e., the spondylolisthesis) occurred with his continued work activity following the injuries. (Ex. 28-18). Dr. Misko opined that claimant's work activity, consisting of twisting and lifting cardboard and feeding it into a machine, is the major contributing cause of the symptomatic spondylolisthesis.[6] (Ex. 24).

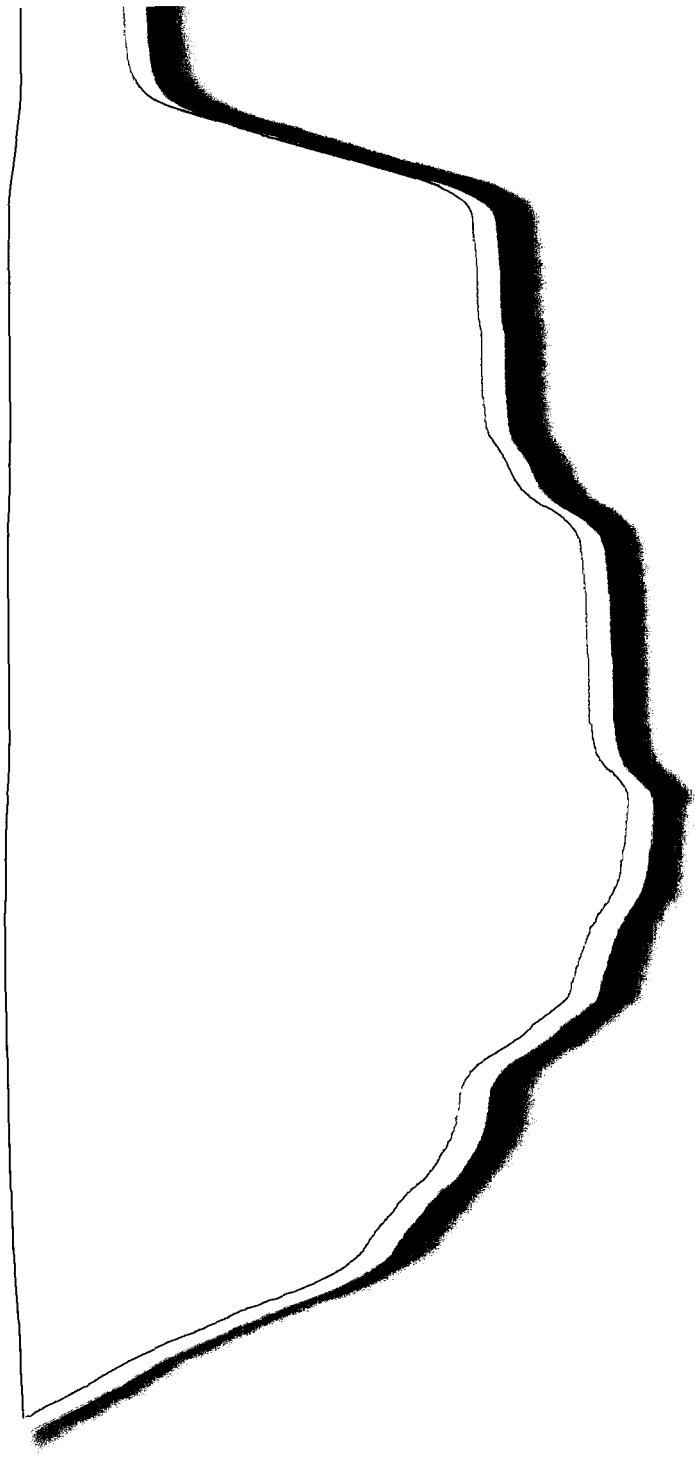
We note that Dr. Duff, in a concurrence letter, did not relate claimant's current condition to work because there was no specific event leading up to the 1994 diagnosis of spondylolisthesis. (Ex. 26). However, as we have stated, we do not find Dr. Duff's opinion persuasive.

In sum, we conclude that claimant has carried his burden of proof under ORS 656.802(2) by establishing that his work activities subsequent to the 1993 accepted strain were the major contributing cause of his L5-S1 spondylolisthesis. We therefore find the claim is compensable as an occupational disease, and not as an aggravation of the accepted September 1993 back strain. See Stacy v. Corrections Division, 131 Or App 610, 614 (1994) (to establish that current condition was a new occupational disease, claimant required to prove that work activities after acceptance of injury claim were the major contributing cause of current condition).

---

[5] Dr. Nash believes claimant may have had a preexisting pars interarticularis defect and spondylolysis, but that claimant's work caused the spondylolisthesis. Dr. Nash further indicated that the diagnosis of a "back strain" following the September 1993 work incident was incomplete in that it did not identify the bony defect at that time. (Ex. 28-18).

[6] The employer challenges Dr. Misko's opinion because he did not consider possible off-work activities or injuries as a cause of claimant's condition. We note, however, that there is nothing in the record to suggest that claimant sustained an off-work injury or that he engaged in strenuous off-work activity. In fact, claimant consistently denied any off-work injury or activity. Therefore, we do not find Dr. Misko's failure to consider off-work activities in any way undermines his conclusion that claimant's condition is due to work-related activities.



In the Matter of the Compensation of
**JEAN M. GORDON, Claimant**
WCB Case No. 94-06925
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
David L. Jorling, Defense Attorney

Reviewed By Board Members Haynes, Christian and Gunn.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Galton's order that increased claimant's scheduled permanent disability award for loss of binocular vision from both eyes from 9.75 percent (29.25 degrees), as awarded by an Order on Reconsideration, to 100 percent (300 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

## FINDINGS OF FACT

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

We do not adopt the sixth paragraph and the last paragraph. We adopt only the first sentence of the eighth paragraph; we do not adopt the remainder of the eighth paragraph.

We replace the last sentence of the fourteenth paragraph with the following. In an advisory letter, the Appellate Review Unit interpreted the medical arbiter's report as indicating a 10 percent impairment loss of each eye for central visual acuity. (Ex. 111A-1).

Claimant was 53 years old at the time of the hearing. She had preexisting diplopia that was treated with eye exercises as a child and surgery on her right eye when she was about 15. (Ex. 36-1, Tr. 19). By her late teens and early twenties, claimant did not wear glasses and was able to successfully fuse her vision. (Tr. 20). In 1976, claimant began treating at the offices of Dr. Plumb, her attending physician.

In a 1983 examination by Dr. Plumb, claimant complained of double vision when reading and Dr. Plumb prescribed prisms in claimant's glasses to correct the double vision. (Ex. 36-1). Claimant did not get the prescribed prisms and did not start wearing prisms in her glasses until after the March 1991 work injury. (Tr. 23-24, 25-26).

Dr. Plumb next examined claimant in April 1990. At that time, claimant complained of acute change in her vision, with difficulty in night driving, distance vision, and depth perception. (Ex. 36-1). In addition, she continued to experience vertical and horizontal imbalance. Id.

On March 31, 1991, claimant tripped and fell in an elevator at work and struck her head against the back wall of the elevator. Following this injury, claimant had frequent headaches and, on April 1, 1991, during one of those headaches, claimant lost vision in her left eye for about 20 minutes and, when the vision returned, she had diplopia. (Ex. 5-1).

On April 10, 1991, Dr. Plumb examined claimant. (Ex. 14). At that time, he noted that claimant had "some right hyperphoria and exophoria that requires prism in her glasses to keep her from seeing double." (Id.) He opined that claimant's vision problems were all preexisting and that she suffered a decompensation of her preexisting problem due to the work injury. (Exs. 14, 36-1). He also stated that the problem should be temporary.

On June 21, 1991, Dr. Plumb declared claimant medically stationary as of July 16, 1991, without permanent impairment. (Ex. 32). On July 15, 1991, Dr. Plumb stated that claimant "did not have a problem specifically caused by an injury, but that an injury or any other stress may have complicated her ability to fuse and may have created an increased likelihood of double vision." (Ex. 36-2).

On November 24, 1992, Dr. Plumb opined that claimant required muscle surgery in the right eye to aid her fusion and decrease the needed prism to a tolerable level. (Ex. 79). He diagnosed "strabismus, decompensated since injury last year," and noted that claimant needed to wear "an ungainly and unsightly amount of prism, which is tolerated only fairly." Id.

Claimant underwent the right eye surgery in January 1993. On February 12, 1993, Dr. Plumb declared claimant medically stationary, without permanent impairment. (Ex. 87).

On August 12, 1993, Dr. Shults, neuro-ophthalmologist, examined claimant on behalf of the employer. (Ex. 97). Dr. Shults found that claimant's preexisting ocular motility disturbance was exacerbated by her work injury and her current ocular motility disturbance "is principally the result of her job related injury and will be permanent." (Ex. 97-5). In addition, Dr. Shults noted that claimant "experienced diplopia in all directions of gaze at a distance of 33 cm. as tested at the Goldmann perimeter with her glasses in place." (Ex. 97-4, -5, -6). Dr. Plumb concurred with Dr. Shults' August 12, 1993 report without reservation. (Exs. 97, 98).

Dr. Shults examined claimant on behalf of the employer on several occasions and wrote several reports. However, Dr. Plumb only concurred with Dr. Shults' August 12, 1993 report. Id.

On October 28, 1993, claimant's claim was closed by Determination Order. Claimant requested reconsideration and appointment of a medical arbiter.

On May 25, 1994, Dr. Hagen examined claimant in his capacity as a medical arbiter. (Ex. 110). Dr. Hagen had an accurate history of claimant's preexisting ocular motility dysfunction. He concluded that claimant has 100 percent impairment of ocular motility.

## CONCLUSIONS OF LAW AND OPINION

Relying on various reports from Dr. Shults, examining physician, the ALJ awarded claimant 100 percent (300 degrees) scheduled permanent disability for loss of binocular vision. The employer argues that claimant is not entitled to an award for loss of binocular vision because her vision loss is due to a preexisting diplopia (double vision) condition and not to the compensable injury. In the alternative, the employer argues that: (1) if claimant's diplopia impairment is causally related to the work injury, the standards do not address claimant's type of diplopia; therefore, the claim must be remanded to the Director to enact the appropriate standards; and (2) if claimant's diplopia impairment is causally related to the work injury and the standards address claimant's type of diplopia, the correct rating is substantially less than 100 percent scheduled permanent disability. While we find that the ALJ's reliance on Dr. Shults' reports is misplaced, we agree that claimant is entitled to 100 percent scheduled permanent disability. However, we find that this award is valued at 100 degrees for loss of monocular vision, rather than 300 degrees for loss of binocular vision.

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 October 28, 1993. Accordingly, those standards contained in WCD Admin. Orders 6-1992 and 17-1992 apply to claimant's claim.

Evidence that may be considered in rating impairment is limited to that provided by the attending physician at claim closure ratified by the attending physician, and evidence from the medical arbiter, if a medical arbiter is appointed. Former ORS 245(3)(b)(B) (renumbered ORS 656.245(2)(b)(B) by Or Laws 1995, ch 332, § 25 (SB 369, § 25)); ORS 656.268(7); Roseburg Forest Products v. Owen, 129 Or App 442 (1994); Alex J. Como, 44 Van Natta 221 (1992).

In reaching his conclusions regarding the causation of claimant's impairment, the ALJ relied on some reports from Dr. Shults which were not concurred with by the attending physician. Subsequent to the ALJ's order, we determined that the above limitation on impairment evidence applies whether the evidence concerns the rating of impairment or the causation of impairment. David B. Weirich, 47 Van Natta 478 (1995).

Here, the medical evidence that may be considered concerning the extent of claimant's scheduled permanent impairment regarding her vision loss comes from Dr. Plumb, claimant's attending physician, and Dr. Hagen, an ophthalmologist appointed as the medical arbiter. In addition, Dr. Plumb concurred with an August 12, 1993 closing examination report from Dr. Shults. (Exs. 97, 98). The multiple other reports issued by Dr. Shults may not be considered in determining claimant's impairment because those reports were not ratified by claimant's attending physician. Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995).

The employer urges us to rely on Dr. Plumb's opinions, including his September 14, 1994 report, to find that claimant's diplopia is preexisting and, therefore, she is not entitled to a permanent disability rating for that condition. 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 persuasive reasons not to defer to Dr. Plumb, whose opinions are inconsistent. Although Dr. Plumb repeatedly opined that the work injury decompensated claimant's ability to fuse her vision, he also opined that there was no impairment due to the injury. (Exs. 14, 36-1, 62-2, 87). In addition, he concurred with Dr. Shults' opinion that the principal cause of claimant's current permanent ocular motility is the work injury and that claimant has impairment due to her diplopia. (Exs. 97, 98). Because Dr. Plumb's opinions are inconsistent and he does not explain these inconsistencies, we do not rely on them.

Finally, the employer's reliance on Dr. Plumb's September 14, 1994 report is misplaced. (Ex. 112). That report is a "post-medical arbiter" report that addresses claimant's impairment. ORS 656.268(7)[1] prohibits the consideration of such a report.[2] Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). We realize that no party objected to admission of Exhibit 112 at hearing. However, we have concluded that, given the express prohibition against admission of post-medical arbiter evidence under ORS 656.268(7), an express objection is not required. David J. Rowe, 47 Van Natta 1295 (1995). Accordingly, we conclude that Exhibit 112 is prohibited by ORS 656.268(7), and do not consider it. David J. Rowe, supra.

We find Dr. Hagen's opinion persuasive. (Ex. 110). The employer argues that Dr. Hagen did not address claimant's pre-injury condition. We disagree. Dr. Hagen reported an accurate history regarding claimant's preexisting diplopia condition. (Ex. 110-1). In addition, the Medical Review Unit advised Dr. Hagen to report "any objective permanent impairment resulting from the accepted condition only." (Ex. 108-2, emphasis in original). In the absence of evidence that an arbiter rated impairment due to causes other than the claimant's compensable injury, we have attributed an arbiter's impairment findings as due to the compensable injury. See Edith N. Carter, 46 Van Natta 2400 (1994); David J. Schafer, 46 Van Natta 2298 (1994).

Here, although the arbiter was aware of claimant's preexisting diplopia condition, there is no evidence that he rated impairment due to any cause other than the work injury. Compare Julie A. Widby, 46 Van Natta 1065 (1994) (where the medical arbiter made impairment findings but also provided comments pertaining to other causes of the claimant's impairment, the medical arbiter's findings were not persuasive evidence of impairment due to the injury). Accordingly, we conclude that Dr. Hagen's impairment ratings relate to the work injury.

In the alternative, the employer argues that, if claimant's diplopia impairment is causally related to the work injury, the claim must be remanded to the Director to enact a temporary rule because the standards do not address claimant's binocular diplopia.

Under ORS 656.726(3)(f)(C), the Director shall stay further proceedings and shall adopt temporary rules when "it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph." The Board has authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993).

---

[1] ORS 656.268(7) was amended by the 1995 legislature. SB 369, § 30. 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, Dr. Plumb's September 14, 1994 report was issued 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 Daniel Bourgo, 46 Van Natta 2505 (1994), 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.

In support of its argument, the employer contends that the standards do not distinguish between monocular and binocular diplopia. The employer further contends that the standards assume that a person suffers from monocular diplopia in order to rate binocular diplopia. For these reasons, the employer argues that the standards do not address claimant's diplopia impairment. We disagree with the employer's argument.

Contrary to the employer's argument, the standards distinguish between monocular and binocular diplopia. OAR 436-35-260(5) provides the rating method for monocular diplopia, a condition that claimant does not have. (Ex. 110-2). OAR 436-35-260(4) provides the method to rate ocular motility impairment resulting in binocular diplopia, the condition claimant has. (Ex. 110-2). Furthermore, there is no indication that, in order to apply OAR 436-35-260(4) to rate binocular diplopia, one must assume that claimant suffers from monocular diplopia. Accordingly, on this record, we are not persuaded that the standards do not adequately address claimant's disability. Compare Susan D. Wells, 46 Van Natta 1127 (1994) (the Board had no authority to remand to the Director pursuant to ORS 656.726(f)(C) where the claimant contended that the standards did not adequately address her disability and failed to prove that contention).

We proceed to rate claimant's impairment under the appropriate standards. According to Dr. Hagen's report, claimant has two potential types of vision impairment: central visual acuity and ocular motility impairment. (Ex. 110-2).

OAR 436-35-260(2) provides that the ratings for loss in central visual acuity are calculated from reports for central visual acuity that "must be for distance and near acuity," with both acuities measured with best correction. OAR 436-35-260(2)(a) [emphasis added]. The distance acuity and near acuity measurements are then translated into a percentage of loss of distance acuity and loss of near acuity using the tables at OAR 436-35-260(2)(b) and (c). These two percentages are then added and the sum is divided by two, which results in the rating for lost central visual acuity. OAR 436-35-260(d).

Although directed by the Medical Review Unit to report both distance acuity and near acuity, Dr. Hagen only reported distance acuity. (Exs. 108-2, 110-2). Because the rules require the reporting of both distance and near acuity to rate loss in central visual acuity and near acuity was not reported, we are unable to rate any loss in central visual acuity on this record. Cf. David A. Kamp, 46 Van Natta 389 (1994) (where no physician rated loss of grip strength in the manner required by the standards, any loss of grip strength that the claimant might have is not ratable under the standards).

OAR 436-35-260(4) provides that the ratings for ocular motility impairment resulting in binocular diplopia are determined by finding the single highest value of loss for diplopia noted on each of the standard 45 degree meridians in the table provided at OAR 436-35-260(4)(b) and adding the values for each meridian to obtain the total impairment for loss of ocular motility. OAR 436-35-260(4)(a) and (b).

Dr. Hagen measured claimant's ocular motility impairment using a diplopic visual field and found that she "showed diplopia throughout the central 20° of fixation with single binocular vision present only inferiorly and to the left of fixation in a small zone extending from approximately 40° to 60° inferior and to the left from the 195 to the 255 meridian." (Ex. 110-2). He also graphed his findings using 45 degree meridians. (Ex. 110-4). Applying Dr. Hagen's diplopic impairment findings to OAR 436-35-260(4)(b), we need only add the first two directions to reach greater than 100 percent impairment. Claimant has diplopia "straight ahead" and "out to 20 degrees" (75 percent) and "down" and "21 degrees to 30 degrees" (50 percent). (Exs. 110-2, -4). OAR 436-35-260(4)(b) provides that a "total of 100% or more shall be rated as 100% of the eye." Therefore, claimant has an impairment rating of 100 percent resulting from the diplopia.

The more difficult question is whether this 100 percent impairment represents 100 percent impairment of one eye or 100 percent impairment of both eyes. For partial or complete loss of vision in one eye, a worker is entitled to a maximum award of 100 degrees scheduled permanent disability. ORS 656.214(2)(h); OAR 436-35-007(18). However, for partial loss of vision in both eyes, a worker is entitled to a maximum award of 300 degrees scheduled permanent disability. ORS 656.214(2)(i); OAR 436-35-007(18).

Binocular diplopia necessarily involves both eyes in that a person who suffers from this condition has double vision when seeing with both eyes. In this regard, we note that claimant testified that she does not have double vision when she closes one eye. This is consistent with Dr. Hagen's finding that claimant does not have monocular diplopia. However, the rule that rates binocular diplopia provides for only one rating value for this type of impairment; it does not provide a method for determining an impairment value for each eye. OAR 436-35-260(4). In addition, OAR 436-35-260(4)(b) states that a "total of 100% or more shall be rated as 100% of the eye." [Emphasis added]. This language is in the singular. For these reasons, we conclude that the 100 percent impairment value represents 100 percent impairment of one eye, not 100 percent impairment of both eyes. Accordingly, claimant is entitled to 100 percent (100 degrees) scheduled permanent disability for monocular loss of vision. ORS 656.212(2)(h).

ORDER

The ALJ's order dated November 16, 1994 is modified. In lieu of the ALJ's award of 100 percent (300 degrees) scheduled permanent disability for loss of binocular vision, claimant is awarded 100 percent (100 degrees) scheduled permanent disability for loss of monocular vision. Claimant's counsel's out-of-compensation attorney fee as awarded by the ALJ is adjusted accordingly. The remainder of the ALJ's order is affirmed.

**Board Member Gunn concurring in part and dissenting in part.**

I agree with the majority that we are unable to rate any loss in central visual acuity on this record. I also agree that the standards provide for rating a binocular diplopia condition and that claimant has an impairment rating of 100 percent resulting from the compensable binocular diplopia condition. However, I disagree with the majority's determination that this impairment is to be valued as a loss of vision in one eye rather than a loss of vision in both eyes. Because I would find that claimant is entitled to 100 percent impairment of both eyes (300 degrees), I respectfully dissent.

As a preliminary matter, OAR 436-35-260(4) provides for ratings for ocular motility impairment resulting in binocular diplopia, and I am statutorily bound to apply that rule to determine claimant's impairment. ORS 656.283(7). However, OAR 436-35-260(4) is so poorly drafted that it is almost unintelligible. Specifically, it provides little basis to determine whether the rating for binocular diplopia is to be valued as a loss of vision in one eye or loss of vision in both eyes. Nevertheless, for the following reasons, I conclude that OAR 436-35-260(4) values binocular diplopia impairment as a loss of vision in both eyes.

First, by definition, "binocular" pertains to both eyes. Therefore, it is not logical to rate as loss of vision in one eye an impairment that necessarily involves both eyes.

Second, examination of the earlier version of the applicable rule reveals that, prior to the current version of the rule, the Director clearly intended to rate binocular diplopia as loss of vision in one eye. To this effect, former OAR 436-35-260(6) provided in relevant part:

> "[r]atings for ocular motility (binocular double vision) are figured as follows:
>
> "(a) The two areas which result in the greatest disability from binocular double vision are vision straight ahead (primary gaze) and downward vision. If a worker has to close an eye to stop binocular double vision, this is, in effect, a loss of an eye. Double vision in the primary gaze is thus rated at 100% of an eye. * * * *"

WCD Admin. Order No. 2-1991. [Emphasis added].

In contrast, the current version of the applicable rule is found at OAR 436-35-260(4), and provides in relevant part:

> "[r]atings for ocular motility impairment resulting in binocular diplopia are determined as follows:

"(a) Determine the single highest value of loss for diplopia noted on each of the standard 45° meridians as scheduled in the following table.

"(b) Add the values obtained for each meridian to obtain the total impairment for loss of ocular motility. A total of 100% or more shall be rated as 100% of the eye. * * * * *"

WCD Admin. Order No. 6-1992. [Emphasis added].

The highlighted language in both versions of the rule shows that the earlier version clearly rated 100 percent impairment due to diplopia as 100 percent loss of one eye. However, the current version is not as clear. I interpret this change in the language to change the meaning to now rate vision loss due to binocular diplopia as a loss of vision in both eyes. This would comply with the definition of "binocular," as addressed above. To hold otherwise would mean that the Director changed the language of the rule without intending to change the meaning, and that would make no sense.

Based on the above reasoning, I find that 100 percent impairment due to binocular diplopia is valued as a loss of vision in both eyes. Therefore, I would affirm the ALJ's award of 300 degrees for this impairment. ORS 656.214(2)(i); OAR 436-35-007(18).

---



In the Matter of the Compensation of
**CONNIE G. JOHNSON, Claimant**
WCB Case No. 94-04315
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order which declined to award penalties and attorney fees for the insurer's allegedly unreasonable claim processing. Claimant has also submitted documents not present in the record before the ALJ. We treat such a submission as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are penalties, attorney fees and remand. We deny the motion for remand and reverse in part and affirm in part.

## FINDINGS OF FACT

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

In April 1993, claimant filed an occupational disease claim for a right shoulder condition. The insurer initially denied the claim, but a prior ALJ ordered it to accept the claim. The prior ALJ's order was affirmed by the Board.

On September 26, 1994, the insurer had a panel of examining physicians, Drs. Fry and Watson, evaluate claimant's right shoulder condition. The panel reported that their examination was very unsatisfactory due to a lack of medical reports and claimant's hostility toward the employer, which caused them to question the validity of their findings. On December 2, 1994, the insurer advised claimant that, owing to her failure to cooperate with the examining physicians, there was a lack of documentation that claimant was disabled from her right shoulder condition. After informing claimant that it was denying her claim for disability benefits, the insurer terminated its payment of temporary disability.

On December 9, 1994, claimant filed a request for hearing raising the issues of compensability, temporary disability rate, penalties and attorney fees pursuant to ORS 656.382(1), 656.262(10), and 656.386(1). On that same date, claimant filed a motion for an expedited hearing with accompanying affidavit from claimant. A hearing was scheduled for February 9, 1995.

On December 20, 1994, claimant filed a "Motion for Judgment on the Pleadings," which included an affidavit of counsel with attachments and memorandum of law. Six exhibits were offered in support of the motion, consisting of an Opinion and Order of February 14, 1994, a September 8, 1994 Order on Review and four medical reports. In her memorandum of law, claimant alleged entitlement to a penalty and associated attorney fee, citing former ORS 656.262(10)(a). In his affidavit, claimant's counsel wrote that the issues at the February 9, 1995 hearing were claimant's entitlement to temporary disability, penalties and attorney fees for unreasonable failure to pay benefits.

After the insurer filed a response opposing claimant's motion, a telephone conference was held on January 5, 1995 between the assigned ALJ, claimant's counsel and the insurer's attorney. The parties stipulated that claimant's motion would be treated as a motion for an Order to Show Cause under OAR 438-06-075(2)(b). The parties also agreed that they would submit written arguments in support of their positions in lieu of a "show-cause" hearing.

On January 6, 1995, the ALJ issued an Order to Show Cause, determining that the matter would be resolved based upon the written factual concessions and legal arguments of counsel. In an attached letter, the ALJ stated that the issue was the "propriety of the termination of compensation payments," and that the parties were to submit any arguments as to whether the insurer was entitled to a hearing on claimant's substantive entitlement to temporary disability. The ALJ advised that the February 9, 1995 hearing would be used to address that issue should it be determined that claimant was entitled to a hearing on substantive temporary disability.

In his order, the ALJ described the issue to be decided as whether the insurer was required to continue payments of temporary disability after December 2, 1994. In making his factual findings, the ALJ relied exclusively on claimant's Motion for Judgment/Motion for an Order to Show Cause, the insurer's objection to the Motion, the insurer's response to the "show-cause" order and the six exhibits submitted by claimant with her original motion.

Concluding that the insurer had shown no basis that would justify its unilateral termination of temporary disability, the ALJ ordered the insurer to resume payment of temporary disability as of the date such compensation was terminated. The ALJ also concluded that the scheduled hearing on February 9, 1995 should not be used to determine substantive entitlement to temporary disability. The parties agreed that the scheduled hearing could be canceled.

On February 13, 1995, claimant moved to have the ALJ abate and reconsider his order, alleging that she was entitled to an award of penalties and attorney fees for the insurer's allegedly unreasonable unilateral termination of temporary disability. The ALJ denied claimant's motion in a February 24, 1995 letter to claimant's and the insurer's counsel. The ALJ reasoned that claimant did not assert entitlement to a penalty or attorney fee in her original motion. The ALJ further noted that the parties had agreed the February 9, 1995 hearing was unnecessary and that, if claimant had other issues for resolution, this would have been the means by which to resolve them.

## CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that she timely raised the issue of penalties and attorney fees in her request for hearing and Motion for Judgment and, further, that the insurer's unilateral termination of temporary disability was unreasonable. Accordingly, claimant alleges that she is entitled to an award of penalties and attorney fees pursuant to ORS 656.262(10) and 656.382(1). Claimant also asserts entitlement to an attorney fee under ORS 656.386(1) because her counsel was instrumental in obtaining compensation without a hearing and because she finally prevailed from an order or decision denying a claim for compensation.

The insurer responds that the ALJ properly held that claimant did not timely raise the issue of penalties and attorney fees in her motion and that claimant's failure to properly raise those issues prevents it from having an opportunity to rebut any allegations of unreasonable conduct. The insurer also argues that the issue of an attorney fee under ORS 656.386(1) was also untimely raised and, assuming arguendo that it was timely raised, that there was no denial of a claim for compensation.

Remand

At the outset, we note the threshold issue concerning claimant's submission of documents that the ALJ did not consider. On March 16, 1995, claimant submitted a February 14, 1995 list of exhibits that she wished the Board to consider in this matter. It consisted of numerous documents, including medical reports, that the ALJ did not consider in rendering his decision on claimant's motion. As previously noted, we generally treat such submissions as a motion for remand. See Judy A. Britton, supra. Claimant avers that she does not desire a remand and that all the documents submitted were in the Board's file.

The record we consider, however, is limited to that developed by the ALJ. Ronald L. Bartlett, 45 Van Natta 948, 949 (1993). Claimant specifically relied on the documents that she submitted with her original Motion for Judgment and the ALJ made his findings of fact based on a limited amount of documents. Under these circumstances, we are not inclined to allow supplementation of the record in the manner in which claimant suggests. Accordingly, we treat claimant's submission as a motion for remand, which we deny for the following reasons.

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 ORS 656.295(5). To warrant remand, the moving party must show good cause or a 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).

In this case, we find no good cause or compelling basis to remand. First, none of the documents submitted is likely to affect the outcome of the case (see discussion of issues below). Second, claimant offers no reason why these documents could not have been submitted with her original motion for judgment. Thus, we find a lack of due diligence.

On April 14, 1995, claimant requested that we take administrative notice of documents consisting of those the ALJ considered in making his decision, as well as other pleadings and agency orders, including claimant's hearing request, her motions for expedited hearing and judgment on the pleadings, the ALJ's show-cause order, the ALJ's opinion and order, claimant's motion to abate and the ALJ's response.

The Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." This has been held to include agency orders and stipulations by the parties. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Mark A. Crawford, 46 Van Natta 725 (1994); Jenetta L. Gans, 41 Van Natta 1791 (1989).

Inasmuch as the documents submitted were either considered by the ALJ or meet the requirements of the above cases, these documents will be considered by the Board on review. However, we have not taken administrative notice of any medical reports not considered by the ALJ or any other "non-noticeable" documents.

Penalties and Attorney Fees

In his February 24, 1995 letter denying claimant's request for reconsideration, the ALJ concluded that claimant did not timely raise the issue of penalties and attorney fees. We disagree.

Claimant filed a request for hearing on December 9, 1994, which expressly raised, among other issues, penalties and attorney fees. Before the scheduled hearing on February 9, 1995, claimant filed her motion for an expedited hearing and a motion for a judgment on the pleadings. In lieu of a full evidentiary hearing, the parties apparently agreed to submit the issue of the "propriety" of the insurer's unilateral termination of temporary disability to the ALJ for a summary decision based on a very limited record. It appears from the ALJ's order, as well as his letter denying claimant's motion to reconsider, that the issue of penalties and attorney fees was not discussed in the January 5, 1995 telephone conference. The insurer contends that the ALJ properly refused to consider the issue of penalties and attorney fees based on claimant's failure to raise the issue during the telephone conference.

However, it is well settled that issues raised in a request for hearing are ripe for resolution, even if they are not raised or argued at hearing. See Liberty Northwest v. Alonzo, 105 Or App 458 (1991); Murray L. Johnson, 45 Van Natta 470 (1993). Inasmuch as claimant clearly raised penalty and attorney fee issues in her hearing request, we are inclined to find that those issues were properly raised and should have been considered by the ALJ.

The insurer contends, however, that the issues raised in claimant's hearing request were to be resolved in the hearing scheduled on February 9, 1995. Because claimant agreed to cancel that hearing after the ALJ issued his order, and because the proceeding concerning claimant's "show-cause" motion was separate from the scheduled February 9, 1995 hearing, the insurer argues that the issues raised in claimant's hearing request did not apply to the expedited "show-cause" proceeding. We disagree.

Even assuming that the insurer is correct that the issues raised in claimant's hearing request pertained exclusively to the canceled February 9, 1995 hearing, claimant nonetheless raised penalty and fee issues in her motion for expedited hearing/judgment. Specifically, claimant raised penalty and attorney fee issues both in claimant's counsel's affidavit and in the memorandum of law which accompanied claimant's motion. Under these circumstances, we conclude that penalty and attorney fee issues were properly raised and should have been considered by the ALJ.

We now turn to the issue of whether the record is sufficiently developed so that we can determine claimant's entitlement to penalties and attorney fees. The insurer asserts that it was deprived of the opportunity to rebut any allegation of unreasonable conduct. The insurer's assertion notwithstanding, we find the record sufficiently developed so that we can make a determination as to claimant's entitlement to a penalty.

The ALJ noted that an insurer may not terminate temporary total disability unless one of the provisions of ORS 656.268(3) is satisfied. See Sandoval v. Crystal Pine, 118 Or App 640 (1993). The insurer did not argue that the requirements of that statute were satisfied, but instead asserted that it was entitled to terminate temporary disability because claimant was not disabled and failed to cooperate with medical examiners. The ALJ rejected the insurer's arguments and concluded that the insurer had shown no basis to justify its unilateral termination of temporary disability on December 2, 1994. Since he did not consider any penalty and attorney fee issues to have been raised, the ALJ did not consider the issue of the reasonableness of the insurer's conduct. The ALJ instead ordered that temporary disability be resumed and that claimant's counsel receive an out-of-compensation attorney fee.

On review, the insurer does not advance any argument that its termination of temporary disability was justified under ORS 656.268(3) or any other statutory provision. Instead, it alleges that the termination of temporary disability was appropriate in light of the claimant's "unreasonable resistance to employer's efforts to verify her alleged disability." However, such is not a legitimate basis for terminating temporary disability under ORS 656.268(3). Cf. Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986) (employer must strictly comply with administrative rule setting forth procedural requirements for terminating TTD).

Given the insurer's failure to cite any evidence reasonably likely to affect the outcome of the case, we find no good cause or compelling reason to remand for further evidence taking on the issue of whether the insurer's conduct was reasonable. See Compton v. Weyerhaeuser Co., supra. Moreover, we find the record sufficiently developed to make a determination as to whether the insurer's conduct was reasonable. See ORS 656.295. Inasmuch as the insurer's explanation for its unilateral termination of claimant's temporary disability has no statutory basis, we find that the insurer's conduct was unreasonable. Accordingly, we assess a 25 percent penalty under ORS 656.262(11) on "amounts then due" (as of the date the record was closed) as a result of the ALJ's order. The penalty is to be shared equally by claimant and her counsel.

Claimant also asserts that she is entitled to a separate attorney fee under ORS 656.382(1) for the insurer's unreasonable resistance to the payment of compensation. We reject her request.

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 or the unreasonable resistance is not the same conduct for which a penalty has

been assessed under ORS 656.262(11). Corona v. Pacific Resource Recycling, 125 Or App 47 (1993); Oliver v. Norstar, Inc., 116 Or App 333 (1993); Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992). Inasmuch as there is compensation on which to base a penalty, and because the unreasonable resistance is the same conduct for which a penalty is assessed under ORS 656.262(11), claimant is not entitled to a separate attorney fee under ORS 656.382(1).

Finally, claimant requests an attorney fee under ORS 656.386(1). Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). 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 the insurer's failure to pay temporary disability benefits. The insurer did not deny the compensability of claimant's condition or medical services. Under these circumstances, the record does not support a conclusion that claimant's compensable right shoulder condition 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; Glenn C. Smith, 47 Van Natta 1568 (1995).

ORDER

The ALJ's order dated February 1, 1995, as supplemented on February 24, 1995, is reversed in part and affirmed in part. That portion which declined to assess a penalty for the insurer's allegedly unreasonable claim processing is reversed. Claimant is awarded a 25 percent penalty under ORS 656.262(11), to be based on the temporary disability due (as of the date the record was closed) as a result of the ALJ's order, to be shared equally by claimant and her attorney. The remainder of the ALJ's order is affirmed.

---

October 12, 1995 Cite as 47 Van Natta 1988 (1995)

In the Matter of the Compensation of
**SANDRA A. KINCAID, Claimant**
WCB Case No. 94-14889
ORDER ON REVIEW
Dwayne R. Murray, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Gunn and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's occupational disease claim for myofascial pain syndrome. On review, the issue is compensability.

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

On review, the insurer challenges the opinion of rheumatology specialist Melnyk as conclusory, in view of the fact that "Dr. Melnyk responded in check-response fashion to a letter posed by claimant's counsel." However, prior to agreeing that claimant's work activity is the major contributing cause of her myofascial pain syndrome, Dr. Melnyk had the opportunity to examine and treat claimant on a long term basis and to consider the reports and studies generated by other consulting and examining physicians. Thus, Dr. Melnyk had a solid foundation for her conclusions.

Under these circumstances, we are persuaded by Dr. Melnyk's opinion that claimant's work activity is the major contributing cause of her myofascial pain syndrome. We find it pertinent that Dr. Melnyk examined claimant on several occasions and that she reviewed the findings of claimant's other examining physicians prior to rendering her opinion. Therefore, we find Dr. Melnyk's opinion persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Although insurer-arranged medical examiners

Watson and Martens concluded that claimant's condition (for which they recommended expert rheumatological evaluation for diagnosis and treatment) could not be work-related, we are suspect of their conclusion, considering they did not evince knowledge of claimant's condition or work activities.

Claimant is entitled to an attorney fee for her counsel's 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 Board review is $1,000, to be paid by 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 31, 1995 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the insurer.

---



In the Matter of the Compensation of
**MALIKA LETHE, Claimant**
WCB Case Nos. 94-14558 & 94-10998
ORDER ON REVIEW
Max Rae, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld the SAIF Corporation's denial of claimant's new injury claim for a low back condition; (2) found that claimant failed to establish an aggravation claim for the same condition; and (3) increased claimant's unscheduled permanent disability from 10 percent (32 degrees), as awarded by an Order on Reconsideration, to 22 percent (70.4 degrees). On review, the issues are compensability, aggravation and extent of unscheduled permanent disability. We affirm in part and modify in part.

## FINDINGS OF FACT

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

Claimant is restricted to work in the light-sedentary strength category with restrictions on walking/standing, bending and squatting.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

We adopt and affirm the ALJ's opinion on the compensability issue.[1]

### Aggravation

We adopt and affirm the ALJ's opinion on the aggravation issue.[2]

---

[1] Subsequent to the ALJ's order, the 1995 Legislature enacted Senate Bill 369, which amended several sections of the Workers' Compensation Law. See Or Laws 1995, ch 332, §§ 37, 66 (SB 369, §§ 37, 66); Volk v. America West Airlines, 135 Or App 565 (1995). However, retroactive application of the new law would have no effect on the outcome of the compensability issue in this case.

[2] SB 369 amended ORS 656.273(1), the aggravation statute. SB 369, §§ 31, 66. Retroactive application of the amended statute would have no effect on the outcome of the aggravation issue in this case.

Extent of Unscheduled Permanent Disability

We adopt and affirm the ALJ's opinion on the extent of unscheduled permanent disability issue with the following supplementation and modification.[3]

The ALJ rated claimant's skills at SVP 5, based on the DOT category "Apartment Manager." Claimant contends that the ALJ erred in the selection of the DOT category, as she merely received checks and performed cleaning and painting duties, not the full range of Apartment Manager duties. Thus, she argues, her skills should be rated at SVP 2, based on cashiering (DOT 311-472-010) and cleaning (DOT 381.687-014 and DOT 381.687-026). We disagree.

Although claimant cannot read and write, she showed apartments to prospective tenants, explained the rent, made arrangements for apartment maintenance, and handled complaints. (Tr. 33-34, 41). Moreover, a medical report stated that claimant was "involved in all facets of apartment management [for a 32-unit apartment] which involves bookkeeping, arranging for maintence and repairs, advertising vacant units, grading the public, interacting with residents." (Ex. 15-10). In addition, claimant described herself as an "apartment manager" and her boyfriend described claimant and himself as "joint managers." (Tr. 17, 48). We have not found another DOT job description which more accurately reflects claimant's job than apartment manager, DOT 186.167-018. Accordingly, we agree with the ALJ's conclusion that claimant's SVP is 5, giving claimant a skills value of 2.

Based on a physical capacities evaluation (Ex. 7), claimant contends that she is not only released to light/sedentary work, but that she also has restrictions within that level. We agree.

Claimant was restricted in walking, bending and crouching (squatting).[4] See OAR 436-35-310(3)(l)(A) and (C). Consequently, the next lower category should be used, which establishes claimant's RFC as sedentary. OAR 436-35-310(7). Comparing claimant's base functional capacity (medium) to her residual functional capacity of sedentary yields an adaptability value of 5. OAR 436-35-310(6).

Having determined claimant's adaptability value, we recalculate claimant's unscheduled permanent disability under the standards. The value for claimant's age and education remains 3. That sum (3) is multiplied by claimant's adaptability value (5). The product (15) is added to the impairment value (10) for a total of 25 percent, which represents claimant's unscheduled permanent disability.

ORDER

The ALJ's order dated March 27, 1995 is affirmed in part and modified in part. In addition to the ALJ's and Order on Reconsideration awards totalling 22 percent (70.4 degrees) unscheduled permanent disability, claimant is awarded an additional 3 percent (9.6 degrees) unscheduled permanent disability for a total award to date of 25 percent (80 degrees) unscheduled permanent disability. Claimant's counsel is awarded 25 percent of the increased compensation created by this order. However, claimant's total "out-of-compensation" attorney fee award shall not exceed $3,800. The remainder of the order is affirmed.

---

[3] The ALJ rejected claimant's assertion that her disability should be rated based on Dr. Arbeene's insurer-arranged medical examination, on the basis that his examination took place after the medical arbiter examination. Subsequent to the ALJ's order, SB 369 amended ORS 656.268(7)(g) to provide: "After 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." Dr. Arbeene's October 21, 1994 report issued after the September 8, 1994 Order on Reconsideration. It thus remains inadmissible for the purpose of rating claimant's permanent impairment.

[4] SAIF contends that claimant's MCO-doctor who issued the evaluation indicated that some of the impairment claimant demonstrated was inconsistent with straight leg raising and that, therefore, we should not rely on his findings. SAIF's argument is not well-taken. First, straight leg raising is a test of range of motion findings, not of work restrictions. In any event, the doctor subsequently attributed the measurements to the work-related injury. (Ex. 9). Moreover, the doctor's report is not used to establish impairment. Finally, in addition to releasing claimant to sedentary/light work, the doctor reliably found that claimant was restricted from frequently performing several kinds of repetitive movements, as shown above.

In the Matter of the Compensation of
**DOLLEY S. MACK, Claimant**
WCB Case Nos. 93-11043 & 93-13311
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

AIAC, claims processing agent for the self-insured employer, Wal-Mart Corporation, requests review of Administrative Law Judge (ALJ) Howell's order which: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for the same condition. On review, the issues are compensability and responsibility. We reverse.

## FINDINGS OF FACT

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

We do not find that claimant's employment activities with Wal-Mart were the major contributing cause of a pathological worsening of claimant's preexisting carpal tunnel syndrome (CTS).

## CONCLUSIONS OF LAW AND OPINION

### Compensability

We adopt the ALJ's conclusions and opinion concerning this issue.

### Responsibility

We adopt the ALJ's application of the last injurious exposure rule to assign initial responsibility for claimant's bilateral CTS to SAIF.

Applying ORS 656.308(1) and 656.005(7)(a)(B), the ALJ then concluded that SAIF had carried its burden of proving that claimant had sustained a "new compensable injury involving the same condition" so as to shift responsibility for the bilateral CTS to Wal-Mart/AIAC. We disagree with this conclusion.

We agree with the ALJ that, in order to shift responsibility to Wal-Mart/AIAC, SAIF must prove that claimant sustained a "new compensable injury involving the same condition" while employed by Wal-Mart. See ORS 656.308(1)[1]; SAIF v. Drews, 318 Or 1 (1993). The term "compensable injury," as used in ORS 656.308(1), is intended to encompass occupational disease claims as well. Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314, 317(1993). Thus, in order to shift responsibility, SAIF would have to establish that, during her employment with Wal-Mart, claimant experienced a new compensable injury or occupational disease. See id.

We disagree with the ALJ's finding that claimant experienced a new compensable injury (as defined in ORS 656.005(7)(a)) with Wal-Mart. The record in this case shows that claimant's recurrent CTS symptoms came on gradually, without any precipitating trauma or event, during her employment with Wal-Mart. Claimant testified that she noticed increased CTS symptoms after working a "couple weeks" in Wal-Mart's pet department. (Tr. 26). Her testimony is supported by Dr. Jany's contemporaneous medical reports which document a gradual increase in symptoms. (Exs. 41-43). Given the gradual onset of recurrent CTS symptoms, we find the symptoms must be analyzed as an ongoing

[1] Subsequent to the ALJ's order, ORS 656.308(1) was amended by the 1995 Legislature. Or Laws 1995, ch 332, § 37 (SB 369, § 37). However, we conclude that the amended version of the statute would not change our analysis or result in this case.

condition, i.e., an occupational disease claim pursuant to ORS 656.802,[2] rather than an accidental injury claim pursuant to ORS 656.005(7)(a). See Mathel v. Josephine County, 319 Or 235, 241-42 (1994); James v. SAIF, 290 Or 343, 348 (1981). Therefore, in order to shift responsibility, SAIF must prove that claimant sustained a new occupational disease involving the bilateral CTS while employed by Wal-Mart.

A new occupational disease claim for the bilateral CTS is established by proof that employment conditions at Wal-Mart were the major contributing cause of the CTS or its worsening. ORS 656.802(2).[3] Because the medical record in this case establishes that the initial onset of claimant's bilateral CTS preexisted, and was not caused by, Wal-Mart's employment conditions, SAIF must prove that Wal-Mart's employment conditions were the major contributing cause of a pathological worsening of the preexisting CTS. See Weller v. Union Carbide, 288 Or 27, 35 (1979).[4] This issue presents a complex medical question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993).

The medical evidence in this case was generated by Drs. Donahoo, Gancher, Martens and Jany. Of these doctors, only Dr. Jany specifically addressed the issue of whether Wal-Mart's employment conditions caused a pathological worsening of the preexisting CTS. He opined that Wal-Mart's employment conditions caused a temporary flare-up of CTS symptoms without an objective worsening, which then returned to "pre-Wal-Mart" baseline level upon her removal from those conditions. (Exs. 62-2, 63-24, 63-25, 63-26). In his deposition, Dr. Jany explained that his opinion was based in part on the normal nerve conduction studies that were performed by Dr. Radecki in June 1993. (Ex. 63-25; see Ex. 46).

Based on Dr. Jany's thorough and well-reasoned opinion, see Somers v. SAIF, 77 Or App 259, 263 (1986), and the absence of any medical opinion to the contrary, we conclude that SAIF has not carried its burden of proving that Wal-Mart's employment conditions caused a pathological worsening of claimant's preexisting CTS. Accordingly, a new occupational disease has not been established, and responsibility for the bilateral CTS remains with SAIF.

Because compensability remained at issue on review, claimant's counsel is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 $500, payable by AIAC, the carrier who requested Board review. Cigna Insurance Companies v. Crawford and Co., 104 Or App 329 (1990). 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.

---

[2] ORS 656.802 was also amended by the 1995 Legislature. SB 369, § 56. Nevertheless, the amended version of ORS 656.802 would not change our analysis in distinguishing an occupational disease claim from an accidental injury claim.

[3] ORS 656.802(2) was also amended by the 1995 Legislature. SB 369, § 56. Amended ORS 656.802(2) provides:

"(a) The worker must prove that employment conditions were the major contributing cause of the disease.

"(b) If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.

"(c) Occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7).

"(d) Existence of an occupational disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings.

"(e) Preexisting conditions shall be deemed causes in determining major contributing cause under this section."

Under this amended statute, we conclude that our analysis and result in this case would remain the same.

[4] The Weller requirement of proof of a pathological worsening of a preexisting disease has since been codified in amended ORS 656.802(2)(b) by the 1995 Legislature. See infra n 3.

ORDER

The ALJ's order dated September 14, 1994 is reversed. AIAC's responsibility denial is reinstated and upheld. SAIF's denial is set aside, and the bilateral CTS claim is remanded to SAIF for processing according to law. The ALJ's assessed fee award of $2,500 shall be paid by SAIF, rather than AIAC. For services on Board review, claimant's counsel is awarded an assessed fee of $500, payable by AIAC.

---

October 12, 1995 Cite as 47 Van Natta 1993 (1995)

In the Matter of the Compensation of
**PAMELA McGEE, Claimant**
WCB Case No. 94-01450
ORDER OF ABATEMENT
Susak, Dean & Powell, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Claimant has requested reconsideration of our September 19, 1995 order that affirmed an Administrative Law Judge's (ALJ's) 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. Contending that she raised at hearing arguments regarding the Americans With Disabilities Act (ADA), 42 USCA § 12101 et seq., claimant asks that we evaluate the compensability of her low back condition without considering her preexisting degenerative spinal condition.

To further consider claimant's contentions, we withdraw our September 19, 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
**CHARLOTTE A. O'NEAL, Claimant**
WCB Case No. 93-11022
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its partial denial of claimant's C5-6 neck condition and need for medical treatment (surgery); (2) found that claimant's claim had been prematurely closed; and (3) awarded claimant an assessed attorney fee. Claimant cross-requests review of that portion of the order that found surgery for claimant's neck condition was not reasonable and necessary. On review, the issues are compensability, jurisdiction over medical services disputes, premature closure, and attorney fees. We vacate in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable neck injury at work in November 1992. X-rays taken in December 1992 showed evidence of degenerative disc disease (DDD) at C4-5 and C5-6. Claimant filed a claim for "strain/neck" which the insurer accepted as a nondisabling "cervical strain." The preexisting DDD was not accepted as part of the injury claim.

Because claimant's symptoms suggested a radicular process, in February 1993, then-treating physician Petersen referred her to neurosurgeon Lax, who thereafter became claimant's treating physician. Also in February 1993, claimant was examined by medical examiners Wilson and Dineen. They found no evidence of cervical radiculopathy, declared claimant medically stationary with regard to the November 1992 injury, and opined that claimant had no permanent impairment as a result of the compensable injury.

In April 1993, medical examiner Rosenbaum also found claimant medically stationary from the industrial injury. Rosenbaum diagnosed cervical spondylosis (i.e., DDD) and cervical strain by history. Although Dr. Rosenbaum recorded restricted ranges of motion and reported that claimant had minimal loss of function based on subjective symptoms, he opined that claimant had no objective findings of impairment.

Dr. Lax interpreted a March 1993 myelogram as showing a significant lesion at C5-6 due to a combined degenerative bone spur and disc herniation. Lax questioned whether a discectomy would result in any change in claimant's condition.

By Notice of Closure, on May 12, 1993, the insurer reclassified the claim as disabling and closed the claim without an award of permanent disability. On May 19, 1993, Dr. Lax agreed with Dr. Rosenbaum's objective findings and conclusions. In addition, Lax noted that claimant's condition had not changed in six months and probably would not improve in the ensuing six months. Notwithstanding his agreement with Rosenbaum's conclusions and his reservations concerning surgery, Lax stated claimant should have the option of C5-6 disc surgery.

On July 23, 1993, the insurer advised Dr. Lax that it would not authorize surgery and that it would refer the dispute to the Medical Director for review. Dr. Lax performed an anterior cervical discectomy on July 29, 1993, during which he removed a small extremely degenerated disc, cartilaginous herniation, and a moderate sized bone spur from the C5-6 level.

An August 16, 1993 Order on Reconsideration modified the award of temporary disability, but otherwise affirmed the Notice of Closure.

On October 11, 1993, the insurer partially denied the compensability of claimant's C5-6 neck condition, stating, in relevant part:

> "We have recently received information that you are seeking treatment for C5-6 radiculopathy which you state is related to your original injury of November 19, 1992. After carefully reviewing your file, we are unable to accept responsibility for any treatment (specifically, Anterior Discectomy at C5-6) and/or disability in connection with your current condition. Therefore, we must deny your claim for benefits."

No party requested Director review. Instead, claimant requested hearing from the insurer's denial and the Order on Reconsideration.

At hearing, the parties identified the issues for resolution as the insurer's C5-6 compensability denial, premature claim closure and, if the C5-6 condition is not compensable, extent of permanent partial disability. The ALJ found that claimant's work injury was not the major contributing cause of claimant's disc herniation. The ALJ further found that the discectomy was inappropriate and ineffectual treatment for claimant's compensable condition. Nonetheless, the ALJ reasoned that because the surgery was a "last gasp" effort to relieve claimant's symptoms, there existed a compensable causal relationship between the work injury and the surgery. The ALJ concluded that "as to claimant, therefore, the surgery is compensable," entitling claimant to temporary and permanent disability benefits related to the surgery. Accordingly, the ALJ ordered the insurer to "accept as compensable, with respect to claimant, the neck surgery," but adjudged that neither claimant nor the insurer was required to pay for the surgery.

Compensability / C5-6 Condition

Subsequent to the ALJ's order, the legislature amended ORS 656.327(1) and added ORS 656.245(6), each of which requires review of medical services disputes by the Director, unless a claim for medical services is denied on the basis that the underlying claim is not compensable.Or Laws 1995, ch 332, §§ 25, 41, 66, and 69 (SB 369, §§ 25, 41, 66, and 69); Newell v. Saif,136 Or App 280 (1995); Walter L. Keeney, 47 Van Natta 1387, 1389, recon den 47 Van Natta 1525 (1995). Inasmuch as the insurer's October 1993 denial was a denial of the compensability of claimant's underlying C5-6 condition, we retain jurisdiction over this matter.

Claimant's original claim was accepted for a neck strain only. This dispute concerns a C5-6 disc condition which culminated in a discectomy in July 1993. We first decide what standard applies to determine compensability of the disputed C5-6 condition. Claimant argues that her claim is for a condition directly resulting from the November 1992 compensable injury, and that the condition is compensable because it was caused in material part by the compensable injury. ORS 656.005(7)(a). We conclude, however, that the applicable statute is ORS 656.005(7)(a)(B).[1]

Dr. Lax has identified a lesion at C5-6 due to a combined degenerative bone spur and disc herniation. At his deposition, Lax explained that claimant's symptoms were caused by "a disc herniation on top of her pre-existing degenerative disease." That opinion is uncontroverted. Therefore, we conclude that claimant must establish the compensability of the C5-6 condition by the "major contributing cause" standard applicable to "combined" conditions under ORS 656.005(7)(a)(B).

Given the multiple potential causes of claimant's neck condition, we find that the causation issue is a medically complex question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993). There is no medical opinion to support a finding that the 1992 work injury was the major contributing cause of claimant's "combined" C5-6 condition and need for surgery.

---

[1] The Legislature has amended ORS 656.005(7)(a)(B). SB 369, §§ 1, 66 and 69. In this case, however, our determination as to the compensability of claimant's current cervical condition would be the same regardless of whether we apply the former or current version of the statute.

Here, Dr. Lax has stated that the compensable November 1992 injury was the major cause of claimant's degenerative neck condition becoming symptomatic. Nevertheless, Dr. Lax did not address the effect of the herniated disc 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.

Therefore, we conclude that claimant has failed to meet her burden of proving that the work injury was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B). Accordingly, to the extent it denied the compensability of claimant's C5-6 condition, we reinstate and uphold the insurer's partial denial.

Given our conclusion that claimant has not established the compensability of the C5-6 neck condition that resulted in surgery, it follows that claimant is not entitled to temporary and permanent disability benefits related to the surgery.

C5-6 Surgery

On review, claimant contends that the denied surgery was "reasonable and necessary." The Director now has exclusive jurisdiction over such medical services disputes. ORS 656.327(1); ORS 656.245(6); Newell v. Saif, supra; SB 369, §§ 25, 41, 66, and 69; Walter L. Keeney, supra. We accordingly vacate that portion of the ALJ's order that found that the discectomy was "inappropriate and ineffectual" treatment for claimant's compensable condition, and dismiss claimant's cross-request for hearing on the medical services issue for lack of jurisdiction.

Premature Closure / Extent of Permanent Disability

Finding that claimant was still under active care and had not been declared stationary by her treating physician, the ALJ concluded that claim closure was premature. On review, the insurer contends that a preponderance of the evidence establishes that claimant was medically stationary on April 22, 1993. We agree.

"Claims shall not be closed if the worker's condition has not become medically stationary." ORS 656.268(1).[2] As we have found herein, the C5-6 herniated disc is not compensable. Thus, the inquiry becomes whether claimant's compensable cervical strain was medically stationary at the time of closure. 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 propriety of the closure turns on whether claimant was medically stationary at the time of the May 12, 1993 Notice of Closure considering claimant's condition at the time of closure but not subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. See, e.g., Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980). Nothing restricts consideration of opinions regarding medically stationary status to those opinions rendered by attending physicians. See Patricia M. Knupp, 46 Van Natta 2406 (1994); Francisco Villagrana, 45 Van Natta 1504 (1993); Timothy H. Krushwitz, 45 Van Natta 158 (1993).

In February 1993, medical examiners Wilson and Dineen declared claimant medically stationary with regard to the November 1992 injury. In April 1993, medical examiner Rosenbaum found claimant medically stationary from the industrial injury. Prior attending physician Brooks concurred. Dr. Lax, on the other hand, opined only that claimant should have the option of surgery for the noncompensable C5-6 disc condition. He never addressed whether the accepted compensable cervical strain was medically stationary on the date of claim closure.

---

[2] The Legislature has amended ORS 656.268. SB 369, §§ 30, 66 and 69. The result would be the same regardless of whether we apply the former or current version of the statute.

Inasmuch as Dr. Lax's opinion does not expressly address the question of whether claimant's compensable cervical strain was medically stationary, we find the opinion insufficient to outweigh the opinions on the subject authored by the examining physicians. Therefore, on this record, claimant has failed to meet her burden to prove that her compensable cervical strain claim was prematurely closed. Consequently, we reinstate the Order on Reconsideration.

Because he found the claim was prematurely closed, the ALJ did not reach the issue of permanent disability. We do so now.

With the exception of a medical arbiter appointed pursuant to ORS 656.268(7),[3] 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);[4] Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994). Impairment findings from a physician, other than the attending physician, may be used, however, if those findings are ratified by the attending physician. Tektronix, Inc. v. Watson, 132 Or App 483 (1995). Consequently, in assessing the extent of claimant's permanent disability arising out of the November 1992 injury, the record on review properly includes the reports of claimant's attending physician issued before the medical arbiter's report, the medical arbiter's report and any report related to claimant's impairment that was ratified by the attending physician before the medical arbiter's report. See Tektronix, Inc. v. Watson, supra, 132 Or App at 486.

In rating the extent of unscheduled permanent disability, we apply the standards in effect at the time of claim closure. Here, the Notice of Closure issued on May 12, 1993. Therefore, we apply the standards for rating unscheduled permanent disability as found in WCD Admin. Order 6-1992, effective March 13, 1992.

Claimant must prove that her disability is due to the compensable injury. See ORS 656.214(5). In other words, her permanent impairment must be caused by the accepted conditions; only accepted compensable conditions are ratable. Former OAR 436-35-007(1) and (2). "'Impairment' means a decrease in the function of a body part or system as measured by a physician[.]" Former OAR 436-35-005(5). If there is no measurable impairment under the rules, no award of unscheduled permanent partial disability is allowed. Former OAR 436-35-270(2).

Dr. Becker was appointed medical arbiter. However, due to the fact that he saw claimant at nine days post-discectomy, Becker did not examine claimant, believing he would be unable to obtain a "meaningful objective examination." Becker thus did not measure claimant's impairment, if any. As for attending physician Lax, he never purported to rate claimant's permanent impairment. At most, Lax indicated his agreement with medical examiner Rosenbaum's findings.

Dr. Rosenbaum reported that claimant has preexisting DDD in addition to the compensable strain and recorded restricted ranges of motion. Yet he opined that claimant has no objective findings of impairment. There can be no award for lost ranges of motion where the physician finds that claimant has no permanent impairment. Kathleen L. Hofrichter, 45 Van Natta 268 (1993), aff'd mem Hofrichter v. Hazelwood Farms Bakeries, 129 Or App 304 (1994). Moreover, even assuming that claimant has permanent impairment, Rosenbaum does not attribute claimant's impairment to her compensable condition. See ORS 656.214(5); former OAR 436-35-007(1) and (2).

Because there is no evidence that claimant has any measurable impairment attributable to the November 1992 injury, claimant has not established entitlement to an award of permanent disability. The Order on Reconsideration award of temporary disability only is affirmed.

ORDER

The ALJ's order dated September 12, 1994 is vacated in part and reversed in part. That portion of the order that found surgery for claimant's C5-6 neck condition was not reasonable and necessary is vacated; claimant's cross-request for review on the medical services issue is dismissed. The insurer's partial denial, insofar as it concerns the compensability of claimant's C5-6 condition, is reinstated and upheld. The Order on Reconsideration is reinstated and affirmed in its entirety. The ALJ's attorney fee award is also reversed.

---

[3] Id.

[4] Renumbered ORS 656.245(2)(b)(B). SB 369, § 25.

In the Matter of the Compensation of
**JULIAN VEGA-CABELLO, Claimant**
WCB Case No. 94-07425
ORDER ON REVIEW
H. Galaviz-Stoller, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Balasubramani's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for his lower back, left upper back, left shoulder, cervical, and thoracic strain injuries. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ with the following supplementation.

On review, claimant urges us to rely on the range of motion findings measured by the medical arbiter, Dr. Dinneen, to determine that claimant is entitled to an impairment rating. However, although Dr. Dinneen noted that the findings "are considered to be valid," he also stated that the reduced ranges of motion "are not medically probably due to the incident." (Ex. 79-2, -3). He stated he did not know the cause; however, he noted that "[r]anges [of] motion are under voluntary control, and this may be a factor." (Ex. 79-3). It appears inconsistent to find the ranges of motion "valid" and then question them as being under "voluntary control." However, we cannot rewrite Dr. Dinneen's report and find the loss of ranges of motion related to the compensable injury when Dr. Dinneen explicitly stated that they were not related. Therefore, we do not find Dr. Dinneen's report supports claimant's argument that he is entitled to an impairment rating.

Furthermore, we agree with the ALJ that the attending physician, Dr. Thompson, also does not provide persuasive evidence of impairment due to the work injury. In this regard, Dr. Thompson repeatedly opined that claimant's subjective complaints outweighed his objective findings and that claimant had a functional overlay problem, at times terming that problem "significant." (Exs. 33, 35, 46-1, 48).[1] In addition, Dr. Thompson noted that claimant moved his neck more freely during the interview portion of examinations than during the physical examination portion. (Exs. 41, 44).

Dr. Thompson did not perform a closing evaluation. However, he concurred with the closing evaluation performed by Dr. Wilson, orthopedist. (Exs. 64, 66). In this closing evaluation, the only possible ratable loss Dr. Wilson indicated was a loss of range of motion in the cervical spine. He did not indicate there was any chronic condition impairment. Furthermore, he noted that claimant probably had a functional element and his subjective complaints outweighed his clinical findings. (Ex. 64-3). Dr. Thompson checked a box indicating that he agreed with Dr. Wilson's closing evaluation.

---

[1] We note that, following the medical arbiter's report, but prior to the Department's reconsideration, Dr. Thompson repeated his opinion that claimant has a "significant functional component" and claimant's "subjective complaints far outweigh his objective findings." (Ex. 80-2). Neither party objected to the admission of this evidence either at hearing or on review. However, pursuant to former ORS 656.268(7), we are expressly prohibited from considering "post-arbiter" medical evidence pertaining to impairment. Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). Furthermore, we have determined that we cannot consider such evidence regardless of a party's failure to object. David J. Rowe, 47 Van Natta 1295 (1995).

On the other hand, ORS 656.268(7) was amended by the 1995 legislature. Or Laws 1995, ch 332, § 30 (SB 369, § 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, we need not decide whether the amended statute is retroactively applicable because, under either version of the statute, the result would be the same.

Given the fact that Dr. Thompson earlier questioned the validity of claimant's range of motion measurements and repeatedly expressed concern over both claimant's functional overlay problem and the fact that claimant's subjective complaints outweighed his objective findings, we do not find Dr. Thompson's check-the-box concurrence, without some additional explanation, persuasive evidence of any impairment related to the work injury.

On this record, claimant has failed to prove that the work injury resulted in any impairment. Without some measurable impairment under the standards, no award of unscheduled permanent disability is allowed. OAR 436-35-270(2) [WCD Admin. Order 6-1992].

ORDER

The ALJ's order dated April 24, 1995 is affirmed.

---

October 12, 1995 Cite as 47 Van Natta 1999 (1995)

In the Matter of the Compensation of
**WENDY YOURAVISH, Claimant**
Own Motion No. 94-0619M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Jon C. Correll, Claimant Attorney
Liberty Northwest Insurance Corp., Insurance Carrier

Claimant requests review of the insurer's June 3, 1995 Notice of Closure which closed her claim with an award of temporary disability compensation from November 8, 1994 through February 22, 1995. The insurer declared claimant medically stationary as of May 24, 1995. Alternatively, claimant contends that she perfected an aggravation claim prior to the expiration of her aggravation rights, and she "objects to the Board's handling of the claim under it's [sic] "Own Motion" jurisdiction."

In a July 21, 1995 letter, we requested that the parties submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response to the Board on August 3, 1995, noting that "[a] copy of this information is being supplied to [claimant's] attorney under separate cover." By letter dated August 4, 1995, claimant notified the parties that no documents had been received from the insurer regarding her claim. On August 11, 1995, the Board advised the insurer that claimant had not received copies of the documents the insurer used to close the claim. As no further response has been received from claimant to indicate that those documents were not subsequently received, we assume the request was satisfied. In addition, no further evidence regarding her claim has been submitted to the Board by claimant. Therefore, we will proceed with our review.

Jurisdiction

Claimant contends that she perfected an aggravation claim before her aggravation rights expired on July 10, 1994. Therefore, she asserts that the Board lacks jurisdiction over this matter. We disagree.

In order to perfect an aggravation claim, the report must put the insurer on notice that the requested medical services are for "worsened condition," see ORS 656.273(1), i. e., something more than continuing conditions. See Krajacic v. Blazing Orchards, 84 Or App 127 (1987).

Here, claimant's aggravation rights expired on July 10, 1994. In a July 8, 1994 chart note, Dr. Davis, claimant's treating physician, opined that claimant "has chronic lateral ankle laxity secondary to torn ligaments presumedly occuring at her original injury five years ago." He recommended ankle strengthening exercises and prescribed a brace. We conclude that Dr. Davis' chart note is not sufficient to put the insurer on notice that claimant's condition had worsened prior to the expiration of her aggravation rights. See Krajacic, supra. In any event, claimant has provided no evidence that the insurer received the chart note prior to expiration of her aggravation rights. See Linda Coiteux, 43 Van Natta 364 (1991).

Accordingly, we find that the case was properly processed under our own motion authority pursuant to ORS 656.278.

Appropriateness of Insurer Claim Closure

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 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 3, 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 only medical evidence in the record is a May 24, 1995 letter from Dr. Davis, in which he opined that "[claimant] is medically stable and is able to do regular activities." Dr. Davis' opinion is unrebutted.

Based on the uncontroverted medical evidence, we find that claimant has not met her burden of proving that she was not medically stationary on the date her claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's June 3, 1995 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
**BEN L. DAVIS, Claimant**
Own Motion No. 95-0366M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant, pro se, requests reconsideration of our August 3, 1995 Own Motion Order in which we declined to reopen his 1977 industrial injury claim with the SAIF Corporation for the payment of temporary disability compensation because he failed to establish that he remained in the work force at the time of disability. With his request for reconsideration, claimant submitted additional evidence regarding the work force issue.

On September 19, 1995, we abated our August 3, 1995 order, and allowed SAIF time in which to file a response to the motion. We have received SAIF's response, and 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 underwent repair of his compensable torn rotator cuff on January 27, 1995. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

In addition, 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 was not in the work force at the time of the current disability. Claimant contends that he was willing to work, but unable to work because of the compensable injury. Claimant has the burden of proof on this issue and must provide evidence, such as an affidavit attesting to his willingness to work and a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question.

Claimant has submitted no evidence of a prior work history. In a September 6, 1995 letter, Dr. O'Neill, claimant's treating physician, opined that:

> "After a work-related injury on February 7, 1977, [claimant] has had chronic problems with his shoulder which was eventually diagnosed as a torn rotator cuff and he underwent repair of that January 27, 1994 [sic]. Because of that injury which severely limited the use of his arm, he has been unable to engage in any type of manual labor since then."

Here, we find that Dr. O'Neill's opinion is ambiguous regarding the onset date of claimant's inability to work. Therefore, we do not find it sufficiently persuasive to support a finding that it has been futile for claimant to work or to seek work since 1977, or at any time before the January 1995 surgery. Absent persuasive evidence of "futility" to work, claimant must provide evidence of work or of work search efforts. See Dawkins, supra. According to the record, we lack evidence that claimant was working or seeking work prior to and until the surgery date.

Finally, in addition to the lack of evidence regarding whether it was futile for claimant to work prior to surgery or that he was working or seeking work at that time, claimant has not established that he was willing to work. See Dawkins, supra; Stephen v. Oregon Shipyards, 115 Or App 521 (1992). The Board received claimant's undated request for reconsideration on September 15, 1995, after the appeal rights on his August 3, 1995 order had expired. See OAR 438-12-065(2). Although the Board determined that claimant's late pro se request for reconsideration was an exception to the 30-day deadline, that determination only allowed claimant the oppportunity to obtain reconsideration of the order. In this case, claimant's request for reconsideration is not a sworn statement which would support his willingness to work, as he merely stated that: "I am Late with my Response because I was waiting for this letter from my doctor. I just got it yesterday 9-12-95. I would like reconsideration on my case."

On this record, we find that claimant has not carried his burden of proving that he was willing to work but unable to work because of the compensable injury or that he was working or seeking work at the time his condition worsened requiring surgery.

Accordingly, as supplemented herein, we adhere to and republish our August 3, 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
**JEANETTE D. MARTIN, Claimant**
WCB Case Nos. 93-15012 & 93-15011
ORDER ON RECONSIDERATION (REMANDING)
Jon C. Correll, Claimant Attorney
Robert Jackson (Saif), Defense Attorney
Steve Maher, Defense Attorney

The SAIF Corporation requests reconsideration of our September 20, 1995 order that affirmed in part, vacated in part and remanded those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) denied Liberty Northwest Insurance Corporation's (Liberty's) 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. Arguing that we erroneously remanded claimant's "new injury" claim with SAIF to the ALJ, SAIF asks that we uphold its "new injury" denial.

We withdraw our September 20, 1995 order for reconsideration. After considering SAIF's request and Liberty's and claimant's responses, as well as reviewing the record, we continue to conclude that claimant's "new injury" claim was properly remanded to the ALJ.

In our prior order, we remanded claimant's aggravation claim for further proceedings in light of amended ORS 656.273(1)'s new "actual worsening" standard. Or Laws 1995, ch 332, § 31. We then said,

> "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." 47 Van Natta at 1662 n 6.

SAIF asserts that, because amended ORS 656.273 has no bearing on claimant's "new injury" claim with it, we erred in remanding the "new injury" claim. We disagree. In light of our decision to remand the aggravation claim for further development of the "actual worsening" issue, we consider it appropriate to give all of the parties to this proceeding the opportunity to address the effect, if any, of that development on claimant's "new injury" claim.

Accordingly, our September 20, 1995 order is withdrawn. On reconsideration, as supplemented herein, we republish our September 20, 1995 order in its entirety. The parties' appeal rights shall begin to run from the date of this order.

IT IS SO ORDERED.

---

In the Matter of the Compensation of
**PAULA M. CORDELL, Claimant**
WCB Case No. 94-06787
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Claimant requests review of Administrative Law Judge (ALJ) Daughtry's order that affirmed an Order on Reconsideration awarding 23 percent (73.6 degrees) unscheduled permanent disability for a back condition. On review, the issue is extent of unscheduled permanent disability.

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

Claimant attempted to prove entitlement to a higher adaptability factor with evidence that she performed surveyor's help work, along with her secretarial and bookkeeping duties. Such evidence included time sheets filled out by claimant describing nonclerical work.

We do not necessarily agree with the ALJ's statement that, in order to be reliable, payroll or time sheet records must be "official ones." In this case, however, we concur with the ALJ that claimant's evidence is not persuasive in view of claimant's inconsistent prior decriptions of her work as entirely clerical, the evidence showing that claimant was hired to provide "business services," and the lack of sufficient corroboration that claimant performed surveyor's help work. Consequently, we agree that claimant failed to prove a greater adaptability value.

ORDER

The ALJ's order dated March 13, 1995 is affirmed.

---



In the Matter of the Compensation of
**RONALD EDWARDS, JR., Claimant**
WCB Case No. 95-00860
ORDER ON REVIEW
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Podnar's order that dismissed claimant's hearing request. On review, the issue is the propriety of the ALJ's dismissal order.

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

On January 19, 1995, claimant, through his then-attorney of record, requested a hearing and raised the issues of premature claim closure and permanent partial disability (scheduled and unscheduled). Subsequently, claimant changed attorneys. On January 31, 1995, claimant, through his new then-attorney of record, submitted another hearing request, reraising the issue of permanent partial disability (scheduled and unscheduled). A hearing was eventually scheduled for April 18, 1995. On April 13, 1995, claimant's then-attorney of record submitted a letter to the ALJ notifying him that claimant was withdrawing his hearing request. On April 27, 1995, the ALJ dismissed claimant's hearing request.

On May 8, 1995, the Board received a letter from claimant. Without benefit of legal representation, claimant requested review of the ALJ's order.

On review, claimant notes that his compensable injuries have not resolved and he is currently seeking medical treatment.[1] Notwithstanding such assertions, the record establishes that claimant's

---

[1] We note that, in general, claimant is entitled to medical services related to his compensable injury. ORS 656.245. Nevertheless, in light of the dismissal of his hearing requests, we are not presently authorized to address any disputes claimant may have regarding his current need for medical services.

hearing request was dismissed in response to his then-attorney's express withdrawal of the request. Claimant does not dispute that his attorney had authority to act on his behalf or that the ALJ dismissed the hearing request in response to his then-attorney's withdrawal of the hearing request. William A. Martin, 46 Van Natta 1704 (1994); Verita A. Ware, 44 Van Natta 464 (1992). Under these circumstances, we find no reason to alter the ALJ's dismissal order.

ORDER

The ALJ's order dated April 27, 1995 is affirmed.

---



In the Matter of the Compensation of
**RONALD L. FREEMAN, Claimant**
WCB Case Nos. 94-11524 & 94-11523
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order which: (1) upheld the employer's denial of his aggravation claim for a neck injury; and (2) upheld the employer's denial of his occupational disease claim for a neck, back and bilateral leg condition. On review, the issues are aggravation and compensability.

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

Relying on the court's decision in Iocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), the ALJ held that in order to prove his aggravation claim, claimant need only prove that his compensable injury was a material contributing cause of his worsened condition. The ALJ found that claimant failed to meet the material contributing cause standard.

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 656.273(1) which now provides that a claimant must establish "an actual worsening of the compensable condition" in order to prove an aggravation claim. Or Laws 1995, ch 332 § 31(1) (SB 369, § 31). We need not decide whether the additional language changes the court's holding in Iocelyn since, assuming that the amendments to ORS 656.273(1) and other statutory changes are applicable to this case, we conclude that the result would not change, because claimant failed to prove even a material causal relationship between his compensable injury and his worsened condition.

ORDER

The ALJ's order dated January 13, 1995 is affirmed.

---

In the Matter of the Compensation of
**TERRANCE NOHRENBERG, Claimant**
WCB Case No. 94-10240
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Livesley's order which: (1) set aside its denial of claimant's injury claim for a cervical disc herniation; and (2) set aside a Determination Order as prematurely issued. On review, the issues are compensability and premature claim closure. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of his finding that the 300 pound hook struck claimant's entire right upper extremity. We also supplement the ALJ's findings as follows.

Claimant, a choker setter/hooker, sustained a compensable right elbow injury on June 1, 1993, when he was struck by a 300 pound hook suspended by a helicopter. The claim was accepted as a disabling right elbow contusion. Drs. Kitchel and Butters provided claimant's medical treatment. The claim was closed by Determination Order of May 19, 1994. Reconsideration of the Determination Order was never requested and the order became final.

Throughout the period from the date of injury to claim closure, there was no mention of cervical or neck symptoms.[1] The contemporaneous medical reports contain numerous reports by claimant that he was struck on the right elbow or arm. (Exs. 2-1, 3, 4-1, 5, 6, 14-1). Medical treatment was concentrated on the right elbow.

After claim closure, and approximately one year after his compensable right elbow injury, claimant sought treatment from Dr. Butters on June 9, 1994. Claimant reported an onset of neck and back pain in March or April 1994. (Ex. 25). Although he related this pain to his June 1993 accident, claimant reported that his "relatively new problem" occurred "since he has been walking up hill." (Ex. 24). Claimant acknowledged that he had sustained a previous neck injury in October 1992. (Ex. 25).

On June 21, 1994, Dr. Kitchel, who practices medicine in the same clinic as Dr. Butters, assumed primary responsibility for claimant's care. Claimant reported to Dr. Kitchel that he had no history of previous injury or treatment for a neck condition and that his neck and bilateral shoulder symptoms began when he was struck by the hook in June 1993. (Ex. 26). Dr. Butters concluded, as he did in several other reports, that, assuming claimant's history was correct, his cervical condition was work related. (Exs. 26, 33, 39-2, 41).

In September 1994, Dr. Kitchel referred claimant to a consulting physician, Dr. Hacker. Dr. Hacker diagnosed a herniated disc at C5-6 based on his clinical examination and review of a September 2, 1994 MRI scan. (Ex. 32-2). Dr. Hacker recommended an anterior cervical microdiscectomy at C5-6.

On October 3, 1994, the insurer denied the compensability of claimant's C5-6 disc herniation, as well as disc bulges at C4-5 and C6-7. Shortly after the denial, the insurer had claimant's cervical condition evaluated by examining physicians, Drs. Reimer and Arbeene.

## CONCLUSIONS OF LAW AND OPINION

At hearing, claimant testified that his neck symptoms began about a week after the June 1993 injury with a sore neck. (Tr. 6). Claimant further testified that he mentioned his neck problems to his physicians, who concentrated instead on his right elbow condition. (Trs. 10, 11).

---

[1] On June 16, 1993, a physical therapist noted upper trapezius "tightness." (Ex. 12-2).

Considering this to be a credibility case and finding that claimant "presented as a credible witness," the ALJ found that claimant's disc herniation at C5-6 was compensable. In reaching this conclusion, the ALJ accepted claimant's testimony that his cervical symptoms began shortly after the June 1, 1993 incident and concluded that the medical evidence was sufficient to establish that the June 1, 1993 accident herniated claimant's cervical disc at C5-6. The ALJ also determined that the evidence was insufficient to establish that claimant's disc bulges at C4-5 and C6-7 were caused by claimant's accident. Thus, the ALJ set aside the insurer's denial to the extent that it denied the compensability of the C5-6 disc herniation, but upheld it to the extent that it denied claimant's cervical disc bulges.

Finally, the ALJ set aside the May 19, 1994 Determination Order, reasoning that it prematurely closed claimant's claim in light of his finding that claimant's cervical disc herniation was compensable. The insurer requested reconsideration of the ALJ's decision regarding the premature claim closure issue, but the request was denied.

On review, the insurer contends that the ALJ erred in finding claimant's cervical disc herniation to be compensable. The insurer asserts that claimant failed to prove that the June 1993 injury was related in material or major part to his current cervical disc condition. The insurer also alleges the ALJ improperly set aside the May 1994 Determination Order because the Hearings Division had no jurisdiction over the May 1994 Determination Order in the absence of a request for reconsideration of the order, which had become final.

We agree with the insurer that claimant's cervical disc herniation is not compensable on this record. Given this finding, we need not address the insurer's jurisdictional argument regarding premature claim closure.

The ALJ stated that claimant "presented as a credible witness." We consider this a finding that claimant was credible based on his demeanor. 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 519, 528 (1991) ("Although the Board should seriously consider the testimony the referee believes to be reliable, the 'substantial evidence' standard does not require the Board to adopt the referee's findings or to 'explain away' disparities between the Board's and the referee's determinations").

Claimant testified that he experienced neck pain shortly after the June 1, 1993 injury, and reported that pain to his physicians, but was unsure he was injured. The ALJ found claimant's testimony credible and, largely on that basis, determined that the June 1993 work incident caused claimant's cervical disc herniation, first diagnosed over a year after the original injury.

However, given the belated diagnosis of a cervical disc herniation, the issue of whether the 1993 work incident caused claimant's cervical disc herniation is a complex medical question even without any dispute concerning the factual histories upon which the medical opinions offered. Because of the unusually marked discrepancy between what claimant alleges he reported to the physicians and what those reports state were his complaints, we will not defer to the ALJ's demeanor credibility finding, but will instead make an independent assessment of the evidence. William K. Porter, 44 Van Natta 937 (1992), aff'd 118 Or App 162 (1993). We, therefore, turn to an examination of the medical evidence. For the following reasons, we do not find it sufficient to satisfy claimant's burden of proof.[2]

Dr. Hacker opined that claimant suffered a traumatic cervical disc injury when struck by the helicopter hook on June 1, 1994. However, he reported a history that claimant was struck in the head and that claimant had ongoing neck symptoms since the June 1993 incident. (Ex. 40). We do not find Dr. Hacker's opinion to be persuasive for several reasons.

There is no indication in the contemporaneous medical records that claimant was struck in the head.[3] As previously noted, those records state that claimant was struck in the right arm and elbow

---

[2] The insurer contends that claimant must prove that the June 1, 1993 incident is the major contributing cause of his current cervical condition. We need not decide the precise level of proof claimant must adduce, inasmuch as we conclude that claimant has failed to establish even a material causal relationship between the June 1993 incident and the C5-6 disc herniation.

[3] It is unclear from claimant's testimony that the hook struck his head. Claimant testified that the hook came "across the-- hard hat" but it is uncertain whether the hard hat was knocked off or whether there was an actual blow to the head. (Tr. 5). In any event, claimant never mentioned being struck in the head on the form 801 or in the contemporaneous medical records. ( Exs. 1, 2, 3, 4-1, 4-2, 5, 6-1). For this reason, we give little credence to the history provided to Dr. Hacker.

only. There is no discussion in Dr. Hacker's report of the history contained in the contemporaneous medical records, nor is it clear that Dr. Hacker even reviewed those records before issuing his report. Inasmuch as we cannot conclude that Dr. Hacker's medical report was based on a complete and accurate history, we give little weight to his opinion. See Somers v. SAIF, 77 Or App 259 (1986).

As previously noted, Dr. Kitchel opined on several occasions that, based on the assumption that claimant's history was accurate, claimant's disc herniation was caused by the June 1, 1993 incident. However, the insurer's counsel had Dr. Kitchel review prior medical records. Dr. Kitchel agreed that, based on a review of those records, as well as the delayed documentation of neck and back pain, the medical record was inconsistent with claimant's history implicating the June 1993 elbow injury as the cause of claimant's cervical problems. (Ex. 42). In light of this report, based on a more thorough examination of the medical record, we give little weight to Dr. Kitchel's earlier conclusory statements regarding causation.

Dr. Butter's only medical opinion regarding the cause of claimant's herniated disc does not assist claimant, either. The insurer's counsel asked Dr. Butters whether he agreed that claimant's cervical condition was not related to "the June, 1993 accident or right elbow injury." (Ex. 43). Dr. Butters checked the box marked "yes," but also circled the words "right elbow injury." In the comments portion of counsel's letter, Dr. Butters wrote "not related to right elbow injury." It is unclear from the report whether Dr. Butters was suggesting that claimant's cervical condition was related to the June 1993 accident itself. However, even if Dr. Butters' report could be construed in that manner, Dr. Butters did not explain his opinion. Therefore, we would not find it persuasive. Johnny C. Tinker, 47 Van Natta 887, 885 (1995) (conclusory medical opinion found unpersuasive).

Finally, claimant was examined by Drs. Reimer and Arbeene. They took an extensive history from claimant and reviewed the medical record. Based on their review of the record and examination of claimant, the doctors concluded that the likelihood of claimant having a disc condition since June 1, 1993 was "rather remote" given the fact that claimant's cervical symptoms did not appear until April 1994. (Ex. 38-6). They noted that there was no mention of any symptoms in the medical record prior to April 1994 that suggested a cervical injury or cervical radiculopathy.[4]

Inasmuch as the medical report submitted by Drs. Reimer and Arbeene does not support claimant's contention that he suffered a cervical disc injury as a result of the June 1, 1993 incident, and because we have found the other medical opinions in this record lacking in persuasiveness, there is insufficient medical evidence on this record to support a finding of compensability.

Accordingly, we conclude that claimant has failed to sustain his burden of proving that his cervical condition is compensable. We, thus, reverse the ALJ's order and reinstate the insurer's denial in its entirety. Moreover, given this finding, it follows that the ALJ erred in setting aside the May 1994 Determination Order as prematurely issued.[5]

## ORDER

The ALJ's order dated March 3, 1995, as reconsidered on March 17, 1995 and April 18, 1995, is reversed in part and affirmed in part. Those portions which set aside the insurer's denial of claimant's cervical disc herniation and set aside the May 19, 1994 Determination Order are reversed. The insurer's October 3, 1994 denial is reinstated and upheld. The May 19, 1994 Determination Order is reinstated and affirmed. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

---

[4] Although upper trapezius "tightness" was noted by a physical therapist on June 16, 1993, there is no medical evidence that such "tightness" is a symptom of a cervical disc herniation.

[5] Even if we were to find that claimant's cervical condition was compensable, we would have serious doubts as to whether the ALJ properly set aside the Determination Order as premature. See Rex A. Howard, 46 Van Natta 1265, 1266 (1994) (a claimant may be precluded from challenging a Determination Order if finality has attached to the order).

In the Matter of the Compensation of
**RICHARD B. PETERS, Claimant**
WCB Case Nos. 94-12407 & 94-02769
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld Liberty Northwest Insurance Corporation's (Liberty Northwest) partial denial, on behalf of Kat Construction, of claimant's preexisting degenerative low back condition; (2) upheld Liberty Northwest's denial of claimant's aggravation claim; and (3) upheld the SAIF Corporation's denial, on behalf of Ashland Hardware, of compensability and responsibility for a new low back injury claim. On review, the issues are compensability, aggravation and responsibility.

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

In August 1993, claimant experienced a compensable low back injury after a heavy lifting incident at Liberty Northwest's insured. Liberty Northwest accepted a low back strain. After x-rays revealed the presence of degenerative disc disease in the low back, Liberty Northwest issued a partial denial of the degenerative condition. Claimant's injury claim was closed on February 16, 1994 with an award of 8 percent unscheduled permanent disability.

On or about February 21, 1994, claimant experienced increased pain and muscle spasm in his low back. (Exs. 30 and 34). Liberty Northwest issued an aggravation denial on the basis that claimant's current condition was not related to his accepted 1993 injury.

In August 1994, claimant began working for SAIF's insured. While walking at work, claimant experienced the onset of severe back pain. He filed a new injury claim and SAIF denied compensability and responsibility.

Applying former ORS 656.005(7)(a)(B)[1], the ALJ concluded that claimant had failed to establish the compensability of his current low back condition, either as an aggravation or as a new injury. He based his conclusion on the opinions of Drs. Saviers, Dickerman, Potter and Rich that the effects of claimant's August 1993 injury at Liberty Northwest's insured had resolved and that the major contributing cause of claimant's low back condition subsequent to about January 1994 was his preexisting degenerative disease.

On review, claimant contends that claimant's current low back condition is compensable because the accepted August 1993 work injury caused his formerly nonsymptomatic low back condition to become symptomatic, as shown by his persistent flare-ups of muscle pain in March, August and September of 1994. Liberty Northwest and SAIF each contend that, by January 1994, claimant's low back strain had resolved and was no longer the major contributing cause of claimant's need for treatment; thus, the above flareups are not compensable. We agree.

Here, claimant's preexisting degenerative low back condition was asymptomatic prior to the 1993 lifting injury. However, an event which precipitates symptoms of a preexisting condition is not

---

[1] Subsequent to the briefing in this case, the Legislature amended the Workers' Compensation Law, including ORS 656.005(7)(a)(B). ORS 656.005(7)(a)(B) now reads:

> "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, (SB 369, § 1).

The analysis and outcome of this case remains the same under the amended statute.

necessarily the major contributing cause of those symptoms. Dietz v. Ramuda, 130 Or App 397 (1994). In Deitz, 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. Thus, the proper analysis turns on whether the medical evidence establishes that the injury is the major contributing cause of claimant's disability and need for treatment.

Here, our evaluation of the medical evidence reaffirms the ALJ's finding that, by January 1994, the accepted injury was no longer the major cause of claimant's disability or need for treatment. Instead, the medical evidence indicates that claimant's combined condition had resolved and that his ongoing symptoms were due in major part to the preexisting degenerative condition, including facet arthropathy, in his spine. (Exs. 25, 26, 36 and 37). Moreover, the conclusory opinion of Dr. Dunn, claimant's current attending physician, does not advance claimant's case. Dr. Dunn opined that claimant's recurrent strains were caused in major part by the injury. He provided no reasoning regarding the relative contribution of the preexisting condition and the August 1993 incident to claimant's current complaints. See Deitz v. Ramuda, supra. Consequently, we are not persuaded by his opinion. Somers v. SAIF, 77 Or App 259 (1986).

Accordingly, we conclude that claimant has failed to prove that his current condition is compensable. Dietz v. Ramuda, supra. Because claimant has failed to establish the compensability of his current condition, it is unnecessary for us to address the aggravation and responsibility issues.

ORDER

The ALJ's order dated February 9, 1995 is affirmed.

---

October 17, 1995 Cite as 47 Van Natta 2009 (1995)

In the Matter of the Compensation of
**DEBRA A. RYAN, Claimant**
WCB Case No. 94-08872
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's occupational disease claim for a sinus condition. On review, the issue is compensability.

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

The insurer argues that claimant's headaches, for which she was treated by Dr. Podemski in 1992, are indicative of sinus problems that preexisted her employment. We do not agree. Claimant's 1992 headaches were located at the back of the head, not in the facial or dental areas. Moreover, Dr. Podemski diagnosed claimant's headaches as tension headaches, based on findings of suboccipital tenderness. In addition, although Dr. Dowsett conceded that the severity of the headaches claimant reported to Dr. Podemski could have been a result of her sinusitis, Dr. Dowsett opined that it would have been unlikely for claimant to have had severe sinusitis prior to her work at the employer without symptoms such as facial pain combined with headaches and nasal discharge. (Ex. 11-17).

The insurer also raises the issue that claimant's prolonged history of smoking caused her sinus condition. In response, Dr. Dowsett conceded that claimant's smoking possibly predisposed her to the development of her sinus condition. He nevertheless maintained that the major contributing cause was claimant's exposure to cleaning chemicals at work. There is no contrary medical opinion. Therefore, we

conclude that claimant has met her burden to prove that her employment conditions were the major contributing cause of her sinus condition.[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 May 4, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

[1] We note that ORS 656.802 was amended by Senate Bill 369. See Or Laws 1995, Ch. 332, sec. 30 (SB 369, sec. 30). However, given our conclusion that claimant's work exposure was the major contributing cause of her sinus condition, the result would not change under either version of the statute.

---



In the Matter of the Compensation of
**EVERETT G. WELLS, Claimant**
Own Motion No. 95-0013M
OWN MOTION ORDER OF ABATEMENT
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 14, 1995 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because: (1) the reasonableness and necessity of his surgery remains in dispute; and (2) he failed to establish that he was in the work force when his condition worsened requiring surgery. With his request for reconsideration, claimant submits evidence regarding the work force issue.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The SAIF Corporation is requested to file a response to the motion within 14 days of the date of this order. In addition, we request that the parties advise the Board of any outcome regarding the treatment dispute before the Director. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
**RICHARD L. WHEELER, Claimant**
WCB Case No. 94-03725
ORDER ON REMAND
Heiling, Dodge & Associates, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. In accordance with the court's August 21, 1995 order, this case has been remanded to us "pursuant to Senate Bill 369."

In our prior order, we upheld the self-insured employer's denials of claimant's medical services/aggravation claims for his current low back condition. Richard L. Wheeler, 47 Van Natta 447 (1995). In reaching our conclusion, we reasoned that claimant's current complaints for his low back condition were not causally related to his 1989 compensable low back injury.

In the absence of a specific exception, the changes to the Workers' Compensation Law made by SB 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995). Here, our prior order was appealed and the case has been remanded to us from the court. Because our appealed order has not become final, SB 369 is applicable. Furthermore, since no relevant exception exists, we shall retroactively apply the statutory amendments enacted by SB 369.

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). Or Laws 1995, ch 332, § 41(1) (SB 369, § 41(1)). 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 656.260 or 656.327." (Emphasis added). SB 369, § 25.

In Walter L. Keeney, 47 Van Natta 1387 (1995), we retroactively applied the amendments to ORS 656.327, as well as the new provision, ORS 656.245(6), to claims currently pending before the Board. Based on the text and context of amended ORS 656.327(1), as read in conjunction with SB 369's retroactively provisions, we concluded that the Director has exclusive jurisdiction over ORS 656.327(1) medical services disputes, including those presently pending before the Board.

In Lynda J. Zeller, 47 Van Natta 1581 (1995), relying on ORS 656.245(6), we held that the Board retained jurisdiction to determine whether a claimant's current condition was related to her compensable injury. However, once that determination was resolved, we further concluded that, under ORS 656.327(1) and Keeney, the Board is without authority to address the propriety of a proposed surgery for that disputed condition. Thus, in Zeller, having found that the claimant's current condition was compensable, we then dismissed the claimant's hearing request insofar as it sought resolution of a dispute regarding whether the proposed medical treatment was reasonable and necessary. See also Janet Anderson, 47 Van Natta 1692 (1995).

Here, as in Zeller and Anderson, and unlike Keeney, the parties' dispute concerns whether medical treatment for claimant's current condition is causally related to his compensable injury. Inasmuch as such a dispute necessarily involves the compensability of the condition on which the medical treatment is based, we find that the employer's formal denial pertained to the "compensability of the underlying claim."[1] Consequently, we retain jurisdiction to consider the parties' dispute. See ORS 656.245(6); Janet Anderson, supra; Lynda J. Zeller, supra.

---

[1] Although not determinative, we note that our rationale that jurisdiction over causation disputes regarding medical treatment rests with the Board is consistent with the Director's administrative rules. OAR 436-10-046(3)(a) provides that, when compensability of treatment is at issue before another adjudicative body, any party may request Director review within 30 days after the order deciding compensability becomes final.

We turn to the merits of the parties' dispute. After conducting our reconsideration of this record, we adhere to our prior conclusion that claimant failed to establish that his medical service claim for his current low back condition was causally related to his compensable low back injury. In addition, we republish the remaining portions of our order, including our determination that claimant had filed an aggravation claim and that the employer's denial of that claim was proper.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our March 16, 1995 order in its entirety.

IT IS SO ORDERED.

---

October 18, 1995 Cite as 47 Van Natta 2012 (1995)

In the Matter of the Compensation of
**MICHAEL T. ALIOTH, Claimant**
Own Motion No. 95-0128M
OWN MOTION ORDER ON RECONSIDERATION
C. David Hall, Claimant Attorney
VavRosky, et al, Defense Attorney

Claimant requests reconsideration of our April 11, 1995 Own Motion Order in which we declined to reopen his 1982 claim for the payment of temporary disability compensation because he failed to establish he was in the work force at the time of his current disability. With his request for reconsideration, claimant submitted additional information regarding the work force issue.

Claimant provided copies of job applications, training requests/counseling and affidavits from himself and Ms. Mesereau, who has lived with claimant for the past six years. In response, the self-insured employer requested an evidentiary hearing regarding the work force issue, contending that the dispute concerning the work force issue would require further discovery, including "subpoenas, interrogatories and depositions."

On May 9, 1995, the Board issued its Own Motion Order Referring for Fact Finding Hearing, and requested that, subsequent to the hearing, the Administrative Law Judge (ALJ) assigned to the case, issue a recommendation on the work force issue. The fact finding hearing was held before ALJ Neal on August 2, 1995. Based on documentary and testimonial evidence offered at the hearing, ALJ Neal recommended that the Board find that claimant was in the work force at the time of disability.

On August 15, 1995, the Board implemented a briefing schedule to allow the parties an opportunity to respond to the ALJ's recommendation. The parties' briefs have been received. The sole issue remains whether claimant can prove that he qualifies for temporary disability compensation because he was in the work force at the time of current disability. We issue the following order in place of our April 11, 1995 Own Motion Order.

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

In a January 24, 1995 letter, Dr. Burchiel, claimant's then-treating physician, stated that he was "going to send [claimant] to see a podiatrist for possible Morton's neuroma surgery." Thus, we conclude that claimant's compensable injury has worsened requiring surgery.

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

The employer contends that claimant was working during 1994, but was not in the work force at the time of disability. The employer relied on a January 24, 1995 letter from Dr. Burchiel, in which he indicated that claimant had performed welding work "on a sporadic basis last year." In this regard, the employer argued that, although claimant contended that he was unable to work at the time of disability, that "[claimant] has not only been willing to work, he has sought and obtained work, although he was out of work at the time of the incident." (See April 13, 1995 letter from employer to the Board). In contrast, claimant contends that he was not working, but he was willing to work and making reasonable efforts to secure employment when his condition worsened requiring surgery. Claimant has the burden of proof on this issue, and must provide persuasive evidence to support his contention.

On May 4, 1995, claimant submitted a sworn affidavit in which he testified that he was last employed for any length of time at Kaiser Hospital (1988), but that he has been willing to work and has sought work and vocational rehabilitation since that time. In addition, claimant submitted copies of applications for employment and letters from vocational rehabilitation counselors for the period between 1989 and 1993. In his affidavit, claimant stated that, prior to his worsening, he was observing the work of a friend to determine whether he could physically handle the job. He further stated that his friend subsequently went out of business, and "I was not able to pursue the lead."

In a sworn affidavit submitted by claimant's girlfriend, Ms. Mesereau, she stated that claimant had attempted employment training and job assistance at various times since 1989, but that, due to his injury, he was unable to complete any of them. In addition, Ms. Mesereau attested that she had "assisted [claimant] on a number of these applications." Finally, Ms. Mesereau stated that claimant did not work for wages during 1994, but he "observed his [friend's] business with the possibility that [claimant] might be interested [in working] if he was physically able to do so."

Notwithstanding the above submissions, on May 4, 1995, the employer requested that the Board refer the matter of whether claimant was in the work force at the time of disability for an evidentiary hearing. On May 9, 1995, we issued our Own Motion Order Referring for Fact Finding Hearing in the matter to allow for the submission of further evidence and testimony.

At the August 2, 1995 hearing, claimant testified that he finished his sophomore year of high school, but dropped out of school due to a learning disability (dyslexia). Claimant was working as a welder when he sustained a left foot crush injury in 1982. Since that time, claimant has undergone eight surgical procedures on his left foot, the last of those surgeries having been performed in 1992. Claimant testified that prior to, and for several months subsequent to these surgeries, he was unable to work "[b]ecause of the pain that I was having, it would be pretty bad." He stated that, subsequent to the injury, it had been difficult to perform welding because of the standing requirement, and he missed a lot of time when employed. Claimant's last regular work occurred in 1988 with Kaiser Hospital, where he participated in a training program as a security guard. He testified that he "was missing a lot of time from there" because of problems with his foot, and was subsequently terminated. Since that time, claimant has only "worked" at Danner Boots for three or four days in 1993 on a placement/evaluation through Oregon State Rehabilitation.

Claimant also testified that he had sought vocational assistance since 1989 with Oregon State Rehabilitation, Oregon State Adult and Family Services, the State Department of Vocational Rehabilitation, and IAM/Cares, and that he had put in applications for employment since that time at "Bonneville Administration, Gunderson Brothers and Wagner Mining and there's several other places." Claimant further testified that, prior to January of 1995 when his condition worsened requiring surgery, if he could have found a job, he would have tried to work even though his foot only allowed him to stand for 30-45 minutes at a time.

Ms Mesereau testified that, due to claimant's dyslexic condition, she had helped claimant to fill out applications, and he had applied with various places of employment and for vocational training. She also stated that, just prior to his January 1995 worsening, claimant was seeking employment with an acquaintance, but the job "never came about, because the guy went out of business."

In its post-hearing brief, the employer stated that it accepts Administrative Law Judge Neal's August 8, 1995 factual findings made pursuant to the evidentiary hearing with the following supplementation:

> "[C]laimant has provided no extrinsic evidence that he made reasonable efforts to gain employment or was actually in the workforce at the time of his worsened left foot condition."

We disagree. Claimant submitted evidence that he was seeking work and training (as previously noted) prior to the employer's request for hearing. Therefore, we find that claimant provided documentation that he applied for jobs and vocational training, and that documentation is part of the record. Further, claimant provided his sworn affidavit and his testimony at hearing that he was willing to work, and that he wanted to work for the "acquaintance" who subsequently went out of business.

Additionally, the employer contends that, in reaching her conclusion that claimant remained in the work force, ALJ Neal:

> "relied solely on the testimony of claimant and Ms. Mesereau, but made no credibility findings. Employer contends that neither claimant nor Ms. Mesereau are credible witnesses and, therefore, the Judge erred in relying on their testimony."

Again, we disagree. The record contains copies of claimant's and Ms Mesereau's affidavits, as well as copies of job applications, vocational referrals and information from Adult and Family Services and the State of Oregon Vocational Rehabilitation Division. Furthermore, ALJ Neal addressed the credibility issue in her recommendation by stating that she had no reason to doubt their testimony, even though it contrasted with a history provided by Dr. Burchiel on January 24, 1995. (See August 8, 1995 Recommendation on Own Motion, page 2, line 31). Dr. Burchiel's letter is based on an interview with claimant, and therefore reflects his interpretation of their conversation. There is no additional evidence in the record to support the employer's contention that claimant worked during 1994.

We are persuaded by the documentation that claimant has submitted which supports his contention that he made reasonable efforts to seek work and that he was willing to work. The employer has provided no evidence to refute claimant's contentions other than Dr. Burchiel's letter cited above. Finally, although there is no medical evidence in the record to support claimant's contention that he was unable to work for a time prior to and for several months subsequent to the surgeries, neither is there medical evidence to the contrary. Therefore, we are also persuaded by the testimony of claimant and Ms. Mesereau.

Based on the entire record, we conclude that claimant has established that he was willing to work and was making reasonable attempts to find work at the time of his current disability.

Accordingly, on reconsideration, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date he is hospitalized for surgery. When claimant is medically stationary, the employer 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 the employer 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
**ROBERT R. BAGLEY, Claimant**
WCB Case No. 94-00386
ORDER ON RECONSIDERATION
Emmons, Kropp, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On August 28, 1995, we abated our July 27, 1995 order that affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's occupational disease claim for a psychological condition. We took this action to consider claimant's motion for reconsideration. Having received the employer's response, we now proceed with our reconsideration.

In order to prove a claim for a mental disorder, a worker in part must prove that employment conditions producing the disease exist in a real and objective sense. ORS 656.803(3)(a). In finding claimant's psychological condition not compensable, we concluded that claimant's mental disorder was not caused by "real and objective" employment conditions. Specifically, we found that claimant incorrectly understood that the former Mayor ordered the police chief to shoot claimant during a city council meeting and that in reality the mayor had shouted to "shoot me."

Claimant first argues that our application of the statute is inconsistent with caselaw. Although claimant concedes that, factually, the Mayor more likely shouted to "shoot me" rather than claimant, he asserts that, "[c]laimant's fear that the Mayor would shoot him, even if incorrect, was based upon real and objective employment conditions of the Mayor's many outbursts and threats[.]" According to claimant, he satisfied the statutory requirement that employment conditions "exist in a real and objective sense" because he reacted to a real, as opposed to imaginary, event that was capable of producing stress.

As we stated in our order, it is sufficient that the worker react to real events that are capable of producing stress, even though the worker's perception of the event is not reasonable. Duran v. SAIF, 87 Or App 509, 512-13 (1987). In applying this rule, we determine whether the record supports or contradicts the claimant's understanding of employment conditions. For instance, in Marilee B. Rutherford, 44 Van Natta 183 (1992), we found that the claimant's belief that she did not receive performance evaluations was not "real and objective" because there was evidence that evaluations were in fact provided to the claimant. 44 Van Natta 183, 184-85 (1992). Conversely, in Katherine F. Taylor, 44 Van Natta 920 (1992), we concluded that the claimant's dual role as an advertising sales representative and production liaison was real and objective and capable of producing stress; thus, the claimant's incorrect assumption that she was responsible for personally producing commercials did not preclude the claim. 44 Van Natta 920, 921 (1992).

Paulette G. Layman, 45 Van Natta 2236 (1993), which claimant relies on, is consistent with this approach. There, we found that the claimant's belief that her manager stared at her and that the manager ordered her work station to be positioned so he could watch the claimant was real and objective since the record showed that the manager did watch claimant and he had ordered the work station to be repositioned within his sight. Hence, Layman also determined whether the record factually proved claimant's understanding of employment conditions.

Here, as claimant concedes, the record shows that the mayor shouted to "shoot me" not claimant. Therefore, we find no basis for finding that claimant's belief that the mayor ordered the police chief to shoot claimant "exists in a real and objective sense."

Claimant also disputes our interpretation of the medical evidence as indicating that the "shooting incident" was the major contributing cause of claimant's psychological condition. According to claimant, his treating physician attributed his condition to all the "hassles and stressors in claimant's job[.]" Our order adequately explains our analysis of the medical evidence and, thus, we find it unnecessary to provide further discussion regarding this issue.

On reconsideration, as supplemented herein, we adhere to and republish our July 27, 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
**ANTHONY N. BARD, Claimant**
WCB Case No. 93-05039
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Bonnie V. Laux (Saif), Defense Attorney
Malagon, Moore, et al, Attorneys

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Marshall's order which directed it to pay an earlier ALJ's award of temporary disability benefits and attorney fees. On review, the issue is claims processing/stay of compensation. We modify.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

The pertinent procedural history is as follows. SAIF accepted claimant's May 1990 left knee injury claim on May 15, 1990. On July 26, 1991, ALJ Livesley directed SAIF to recalculate and pay temporary total disability (TTD) from January 4, 1991 until the benefits could be terminated by rule or statute, and assessed a penalty and attorney fees. The Board affirmed on July 31, 1992. On May 12, 1993, the Court of Appeals affirmed, without opinion, the Board's order. SAIF v. Bard, 120 Or App 536 (1993). On September 21, 1993, the court issued its appellate judgment.

In the interim, on August 9, 1991, SAIF had issued a "back-up" denial of the knee injury claim based on fraud and misrepresentation. In a July 28, 1992 order, ALJ Nichols found the "back-up" denial proper, but set it aside on compensability grounds. On June 30, 1993, we reversed ALJ Nichols' order and upheld SAIF's denial in its entirety. Tony N. Bard, 45 Van Natta 2225 (1993). Claimant requested judicial review, but later withdrew his appeal. On October 27, 1993, the court issued an Order of Dismissal and Appellate Judgment.

When SAIF failed to pay the compensation and attorney fees awarded under ALJ Livesley's order, the Board's July 1992 order, and the court's September 1993 order, (hereinafter the TTD order), claimant brought this enforcement proceeding. The ALJ directed SAIF to pay the compensation, penalties and attorney fees awarded by the above orders, because those orders were final. In reaching this conclusion, the ALJ determined that SAIF was allowed to stay, pursuant to ORS 656.313(1), the compensation awarded by ALJ Livesley and the Board. However, when the Court of Appeals' decision, which affirmed ALJ Livesley's and the Board's orders, became effective on September 21, 1993, the ALJ concluded that SAIF was obligated to pay the prior ALJ's award within 14 days. The ALJ further reasoned that SAIF could not collaterally attack the prior award, notwithstanding the subsequent upholding of the "back-up" denial.

Citing Ronald G. Miller, 47 Van Natta 277 (1995), SAIF contends that the Board's final order finding the claim not compensable terminated its obligation to pay benefits under the claim. Therefore, SAIF reasons that the court's judgment ordering payment of temporary disability benefits is moot. We disagree.

In Miller, pursuant to an appealed Department's noncompliance order, SAIF accepted and processed the claimant's claim on behalf of the noncomplying employer. When the Department's noncompliance order was ultimately set aside, SAIF refused to pay the claimant any further compensation. In finding that SAIF was no longer required to process the claim, we reasoned that the claimant was not precluded from contesting the compensability of his claim or SAIF's claims processing conduct. However, in light of the finality of the noncompliance decision, we further determined that the compensability issue would be moot inasmuch as there was no subject employer against which claimant could claim. Consequently, we concluded that the final order holding the alleged noncomplying employer not a subject employer eliminated SAIF's statutory authority to process the claim.

We find Miller, supra, inapposite. In Miller, SAIF's claims processing obligations were contingent upon the statutory requirement that the employer be a subject employer. When a final order subsequently issued finding the employer not a subject employer, SAIF's statutory authority to process the claim automatically ended.

Here, SAIF's obligation to pay temporary disability benefits was created by ALJ Livesley's order directing it to pay such benefits on a then-accepted claim. Notwithstanding further appeals, ALJ Livesley's order was effective and enforceable when issued. See Theodore W. Lincicum, 40 Van Natta 11953, 1955 (1988) aff'd mem, Astoria Oil Service v. Lincicum, 100 Or App 100 (1990) (Board relied on former ORS 656.313(1) to enforce prior order awarding compensation, although prior order subsequently reversed). Although the claim has subsequently been found not compensable, the court's September 1993 final order (affirming Livesley's order) cannot be unilaterally ignored. See Mischel v. Portland General Electric, 89 Or App 140, 144 (1987); Imre Kamasz, 47 Van Natta 332 (1995). These final orders obligated SAIF to process claimant's TTD benefits.

SAIF also relies on Raymond J. Seebach, 44 Van Natta 1829 (1992), to support its mootness argument. In Seebach, while an appeal was pending concerning an ALJ's order to pay temporary disability benefits, the parties entered into a Disputed Claim Settlement (DCS) which resolved the dispute regarding the compensability of the claim from its inception. We held that the DCS, which had become final by operation of law, rendered our pending review of the ALJ's order moot. Id. Here, in contrast, the appeal of ALJ Livesley's TTD order became final before finality attached to the subsequent "back-up" denial. Because the prior TTD orders are final by operation of law, the issue remains the enforceability of those orders. Therefore, there is a justiciable controversy.

Having concluded that the enforceability of the court's September 1993 order (TTD order) is not moot, the question remains what amount of temporary disability benefits SAIF is required to pay under the TTD orders. The ALJ found that the "back-up" denial did not relieve SAIF of its obligation to pay temporary disability benefits awarded by ALJ Livesley. The ALJ, however, found that SAIF could stay, pursuant to ORS 656.313(1), the "pre-litigation order" compensation.

Under ORS 656.313(1), SAIF was entitled to stay "pre-litigation order" compensation (time loss from January 4, 1991 through July 26, 1991, the issuance date of ALJ Livesley's order). John R. Heath, 45 Van Natta 840 (1993) aff'd Anodizing, Inc. v. Heath, 129 Or App 356 (1994). SAIF issued its "back-up" denial on August 9, 1991. The "back-up" denial lawfully terminated "post-litigation order" compensation. ORS 656.262(6)(a). In addition, the denial issued within 14 days of ALJ Livesley's order. See OAR 436-60-150(4)(h). Thus, when it issued its "back-up" denial, SAIF was not yet obligated to pay temporary disability benefits pursuant to ALJ Livesley's order pending its appeal of that order.

However, ALJ Nichol's order dated July 28, 1992 set aside SAIF's "back-up" denial and remanded the claim to SAIF for processing. Claimant, thus, was entitled to temporary disability benefits from the date of ALJ Nichol's order until reversal or lawful termination. ORS 656.262(6)(a). SAIF requested Board review, thereby invoking a stay of "pre-litigation order" compensation (temporary disability from August 9, 1991 through July 28, 1992). Thereafter, SAIF closed the claim by Notice of Closure dated December 30, 1992, which awarded TPD from August 26, 1992 through November 12, 1992. Accordingly, claimant is entitled to temporary disability benefits accruing from July 28, 1992 (the date of ALJ Nichols' order) until December 30, 1992 (the date of claim closure).[1]

Because claimant's compensation (the temporary disability benefits granted by ALJ Marshall's order) has been reduced as a result of our decision, claimant's counsel is not entitled to an attorney fee for services on review. ORS 656.382(2).

---

[1] Although the claim is deemed denied, ab initio, as a result of the "back-up" denial, our award of temporary disability benefits does not result in an overpayment. ORS 656.313(1) created a statutory obligation to pay temporary disability benefits, which was unaffected by the subsequent reversal of ALJ Nichol's order. Lela K. Mead-Johnson, 45 Van Natta 1754, 1756 (1993); John R. Heath, supra.

ORDER

The ALJ's order dated May 18, 1995 is modified. In lieu of the ALJ's award of temporary disability benefits, claimant is entitled to such benefits from July 28, 1992 through December 30, 1992. SAIF is also directed to pay the penalty and out-of-compensation attorney fee awarded by ALJ Livesley and the assessed attorney fees awarded by the prior final Board order and the Court of Appeals appellate judgment.

---



In the Matter of the Compensation of
**JOSIE A. BEVARD, Claimant**
WCB Case No. 94-13854
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Garaventa's order that: (1) declined to award claimant additional temporary disability; and (2) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable failure to pay temporary disability benefits. On review, claimant also asserts that the ALJ erred in declining to award an out-of-compensation attorney fee for her counsel's services in obtaining without a hearing additional temporary disability compensation. On review, the issues are temporary disability, penalties 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

Temporary Disability

Claimant asserts that, because SAIF impermissibly offset her overpaid temporary disability compensation against her underpaid temporary disability compensation, she is entitled to further temporary disability compensation. We disagree.

We lack the authority to impose an "administrative" overpayment of temporary disability benefits when a claimant is not substantively entitled to them. Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Claimant has received payment in an amount equal to all the temporary disability benefits to which she is substantively entitled. Therefore, irrespective of the offset issue, she is not entitled to any additional temporary disability compensation. Accordingly, we affirm the ALJ's decision not to award any such compensation.[1]

Attorney Fees

Claimant asserts that, under ORS 656.386(2) and Nancy E. O'Neal, 45 Van Natta 1490, recon 45 Van Natta 1591, recon 45 Van Natta 2081 (1993), aff'd SAIF v. O'Neal, 134 Or App 338 (1995), she is entitled to an out-of-compensation attorney fee for her counsel's services in obtaining without a hearing the payment of $889.46 in temporary disability compensation.[2] We agree.

---

[1] Claimant asserts that, because former ORS 656.268(13) authorizes the offset of time loss overpayments against permanent disability awards only, SAIF should not have offset her "post-closure" temporary disability overpayments against her "pre-closure" temporary disability underpayments. Amended ORS 656.268(13) authorizes offsets "against current or future permanent or temporary disability awards or payments * * *." Or Laws 1995, ch 332, § 30 (SB 369, § 30; emphasis added). In view of our analysis under Seiber, we do not address either claimant's argument or the impact, if any, of amended ORS 656.268(13) on this case.

[2] Claimant also asserts that OAR 438-15-045 supports her position. We do not address that argument.

If a claimant's compensation is increased prior to hearing, the claimant's counsel is entitled to an attorney fee payable from the increased compensation. Nancy E. O'Neal, supra; see ORS 656.386(2).[3] When a carrier has paid to a claimant before hearing compensation that included an out-of-compensation fee that was owed to the claimant's attorney, we will order the carrier to pay the fee to the attorney if, at the time of payment, the carrier was aware of the claimant's hearing request and of the existence of an executed retainer agreement providing for an approved fee payable out of the paid compensation. Nancy E. O'Neal, supra, 45 Van Natta at 2081.

Here, claimant had filed a hearing request regarding temporary disability in November 1994. After conducting an internal audit, but prior to hearing, SAIF determined that claimant had been underpaid $889.46 in temporary disability compensation. SAIF paid claimant that amount before hearing. Because claimant's compensation was increased prior to hearing, her counsel is entitled to an attorney fee payable from this increased compensation. Nancy E. O'Neal, supra, 45 Van Natta 1490, 1591.

SAIF has already paid claimant all of the increased compensation. The record reveals that, before it paid that compensation, SAIF was aware of claimant's hearing request and of the existence of her executed retainer agreement providing for an approved fee payable out of the any increased temporary disability compensation obtained by her counsel. Under the circumstances, it would not be inequitable to require SAIF to pay claimant's counsel an out-of-compensation fee. Nancy E. O'Neal, supra, 45 Van Natta at 1592, 2082; SAIF v. O'Neal, supra, 134 Or App at 343. Accordingly, SAIF is directed to pay claimant's counsel an out-of-compensation attorney fee equal to 25 percent of the $889.46 additional temporary disability compensation it paid to claimant before hearing.

Penalties

Reasoning that there were no amounts due on which to base a penalty, the ALJ concluded that claimant was not entitled to a penalty for SAIF's late temporary disability payments. Claimant asserts that she is entitled to a penalty under former ORS 656.262(10)(a) (renumbered ORS 656.262(11)(a), SB 369, § 28) and a penalty-related attorney fee under former ORS 656.382(1) (since amended by SB 369, § 42d) for SAIF's untimely payment of $2868.76 in temporary disability compensation. We agree that she is entitled to a penalty under former ORS 656.262(10)(a).

If a carrier "unreasonably delays or refuses to pay compensation," it shall be liable for a penalty of up to 25 percent of the "amounts then due." Former ORS 656.262(10)(a). Unreasonable resistance to payment of compensation exists when, from a legal standpoint, the carrier had no legitimate doubt about its liability at the time of resistance. E.g., International Paper Co. v. Huntley, 106 Or App 107 (1991).

Here, a December 1994 Determination Order found that claimant was entitled to temporary disability compensation between August 1993 and September 1994. SAIF's subsequent internal audit determined that it had underpaid claimant in the amount of $2868.76 in TTD for the period covered by the Determination Order. SAIF's audit also revealed that it had overpaid claimant $1979.30 in TTD benefits beyond her medically stationary date. SAIF offset the overpaid benefits against the underpayments, leaving an underpayment of $889.46, which it paid to claimant shortly thereafter.

SAIF was late in paying claimant temporary disability compensation. See ORS 656.262(4)(a) (first payment of temporary disability compensation due no later than 14 days after subject employer has notice of knowledge of claim).[4] There is no evidence that SAIF had a legitimate doubt about its liability for that compensation at the time the compensation was due; indeed, SAIF's audit reveals that the delay in payment was the result of inaccurate claim processing. That is insufficient to immunize SAIF from liability for a penalty. Moreover, SAIF's offset and payment of the $889.46 after the Determination Order issued do not change the fact that it was late in paying claimant $2868.76 in TTD compensation and that sum constitutes the "amounts then due" at the time of SAIF's delayed payments.

---

[3] The 1995 Legislature recently amended ORS 656.386(2). SB 369, § 43. Former ORS 656.386(2) provided that, "[i]n 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." Amended ORS 656.386(2) provides that, "[i]n 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." SB 369, § 43 (emphasis added).

[4] SB 369, § 28 amends ORS 656.262(4)(a); those amendments are not germane to this case.

Accordingly, we assess a penalty against SAIF in the amount of 25 percent of the $2868.76 in late temporary disability payments. Because we award claimant a penalty pursuant to former ORS 656.262(10)(a), she is not entitled to a penalty-related attorney fee under ORS 656.382(1) for the same conduct. Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992).

ORDER

The ALJ's order dated February 24, 1995 is affirmed in part and reversed in part. That portion of the ALJ's order declining to assess a penalty is reversed, and SAIF is ordered to pay claimant a penalty in the amount of 25 percent of the $2868.76 late temporary disability compensation it paid claimant. This penalty shall be shared in equal amounts between claimant and her counsel. SAIF is further ordered to pay claimant's counsel an out-of-compensation attorney fee equal to 25 percent of the $889.46 in temporary disability compensation it paid claimant before hearing. The remainder of the ALJ's order is affirmed.

---



In the Matter of the Compensation of
**CAROLYNE D. FLOREA, Claimant**
WCB Case No. 94-13521
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order which set aside its denial of claimant's claim for multiple injuries sustained in a motor vehicle accident. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "findings of fact" and offer the following summary of the relevant facts.

Claimant, an office manager at a long-term residential health-care facility, sustained multiple injuries in a motor vehicle accident on September 19, 1994. The circumstances of the accident require some explanation.

The administrator of the facility had directed claimant to deliver a check to a vendor who lived a short distance from claimant's residence after the work day had been completed. At the time, claimant was an alcoholic who drank frequently to excess. Claimant left the premises shortly after 5 p.m. (the end of her work day), along with the check she was supposed to deliver to the vendor. Claimant was accompanied by a small dog which rode next to her in the passenger seat of her 1967 Volkswagen "bug." Claimant proceeded to a liquor store and purchased a pint of vodka. She consumed some of it while she returned home to use the bathroom. Claimant resumed her trip and continued consuming vodka as she proceeded on a winding road toward the vendor's home. The road on which claimant was traveling was well-known to her. Driving conditions were good. The weather was warm and sunny and the pavement was dry.

As claimant approached a curve in the road, the small dog next to her jumped to the floor and scrambled beneath claimant's feet. Claimant took her eyes off the road after removing her seat belt and bending over to retrieve the dog from beneath her feet. Thereafter, failing to negotiate the turn, she drove her car onto the gravel shoulder, lost control of the vehicle, and slid into a tree, sustaining her injuries.

Claimant was air-lifted to a hospital, where she was diagnosed with multiple injuries, as well as ethanol intoxication. Dr. Jacobsen, a specialist in addiction medicine, later characterized claimant's blood alcohol level as twice the legal limit in Oregon. (Ex. 18).

Claimant filed a form 801 on September 27, 1994. On October 18, 1994, Dr. Jacobsen wrote the insurer that claimant would have been physically and mentally impaired by alcohol at the time of the accident, and that it was medically probable that the alcohol was the major contributing cause of the claimant's accident. (Ex. 18). Based on Dr. Jacobsen's opinion, the insurer denied the compensability of claimant's accident on the grounds that the major contributing cause of claimant's multiple injuries was the consumption of alcoholic beverages. See ORS 656.005(7)(b)(C).

## CONCLUSIONS OF LAW AND OPINION

Dr. Jacobsen was among the witnesses testifying at hearing. After listening to claimant's testimony regarding the circumstances of the accident, Dr. Jacobsen testified that reaction time for an individual impaired by alcohol is significantly decreased by distracting visual or auditory stimuli. Dr. Jacobsen further testified that having a dog between her feet would have been very distracting to claimant and would have "aggravated the--the impairment from alcohol." (Tr. 90). Dr. Jacobsen admitted, however, that this testimony was "speculation." Although conceding that he didn't know exactly what claimant's blood alcohol level was at the time of the accident, Dr. Jacobsen concluded that claimant's driving ability was "markedly impaired." (Trs. 94, 95). Based on claimant's testimony, the medical record and the evidence of alcohol consumption, Dr. Jacobsen reiterated that claimant's alcohol consumption was the major contributing cause of her accident. (Tr. 95).

Claimant testified that she was not feeling the effects of alcohol at the time of the accident. (Tr. 33). Claimant insisted that the dog caused her accident, not her alcohol consumption, and that her driving ability was not impaired prior to the accident. (Tr. 38).

The ALJ rejected the insurer's argument that claimant's alcohol consumption removed her from the course and scope of her employment, reasoning that the compensability of claimant's accident should be determined under former ORS 656.005(7)(b)(C).[1] Relying on Dr. Jacobsen's medical opinion, the ALJ found that claimant was impaired by alcohol at the time of her accident. However, on reviewing the relevant case law regarding the determination of causation under the statute, the ALJ concluded that he was not required to adopt even the uncontroverted opinion of a medical expert. Reasoning that this case involved a mixed question of medicine and fact, the ALJ determined that he was required to evaluate both the medical and physical evidence and make an independent determination of the causation issue.

The ALJ completed his analysis by finding Dr. Jacobsen's medical opinion unpersuasive with regard to the cause of claimant's accident. The ALJ ruled that the causation issue was factual rather than medical, reasoning that whether claimant was sober or drunk, she still had to remove the dog from between her feet. Finding a "logical and uncontroverted" explanation for the accident, the ALJ concluded that there was no persuasive evidence that linked the accident to the effects of alcohol, and that the insurer had failed to sustain its burden of proving by "clear and convincing" evidence that alcohol was the major contributing cause of claimant's accident. The ALJ, thus, set aside the insurer's denial.

On review, the insurer contends that claimant was not in the course and scope of her employment at the time of the motor vehicle accident. It asserts that claimant had overstepped the boundaries defining the "ultimate work" to be done by drinking while driving and driving under the influence of alcohol. See Davis v. R & R Truck Brokers, 112 Or App 485 (1992); Patterson v. SAIF, 64 Or App 652 (1983); Michael Thornton, 45 Van Natta 743 (1993). Alternatively, the insurer argues that it sustained its burden of proving by "clear and convincing evidence" that alcohol consumption was the major contributing cause of her injuries. We need not determine whether claimant was in the course and scope of her employment at the time of her accident, for, even if she was, we conclude that the insurer has satisfied its burden of proving that claimant's injuries are not compensable under ORS 656.005(7)(b)(C).

---

[1] At the time of the hearing, former ORS 656.005(7)(b)(C) excluded from the definition of compensable injuries an "injury the major contributing 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."

Under ORS 656.005(7)(b)(C), claimant must first establish a prima facie case of compensability. If established, then to defeat a finding of compensability under former ORS 656.005(7)(b)(C), the insurer had to prove, by "clear and convincing evidence," that claimant's consumption of alcoholic beverages and/or the unlawful consumption of any controlled substance was the major contributing cause of the injury. To be "clear and convincing," the truth of the facts asserted must be highly probable. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987). Under the former version of the statute, the insurer could not meet its burden by merely showing that claimant consumed alcohol or a controlled substance. Rather, the insurer had to establish that it was highly probable that claimant was impaired by the alcohol or controlled substance and that such impairment was the major contributing cause of the injury. Grace L. Walker, 45 Van Natta 1273 (1993), aff'd mem Walker v. Danner Shoe Manufacturing, 126 Or App 313 (1994); Dave D. Hoff, 45 Van Natta 2312 (1993).

Effective June 7, 1995, however, Senate Bill 369 amended ORS 656.005(7)(b)(C). That statute, as amended, has reduced the level of evidence an employer or insurer must adduce from "clear and convincing" to a "preponderance." We need not decide, however, whether amended ORS 656.005(7)(b)(C) applies retroactively, see Or Laws 1995, ch 332, § 66(1) (SB 369, § 66(1)), for we conclude that the insurer has sustained its burden of proof even under the more stringent "clear and convincing" standard of proof of former ORS 656.005(7)(b)(C).

We have applied former ORS 656.005(7)(b)(C) in several recent cases. In one instance, the claimant was injured after the log skidder he was operating rolled down a hill. Ronald Martin, 47 Van Natta 473 (1995). There, we relied on the unrebutted opinion of Dr. Burton, a board certified physician in medical toxicology and occupational medicine, who opined that the combined impairment from the effects of drugs and alcohol and sleep deprivation was the most likely cause of the claimant's accident. We also noted the testimony of the employer who described how the accident occurred and testified that there was no mechanical failure in the skidder. The employer concluded that the accident was the result of an error in the claimant's judgment while operating the skidder.

We found that the employer's uncontroverted testimony established that operator error had caused the skidder to roll. Moreover, we concluded that, based on Dr. Burton's expert medical opinion, the claimant's consumption of alcohol and drugs was the cause of the error in judgment. Thus, we further concluded that the employer had established by "clear and convincing" evidence that the major contributing cause of the claimant's injury was the consumption of alcohol and controlled substances. Therefore, the employer had established that the claimant's injury was not compensable under former ORS 656.005(7)(b)(C).

In Duane A. Menestrina, 47 Van Natta 694 (1995), we held that the claimant's consumption of alcohol was the major cause of his accident where he lost control of the straddle lumber carrier he was driving while negotiating an "S" curve. In Menestrina, 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 medical opinions of several physicians who opined that, after 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 his accident, we determined that the employer had sustained its burden of proof under former ORS 656.005(7)(b)(C).

More recently, in Scott S. Fromm, 47 Van Natta 1476 (1995), the claimant injured his left thumb when he lost his balance on a ladder and his hand came into contact with a large fan. We found that the insurer had proved by clear and convincing evidence that the claimant was alcohol-impaired at the time of the accident and that this impairment was the major cause of the claimant's accident. We reasoned that the work the claimant was doing when injured, standing on a ladder and installing electrical wire and conduit, involved small muscle coordination and balance. Thus, we concluded that the claimant's 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. Relying on an uncontradicted medical opinion that the claimant's judgment, coordination and balance were impaired at the time of the accident as a result of alcohol consumption, we were persuaded by clear and convincing evidence that the claimant's alcohol consumption was the major contributing cause of his injury.

In this case, like Martin and Fromm, there is unrebutted medical evidence that alcohol consumption was the major contributing cause of claimant's accident. Dr. Jacobsen testified that claimant's reaction time would be significantly decreased because of her alcohol consumption in the presence of distracting visual or auditory stimuli. Dr. Jacobsen emphasized that claimant would have

been "significantly impaired" at the time of the accident, even if she had developed a significant tolerance of alcohol over the course of her history of drinking. (Tr. 93). Although Dr. Jacobsen never testified that claimant's accident was unlikely to have occurred in the absence of her drinking, Dr. Jacobsen concluded that, given all the data available in the case, claimant's alcohol consumption was the "major contributing cause of the accident." (Tr. 95). According to Dr. Jacobsen, claimant was at high risk of an accident because of her drinking, even if the small dog had not been present in the car. Id. Inasmuch as it is well-reasoned, thorough and supported by the record, we are persuaded by Dr. Jacobsen's medical opinion that claimant's drinking was the major factor in her accident.[2] See Somers v. SAIF, 77 Or App 259 (1986).

It is true that this accident could have occurred even if claimant was not alcohol impaired.[3] Nevertheless, we conclude that the insurer sustained its burden of proving consumption of alcohol was the major contributing cause of claimant's accident. We reach this conclusion regardless of whether the insurer must prove its case by "clear and convincing," or by a "preponderance" of, evidence. Therefore, we reverse the ALJ's order and reinstate the insurer's denial.

## ORDER

The ALJ's order dated March 6, 1995 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

---

[2] We recognize that apart from Dr. Jacobsen's testimony, there is no other evidence that claimant's drinking played a major role in her accident. The police reports do not state that alcohol was a factor in claimant's accident. (Exs. 10A, 13A). Moreover, there were no witnesses who observed the accident or testified that claimant was driving in an unusual manner prior to the accident. However, considering Dr. Jacobsen's unrebutted testimony that claimant was significantly impaired and that her impairment from alcohol was the major causal factor in her accident, we are persuaded that claimant's accident is not compensable.

[3] Both the ALJ and claimant emphasize the presence of a non-alcohol related factor (the small dog that scrambled beneath claimant's feet) in arguing that alcohol was not the major factor in the accident. While the dog's presence could constitute an intervening cause of claimant's accident, we find this case similar to Menestrina, supra, in which there were also non-alcohol related factors (fatigue and low tire pressure) that may have played a role in the claimant's accident. As was the case in Menestrina, we are persuaded by the cogent medical evidence that alcohol was the major causal factor in this accident.

**Board Member Hall dissenting.**

I disagree with the majority's conclusion that the insurer has carried its burden of proof on the issue of causation and thus, respectfully dissent. As set forth in my dissents in Ronald Martin, 47 Van Natta 473 (1995) and Scott S. Fromm, 47 Van Natta 1476 (1995), I believe that it is error to let evidence of a claimant's impairment, even if overwhelming, influence 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] The ALJ correctly recognized this when he determined that he was not bound by the uncontradicted medical opinion of Dr. Jacobsen in determining whether impairment from alcohol consumption caused claimant's accident.

In this case, as in Fromm, there were no eyewitnesses to the accident and the only evidence regarding how the injury occurred came from claimant. As the majority correctly notes, the police reports do not identify alcohol as a factor in this accident. Under these circumstances, I submit the majority errs, as it did in Fromm, in relying upon the opinion of Dr. Jacobsen to find that the carrier carried its burden of proving causation. Because the majority persists in combining the two elements, I must once again dissent.

---

[1] As noted in my dissent in Fromm, 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.

In the Matter of the Compensation of
**LAURA L. FREE, Claimant**
WCB Case No. 94-05822
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) set aside its denial of claimant's medical services claim for a back condition; and (2) awarded a $2,500 attorney fee under former ORS 656.386(1). On review, the issues are compensability and attorney fees. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, and briefly summarize the pertinent facts as follows:

Claimant sustained a compensable injury to her low back and left calf on January 17, 1992. While treating for this injury, claimant complained of an increased frequency of headaches. Her then-treating physicians (Drs. Hubbard and Pribnow) did not relate claimant's headaches to her compensable injury.

In May 1992, around the same time the insurer closed the claim, claimant changed her attending physician to chiropractor Colgan. Dr. Colgan subsequently opined that claimant had both a low back condition and a cervical strain-subluxation condition as a result of her industrial injury, and that the cervical condition was causing the headache symptoms. The insurer denied claimant's headache and cervical condition, which denial was upheld by an April 1993 Opinion and Order.

Dr. Colgan submitted several billings to the insurer for claimant's chiropractic treatments in May and June 1992, none of which were paid. On March 1, 1994, Dr. Colgan wrote to claimant's attorney stating that all of his treatments and adjustments of claimant's spine were to correct her low back condition.

## CONCLUSIONS OF LAW AND OPINION

### Medical Services

We retain jurisdiction to resolve this medical services dispute under amended ORS 656.245(6) because the dispute involves the compensability of the underlying claim.[1] The insurer had previously issued a formal denial of claimant's neck and headache condition which had been upheld. Thereafter, claimant requested a hearing, seeking payment of medical bills that she contended were attributable to her compensable low back condition. The insurer refused to pay for Dr. Colgan's treatments asserting that such treatments were related to her noncompensable headache and cervical condition rather than to her accepted low back condition. Inasmuch as the insurer had expressly refused to pay the disputed medical bills on the ground that the bills are not attributable to claimant's compensable condition, we conclude that this dispute pertains to a "formal denial of the compensability of the underlying claim." See amended ORS 656.245(6). Consequently, we have jurisdiction to consider this dispute.

Unlike the ALJ, we agree with the insurer's contention that Dr. Colgan engaged in "revisionist history" in March 1994 when he asserted that all but one of claimant's treatments in May and June of 1992 were geared toward correction of her low back problem. (Ex. 35.) Although Dr. Colgan does not make or keep chart notes, other medical reports in the record indicate that at the time claimant treated with Dr. Colgan in 1992, her primary complaints were headaches and neck pain rather than low back pain. For example, on April 9, 1992, claimant saw Dr. Pribnow complaining of headaches which she related to her January 1992 fall at work. (Ex. 8-2). On April 24, 1992, Dr. Hubbard indicated that

---

[1] Amended ORS 656.245(6) provides, in pertinent part: "If a medical services claim 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 . . . ." Or Laws 1995, ch 332 § 25 (SB 369, § 25) (Emphasis added).

claimant had called him intermittently since her fall complaining of headaches. (Ex. 13). Dr. Hardiman's report of April 30, 1992 refers to headaches, neck discomfort and only occasional low back and leg problems. (Ex. 14). Finally, claimant's primary complaint to Dr. Schubert (the chiropractor she saw immediately before switching to Dr. Colgan) was headaches. Dr. Schubert's chartnotes from May 6, 8 and 11, 1992 refer to headaches, but do not mention any low back problems. (Ex. 15). Claimant began treating with Dr. Colgan on May 15, 1992

Given the contemporaneous evidence and Dr. Colgan's position in 1992 and 1993 that claimant's cervical condition was compensably related to her industrial accident, we do not find Dr. Colgan's March 1, 1994 letter persuasive. On this record, we are not persuaded that the disputed medical bills are materially related to claimant's compensable low back condition. To the contrary, the record suggests that they were to treat claimant's cervical condition and headaches which have been adjudicated to be noncompensable. Accordingly, we uphold the insurer's denial of Dr. Colgan's medical bills.

ORDER

The ALJ's order dated January 25, 1995 is reversed. The insurer's denial is reinstated and upheld. The ALJ's award of attorney fees is reversed.

---

October 18, 1995 Cite as 47 Van Natta 2025 (1995)

In the Matter of the Compensation of
**ELIZABETH JUVET, Claimant**
WCB Case No. 94-02742
ORDER ON REVIEW
Olson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) McCullough's order which set aside its denial of claimant's occupational disease claim for a right upper extremity condition. On review, the issue is compensability.

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

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 656.802, which now provides that if an occupational disease claim is based on the worsening of a preexisting disease, claimant must prove that work conditions were the major contributing cause of the "combined" condition and a pathological worsening of the disease. In addition, occupational disease claims are now subject to the same limitations and exclusions as accidental injuries under ORS 656.005(7). Or Laws 1995, ch 332, §§ 56(2)(b), (c) (SB 369, §§ 56(2)(b), (c).

Assuming the amendments to ORS 656.802 are applicable to this case, we conclude that the result would not change, since we find that claimant has established the compensability of her occupational disease claim under amended ORS 656.802. Specifically, we agree with the ALJ's analysis that the claim is for an occupational disease condition, variously termed tenosynovitis, tendinitis, or overuse syndrome, which required treatment and resulted in disability in December 1993 and January 1994. Because we find this right upper extremity condition to be a separate condition from claimant's preexisting right upper extremity radicular pain, the preexisting condition provisions of amended ORS 656.802 are not implicated.

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 March 3, 1995 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the insurer.

---



In the Matter of the Compensation of
**SANTOS KING, Claimant**
WCB Case No. TP-95007
THIRD PARTY DISTRIBUTION ORDER
Warren, Allen, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant has petitioned the Board for resolution of a dispute regarding a "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute concerns the SAIF Corporation's entitlement to a share of the proceeds resulting from claimant's settlement with a third party. We conclude that a distribution in which SAIF receives reimbursement for its claim costs from the remaining balance of settlement proceeds would be "just and proper."

FINDINGS OF FACT

In July 1992, while performing his work activities, claimant was struck in the forehead by a falling door whose hinges were not securely fastened by a third party. SAIF accepted claimant's injury claim for acute cervical strain, C5-6 and C6-7 herniated discs, and torticollis.

With SAIF's approval, claimant settled his action against the allegedly negligent third party for $60,000. SAIF asserted a lien for claim costs totaling $47,241.37. These expenses are comprised of medical service payments ($21,572.93), permanent disability ($20,944.74), temporary disability ($2,342.70) and anticipated future medical costs of $2,381.46.

SAIF proposed to reduce its lien to $26,000. In response, claimant sought further reduction of SAIF's statutory lien. When SAIF refused, claimant petitioned the Board pursuant to ORS 656.593(3) for resolution of the parties' dispute.

CONCLUSIONS OF LAW AND OPINION

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 paying agency has a lien against the worker's cause of action, which lien shall be preferred to all claims except the cost of recovering such damages. ORS 656.580(2). 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 allegedly as a result of the negligence or wrong of a third person. The claim was accepted by SAIF, which has provided compensation. Inasmuch as SAIF has paid benefits to claimant as a result of a compensable injury, it is a paying agency. ORS 656.576. Moreover, when claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable. In other words, by virtue of the aforementioned statutory provisions, SAIF's lien for its claim costs attaches to claimant's recovery and that lien is preferred to all other claims.

Since claimant settled his third party claim and SAIF has approved that settlement, SAIF is authorized to accept as its share of the proceeds "an amount which is just and proper," provided that claimant receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). The amounts referred to in ORS 656.593(1) and (2) pertain to attorney fees, litigation expenses, and claimant's statutory 1/3 share of the settlement. Thereafter, any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

In determining a "just and proper" distribution, we judge each case based on its own merits. Urness v. Liberty Northwest, 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) 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 this case, claimant does not challenge SAIF's assertion that it will incur claim costs totaling $47,241.37. Following distribution of the statutory 1/3 share of attorney fees ($20,000) and a proposed share of $14,000[1] to claimant, SAIF seeks recovery of the $26,000 remaining balance in partial reimbursement of its actual and anticipated claim costs. On the other hand, claimant proposes that SAIF reduce its lien to the sum of $15,000, asserting that this would increase her recovery by $11,000 and would more fairly distribute the proceeds of the third party settlement. Based on the following reasoning, we find that it is a "just and proper" distribution of the settlement proceeds for SAIF to recover $26,000 in partial reimbursement of its claim costs.

In resolving this dispute, we are 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). Rather, to assist us in conducting our deliberations, we have examined the components of compensation which are subject to reimbursement from a third party judgment under Section (1)(c). Such an examination provides some general guidance to us in determining what portion of the remaining balance of claimant's third party settlement would be "just and proper" for SAIF to receive in partial satisfaction of its 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. Norman H. Perkins, 47 Van Natta 488, 490 (1995); Jack S. Vogel, 47 Van Natta 406 (1995).

Here, as previously noted, claimant does not contest SAIF's assertion that it incurred the aforementioned $26,000 in temporary disability, permanent disability and medical expenses while processing claimant's injury claim. Instead, claimant argues that SAIF should further reduce its share of the settlement proceeds because it would be in the "interests of justice" that she receive a larger portion of the third party settlement. Finally, claimant estimates the total value of the third party claim as in excess of $100,000. Nonetheless, in light of the "disputed and uncertain" liability aspect of the case, claimant reasons that the $60,000 settlement was well advised. Because of such circumstances, claimant contends that a further reduction of SAIF's lien would be "just and proper."

We have in the past rejected arguments that it would be more equitable to order a distribution that results in a claimant receiving a larger portion of a third party settlement by reducing a paying agency's unchallenged lien for claim costs. See e.g. Gerald L. Davidson, 42 Van Natta 1211 (1990). In addition, we have previously ruled that the liability risks present in a third party action are of no consequence in determining a "just and proper" distribution of settlement proceeds. See Delores M. Shute, 41 Van Natta 1458 (1989). In reaching such a conclusion, we have reasoned that such liability risks properly rest with the worker who is pursuing the action and have no logical correlation to the amount of a paying agency's lien. Id.

---

[1] SAIF correctly observes that this amount is actually more than one-third of the balance of the recovery after deduction of attorney fees.

Moreover, SAIF has already substantially reduced its original lien of $47,241.37 by over $21,000 and has proposed that claimant receive more than her statutory one-third share of the balance of the third party recovery after attorney fees are deducted. In light of such circumstances and since SAIF's expenditures constitute "compensation" which has previously been provided to claimant, we find it "just and proper" for SAIF to receive reimbursement for these expenses from claimant's third party settlement. See ORS 656.593(3); Norman H. Perkins, supra; Jack S. Vogel, supra.

Consequently, claimant's attorney is directed to distribute the remaining balance of the third party settlement proceeds in the following manner. Claimant shall receive $14,000, with the remaining $26,000 to be forwarded to SAIF as partial reimbursement for its third party lien for claim costs.

IT IS SO ORDERED.

---



In the Matter of the Compensation of
**DAVID C. McKEE, Claimant**
WCB Case No. 94-12702
ORDER ON REVIEW
Zbinden & Curtis, Claimant Attorneys
David O. Horne, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Galton's order that: (1) set aside a Director's "Proposed and Final Order on Weekly Wage for Computing Temporary Disability Rate;" and (2) recalculated claimant's rate of pay and awarded additional temporary disability benefits. On review, the issue is the rate of temporary disability benefits. We modify.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant was a member of the ground crew for the employer, which operates blimps. Claimant's job required constant travel from city to city doing advertisements. Claimant was compensably injured, and claimant and the insurer were unable to agree on the proper wage calculation for computing temporary total disability compensation (TTD). The dispute was submitted to the Director and an October 6, 1994 Director's order found that claimant's TTD rate should be calculated based on his weekly salary of $350, plus a reasonable value for lodging, which the Director determined was $238. The $238 figure was calculated by using the rate of reimbursement for State of Oregon classified employees for in-state travel, which was $34 dollars per day ($238 per week). In determining claimant's TTD rate, the Director declined to include a $189 per week per diem allowance.

The insurer requested a hearing from the Director's order and claimant cross-appealed. The ALJ found that the reasonable value of claimant's lodging ($238 a week) and the $189 a week per diem allowance paid by the employer should be included in calculating claimant's TTD rate. We agree with the ALJ that the Director's calculation should be increased, but, based on the following reasoning, we modify the amount given for lodging expenses.

The ALJ agreed with the Director that $238 was a reasonable value for lodging and that the lodging costs should be included in calculating claimant's temporary disability rate. On review, the insurer argues that claimant's lodging and per diem expenses should not be included in his TTD rate. The insurer also challenges the use of the State of Oregon rate for reimbursement of lodging costs. The insurer contends that, if the lodging costs should be included in claimant's wages, they should be based on evidence that claimant generally shared a room with another employee and that the average cost of a room was $50 a night. On this basis, the insurer argues that the lodging costs should be half of $50 a night, i.e., $25 a night or $175 a week. Claimant argues that use of the State of Oregon rate for reimbursement of lodging costs is appropriate and is authorized by OAR 436-60-070(1).

"Wages" means 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 * * *." ORS 656.005(29) (formerly ORS 656.005(27)).

Claimant's employment contract with the employer provided that claimant would receive a weekly salary of $350 plus a "weekly per diem of $189" for "personal expenses such as meals, laundry, telephone calls, personal transportation and tips." (Ex. 0A). In addition to the weekly salary, the employer also paid the lodging costs of its employees.

Claimant testified that the hotel rooms cost about $45 a night. In addition, the employer's account manager, who was responsible for paying the hotel bills, testified that the employer tried to keep the hotel rooms to about $50 a night. The account manager also testified that claimant generally shared a room with another employee.

Given that there is persuasive evidence concerning the actual amount paid by the employer for the hotel rooms, we do not find it necessary or appropriate to rely on OAR 436-60-070(1). That rule pertains to reimbursement by the insurer of actual and reasonable claims related costs, such as travel and prescriptions. OAR 436-60-070(2) provides that reimbursement at the rate of reimbursement for State of Oregon classified employees of the costs of meals, lodging, public transporation and use of a private vehicle complies with the rule. First, OAR 436-60-070 appears to pertain to costs of the carrier which are related to the compensable injury. The rule does not appear to pertain to the determination of a reasonable value for lodging in determining a worker's TTD rate. Nevertheless, even assuming the rule does apply in such a context, we need not rely on the rule, because there is persuasive evidence, in the form of testimony, concerning the actual cost of the lodging.

We rely on the employer's account manager's testimony that it generally tried to keep hotel rooms to $50 a night for a double occupancy room. We conclude that a reasonable value for claimant's lodging is $25 per night (half of the $50 paid for a double occupancy room).[1]

The insurer argues, based on Rickie S. Krohnke, 46 Van Natta 719 (1994), that the amounts paid for claimant's lodging and the per diem expenses should not be included in the calculation of his TTD rate, because these amounts were travel reimbursements rather than wages. We find Krohnke distinguishable. In Krohnke, the self-insured employer paid the claimant an hourly rate. The employer did not pay for the claimant's food or housing in addition to this amount. However, when a job required an overnight stay away from home, the employer consistently paid for meals and lodging. When the employer asked the claimant to work in California for an extended period, the employer agreed to pay the claimant's room and board while in California.

The ALJ in Krohnke found that the claimant's room and board should be included in calculating his temporary disability. However, on review, we concluded that the employer's payment of the claimant's room and board while in California was not remuneration for the claimant's services, but was reimbursement for travel expenses. On this basis, we concluded that the employer's reimbursement of meals and lodging should not be included in the claimant's wages for temporary disability.

In the present case, unlike in Krohnke, claimant's job consisted of constant travel with no return to a "home base." Here, because of claimant's constant travel, the employer's payment for claimant's lodging was part of claimant's remuneration rather than merely a travel expense as in Krohnke. On this basis, we find Krohnke to be distinguishable. We also note that, by its plain language, ORS 656.005(27) (now 656.005(29)) explicitly includes in the definition of "wages," a reasonable value for lodging and board.

The ALJ also included the $189 weekly "per diem" payment in his calculation of claimant's wages. The employer argues, citing Rickie S. Krohnke, supra, that these expenses were merely reimbursement for expenses caused by the work-related travel. We disagree.

---

[1] We note that the Director's order reasoned that most hotels charge a flat rate for single occupancy rooms and do not double the rate for double occupancy. Based on this reasoning, the Director concluded that allowing only half (approximately $25) was not a reasonable value for a hotel room valued at $50 for double occupancy. We disagree with the Director's reasoning. Half of the rate for a double occupancy room is the amount that the employer generally paid for claimant's nightly lodging. Thus, we find this amount to be a reasonable value of the lodging claimant received.

The employment contract provides for the $189 payment for "personal expenses" and indicates that the money can be used for such things as "meals, laundry, telephone calls, personal transportation and tips." The $189 was paid to claimant in advance and claimant was not required to submit receipts or to establish that the money was spent only on work-related or travel expenses. No restrictions were placed on the use of the money. Given these facts, we are not persuaded that the $189 "per diem" was merely a reimbursement for work-related or travel expenses. Instead, we conclude that it was compensation for claimant's services. Accordingly, we agree with the ALJ that the $189 "per diem" should be included in the calculation of claimant's TTD rate.[2]

ORDER

The ALJ's order dated April 25, 1995 is modified in part and affirmed in part. The October 6, 1994 Director's order is modified to provide that claimant's temporary disability rate shall be based on his weekly salary of $350, a reasonable value for lodging of $175 a week and a $189 weekly payment The remainder of the order is affirmed.

---

[2] We note that the Director's order relied on the version of OAR 436-60-025(5)(b) contained in WCD Admin. Order 94-055. This rule went into effect on August 28, 1994 and does not apply to this case. See OAR 436-60-003(2). The rule provides, in part, that "[e]xpenses incurred due to the job and reimbursed by the employer (e.g. meals, lodging, per diem, equipment rental) are not considered part of the wage." Even assuming that this rule applies to this dispute (and assuming that it is consistent with ORS 656.005(29)), we would still conclude that the $189 "per diem" payment should be included in claimant's wages for temporary disability. We reach this conclusion because, as explained above, we do not find that the "per diem" paid by the employer in this case is intended as a reimbursement for expenses incurred on the job. As stated above, no limitations were placed on the use of this money and the money was paid in advance with no restrictions. Under these circumstances, even if the rule applied to this case, we would conclude that the "per diem" was part of claimant's remuneration for his services and was not a reimbursement of expenses incurred on the job.

---



In the Matter of the Compensation of
**DARAL T. MORROW, Claimant**
WCB Case Nos. 94-10771 & 94-08852
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Sedgwick James, as claims administrator for a self-insured employer, requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant has an accepted low back condition with SAIF stemming from a July 1991 claim. SAIF accepted a lumbosacral strain and shoulder contusion. (Ex. 23). Claimant was awarded 25 percent unscheduled permanent disability pursuant to a Stipulation and Order. (Ex. 41).

On February 1, 1993, claimant sought emergency room treatment for back pain and was given a pain shot. (Tr. 9). Claimant began working for the employer in approximately the fall of 1993. (Tr. 5). He testified that he was not having any low back problems and did not seek any medical treatment for his low back between the fall of 1993 and June 1994. (Tr. 7). He did not have any restrictions or limitations with respect to his low back during that time period. (Id.) Claimant said that after the February 1993 back pain treatment, his back pain went away. (Tr. 10).

On June 13, 1994, claimant was working for a landscape company through the employer doing heavy work. When he went to work that morning, he felt great and was not having any problems. (Tr. 8-10). His job duties on that date entailed loading cinder rock into a truck. While attempting to push the loaded wheelbarrow up a ramp, claimant testified that he "didn't have quite enough juice to make it" and when the wheelbarrow started to go back down the ramp, another employee came up behind him and gave him a light shove. (Tr. 12, 17). Approximately 20 to 30 minutes later, claimant's back began stiffening up and, after taking a break, he could not get off a bench. (Tr. 13, 17). Thereafter, claimant was excused from work by his supervisor. (Tr. 28). Later that day, claimant received emergency room treatment and was referred to Dr. Belza, who diagnosed a lumbar strain.

The ALJ found that ORS 656.308(1) applied to the claim because claimant's current low back condition was the "same condition" as the prior low back claim accepted by SAIF. Applying ORS 656.005(7)(a)(B), the ALJ concluded that claimant had sustained a "new injury" on June 13, 1994.[1] Consequently, responsibility was assigned to Sedgwick James, as claims administrator for the employer.

Claimant agrees with the ALJ that he sustained a new compensable injury on June 13, 1994 to the same body part injured on July 3, 1991. Claimant contends that the persuasive medical opinions establish that his resultant back condition was caused, in major part, by the June 13, 1994 compensable injury.

Dr. Belza, neurosurgeon, examined claimant on June 13, 1994 and reported a limited range of motion in claimant's back secondary to muscle spasm with "palpable tenderness in the paraspinous muscles of the lumbar spine, greater on the left than the right." (Ex. 45). Dr. Belza recorded a prior history of a work injury in July 1991 and further reported that claimant had been asymptomatic over the past year. (Ex. 45). Dr. Belza diagnosed claimant with a lumbar strain.

Dr. Belza was asked to review a report from Dr. Potter, who concluded that claimant had an "exacerbation of a chronic back problem which was not caused or worsened by the incident of June 13, 1994." (Ex. 51). Dr. Belza responded that claimant "did not have any problems for a year prior to his injury sustained in 1994 to suggest that his current symptomatology may be an exacerbation of a prior problem." (Ex. 52). He concluded that claimant "sought treatment and was disabled on June 13, 1994 as a result of the work incident on June 13, 1994" and that "the major contributing cause of his need for treatment was the June 13, 1994 incident." (Ex. 59).

Dr. Dickerman diagnosed a "[f]lare-up of symptoms secondary to incident of June 13, 1994, with no change in the underlying pathology." (Ex. 56). He found that claimant had an exaggerated pain response and found no evidence of a worsening since the SAIF closure. Dr. Dickerman reported that the June 13, 1994 incident was the specific cause for claimant's need for medical treatment and that the incident increased claimant's symptomatology. (Id.) Dr. Dickerman concluded that the June 13, 1994 incident contributed to claimant's need for treatment, although it did not change the underlying condition.

Although Sedgwick James relies on the opinions of Drs. Potter and Shames, we find a persuasive reason to discount their reports. Dr. Potter agreed with Sedgwick James that "the diagnosis of lumbosacral strain/sprain without radiculopathy is an exacerbation of a chronic back problem which was not caused or worsened by the incident of June 13, 1994." (Ex. 51). He concluded that "the June 13, 1994 incident was not the major contributing cause for his need for treatment and any resulting disability." (Id.)

---

[1] Subsequent to the ALJ's order, Senate Bill 369 was enacted, amending ORS 656.308(1) and ORS 656.005(7)(a)(B). Or Laws 1995, ch 332, §§ 1, 37 (SB 369, §§ 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.

However, Dr. Potter's review of claimant's history does not reveal a chronic back problem. Dr. Potter was aware of claimant's 1991 injury and noted that he had low back pain for approximately one year. (Ex. 51). He next noted, however, "[t]hat cleared and he had no pain except for an occasional discomfort when he would awaken in the morning, being stiff and sore." (Id.) Later in his report, Dr. Potter mentioned the 1991 injury and said that claimant "apparently resolved that problem." (Id.)

In light of Dr. Potter's report that claimant's 1991 injury had "resolved" and "cleared," his conclusion that claimant suffered "an exacerbation of a chronic back problem" is inconsistent. Since Dr. Potter did not explain this inconsistency, his conclusion is not persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980); see also Kelso v. City of Salem, 87 Or App 630 (1987). Similarly, we do not find Dr. Shames' "check-the-box" concurrence with Dr. Potter persuasive.

Citing Kuhn v. SAIF, 73 Or App 768 (1985), Sedgwick James argues that Dr. Belza's opinion that claimant's prior low back condition had resolved was erroneous because the prior permanent disability award established the law of the case, i.e., that claimant has permanent disability. We disagree.

In Queener v. United Employers Ins., 113 Or App 364, rev den 314 Or 176 (1992), the court found that the "law of the case" theory in Kuhn v. SAIF, supra, did not apply in a case where the doctors who examined the claimant were aware that she had previously suffered a compensable injury but found that her present symptoms were no longer causally related to it. The court held that the Board's acceptance of those findings did not disregard the claimant's permanent disability.

Here, Dr. Belza was aware of claimant's prior back injury and that he was off work for one year. Under these circumstances, Dr. Belza's opinion that claimant's back condition had not been symptomatic for the past year and that his current symptomatology was not an exacerbation of a prior problem does not disregard claimant's permanent disability and does not contradict the "law of the case." See Queener v. United Employers Ins., supra.

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 (1986). Here, we are persuaded by the reports of Dr. Belza, claimant's treating physician, that claimant's June 1994 industrial injury was the major contributing cause of his current disability and need for treatment.

Disclaimer of Responsibility

Sedgwick James argues that SAIF failed to issue a timely disclaimer of responsibility pursuant to ORS 656.308(2), and, therefore, SAIF could not shift responsibility to another carrier. SAIF contends that its disclaimer was timely, and, in any event, the timeliness of its disclaimer is irrelevant.

After the ALJ's order, the legislature amended ORS 656.308(2). Or Laws 1995, ch 332, § 37 (SB 369, § 37). The statute, as amended, no longer requires a carrier to issue a timely "disclaimer" of responsibility. Although the changes made to the Workers' Compensation law may apply retroactively, see Volk v. America West Airlines, 135 Or App 565 (1995), to the extent that Sedgwick James' argument about SAIF's disclaimer involves a procedural time limit, the changes made by SB 369 are not applicable. See Motel 6 v. McMasters, 135 Or App 583 (1995).

In this case, however, even if we apply the previous version of ORS 656.308(2), the timeliness of SAIF's disclaimer is irrelevant. A carrier's violation of the disclaimer notice requirement does not preclude a claimant from pursuing the claim with another carrier. See Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994); Jon F. Wilson, 45 Van Natta 2362 (1993). Consequently, even if we assume, without deciding, that SAIF failed to issue a timely disclaimer of responsibility under former ORS 656.308(2), that does not preclude claimant from pursuing a claim with Sedgwick James. Therefore, the fact that SAIF allegedly failed to issue a timely disclaimer of responsibility is of no consequence in this case under either version of ORS 656.308(2).

Responsibility

Sedgwick James argues that the ALJ erred by concluding that claimant had sustained a new injury on June 13, 1994 and it asserts that the claim should have been treated as a request for medical services under ORS 656.245. We disagree.

Given our finding that the June 13, 1994 injury is the major contributing cause of claimant's condition, we conclude the ALJ properly assigned responsibility for claimant's current condition to Sedgwick James. See Antonio J. Lopez, 47 Van Natta 1304 (1995) (since the injury was the major contributing cause of the claimant's condition, the carrier was responsible regardless of the analysis adopted).

In addition, given our determination that the 1994 injury is the major contributing cause, we need not address whether claimant's current low back condition is the "same condition" as the condition accepted by SAIF or a separate injury to the same body part. Even if we assume it is the same condition and ORS 656.308(1) applies, Sedgwick James is responsible because claimant sustained a "new compensable injury involving the same condition" in June 1994.

In sum, we conclude that claimant's low back condition is compensable and that Sedgwick James is responsible for that condition. Consequently, we affirm the ALJ's order reaching the same conclusions.

Claimant is entitled to an assessed attorney fee for prevailing over Sedgwick James' 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 Sedgwick James. 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 17, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by Sedgwick James.

---



In the Matter of the Compensation of
**ROSALIE NAER, Claimant**
WCB Case Nos. 93-03649 & 93-00733
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

AAAA All About Auto Shipping (Auto Shipping), a noncomplying employer, pro se, requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that set aside the SAIF Corporation's denial of claimant's left shoulder injury claim. Claimant moves to strike portions of Auto Shipping's brief referring to evidence not admitted at hearing. In its brief, SAIF argues that the attorney fee awarded by the ALJ was excessive. Claimant moves to strike SAIF's brief, contending that SAIF may not challenge the ALJ's attorney fee award for the first time on review. On review, the issues are compensability (subjectivity), scope of review (remand), motions to strike, 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

### Preliminary Matters

With its brief, Auto Shipping submits 3 affidavits and 2 letters (from individuals who did not testify at hearing) which were not offered at hearing. Claimant objects to this post-hearing "evidence" and moves to strike portions of Auto Shipping's brief which refer to it. We grant claimant's motion.

Our review must be based on the record certified to us. See ORS 656.295(5). Consequently, we treat Auto Shipping's submission of evidence as a motion to remand to the ALJ for the taking of additional evidence. Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

In this case, there is no evidence that the documents submitted for the first time on review were unavailable with due diligence at the time of hearing. Moreover, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of this additional evidence would not likely affect the outcome. See id. Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Accordingly, it does not merit remand. See ORS 656.295(5).

As we have stated, our review is limited to the record certified to us. Id. Thus, because Auto Shipping's brief refers to evidence not offered and admitted at hearing (and therefore not certified to us), we grant claimant's motion to strike those portions of Auto Shipping's brief which refer to such evidence.

We turn to claimant's motion to strike SAIF's brief.

On December 29, 1994, Auto Shipping requested review. On February 14, 1995, Auto Shipping filed its "Appellant's Brief."

On February 7, 1995, SAIF filed an "Appellant's Brief," which it later resubmitted as a "Respondent's/Cross Appellant's Brief" (hereafter SAIF's "Respondent's Brief"), on February 21, 1995.

On February 28, 1995, claimant filed a "Respondent's Brief," wherein he objected in advance to SAIF's anticipated filing of a "Cross-Reply Brief." In the event that SAIF filed a "Cross-Reply Brief," claimant moved to strike it. On March 6, 1995, SAIF filed a "Cross-Reply Brief."

Under the Board's rules, only a "Cross-Appellant" may file a "Cross-Reply" Brief. See OAR 438-11-020(2). Here, because SAIF did not cross-request Board review, it cannot be a "Cross-Appellant." Accordingly, claimant's motion to strike SAIF's "Cross-Reply Brief" is granted.

Claimant also moves to strike SAIF's entire "Respondent's Brief," which is devoted to challenging the amount of the attorney fee awarded by the ALJ. Claimant contends that SAIF may not raise that issue on review, because it did not raise it at hearing. We deny claimant's motion.

The scope of our de novo review encompasses all issues considered by the ALJ. See Destael v. Nicolai Co., 80 Or App 596 (1986). We have also previously held that we have authority to consider issues which are not raised via formal cross-requests for review. See Jeffrey A. Guild, 42 Van Natta 191 (1990).

Here, the issue of an attorney fee was considered at the hearings level because the ALJ's order provided for such an award. However, SAIF could not object at hearing to the amount of the ALJ's attorney fee award, because the amount of the ALJ's award was not known until after the hearing record was closed and the fee was awarded. Under these circumstances, we conclude that we are authorized to consider SAIF's objection to the amount of the ALJ's attorney fee award. Accordingly, claimant's motion to strike argument on this issue is denied.

Compensability (Subjectivity)

We adopt the ALJ's opinion on this issue.

Attorney Fees

SAIF argues that the ALJ's $10,000 attorney fee award was not reasonable in light of the factors set forth in OAR 438-15-010(4) and particularly considering the fact that the fee requested ($11,375) represents twice claimant's counsel's customary rate. We modify the ALJ's attorney fee award.

On de novo review, we consider the amount of claimant's counsel's attorney fee for services at the hearings level by applying the factors set forth in OAR 438-15-010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. Because the risk of an attorney's efforts going uncompensated is already a factor which must be considered under the rule, we decline to apply a contingency multiplier in determining a reasonable attorney fee under ORS 656.386(1). See Lois J. Schoch, 46 Van Natta 1816 (1994).

Our review of the record reveals the following information. The issue in dispute was whether claimant was a subject worker for Auto Shipping. Approximately 24 exhibits were received into evidence, about half of these apparently generated by claimant's counsel. The hearing lasted for roughly 8 hours, resulting in a 253 page transcript. Claimant's counsel submitted an affidavit attesting to 45.5 hours of services at an hourly rate of $125. Such services would total $5,625. However, asserting that a "double contingency factor" should be applied, claimant sought an attorney fee award totaling $11,375.

As compared to typical "subject worker" cases, the issue at hearing in this case was of average to above-average complexity. The claim's value and the benefit secured are of average proportions, consisting of temporary disability, medical services, and, potentially, permanent disability. Claimant's counsel has skillfully advocated claimant's claim in the face of a vigorous defense. The hearing was relatively lengthy (lasting more than one day) and involved extensive examination of six lay witnesses to resolve the credibility questions. Finally, particularly in light of the credibility dispute, there was a substantial risk that claimant's counsel's efforts might go uncompensated.

After considering these factors, we acknowledge the skill demonstrated by claimant's counsel in securing this successful result. However, our review of this record does not establish that the complexity of the issues or the value of the benefits resulting from this claim differ appreciably from those in most cases litigated before this forum. In other words, the record does not support an attorney fee award consistent with claimant's request, particularly when claimant seeks an award twice that which comports with her counsel's regular billable rate. Consequently, after applying the aforementioned factors to this record, we conclude that $6,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. We modify the ALJ's award accordingly.

Claimant's attorney is entitled to an assessed fee for services on review successfully defending the merits of the claim in response to Auto Shipping's appeal. 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 Auto Shipping's appeal is $1,200 payable by SAIF, on behalf of Auto Shipping. In reaching this conclusion, we have particularly considered the time devoted to the subjectivity issue (as represented by claimant's attorney's statement of services and his respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for her counsel's services devoted to the attorney fee issue.

ORDER

The ALJ's order dated November 28, 1994 is modified in part and affirmed in part. In lieu of the ALJ's $10,000 attorney fee award, claimant's counsel is awarded a $6,000 attorney fee, payable by SAIF on behalf of Auto Shipping. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded a $1,200 attorney fee, payable by SAIF, on behalf of Auto Shipping.

In the Matter of the Compensation of
**JAMES F. RUTLEDGE, JR., Claimant**
WCB Case No. 94-07873
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

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

## FINDINGS OF FACT

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

Claimant, a heavy equipment operator, injured his right knee at work on February 18, 1994, stepping down from his equipment. He felt a sharp pain in his knee, and the knee was swollen for about three days. Claimant did not seek medical treatment, nor did he stop working; however, he rested his knee during a lay-off beginning March 1, 1994. In April 1994, while mowing his lawn at home, claimant again twisted his right knee. He sought medical treatment from his family physician, Dr. Swiridoff. An MRI revealed a torn medial meniscus. Dr. Harris, an orthopedist who examined claimant on referral from Dr. Swiridoff, recommended surgery to repair the right knee. SAIF denied the claim on June 10, 1994. (Ex. 11).

## CONCLUSIONS OF LAW AND OPINION

Applying the material contributing cause standard under ORS 656.005(7)(a), the ALJ found the claim compensable. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). In doing so, the ALJ concluded that claimant did not have a preexisting condition under ORS 656.005(7)(a)(B). We disagree.

When a preexisting disease or condition combines with a compensable injury to cause or prolong disability or the need for treatment, the resultant condition is compensable only if the compensable injury is the major contributing cause of the resultant condition. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993).[1]

Here, we find that claimant had a preexisting condition which combined with his February 1994 compensable injury to cause or prolong his disability or need for treatment. When Dr. Harris examined claimant in May 1994, he noted that claimant had symptoms in his right knee off and on for "several years." (Ex. 7). Dr. Duff, who examined claimant at SAIF's request, noted a history of right knee symptoms for the past 1-2 years, without any specific injury. (Ex. 10-2). Dr. Duff opined that claimant's history is most compatible with a degenerative tear of the medial meniscus with an unstable fragment that periodically has displaced into the joint and then has spontaneously relocated. (Ex. 10-5).

---

[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). The amendments also contain a definition of "preexisting condition," which provides:

> "'Preexisting condition' 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." SB 369, § 1(24).

Assuming the amendments to ORS 656.005(7)(a)(B) and 656.005(24) are applicable to this case, we find that the result would not change, since claimant has not established that his condition is compensable under former ORS 656.005(7)(a)(B). Consequently, we do not address which version of the statute should apply to this case.

He concluded that claimant "most probably [had] a chronic meniscal tear present at least a year and possibly two years." (Id.). Dr. Swiridoff agreed with Dr. Duff's analysis. (Exs. 12, 14). Under such circumstances, we conclude that claimant had a preexisting right knee condition which combined with the February 1994 work injury to cause or prolong his disability and need for treatment.

It is claimant's burden to prove the compensability of his claim by a preponderance of the evidence. ORS 656.266. Drs. Harris, Swiridoff and Duff offered opinions regarding the cause of claimant's resultant condition. We conclude that claimant has failed to carry his burden of proof.

Dr. Duff opined that the February 1994 work incident did not materially contribute to claimant's current need for treatment. (Ex. 10-5). He based his opinion on his understanding that claimant had a 1-2 year history of his right knee popping, accompanied by pain but with or without swelling, and that claimant's condition at the time of Dr. Duff's examination in June 1994 was very much the same as it was a year ago. (Id.). Dr. Duff believed that claimant had a chronic meniscal tear which had been present for at least a year, possibly two years. (Id.).

Dr. Swiridoff initially agreed with Dr. Duff's analysis and opinion. (Ex. 14). Subsequently, he changed his opinion, stating that he believed the February 18, 1994 injury "was the actual incident causing the meniscus tear." (Ex. 15). Dr. Swiridoff indicated that his initial opinion was based on the history provided by Dr. Duff, but he did not indicate the basis for his changed opinion. Since Dr. Swiridoff did not explain the basis for the change in his opinion, we do not find his opinion persuasive. Freida L. Ernest, 46 Van Natta 1806, 1808 (1994), citing Moe v. Ceiling Systems, 44 Or App 429 (1980).

Dr. Harris stated that his opinion depends on which history is correct. If Dr. Duff's history is correct, or if there is evidence that claimant received treatment for similar symptoms in his right knee prior to February 1994, then Dr. Harris would agree with Dr. Duff's opinion. (Ex. 13-2). On the other hand, if claimant's knee was "significantly worse" after the February 1994 episode, causing him to seek treatment for the first time, then it would be Dr. Harris' opinion that "the need for arthroscopy would be due to [the February 1994] episode." (Id.).

Claimant testified that after the February 1994 incident, his knee has not been the same; it hurts and aches all the time. (Tr. 38). He testified that his knee has been getting worse since the February 1994 incident. (Tr. 47). However, the evidence does not establish that claimant's right knee became "significantly worse" after the February 1994 incident. Nor did claimant refute Dr. Duff's statement that his knee is no worse now than it was a year ago. (Ex. 10-3). Claimant apparently continued working after the February 18, 1994 incident until March 1994, when he was laid off due to lack of work. (Exs. 1, 2; Tr. 25-26). Claimant did not seek medical treatment until after he twisted his right knee at home in April 1994. (Exs. 5, 14).

Under such circumstances, we are not persuaded that Dr. Harris would render an opinion in support of compensability. The factors Dr. Harris identified as being necessary for his opinion that claimant's need for treatment was due to the February 1994 work incident are not present here. Specifically, claimant did not seek medical treatment as a result of the February 1994 incident, and the evidence does not establish that claimant's knee was "significantly worse" after the February 1994 incident. Accordingly, we conclude that claimant failed to carry his burden of proof.

## ORDER

The ALJ's order dated January 5, 1995 is reversed. The SAIF Corporation's June 10, 1994 denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

**Board Member Gunn dissenting.**

Because I would find claimant's right knee condition compensable, I respectfully dissent.

In this case, the history of claimant's condition determines which medical opinion is more persuasive. (See Ex. 13-2). Claimant credibly testified that the only right knee symptom he had prior to the February 1994 incident was occasional popping, but he had no swelling or pain in his right knee. (Tr. 29). Claimant further testified that since the February 1994 incident, his knee has not been the same

as it was prior to the incident. Since February 1994, claimant testified that his right knee hurts and aches constantly, whereas prior to February 1994, claimant had no restrictions on his activities on account of his right knee. (Tr. 38, 39). Claimant testified that since the February 1994 incident, his right knee has been getting worse. (Tr. 47).

The ALJ found claimant to be truthful and credible, and I find no basis on which to question claimant's credibility. I believe the opinion of Dr. Swiridoff, claimant's attending primary care physician, is based on the history as related by claimant. It was Dr. Swiridoff's opinion that the February 1994 incident "was the actual incident causing the meniscus tear." (Ex. 15). In addition, consulting orthopedist Dr. Harris opined, based on the history as related by claimant, that the February 1994 incident "most likely" caused the meniscus tear. (Ex. 13). I believe the opinions of Drs. Swiridoff and Harris are persuasive and sufficient to establish that the February 1994 work incident was the major contributing cause of claimant's right knee condition.

On the other hand, I find that Dr. Duff's history is markedly different from the history as related by claimant. (Compare Ex. 10 with Tr. 33-35). Indeed, I believe it is entirely possible that Dr. Duff confused claimant's right and left knee symptoms. (Tr. 34-37). In any case, I do not find Dr. Duff's opinion persuasive, because it is based on an inaccurate history of claimant's right knee condition. Therefore, I do not believe that Dr. Harris would concur with Dr. Duff's opinion. (See Ex. 13-2).

Accordingly, because I would rely on the medical opinions which are most consistent with claimant's credible testimony, I find claimant's right knee condition compensable. Therefore, I respectfully dissent.

---

October 19, 1995 Cite as 47 Van Natta 2038 (1995)

In the Matter of the Compensation of
**KENNETH E. BEGLAU, Claimant**
WCB Case No. 93-07031
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bostwick, 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) Michael V. Johnson's order that set aside its denial of claimant's C5-6 disc condition. Claimant cross-requests review of those portions of the order that: (1) found that claimant filed a claim for a C3-4 disc condition; and (2) upheld the employer's denial of claimant's C3-4 disc condition, cervical strain, and cervicalgia. On review, the issues are compensability and the propriety of the employer's denial of claimant's C3-4 disc condition.

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

Compensability / C5-6 Disc Condition

Finding that claimant's herniated C5-6 disc arose on January 22, 1993 over a discrete period of time, the ALJ analyzed the case as an industrial injury claim. Further, finding that the herniated disc did not precede claimant's January 1993 injury, the ALJ concluded that ORS 656.005(7)(a)(B)[1] is not applicable to the claim. Finally, the ALJ concluded that claimant established that his work is a material contributing cause of the herniated disc. On review, the employer argues, *inter alia*, that the ALJ erred in analyzing the claim as an industrial injury rather than an occupational disease and, in the alternative, even if the claim is properly analyzed as an industrial injury, the ALJ erred in failing to apply the major contributing cause standard of ORS 656.005(7)(a)(B).

---

[1] After the ALJ's order issued, the legislature amended ORS 656.005(7)(a)(B). Or Law 1995, ch 332, § 1 (SB 369, § 1). However, we need not decide whether amended or former ORS 656.005(7) (a)(B) applies, because the outcome in this case would be the same under either the former or amended versions of the statute.

To the extent the employer contends applicability of ORS 656.005(7)(a)(B) depends not on whether the herniated disc existed prior to January 22, 1993 but rather whether the January 1993 injury combined with claimant's preexisting degenerative disc disease to cause or prolong disability, we agree. Nonetheless, because there is no persuasive medical opinion that the January 1993 injury in fact "combined" with claimant's preexisting degenerative condition, ORS 656.005(7)(a)(B) is not applicable.

Moreover, were we to analyze the claim as an occupational disease, we would find that claimant has satisfied his burden of proof under ORS 656.802. Of the two physicians offering an opinion on major causation, for the reasons expressed by the ALJ, we find the opinion of Dr. Freeman, claimant's treating neurologist, more persuasive. Dr. Wilson asserts that claimant does not have a herniated C5-6 disc. By affirming the ALJ, we have herein found that claimant has a herniated C5-6 disc. Therefore, we afford Dr. Wilson's causation opinion little weight. Dr. Freeman, on the other hand, has persuasively explained that twisting and lifting at work was the major contributing cause of claimant's disc herniation. Thus, whether analyzed as an injury or an occupational disease, claimant has established the compensability of his C5-6 disc condition.

Denial / C3-4 Disc Condition

The ALJ upheld the employer's denial of claimant's C3-4 disc condition. Claimant asserts that he has not made a claim for the C3-4 disc condition as no claim has been tendered by his attending physician. We disagree.

As the parties recognize, a claimant's attending physician's reference to another condition at the same time he is treating a compensable condition may constitute filing a claim for said condition. The ALJ found that consulting radiologist Osborne's references to claimant's C3-4 degenerative disc condition were sufficient to constitute filing a claim for that condition. We instead find that attending physician Freeman's reference to claimant's C3-4 degenerative condition at the same time he was investigating and treating claimant's C5-6 herniated disc and C-6 radiculopathy constituted filing a claim for that condition.

On April 16, 1993, Dr. Freeman reported "osteophytic material sandwiching disk at C3-4 and 5-6." (Ex. 8). The report from Dr. Freeman constituted a claim for claimant's C3-4 disc condition, which the employer had a legal duty to accept or deny. Accordingly, the employer's denial of claimant's C3-4 condition, which it reasonably believed was encompassed in the claim, was procedurally appropriate. Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989).

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 C5-6 compensability issue is $1,200, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue as represented by claimant's respondent's brief, the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 17, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200 to be paid by the self-insured employer.

In the Matter of the Compensation of
**LARRY R. BURNSIDE, Claimant**
WCB Case No. 94-06323
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order which set aside its denial of claimant's consequential condition claim for a psychological condition. In his brief, claimant asserts that the ALJ erred in failing to award a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability and penalties. We affirm.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

On August 5, 1993, claimant sustained multiple injuries when he fell from 25 to 30 feet while working as a carpenter. The insurer formally accepted the claim on September 1, 1993, listing a fractured clavicle, rib and cervical/lumbar strains as the accepted conditions. (Ex. 10). An osteopath, Dr. Winans, became claimant's attending physician. Dr. Vigeland performed arthroscopic left knee surgery in January 1994, which revealed an attenuated tear of claimant's anterior cruciate ligament with hypertrophic medial plica.

On February 7, 1994, Dr. Winans reported that claimant had two or three episodes of depression each week, as well as a sense of loss of his career and of uncertainty surrounding the outcome of his left knee injury. Dr. Winans diagnosed a depressive reaction secondary to trauma and began prescribing Zoloft to treat claimant's psychological condition. (Exs. 8-22, 23). By March 7, 1994, Dr.Winans opined that claimant's "acute depressive reaction of adulthood secondary to trauma" was controlled. (Ex. 8-17).

On March 29, 1994, an examining psychiatrist, Dr. Klein, evaluated claimant's psychological complaints in conjunction with an examination of claimant's physical condition conducted by Drs. Duff and Keist. Dr. Klein opined that claimant did not have any psychiatric problems as a result of the on-the-job injury. (Ex. 27-5). Although she could not detect any specific symptoms of depression, Dr. Klein could "see no reason to stop the Zoloft if [claimant] feels it seems to help him feel happier." Dr. Klein emphasized that there was no "real indication of a significant depression."

Based on Dr. Klein's report, the insurer issued a denial on April 11, 1994 of "depression" on the ground that "there is no objective evidence of a diagnosable psychological condition." (Ex. 30). Claimant requested a hearing from the denial, after the insurer had refused to pay for his Zoloft.

Dr. Klein subsequently agreed in a March 9, 1995 "check-the-box" report that Dr. Winans' diagnosis of depressive reaction of adulthood secondary to trauma and use of similar terminology were not generally accepted in the medical community. (Ex. 41-2). Dr. Klein also agreed that there was no "real indication" of a clinical depression in claimant and that Zoloft is often prescribed and can improve mood even in the absence of a diagnosable psychiatric condition. Dr. Klein reiterated her opinion that claimant does not have any psychiatric problems as a result of his injury.

On March 10, 1995, Dr. Winans confirmed that his diagnosis of depressive reaction of adulthood secondary to trauma was the same diagnosis as the DSM III diagnosis of adjustment reaction or adjustment disorder. (Ex. 42).

At hearing, the ALJ described the issue as whether claimant had a consequential condition as a result of his compensable injuries incurred in his fall. See ORS 656.005(7)(a)(A). Recognizing the conflict in the medical evidence regarding whether claimant has a depressive disorder, the ALJ, nevertheless, concluded that the weight of the medical evidence established that claimant's compensable

injuries were the major contributing cause of an emotional condition requiring medical services, regardless of the diagnostic terminology employed. The ALJ, therefore, set aside the insurer's denial. The ALJ, however, refused claimant's request for a penalty for unreasonable refusal to pay compensation under former ORS 656.262(10)(a) (since renumbered ORS 656.262(11)(a)), reasoning that the insurer's conduct was not unreasonable given the competing evidence on the compensability issue.

On review, the insurer contends that the ALJ erred in finding that claimant's compensable injuries were the major contributing cause of a psychological condition under ORS 656.005(7)(a)(A). In particular, the insurer contends that Dr. Klein's opinion is more persuasive than that of Dr. Winans, who is not a psychiatrist. Claimant asserts that, by arguing causation on review, the insurer has impermissibly broadened the scope of its written denial. Claimant also argues that the insurer's denial was unreasonable because the legal theory underlying its denial was invalid.

We conclude for the following reasons that the ALJ properly set aside the insurer's denial. We do not find the denial, however, to have been unreasonably issued.

An insurer is bound by the express language of its denial. Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993). In this case, the basis for the insurer's denial was limited to an allegation that claimant's claim for depression was not compensable because of no objective evidence of a "diagnosable" psychological condition. No issue of causation is expressly raised by the insurer's denial.

Parties to a workers' compensation proceeding may, however, by agreement, try an issue that falls outside the express terms of a denial. See Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 ( 1990); Ronald A. Krasneski 47 Van Natta 852 (1995); Judith M. Morley, 46 Van Natta 882, 883, on recon 46 Van Natta 983 (1994). We do not find that the parties agreed to do so in this case.

Claimant's counsel described the issues at the beginning of the hearing as follows: "Just to make sure the issues are clear, there is nothing in the denial letter, and no discussion prior to today has raised any issue of arising out of and in the course of, so this is not an issue of causation." (Tr. 1). The insurer's counsel did not disagree with that characterization of the issues. Therefore, we find that there was no agreement, express or implied, to try a causation issue that fell outside the express terms of the denial. Weyerhaueser Co. v. Bryant, supra. Thus, we limit the issue to be decided to that which was expressly raised by the denial, i.e., whether claimant has a diagnosable psychological condition.

The insurer denied the existence of a psychological condition based on Dr. Klein's opinion that claimant has no psychological problems resulting from his injury. Dr. Winans, however, has diagnosed a psychological or emotional disorder secondary to claimant's traumatic injuries. While Dr. Winans' diagnostic terminology has varied somewhat, claimant need not prove the appropriateness of a particular diagnosis for his psychological problems under ORS 656.005(7)(a)(A). See David R. Brawner, 46 Van Natta 1108 (1994)(citing Carling v. SAIF, 119 Or App 466 (1993)); Tripp v. Runner Ridge Timber Services, 89 Or App 355 (1988).

Claimant must prove that his emotional condition, however diagnosed, was caused in major part by his compensable injuries in order to constitute a compensable consequential condition. Roseburg Forest Products v. Zimbelman, 136 Or App 75 (1995). Inasmuch as we have determined that the insurer has not raised the issue of causation, the sole issue is whether claimant has an emotional condition. Given Dr. Winans familiarity with claimant's emotional state, we are persuaded by his opinion that claimant has a psychological or emotional condition which required medical services in the form of prescriptions of Zoloft. Thus, we find that claimant does have an emotional condition attributable in major part to his compensable injuries.

The insurer contends that Dr. Winans' opinion is not persuasive given his lack of psychiatric expertise. The fact that Dr. Winans is not a psychiatrist, however, does not deter us from finding his opinion persuasive. See William C. Peterson, 47 Van Natta 663 (1995) (internist found more persuasive than psychiatrist when former more familiar with claimant's psychological condition). Moreover, we find his opinion that claimant does suffer from a psychological disorder more persuasive than Dr. Klein's. Dr. Klein only examined claimant one time after his psychological condition had been stabilized by Dr. Winans' prescriptions of Zoloft.

We next address claimant's contention that the insurer's denial was unreasonable. Penalties may be assessed when a carrier unreasonably delays or unreasonably refuses to pay compensation. Amended ORS 656.262(11). Claimant asserts that the denial was unreasonable because it was in effect an attempt to deny the psychological claim using ORS 656.802(3)(c) as a basis. Claimant, citing cases such as Boeing Co. v. Viltakis, 112 Or App 396 (1992), argues that it is well-settled that the compensability of consequential psychological conditions need not meet the criteria of the occupational disease statute.

Claimant's argument is not persuasive because we do not interpret the insurer's denial as being based on the theory that claimant does not have a diagnosis of a mental disorder generally recognized in the medical or psychological community. Instead, we interpret the insurer's denial as denying the existence of a psychological condition. Inasmuch as Dr. Klein had opined prior to issuance of the insurer's denial that claimant did not have a psychological problem as a result of the compensable injuries, we find that the insurer had a "legitimate doubt" as to its liability for Dr. Winans' prescriptions of Zoloft. International Paper Co. v. Huntley, 106 Or App 107, 110 (1991) (The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the insurer had a legitimate doubt about its liability); Brown v. Argonaut Insurance Company, 93 Or App 588, 592 (1988) (the reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial). Therefore, we agree with the ALJ's finding that the insurer's conduct was not unreasonable.

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 compensability issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

## ORDER

The ALJ's order dated April 7, 1995 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
**MICHAEL J. JOSEPH, Claimant**
WCB Case Nos. 93-07399, 92-01444, 93-07400, 92-03952, 93-07401, 92-07383, 93-07402, 92-14801, 93-07404, 93-00044, 93-07405, 92-02820, 93-07406, 92-07305, 93-07407, 92-15447, 93-07403 & 92-05060
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Bostwick, et al, Defense Attorneys
Stoel, Rives, et al, Defense Attorneys
Moscato, Byerly, et al, Defense Attorneys
Marcia Barton (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys
Roberts, et al, Defense Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Livesley's order[1] that: (1) set aside its disclaimer/denial of responsibility, issued on behalf of Al Beyer Logging (Beyer), of claimant's occupational disease claim for his bilateral knee condition; (2) upheld SAIF's disclaimer of responsibility, issued on behalf of Gary Kronberger Cutting (Kronberger), for the same condition; (3) upheld the self-insured employer Weyerhaeuser Company's disclaimer/denial of responsibility for the same condition; (4) upheld SAIF's disclaimer of responsibility, issued on behalf of R.L. Coats Construction (Coats), for the same condition; (5) upheld SAIF's disclaimer/denial of responsibility, issued on behalf of J. Spath Contractor (Spath), for the same condition; (6) upheld Liberty Northwest Insurance Corporation's disclaimer/denial of responsibility, issued on behalf of Crown Pacific, for the same condition; (7) upheld SAIF's disclaimer/denial of responsibility, issued on behalf of the noncomplying employer Shoestring Valley Logging (Shoestring); (8) upheld SAIF's disclaimer/denial of responsibility, issued on behalf of R.D. Harris Construction (Harris), for the same condition; and (9) awarded claimant's counsel an assessed fee of $10,710 under ORS 656.307(5) for participation in the responsibility proceeding. Claimant cross-requests review of that portion of the order that declined to award his counsel an assessed fee under ORS 656.386(1) for prevailing over Kronberger/SAIF's "back-up" denial of responsibility for the October 25, 1991 reopening of claimant's 1988 left knee injury claim. On review, the issues are responsibility and attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Standard of Review

As a preliminary matter, the parties disagree over the applicable standard of our review of the ALJ's responsibility determination. Beyer/SAIF contends that our review standard is de novo, while claimant, Shoestring/SAIF and Harris/SAIF contend that we may review for "errors of law" only.

Subsequent to the ALJ's order and the parties' briefing, ORS 656.307(2) was amended by the 1995 Legislature to provide that proceedings under ORS 656.307 "shall be conducted in the same manner as any other hearing and any further appeal shall be conducted pursuant to ORS 656.295 and 656.298." Or Laws 1995, ch 332, § 36 (SB 369, § 36). The amendments became effective June 7, 1995.

---

[1] The ALJ previously issued an order in this matter on August 10, 1993, which Beyer appealed to the Board on the responsibility issue. On review of the 1993 order, the Board declined to address the merits of the responsibility issue and, by Order on Review dated June 28, 1994, remanded this matter to the ALJ to review the propriety of Kronberger's February 9, 1993 "back-up" denial and to issue a final order regarding the responsibility issue. Michael J. Joseph, 46 Van Natta 1257 (1994). Pursuant to the Board's instruction, the ALJ issued an Order on Remand on November 7, 1994. The ALJ's November 7, 1994 order is the subject of this review.

Except as provided otherwise, SB 369 retroactively 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). Because amended ORS 656.307(2) does not alter a procedural time limitation, we apply it retroactively. See Motel 6 v. McMasters, 135 Or App 583 (1995) (under SB 369 § 66(6), amendments that alter procedural time limitations do not apply retroactively); Walter L. Keeney, 47 Van Natta 1387 (1995). Therefore, our review of the responsibility issue is de novo. ORS 656.295(5); Dan J. Anderson, 47 Van Natta 1929 (1995).

Responsibility- Left Knee

We adopt and affirm the ALJ's conclusion and opinion that SAIF/Beyer is responsible for claimant's left knee condition, with the following reversal and supplementation.

SAIF/Kronberger's "Back-Up" Denial

The ALJ determined that SAIF/Kronberger's February 9, 1993 denial letter was an invalid "back-up" denial. We disagree, and reverse that portion of the ALJ's order as follows.

We begin with a summary of the pertinent facts. In 1989, a prior ALJ assigned responsibility for claimant's left knee condition to SAIF/Kronberger, with a date of injury of July 1, 1988. (Ex. 60). That claim was closed in 1990. (Ex. 74). Claimant's knee symptoms worsened in 1991, and bone scans revealed increased degenerative changes requiring surgery to both knees. (Exs. 95-97). Claimant filed claims against multiple employers, including SAIF/Kronberger.

Following receipt of an insurer-arranged medical examination (IME) report from Dr. Woolpert, SAIF/Kronberger mailed claimant a letter dated October 25, 1991, stating: "We have reviewed all information regarding the worsening of your condition and have reopened your [July 1, 1988] claim for CHONDROMALACIA OF THE PATELLA LEFT KNEE." (Ex. 100). The 1988 claim was reclosed in June 1992, and later reopened for vocational assistance.

On February 9, 1993, while the 1988 claim remained open for vocational assistance, SAIF/Kronberger mailed claimant a letter stating, in pertinent part:

> "[O]ur investigation of your claim has obtained later evidence that your present left knee claim, for which reopening and surgery were requested, is not the responsibility of SAIF Corporation. Pursuant to ORS 656.262(6), we are constrained to issue this revocation of our October 25, 1991 reopening of your left knee claim.
>
> "SAIF Corporation formally disclaims responsibility for your left knee condition, including chondromalacia of the left knee. It is our position that your condition and need for treatment may be the result of a separate injury or occupational disease." (Ex. 154).

The ALJ gave several reasons for concluding that SAIF/Kronberger's "back-up" denial was invalid. Citing Darwin G. Widmar, 46 Van Natta 1018, 1019 (1994), the ALJ reasoned that, because SAIF/Kronberger was not designated as a "paying agent" pursuant to ORS 656.307, its "back-up" denial of responsibility was not permissible under ORS 656.262(6). However, subsequent to the ALJ's order, we disavowed our holding in Widmar that a "back-up" denial of responsibility must be issued by a "paying agent" designated under ORS 656.307. Wayne A. Moltrum, 47 Van Natta 955 (1995) (citing the court's holding in SAIF v. Shaffer, 129 Or App 289 (1994), that ORS 656.262(6) encompassed "back-up" denials based on lack of coverage). Rather, we held that the designation of a "paying agent" under ORS 656.307 is not a prerequisite for issuance of a "back-up" denial of responsibility under ORS 656.262(6). See id.

Furthermore, subsequent to the ALJ's order, ORS 656.262(6) was amended by the 1995 Legislature, effective June 7, 1995. SB 369, § 28. Those amendments apply retroactively to this case. See SB 369, § 66; Volk v. America West Airlines, supra. Amended ORS 656.262(6)(a) provides, in pertinent part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section . . . . If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim." (Emphasis supplied.)

Unlike the former version of the statute, amended ORS 656.262(6)(a) no longer refers to a "paying agent."[2] It now refers to evidence that the "insurer or self-insured employer" is not responsible for the claim. Therefore, the absence of "paying agent" designation is immaterial to our analysis under amended ORS 656.262(6)(a).

The ALJ also reasoned that SAIF/Kronberger's "back-up" denial was invalid because its claim acceptance was mandated by the prior ALJ's litigation order and, therefore, was not made in "good faith" within the meaning of ORS 656.262(6). We find, however, that the ALJ is confusing the original 1988 occupational disease claim, which the prior ALJ ordered SAIF/Kronberger to accept, with the 1991 claim for reopening, which SAIF/Kronberger voluntarily accepted by the October 25, 1991 letter. It is the latter, voluntary acceptance which SAIF/Kronberger revoked by its "back-up" denial; that 1991 acceptance was not mandated by any litigation order. We conclude that the October 25, 1991 claim acceptance was made in "good faith" and could therefore be revoked in February 1993 (within two years of the acceptance) pursuant to ORS 656.262(6).

Finally, the ALJ reasoned that the "back-up" denial was invalid because there was no showing that the claim is not compensable. Before we address this basis for the ALJ's decision, however, we turn to SAIF/Beyer's contention on review that the "back-up" denial was not based on "later obtain[ed] evidence," as required by ORS 656.262(6). The requirement of "later obtained evidence" in ORS 656.262(6) refers to new material, i.e., something other than the evidence that the insurer had at the time of the claim acceptance. CNA Ins. Co. v. Magnuson, 119 Or App 282, 286 (1993). A reevaluation of known evidence, for whatever reason, is not "later obtained evidence" under ORS 656.262(6). Id.[3]

Here, SAIF/Kronberger asserts that Exhibits 104, 139 and 142, which were generated after its October 25, 1991 acceptance, constitute later obtained evidence that it was not responsible for the claim. SAIF/Beyer responds that none of those exhibits adds any evidence that was not addressed in Dr. Woolpert's "pre-acceptance" IME report dated October 20, 1991. (See Ex. 99). We disagree.

In his October 20, 1991 "pre-acceptance" report, Dr. Woolpert stated that the major contributing cause of claimant's left knee condition and need for treatment was the sum total of his work activities from 1987 onward. (Ex. 99-5). He also stated that claimant's work exposure after 1988 was a contributing cause of an increase in patella femoral pathology. (Id.) However, there was no medical opinion, rendered by Dr. Woolpert or any other medical expert prior to the October 25, 1991 acceptance,

---

[2] Former ORS 656.262(6) provided, in pertinent part:

> "[I]f the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial." (Emphasis supplied.)

[3] Amended ORS 656.262(6)(a) includes the same "later obtained evidence" language that existed in the former version of the statute. Therefore, we conclude the Magnuson holding is equally applicable under amended ORS 656.262(6)(a).

stating that claimant's work exposure after 1988[4] was the major contributing cause of claimant's worsened knee condition. That medical opinion was first rendered by Dr. James in a June 1992 telephone conference with SAIF/Kronberger's attorney. Subsequently, by a "check-the-box" report dated June 16, 1992, Dr. James concurred that claimant's work activities between January 1989 and July 1991 collectively contributed in major part to the worsened left knee condition and resultant need for surgery. (Ex. 142-2).

We conclude that Dr. James' June 1992 concurrence report constituted new evidence, not available at the time of the October 1991 acceptance, indicating that SAIF/Kronberger was not responsible for the worsened left knee condition, and that responsibility should be shifted to a subsequent employer. Therefore, we find that Dr. James' report constituted "later obtained evidence" within the meaning of ORS 656.262(6). See CNA Ins. Co. v. Magnuson, supra. Inasmuch as SAIF/Kronberger issued its revocation of acceptance, or "back-up" denial, within two years from the date of its October 1991 acceptance, we conclude that its "back-up" denial was issued in accordance with the terms of ORS 656.262(6).

We turn now to the ALJ's conclusion that the "back-up" denial was invalid because there was no showing that the claim was not compensable. Because SAIF/Kronberger issued a "back-up" denial of responsibility, ORS 656.262(6) does not require SAIF/Kronberger to prove that the claim is not compensable. Rather, in order to sustain its "back-up" denial, SAIF/Kronberger must prove that it is not responsible for the claim. In this regard, we note that the 1995 Legislature has reduced the burden of proof a carrier must satisfy in order to sustain its "back-up" denial at hearing. Whereas former ORS 656.262(6) required "clear and convincing evidence," amended ORS 656.262(6)(a) requires only "a preponderance of the evidence" to prove a carrier is not responsible for the claim.

Here, we find that SAIF/Kronberger carried its burden of proving by a preponderance of the evidence that responsibility shifted to a subsequent employer under ORS 656.308(1).[5] As the last carrier with an accepted claim for claimant's left knee condition (in 1988), SAIF/Kronberger is presumptively responsible for further medical services and disability relating to the condition unless it proves that claimant sustained a "new compensable injury" involving the same condition. See ORS 656.308(1); SAIF v. Drews, 318 Or 1 (1993); Smurfit Newsprint v. DeRosset, 118 Or App 368 (1993). The term "compensable injury" encompasses occupational disease claims as well. Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314, 317 (1993).

It is undisputed that the worsening of claimant's left knee condition came on gradually, without any precipitating trauma or event. Therefore, we find the condition must be analyzed as an ongoing condition, i.e., an occupational disease claim pursuant to ORS 656.802,[6] rather than an accidental injury claim pursuant to ORS 656.005(7)(a). See Mathel v. Josephine County, 319 Or 235, 241-42 (1994); James v. SAIF, 290 Or 343, 348 (1981). Therefore, in order to shift responsibility, SAIF/Kronberger must prove that claimant sustained a new occupational disease involving the left knee condition while working for subsequent employers.

The occupational disease statute, ORS 656.802, was extensively amended by the 1995 Legislature. SB 369, § 56. Those amendments apply retroactively to this case. Volk v. America West Airlines, supra. Amended ORS 656.802(2) provides:

> "(a) The worker must prove that employment conditions were the major contributing cause of the disease.
>
> "(b) If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.

---

[4] Claimant worked for Kronberger for 14 months from 1987 through 1988, falling and bucking timber.

[5] ORS 656.308(1) was also amended by the 1995 Legislature. SB 369, § 37. However, the analysis and result in this case would be the same under either the former or amended version of the statute.

[6] ORS 656.802 was also amended by the 1995 Legislature. SB 369, § 56. Nevertheless, the amended version of ORS 656.802 would not change our analysis in distinguishing an occupational disease claim from an accidental injury claim.

"(c) Occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7).

"(d) Existence of an occupational disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings.

"(e) Preexisting conditions shall be deemed causes in determining major contributing cause under this section."

The occupational disease claim in this case is based on a worsening of the preexisting left knee condition. Hence, pursuant to amended ORS 656.802(2)(b), there must be proof that post-Kronberger "employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." In addition, the worsening of the preexisting knee condition must be established by medical evidence supported by objective findings. Amended ORS 656.802(2)(d).

Dr. James, the treating orthopedic surgeon, opined that claimant's work activities between January 1989 and July 1991 (i.e., after Kronberger's employment) collectively contributed in major part to the worsened left knee condition which eventually required surgery in December 1991. (Ex. 142-2). Dr. James opined that the cumulative and repetitive stress to the patella and surrounding tissues led to progressive degeneration of the cartilage/cushion between the patella and the underlying bone, resulting in increased sensitivity and irritation of the nerve fibers within the bone itself. (Id.) Later, in his deposition, Dr. James explained that, although a comparison of bone scans taken in 1986 and 1991 may not show the extent of the pathological changes which occurred, clinical evidence (such as physical complaints and decreased function) showed increased pathological changes. (Ex. 158-23).

Dr. Woolpert, the IME orthopedic surgeon, also opined that claimant's work exposure after 1988 was a contributing cause of the increase in patella femoral pathology. (Ex. 99-6). Dr. Woolpert noted that there was crepitation in the left patella in October 1991, an examination finding that was not present in August 1989. (Ex. 99-5). He viewed that finding as objective evidence of worsening in the left knee. (Id.)

The opinions of Drs. James and Woolpert provide ample medical evidence to prove that claimant's "post-Kronberger" work conditions were the major contributing cause of the combined left knee condition and pathological worsening of the preexisting left knee condition. In addition, the doctors' clinical findings (e.g., crepitation) and the bone scan results establish the existence of the worsening by medical evidence supported by objective findings. (Exs. 95, 99, 139-2,142-2, 158-23). Therefore, we conclude that SAIF/Kronberger has carried its burden of proving a new occupational disease claim for the worsened left knee condition. See amended ORS 656.802(2). Thus, responsibility for the worsened left knee condition shifts to a subsequent employer. See ORS 656.308(1); Drews v. SAIF, supra; Liberty Northwest Ins. Corp. v. Senters, supra. Accordingly, SAIF/Kronberger's "back-up" denial of responsibility is upheld. The portion of the ALJ's order which set aside the "back-up" denial is reversed accordingly.

However, the question remains: Which one of the subsequent employers---Coats, Spath, Crown Pacific, Beyer, Shoestring or Harris---is responsible for this new occupational disease claim for the worsened left knee condition? Because the new occupational disease claim for the "post-Kronberger" worsening of the left knee condition has not been accepted, we apply the last injurious exposure rule, which governs the initial assignment of responsibility for conditions arising from an occupational disease claim which has not been previously accepted. Steven K. Bailey, 45 Van Natta 2114, 2117 (1993); Ronda J. Styles, 44 Van Natta 1496 (1992); Fred A. Nutter, 44 Van Natta 854 (1992).

The last injurious exposure rule provides that where, as here, there is proof that an occupational disease was caused by work conditions that existed where 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); Meyer v. SAIF, 71 Or App 371, 373 (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). The onset of disability is the date upon which the claimant first seeks treatment for, or becomes disabled by, the compensable condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994); SAIF v. Kelley, 130 Or App 185 (1994).

On review, SAIF/Kronberger contends that claimant first sought treatment for his worsened left knee condition on August 14, 1989, when Crown Pacific was on the risk. (See ex. 63). We disagree. On that date, claimant saw Dr. James with complaints of some left knee give-way and aching with occasional popping or snapping. (Ex. 63-1). Dr. James diagnosed a possible meniscal lesion, but he prescribed no treatment and asked claimant to return as needed. (Ex. 63-2). In his deposition, Dr. James agreed that the August 1989 visit was like a "status check" and described claimant as not being interested in pursuing treatment for the symptoms at that time. (Ex. 158-28).

After the August 1989 visit, claimant did not return to Dr. James for left knee treatment until March 11, 1991. On that date, Dr. James' examination revealed a new objective finding of patellar crepitus with passive motion of the left knee. (Ex. 84). Dr. James referred claimant for bone scans of both knees in July 1991. (Ex. 95). Based on scan results, Dr. James diagnosed further degenerative changes in the left patellofemoral joint, and recommended surgery which was performed in December 1991. (Exs. 96, 103). In his deposition, Dr. James indicated that, from March 1991 onward, claimant's left knee condition worsened to the extent that surgery was required. (Ex. 158-33).

Based on our review of the medical record, we find that claimant's first treatment for his worsened left knee condition was on March 11, 1991. Although claimant had prior knee symptoms in August 1989, we are more persuaded by the fact that Dr. James did not feel that treatment was indicated until March 1991 and beyond. Accordingly, we designate March 11, 1991 as the date of "onset of disability." See Timm v. Maley, supra; SAIF v. Kelley, supra.

The last potentially causal employment prior to the March 11, 1991 examination was with SAIF/Beyer. Claimant worked as a timber faller and bucker for Beyer from March 1990 through July 1990. The work was heavy and required walking on uneven surfaces, (Tr. 16, 23); it was the type of work which Dr. James implicated as a contributing cause of further deterioration in the knee. (Ex. 158-9, 158-14). As the last potentially causal employer on the risk prior to the onset of disability, SAIF/Beyer is assigned initial responsibility for the worsened left knee condition. See Boise Cascade Corp. v. Starbuck, supra; Meyer v. SAIF, supra.

SAIF/Beyer can shift responsibility to a prior employer by showing that the prior employments were the sole cause of claimant's worsened left knee condition, or that it was impossible for conditions while SAIF/Beyer was on the risk to have caused the left knee condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, on recon 73 Or App 223, rev den 299 Or 203 (1985). However, in light of Dr. James' opinion that claimant's work activities as a timber faller and bucker contributed to his worsened knee condition, we conclude that SAIF/Beyer has established neither fact.

SAIF/Beyer can also shift responsibility forward to a subsequent employer by proving that subsequent employment conditions actually contributed to a worsening of the left knee condition. See Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Spurlock v. International Paper Co., 89 Or App 461, 465 (1988). After his employment with SAIF/Beyer, claimant worked as a log loader operator for Shoestring and an excavator operator for Harris. Both jobs were sedentary requiring minimal use of the legs. (Tr. 23-25). Dr. James opined it was improbable that work conditions at either Shoestring or Harris contributed to a worsening of the knee condition. (Ex. 158-42, 158-43). Accordingly, we conclude that SAIF/Beyer is responsible for the worsened left knee condition.[7]

Responsibility - Right Knee

We adopt and affirm the ALJ's conclusions and opinion that SAIF/Beyer is responsible for the right knee condition, with the following supplementation.

Weyerhaeuser is the last carrier with an accepted claim for claimant's right knee condition (in 1976). Therefore, Weyerhaeuser is presumptively responsible for further medical services and disability relating to the condition unless it proves that claimant sustained a new compensable injury or

[7] Our conclusion that SAIF/Beyer is responsible would be unchanged by an alternative finding that claimant first sought treatment for the left knee condition in August 1989, rather than in March 1991. Based on Dr. James' opinion, we would still find that employment conditions at Beyer actually contributed to a worsening of the knee condition, thereby shifting responsibility forward to SAIF/Beyer.

occupational disease involving the same condition. See ORS 656.308(1); SAIF v. Drews, supra; Liberty Northwest Ins. Corp. v. Senters, supra; Smurfit Newsprint v. DeRosset, supra. Based on our finding that the worsening of the right knee condition came on gradually, without any precipitating trauma or event, we conclude the condition must be analyzed as an occupational disease claim pursuant to ORS 656.802. See Mathel v. Josephine County, supra; James v. SAIF, supra. In order to shift responsibility, Weyerhaeuser must prove that claimant sustained a new occupational disease involving the right knee condition while working for subsequent employers.

Dr. James opined that the increased deterioration in both of claimant's knees, which was evident from bone scans taken in 1991 and 1992, was caused in major part by his work conditions from 1987 onward. (Ex. 158-14 through 158-16). Dr. Woolpert opined that work conditions from 1989 through 1991 were the major contributing cause of the progression of the degenerative knee condition. (Ex. 139-2). Although Dr. Woolpert's opinion was directed to the left knee which he examined, we agree with the ALJ that Dr. Woolpert's opinion is equally applicable to the right knee. Drs. James' and Woolpert's opinions provide sufficient medical evidence to prove that work conditions after February 1988[8] were the major contributing cause of the combined right knee condition and pathological worsening of the preexisting right knee condition. In addition, Dr. James' clinical findings (e.g., crepitus) and bone scan results establish the existence of the worsened right knee condition by medical evidence supported by objective findings. (Exs. 95, 158-12, 158-13). Therefore, we conclude that Weyerhaeuser has carried its burden of proving a new occupational disease claim for the worsened right knee condition. See amended ORS 656.802(2). Thus, responsibility for the worsened right knee condition shifts to a subsequent employer. See ORS 656.308(1); Drews v. SAIF, supra; Liberty Northwest Ins. Corp. v. Senters, supra.

To assign initial responsibility for this new occupational disease claim, we apply the last injurious exposure rule. Steven K. Bailey, supra; Ronda J. Styles, supra; Fred A. Nutter, supra. We find that claimant first sought treatment for his worsened right knee condition on March 11, 1991. On that date, claimant saw Dr. James with complaints of almost continual right knee pain. (Ex. 84). On examination, Dr. James found retropatellar crepitus, and bone scans revealed increased degenerative changes requiring surgery. (Ex. 97). We reject SAIF/Beyer's contention that claimant first sought treatment for the worsened right knee condition on August 14, 1989. Although claimant had right knee pain on August 14, 1989, there were no significant examination findings, and no treatment was either recommended by Dr. James or pursued by claimant. (Ex. 63). Furthermore, claimant did not require further treatment until March 11, 1991. Accordingly, we designate March 11, 1991 as the date of "onset of disability." See Timm v. Maley, supra; SAIF v. Kelly, supra.

As the last potentially causal employer on the risk prior to the onset of disability, SAIF/Beyer is assigned initial responsibility for the worsened right knee condition. See Boise Cascade Corp. v. Starbuck, supra; Meyer v. SAIF, supra. Based on the same reasoning set forth in our earlier opinion regarding the left knee condition, we conclude that SAIF/Beyer has not carried its burden to shift responsibility for the right knee condition either to a previous employer or to a subsequent employer. See FMC Corp. v. Liberty Mutual Ins. Co., supra; Oregon Boiler Works v. Lott, supra; Spurlock v. International Paper Co., supra. Accordingly, we conclude SAIF/Beyer is responsible for the worsened right knee condition.[9]

Attorney Fee - ORS 656.307(5)

SAIF/Beyer contends that claimant's attorney is not entitled to an assessed fee under ORS 656.307(5) because he did not "actively and meaningfully" participate in the responsibility proceeding. Alternatively, SAIF/Beyer contends that the ALJ's $10,710 assessed fee award is excessive.

---

[8] Claimant's last award under the 1976 injury claim with Weyerhaeuser was made under a Stipulation and Order dated February 8, 1988. (Ex. 54).

[9] Alternatively, we conclude that, even if we found that claimant first sought treatment for his right knee condition in August 1989, Dr. James' opinion would be sufficient to prove that Beyer's work conditions actually contributed to a worsening of the knee condition, thereby shifting responsibility forward to SAIF/Beyer.

Amended ORS 656.307(5)[10] provides that if claimant appears at a responsibility proceeding and "actively and meaningfully participates" through an attorney, the ALJ may award claimant's attorney an assessed fee payable by the responsible carrier. In Darrell W. Vinson, 47 Van Natta 356 (1995), we held that "active and meaningful participation" in a responsibility proceeding required that: (1) claimant have a material, substantial interest in deciding which carrier is the responsible party; and (2) claimant actively take a position advocating that interest. See Keenon v. Employers Overload, 114 Or App 344 (1992).

Here, we find that claimant had a material, substantial interest in having responsibility for his knee conditions shifted to a later employer. Claimant's temporary total disability (TTD) rate with SAIF/Beyer ($341.44) was higher than the TTD rate she would have received with SAIF/Harris ($296.57). (See Ex. 159).

In addition, claimant's attorney actively participated in the responsibility proceeding by eliciting testimony from claimant regarding the work conditions in his various employments, and the course of his knee conditions during those employments. Finally, in written closing argument before the ALJ, claimant's attorney contended that responsibility for both knee conditions should be shifted to SAIF/Beyer. Therefore, we conclude that claimant actively and meaningfully participated in the responsibility proceeding through his attorney. See Keenon v. Employers Overload, supra; Darrell W. Vinson, supra. Accordingly, the ALJ properly awarded claimant's attorney an assessed fee under ORS 656.307(5).

SAIF/Beyer also contends the ALJ's assessed fee award is excessive. We disagree. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that the ALJ's assessed fee award of $10,710 for claimant's attorney's services at the responsibility proceeding (two hearings) was reasonable. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's attorney's June 17, 1993 affidavit), the complexity of the issue and the value of the interest involved. Finally, we note that claimant is not entitled to an attorney fee award under ORS 656.307 for his counsel's services on review. See Lynda C. Prociw, 46 Van Natta 1875 (1994); Ernest C. Blinkhorn, 42 Van Natta 2597 (1990).

Attorney Fee - ORS 656.386(1)

On cross-appeal, claimant contends that the ALJ erred in declining to award his attorney an assessed fee under ORS 656.386(1) for prevailing over SAIF/Kronberger's February 9, 1993 "back-up" denial of responsibility for the left knee condition. However, inasmuch as we have upheld SAIF/Kronberger's "back-up" denial of responsibility, as properly issued under amended ORS 656.262(6)(a), we conclude that claimant has not prevailed over the denial. Accordingly, claimant's attorney is not entitled to an assessed fee award under ORS 656.386(1).

Attorney Fee - ORS 656.382(2)

Claimant's temporary total disability (TTD) rate was at risk for a reduction due to SAIF/Beyer's appeal on the responsibility issue. (See Ex. 159). Therefore, inasmuch as claimant's compensation was not reduced on appeal, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2).

In determining the amount of the assessed fee under ORS 656.382(2), we turn to amended ORS 656.308(2)(d) which provides:

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the insured 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." SB 369, § 37 (Emphasis supplied.)

---

[10] The amendments to ORS 656.307(5) by SB 369, § 36, retroactively apply to this case. See Volk v. America West Airlines, supra.

In Dan J. Anderson, supra, we held that amended ORS 656.308(2)(d) applies retroactively to cases pending on Board review, but it does not apply to limit assessed fees awarded under ORS 656.307(5) for services rendered in a "307" responsibility proceeding. In reaching our conclusion, we relied on the fact that ORS 656.307 was not included among the statutes listed in amended ORS 656.308(2)(d). Id.

ORS 656.382(2), on the other hand, is included among the statutes listed in amended ORS 656.308(2)(d). Therefore, the $1,000 cap arguably applies to limit assessed fees awardable under ORS 656.382(2) for services rendered on Board review, in defense of compensation awarded by the ALJ in a "307" responsibility proceeding. We need not decide that question in this case, however, because we conclude that, even if we applied amended ORS 656.308(2)(d), we would find that claimant has shown extraordinary circumstances justifying an assessed fee greater than $1,000.

As previously noted, this is the second Board review in this case, following our remand of the case to the ALJ for further proceedings. The medical and legal issues in this voluminous record (consisting of approximately 160 exhibits) are complex, involving both knees, eight potentially responsible employers, and application of ORS 656.262(6), ORS 656.308 and the last injurious exposure rule. The value of claimant's interest is substantial, with the risk of a reduction in TTD benefits and potential loss of future permanent disability benefits and vocational assistance.[11] Claimant's counsel has skillfully and successfully advocated claimant's position in this procedurally and substantively complex case.

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 $3,000, payable by SAIF/Beyer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's briefs filed in this appeal and the prior appeal, and claimant's attorney's November 4, 1993 statement of services), the complexity of the issues, and the value of the interests involved. In determining a reasonable fee, we did not consider claimant's attorney's services rendered in defense of the ALJ's "307(5)" assessed fee award, and services rendered in claimant's cross-appeal on the "386(1)" assessed fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986) ("compensation" does not include attorney fees).

## ORDER

The ALJ's order dated November 7, 1994 is reversed in part and affirmed in part. That portion of the order that set aside SAIF/Kronberger's February 9, 1993 "back-up" denial as invalid, is reversed. SAIF/Kronberger's February 9, 1993 "back-up" denial is reinstated and upheld. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $3,000, payable by SAIF/Beyer.

---

[11] Because claimant's TTD rate with SAIF/Harris was lower than the TTD rate with SAIF/Beyer, a shifting of responsibility to SAIF/Harris would have resulted in lesser TTD benefits. In addition, because the 1976 claim with Weyerhaeuser was in "own motion" status, a shifting of responsibility to Weyerhaeuser's 1976 claim would have resulted in no future awards of either vocational assistance or permanent disability for his knee condition. See ORS 656.278; Independent Paper Stock v. Wincer, 100 Or App 625 (1990).

In the Matter of the Compensation of
**HOWARD R. MATHER, Claimant**
WCB Case No. 94-10022
ORDER ON REVIEW
Max Rae, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) declined to assess a penalty for the insurer's allegedly untimely payment of certain medical bills; and (2) declined to assess an attorney fee under former ORS 656.386(1) for overcoming the insurer's alleged denial of compensation. On review, the issues are penalties and attorney fees. We vacate the ALJ's order for lack of jurisdiction.

This case arises out of the insurer's processing of four medical billings related to claimant's accepted cervical condition. Claimant contends that he is entitled to attorney fees for overcoming the insurer's alleged denial of these claims and penalties based on the insurer's untimely payment. The ALJ determined that the insurer's letters to the medical providers were not denials of payment, but merely returns of the billings for "correction and resubmission" pursuant to OAR 436-10-100(9). The ALJ then found that, although the insurer violated OAR 436-10-100(9) (in that it did not respond to the billings and request additional information within 20 days), it ultimately timely paid all of the billings pursuant to former ORS 656.262(6) and therefore no penalty was appropriate. The ALJ further found that claimant was not entitled to an assessed attorney fee under former ORS 656.386(1) because the insurer never "denied" claimant's medical billings but in fact paid them.

Subsequent to the ALJ's order, the legislature enacted Senate Bill 369, which amended the workers' compensation law to provide:

> "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." Or Laws 1995, ch 332, § 42d(5)(SB 369, § 42d(5)).
>
> 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 . . . ."

In Walter L. Keeney, 47 Van Natta 1387 (1995), we concluded, among other things, that the language of 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. We further concluded, based on Section 66 of Senate Bill 369, that amended ORS 656.245(6) applies retroactively to all claims currently pending before the Board. The 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 (July 26, 1995). Since none of those exceptions are applicable, we apply the new law in this case.

Here, claimant's hearing request pertained only to the insurer's alleged failure to pay certain medical bills related to claimant's compensable condition. Under such circumstances, we find this dispute does not involve a formal denial of the compensability of claimant's underlying claim for his accepted cervical condition. In light of the text of amended ORS 656.245(6) and Section 42d(5) of SB 369, we conclude that neither the ALJ nor the Board have the authority to award the relief claimant seeks. We therefore vacate the ALJ's order.[1]

ORDER

The ALJ's order dated December 15, 1994 is vacated. Claimant's hearing request is dismissed.

[1] Board Member Gunn notes that not answered is the question of what responsibility remains for employers and insurers under ORS 656.262(1) and (2).

In the Matter of the Compensation of
**KENNETH E. AWMILLER, Claimant**
WCB Case Nos. 94-15045 & 94-14707
ORDER ON REVIEW
Ackerman, et al, Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Marshall's order that awarded a penalty under former ORS 656.268(4)(g). Claimant cross-requests review, seeking an alternative penalty under former ORS 656.262(10)(a). On review, the issue is penalties. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Penalty Under Former ORS 656.286(4)(g).[1]

The ALJ determined that since the Order on Reconsideration increased the compensation awarded by the Notice of Closure by more than 25 percent and claimant was found to be more than 20 percent disabled in his left foot, claimant was entitled to a penalty under former ORS 656.268(4)(g). On review, SAIF argues that the ALJ erred in not applying OAR 436-30-050(13) and in not converting claimant's left foot disability to a percentage of claimant as a whole person. SAIF contends that under OAR 436-30-050(13), claimant is not entitled to a penalty under former ORS 656.268(4)(g) because his total award is less than 64 degrees.

Subsequent to the ALJ's order, the Court of Appeals issued its decision in SAIF v. Cline, 135 Or App 155 (1995). In Cline, the court upheld the validity of OAR 436-30-050(13) and held that former ORS 656.268(4)(g) permits an award of penalties only if the entire worker, not just a body part, has been determined to be at least 20 percent disabled. Thus, only a worker who receives a total sum of 64 degrees of permanent scheduled and/or unscheduled disability is considered to be "at least 20 percent permanently disabled" for purposes of former ORS 656.268(4)(g).[2]

In this case, claimant's total award for his left foot was 32.4 degrees. Claimant is therefore not "at least 20 percent permanently disabled" and is not entitled to a penalty under former ORS 656.268(4)(g).[3] OAR 436-30-050(13); SAIF v. Cline, supra. Consequently, we reverse that portion of the ALJ's order which awarded a penalty under former ORS 656.268(4)(g).

Penalty Under Former ORS 656.262(10)(a).

As an alternative to ORS 656.268(4)(g), claimant argues that SAIF should be assessed a penalty under former ORS 656.262(10)(a) (now renumbered 656.262(11)(a)) based on its failure to pay the 5 percent permanent partial disability that it did not challenge at hearing. Specifically, claimant argues that, since SAIF ultimately contested only a portion of the 23 percent of the foot awarded by the Order on Reconsideration, it should have paid the difference between the 6 percent awarded by the Notice of Closure and the 11 percent permanent disability it argued in favor of at hearing. We disagree.

---

[1] ORS 656.268(4)(g) was amended by the 1995 legislature. Or Laws 1995, ch 332 § 30 (SB 369, § 30).

[2] In reversing our decision in Steven L. Cline, 46 Van Natta 512 (1994), the court expressly overruled Nero v. City of Tualatin, 127 Or App 458 (1994) to the extent it awarded the claimant a penalty under former ORS 656.268(4)(g) when he suffered less than 64 degrees of permanent disability.

[3] Although ORS 656.268(4)(g) has been amended by SB 369, the outcome would be the same under the new law.

Pursuant to former OAR 656.313(1)(a),[4] SAIF's filing of a request for hearing on the reconsideration order stayed payment of all additional compensation awarded by that order. Accordingly, until the litigation authorizing permanent disability becomes final, SAIF has no legal duty to pay any portion of the additional compensation. See OAR 436-60-150(6)(c), (d). This is true notwithstanding the fact that, at hearing, SAIF acknowledged that it would not contest 5 percent of the additional compensation awarded.[5]

In the absence of any legal obligation to pay any of the additional compensation awarded by the reconsideration order until after a final order is issued, SAIF's failure to pay the 5 percent it did not contest at hearing is not unreasonable. Therefore, no penalty is warranted under former ORS 656.262(10)(a).

ORDER

The ALJ's order dated February 6, 1995 is affirmed in part and reversed in part. That portion of the order awarding a penalty as a result of the Order on Reconsideration is reversed. The remainder of the order is affirmed.

---

[4] ORS 656.313(1)(a) was also amended by SB 369, § 38. However, those amendments are not relevant to the outcome in this case.

[5] Further, in light of SAIF's hearing request, the entire award of permanent disability set forth in the reconsideration order was at issue, even if SAIF subsequently conceded at hearing that claimant was entitled to an additional 5 percent. For this reason, this case is distinguishable from Linda J. Hughes-Smith, 44 Van Natta 1801 (1992). There, applying an earlier version of ORS 656.313, we upheld a penalty for untimely payment of temporary disability where the carrier was ordered by an ALJ to pay both permanent partial disability and temporary disability benefits and stayed payment of both awards of compensation after filing its request for review, but appealed only the award of permanent disability and not the award of temporary disability benefits. We held that the temporary disability benefits did not qualify as "compensation appealed," and that the carrier was not permitted to stay the payment of these benefits. Here, on the other hand, SAIF, without equivocation or exception, appealed the permanent partial disability benefits awarded by the order on reconsideration. Under such circumstances, the entire permanent partial disability award qualifies as "compensation appealed" even though SAIF ultimately stipulated to a portion of those benefits.

---



In the Matter of the Compensation of
**MICHAEL BLAIR, Claimant**
WCB Case No. C5-02927
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Coons, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On October 13, 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 set aside the proposed disposition.

Here, the proposed CDA provides that claimant waives the 30-day "cooling off" period within which he may reject the agreement. The CDA further provides that "[c]laimant understands his waiver is irrevocable, and he expressly waives the 30-day waiting period for his own purpose, namely to accelerate receipt of the payment described in paragraph 13." (CDA pg. 3, lines 24-26) (emphasis added).

Pursuant to amended ORS 656.236(1)(b), a represented worker may waive the 30-day waiting period. Or Laws 1995, ch 332 § 24 (SB 369, § 24); Jeanne P. Morgan, 47 Van Natta 1062 (1995). The

statute, however, does not provide that the waiver, once made, is irrevocable.[1] Therefore, we find that the CDA provision quoted above, specifically in providing that a waiver is irrevocable, exceeds the statutory provisions of amended ORS 656.236. Under such circumstances, we find that the proposed disposition is unreasonable as a matter of law. Amended ORS 656.236(1)(a)(A). Accordingly, we decline to approve the agreement.

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed CDA. See OAR 436-60-150(4)(k) 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). At that time, the parties may submit an addendum, signed by their respective legal representatives, that removes the offending language.

IT IS SO ORDERED.

---

[1] The statutory scheme would appear to permit a worker to waive the 30-day "cooling off" period, but also to subsequently withdraw that waiver or to seek disapproval of the agreement prior to Board approval. Although the time period for such a revocation or disapproval request would likely be limited, it would be inaccurate to characterize a worker's waiver of such rights as irrevocable.

---



In the Matter of the Compensation of
**DAVID W. BUCKNUM, Claimant**
WCB Case Nos. 94-12368, 94-08533, 94-06235 & 94-00077
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Lundeen, et al, Defense Attorneys
Employers Defense Counsel, Defense Attorneys
Malagon, et al, Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Livesley's order which: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) upheld the denial by Willamette Industries, a self-insured employer of claimant's occupational disease claim for the same condition. On review, the issues are compensability and responsibility.

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

Claimant was diagnosed with bilateral carpal tunnel syndrome in February 1988. Liberty accepted claimant's claim as nondisabling. (Ex. 4). In January 1992, claimant experienced bilateral carpal tunnel complaints. Nerve conduction studies revealed bilateral carpal tunnel syndrome worse on the right. Claimant underwent right carpal tunnel release on January 3, 1993. Liberty reopened his claim as an aggravation of his 1988 claim. (Ex. 17). The claim was closed by a Notice of Closure, which awarded 14 percent scheduled permanent disability. (Ex. 20). A December 1993 Order on Reconsideration provided a 10 percent right arm award and 9 percent left arm award. (Ex. 30). In February 1994, claimant filed an occupational disease claim. He asserted claims against both Willamette and Liberty.

The ALJ found that claimant's 1988 CTS never resolved. Therefore, the ALJ determined that claimant's 1992 CTS symptoms were related to his 1988 CTS and not a "new" occupational disease claim under either carrier's coverage. In so doing, the ALJ disregarded Liberty and Willamette's argument that claimant is precluded from litigating a "new" injury when such injury is the same condition for which claimant has already been compensated.

Claimant may file a new claim to establish the compensability of a new and different condition that developed after closure of an earlier claim. Drews v. EBI Companies, 310 Or 134, 149 (1990). Christopher H. Peppler, 44 Van Natta 856, 857 (1992); However, the ALJ found, and we agree, that claimant's 1988 CTS never resolved; therefore, his 1992 CTS is not a "new" injury but an aggravation of his 1988 CTS. Claimant seeks to have the same CTS that was accepted as an aggravation of his 1988 injury claim found to be compensable as an occupational disease. He cannot do so. Christopher H. Peppler, supra; see also, Arthur D. Esgate, 44 Van Natta 875 (1992).

Alternatively, even if we consider the merits of claimant's occupational disease claim, we find that he has not established the compensability of his 1992 CTS as a "new" occupational disease.

In order to establish a "new" occupational disease, claimant is required to prove that his work exposures subsequent to the December 1993 Order on Reconsideration were the major contributing cause of his current 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); Floyd D. Maugh, 45 Van Natta 442 (1993).

In October 1992, Dr. Carter, examining physician, reported a history which stated that claimant developed bilateral CTS in 1988, with increasing right wrist symptoms since that time and left wrist symptoms increasing since 1990. (Ex. 13-1). Dr. Englander, medical arbiter, noted that claimant had recurring CTS symptoms for which he would be re-treated intermittently. (Ex. 29-1). Dr. Englander's report documents an ongoing symptomatology of claimant's CTS from 1988 until 1992, when claimant's CTS symptoms became severe requiring a right carpal tunnel release. Id. Dr. Herring, on referral by Dr. Bianchini, noted that claimant has had a "long-standing history of bilateral upper extremity symptoms." (Ex. 11-1).

After reviewing the medical record, as well as claimant's testimony, we are unable to conclude that claimant's 1988 CTS resolved or that his current CTS is a "new" occupational disease. Consequently, Willamette's and Liberty's denials of claimant's claim for an occupational disease are upheld. Inasmuch as we have determined that claimant's current condition is not a "new" occupational disease, the issue of responsibility is moot.

ORDER

The ALJ's order dated February 9, 1995 is affirmed.

---



In the Matter of the Compensation of
**LEON M. HALEY, Claimant**
WCB Case No. 93-14807
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Gunn and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order which upheld the self-insured employer's denial of claimant's neck and back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant sustained a neck and back injury at work on December 1, 1993, when a 4x8 piece of wood fell on his head. However, the ALJ further found that claimant failed to establish that the work injury was the major contributing cause of his neck and back condition under ORS 656.005(7)(a)(B), and concluded that the claim was not compensable.

We agree with the ALJ's reasoning and conclusion that claimant sustained an injury at work on December 1, 1993.[1] However, we disagree that claimant's injury combined with a preexisting condition to cause or prolong his disability or need for treatment.

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 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 the amendments to ORS 656.005(7)(a)(B) apply to this case, we conclude that the result would not change, since we find that neither former nor amended ORS 656.005(7)(a)(B) is controlling in this case. Consequently, we need not address which version of the statute should apply.

Under both versions of the statute, there must be evidence of a preexisting condition combining with the work injury to cause or prolong disability or a need for treatment before compensability is analyzed under ORS 656.005(7)(a)(B). Gary Stevens, 44 Van Natta 1178 (1992). Here, the evidence does not establish that, at the time of his December 1, 1993 work injury, claimant had a preexisting condition which combined with his work injury.

Claimant sustained a compensable neck and shoulder injury in September 1993. He was treated with physical therapy for "[p]robable right cervical, trapezius strain with contusion secondary to on-the-job injury 9-7-93." (Ex. 1c-2). On November 12, 1993, claimant was seen by Dr. Donovan in follow-up for his September 1993 injury. (Ex. 1f-1). Dr. Mayhall, who also treated claimant for his September 1993 injury, explained that at the time of his December 1993 injury, claimant was still under active treatment for his shoulder condition. (Ex. 23-8). However, the medical record is silent on the question of whether claimant's December 1993 work injury combined with his preexisting shoulder and neck condition. Claimant testified that his shoulder was the main problem related to the September 1993 injury, and that by the time he returned to work in November 1993, he was not having any neck problems. (Tr. 64, 87).

Absent evidence that claimant's preexisting neck and shoulder injury combined with his December 1993 work injury, claimant need only establish that his work injury was a material contributing cause of his disability and need for treatment. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); see also Ronald L. Ledbetter, 47 Van Natta 1461 (1995) (ORS 656.005(7)(a)(B) applies only if there is evidence that a compensable injury combined with a preexisting condition).

Dr. Kelly, a hospital emergency room physician, treated claimant on the day the work injury occurred. Noting a history of claimant being struck on his head that day by a falling piece of plywood, he diagnosed an acute cervicothoracic strain and prescribed treatment. (Ex. 3). Dr. Kelly later opined that this work incident was the direct cause of claimant's acute cervicothoracic strain and need for treatment. (Ex. 14-1). Dr. Kelly also explained that the objective findings to support his diagnosis and opinion included spasm on both sides of claimant's neck and restricted movement of the neck. (Ex. 14-2).

Dr. Mayhall, who treated claimant some time after the December 1993 injury, was unable to give an opinion as to whether an injury had occurred or not, since he did not see claimant when he was first injured. (Ex. 23 at 26-27). However, he opined that it was possible that claimant could have sustained a neck injury as a result of the December 1993 work incident. (See generally Ex. 23). He did not contradict Dr. Kelly's diagnosis or opinion.

Accordingly, relying on Dr. Kelly's opinion, we conclude that the December 1, 1993 work incident was at least a material contributing cause of claimant's disability and need for treatment for a neck and back condition. Therefore, we set aside the employer's denial.

---

[1] We also agree with the ALJ's reasoning and conclusion that references to a motor vehicle accident in the December 3, 1993 emergency room record reflect either a mistake or misunderstanding. (See Ex. 5).

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 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.

ORDER

The ALJ's order dated February 10, 1995 is reversed. The employer's December 15, 1993 denial is set aside, and the claim is remanded to the self-insured employer for processing in accordance with law. Claimant's attorney is awarded $3,500 for services at hearing and on Board review, to be paid by the self-insured employer.

---



In the Matter of the Compensation of
**MERIDEE A. KAIEL, Claimant**
WCB Case No. 94-13358
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that declined to assess penalties under former ORS 656.262(10)(a) for allegedly unreasonable claim processing. On review, the issue is penalties.

We adopt and affirm the ALJ's order with the following modification and supplementation. We change the findings of fact to reflect that the Order on Reconsideration was dated October 26, 1994, rather than August 26, 1994. (Ex. 25).

We briefly recap the procedural facts. Claimant's August 18, 1989 injury was found compensable by an Opinion and Order dated June 27, 1991. (Ex. 13). The Board reversed and claimant appealed that decision. Meridee A. Kaiel, 44 Van Natta 1616, on recon 44 Van Natta 1860 (1992). On August 10, 1994, the Court of Appeals concluded that claimant's injury arose out of and in the course of her employment and "reversed and remanded on petition." Kaiel v. Cultural Homestay Institute, 129 Or App 471, rev den 320 Or 453 (1994). The Court of Appeals denied the noncomplying employer's motion for reconsideration on September 28, 1994. (Ex. 23A). The Supreme Court denied the noncomplying employer's petition for review on December 13, 1994. (Ex. 26).

An Order on Reconsideration issued on October 26, 1994, awarding claimant scheduled permanent disability of 6 percent (9 degrees) and temporary total disability. (Ex. 25). On October 31, 1994, claimant requested a hearing concerning the October 26, 1994 Order on Reconsideration. The parties waived personal appearance at hearing and submitted the matter in writing. Claimant argued that SAIF's failure to pay the temporary total disability and outstanding medical bills owed subsequent to the Court of Appeals' decision was unreasonable and that she was entitled to penalties under former ORS 656.262(10)(a). Claimant also argued that payment of permanent disability awarded by the Order on Reconsideration was due on November 26, 1994.

The ALJ found that claimant's request for relief and a penalty was premature because no "final order" had been entered. The ALJ reasoned that since the Court of Appeals had reversed and remanded the case, it was necessary for the Board to issue a final order before SAIF was required to pay compensation.

On March 16, 1995, the date of the ALJ's order, the appellate judgment issued from the Court of Appeals.[1] The Court of Appeals had previously issued an order on February 7, 1995 awarding attorney fees for work done at hearing, before the Board and before the Court of Appeals. On March 22, 1995, we issued an Order on Remand that set aside SAIF's denial (on behalf of the noncomplying employer) and remanded the claim to SAIF for processing according to law.

Under ORS 656.313(1)(a), filing by an employer or insurer of a request for Board review stays payment of the compensation appealed, with certain exceptions that do not apply in this case. Here, the compensation appealed from was stayed when the noncomplying employer sought Board review of that portion of the June 27, 1991 order that found claimant's claim compensable.

ORS 656.313(1)(b) provides, in part: "If ultimately found payable under a final order, benefits withheld under this subsection shall accrue interest at the rate provided in ORS 82.010 from the date of the order appealed from through the date of payment." Claimant argues that ORS 656.313(1)(b) only requires issuance of a final order, not an appellate judgment, and she contends that the decision on compensability was final on January 4, 1995, when the time for appealing the Court of Appeals' decision had expired. Claimant asserts that all that remained was the "paper work by the court administrator's staff issuing the appellate judgment." We disagree.

Since claimant sought judicial review of our order that concluded that her injury was not compensable, our order was not a "final order." See ORS 656.295(8). On August 10, 1994, the Court of Appeals concluded that claimant's injury arose out of and in the course of her employment and the court "reversed and remanded on petition." Kaiel v. Cultural Homestay Institute, supra. The Court of Appeals denied the noncomplying employer's motion for reconsideration on September 28, 1994 and the Supreme Court denied review on December 13, 1994.

Contrary to claimant's argument, the decision on compensability was not final on January 4, 1995, when the time for appealing the Court of Appeals' decision had expired. ORAP 14.05(2)(b) provides that the decision of the Court of Appeals is effective "with respect to judicial review of administrative agency proceedings, on the date that the Administrator sends a copy of the appellate judgment to the administrative agency."[2] See also ORS 183.485(1) ("[t]he court having jurisdiction for judicial review of contested cases shall direct its decision, including its judgment, to the agency issuing the order being reviewed"); cf. ORS 19.190(2) (appellate judgment is effective when a copy of the appellate judgment is entered in the court's register and mailed by the State Court Administrator to the court from which the appeal was taken).[3]

Here, the appellate judgment is dated March 16, 1995 and was effective on that date. See ORAP 14.05(2)(b). The appellate judgment, as well as the court's decision, "reversed and remanded" the case. On March 22, 1995, we issued an Order on Remand that set aside SAIF's denial (on behalf of

---

[1] Claimant requests that we take administrative notice of the Court of Appeals' order awarding attorney fees and its appellate judgment. 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 40.065(2). A court order is an official act of the judicial department that is expressly subject to judicial notice under ORS 40.090(2). We similarly take administrative notice of our March 22, 1995 Order on Remand.

[2] An "appellate judgment" is defined, in part, under ORAP 14.05(1)(a) as "a decision of the Court of Appeals or Supreme Court together with a final order and a seal of the court." ORAP 14.05(1)(b)(i) defines a "decision" as a "designation of prevailing party and allowance of costs together with * * * an opinion indicating the author, the title page of the opinion containing the court's judgment." ORAP 14.05(1)(d) defines a "final order" as "that portion of the appellate judgment ordering payment of costs or attorney fees in a sum certain by specified parties or directing entry of judgment in favor of the Judicial Department for unpaid appellate court filing fees, or both."

[3] We note that the ALJ relied on SAIF v. Castro, 60 Or App 112 (1982), rev den 294 Or 491 (1982), to support the conclusion that no final order had been issued. In that case, the court held that the carrier did not have to pay compensation pending appeal of the court's decision because the court had not issued its mandate. At the time Castro was decided, mandates were necessary to make the appellate decision effective. Although appellate procedure has changed and the court no longer issues mandates, the principal in Castro is similar with respect to appellate judgments. Under ORAP 14.05(2)(b), the Court of Appeals' decision in this case was not effective until a copy of the appellate judgment was sent to the Board.

the noncomplying employer) and remanded the claim to SAIF for processing according to law. In the event that our March 22, 1995 order was not timely appealed, that order constitutes a "final order." See ORS 183.310(5)(b) (order is an "agency action expressed in writing" and is not a tentative or preliminary decision); ORS 656.295(8).

Nevertheless, at the time the record was closed in this case (March 9, 1995), no "final order" had issued. Consequently, we agree with the ALJ that claimant's request for penalties under former ORS 656.262(10)(a) was premature. Although this issue involves a claims processing matter which may result in a justiciable controversy in the future, it is not ripe for review in this proceeding.

ORDER

The ALJ's order dated March 16, 1995 is affirmed.

---

October 24, 1995 Cite as 47 Van Natta 2060 (1995)

In the Matter of the Compensation of
**LUCILLE BOYER, Claimant**
WCB Case No. C5-02703
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Coons, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On September 26, 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.

One part of the agreement states:

> "The parties agree that the workers' compensation insurer bears a risk of paying PTD benefits. Therefore, the reverse offset of ORS 656.209 has application. Claimant would have insisted on and received a larger settlement sum, but the insurer insisted on applying the reverse offset. Accordingly, the proceeds should not be offset under 42 USC § 424a."

Parties may dispose of "any or all matters regarding a claim, except for medical services," subject to the Board's rules. ORS 656.236(1). Thus, our approval of a CDA also is limited to the disposition of "matters regarding a claim." Karen A. Vearrier, 42 Van Natta 2071 (1990). When a CDA includes a release of rights and obligations outside chapter 656, it does not qualify as a "claim disposition agreement," especially when such provision cannot be excised without substantially altering the bargain underlying the exchange of consideration. Id.

Here, the disposition expressly prohibits the offset of the proceeds under a federal statute. Such an agreement is outside "matters regarding a claim" in that it does not solely concern matters under chapter 656. Furthermore, the provision appears to be a substantial part of the underlying bargain in that it states that claimant "would have insisted on and received a larger settlement sum" if the insurer had not insisted on applying the reverse offset. Accordingly, we are without authority to approve any portion of the approved disposition.[1]

---

[1] We acknowledge that we routinely approve CDAs containing discussion of the effect of Social Security benefits on the valuation of the settlement amount. Such language typically provides as follows:

> "Oregon law provides that the amount of any permanent total disability benefits payable to an injured worker shall be reduced by the amount of any disability benefits the worker receives from federal Social Security. ORS 656.209(1).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed CDA. See OAR 436-60-150(4)(k) 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). At that time, the parties may submit an addendum, signed by their respective legal representatives, that removes the offending provision.

IT IS SO ORDERED.

---

Claimant's expected Social Security Disability compensation would be awarded to claimant for all times pertinent to this agreement. Therefore, the parties based their valuation of the settlement amount in this agreement on this assumption. The parties reduced their allocation of benefits for future disability payments by the monthly sums that it was anticipated claimant would receive in Social Security Disability, based on claimant's current earnings record."

The difference between the "routine" provision cited above and the offensive portion of this CDA is that in the "routine" provision there is no directive to the federal government not to offset the proceeds . Instead, in the "routine" CDA provision the parties only explain how their assumptions concerning Social Security benefits have affected the consideration. Thus, unlike this CDA, there is no disposition concerning a matter outside chapter 656.

---

October 24, 1995 Cite as 47 Van Natta 2061 (1995)

In the Matter of the Compensation of
**JODI G. PALMER, Claimant**
WCB Case No. C5-02898
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Coons, Cole & Cary, Claimant Attorneys
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On October 11, 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 set aside the proposed disposition.

Here, the agreement provides that the amount of the consideration is $37,900.[1] Out of that amount, $4,400 is payable to a diesel truck driver training school, and up to $1,000 is payable to a vocational consulting firm. (CDA Addendum A).

ORS 656.234(1) prohibits the assignment by an injured worker or any other beneficiary of any moneys payable under ORS Chapter 656 prior to their receipt. Thus, because the agreement proceeds here are payable under ORS 656.236, such proceeds cannot be assigned by claimant to any entity or individual prior to their receipt.[2] See Robert K. Wilson, 45 Van Natta 1747 (1993) (CDA assigning proceeds to spouse disapproved); Debbie K. Ziebert, 44 Van Natta 51 (1992) (CDA assigning proceeds to attorney for costs disapproved); see also Catarino Garcia, 40 Van Natta 1846 (1988). Therefore, for the

---

[1] The summary page of the CDA provides that the total consideration is $32,500. However, later the agreement provides that the total consideration is $37,900. (CDA pg. 2, item 13 and Addendum A). Because it appears from the agreement that the amounts payable to the truck driver training school and to the vocational consultant are to be included in the consideration for the CDA, we construe the agreement as providing that the total consideration is $37,900.

[2] Of course, following approval of a CDA which provides for payment of all proceeds to claimant, and after that full payment is made to claimant, there is no statutory prohibition restricting claimant from distributing all or any portion of the proceeds to any other individual or entity.

above reasons, we conclude that the portion of the CDA providing payment to the diesel truck driver training school and to a vocational consultant is unreasonable as a matter of law. Robert K. Wilson, supra.

Because the offensive portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we conclude that we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990) . Consequently, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(k) 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). In other words, if the parties submit an addendum, executed by their respective legal representatives, eliminating the offensive portion of the current disposition, we would be willing to consider it for approval.

IT IS SO ORDERED.

---

October 25, 1995 Cite as 47 Van Natta 2062 (1995)

In the Matter of the Compensation of
**ARTHUR D. CASE, JR., Claimant**
WCB Case Nos. 94-14005, 94-12410, 94-12170, 94-12026 & 94-07589
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Paul L. Roess, Defense Attorney
Wallace & Klor, Defense Attorneys
David O. Horne, Defense Attorney
Meyers, Radler, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

James River Corporation (James River) requests and claimant cross-requests review of Administrative Law Judge (ALJ) Brazeau's order which: (1) set aside James River's denial of claimant's occupational disease claim for a bilateral hearing loss condition; (2) upheld Brooks Willamette Corporation/Employers Insurance of Wausau's (Brooks) denial for the same condition; (3) upheld International Paper Company/Sedgwick James' (International) denial for the same condition; (4) upheld Pope & Talbot, Inc./Sedgwick James' (Pope & Talbot) denial for the same condition; (5) upheld American Can Company/Employers Insurance of Wausau's (American) denial for the same condition; (6) declined to assess penalties and attorney fees for allegedly unreasonable denials issued by Pope & Talbot, American, and Brooks; (7) declined to award attorney fees for American's withdrawal of its compensability denial before hearing; and (8) awarded claimant's attorney a $3,000 fee for services at hearing. On review, the issues are responsibility, penalties 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

### Responsibility

In determining which carrier is responsible for claimant's condition, we must first decide whether this case is governed by ORS 656.308 or the last injurious exposure rule. Since there is no accepted hearing loss claim in this case, we do not apply ORS 656.308. 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).

The "last injurious exposure rule" provides that where, as here, 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, 241 (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).

The ALJ found that claimant's industrially-caused hearing loss substantially worsened during the time he was employed by James River and subsequent to 1989, claimant's increased loss, if any, was negligible. The parties do not dispute the ALJ's finding that responsibility is initially assigned to American Can Company (American). Similarly, the parties do not dispute that American demonstrated that subsequent employment at James River actually contributed to claimant's hearing loss.

James River argues that, although the documented hearing loss during claimant's employment at Pope & Talbot (which followed claimant's exposure at James River) was slight, that exposure contributed to claimant's hearing loss, which is sufficient to shift responsibility from James River to Pope & Talbot. Claimant was employed by James River from July 1982 to April 1989 and from April 1989 to present by Pope & Talbot. (Tr. 30, 35).

In order to shift responsibility to a later carrier, the later employment conditions must "contribute to the cause of, aggravate, or exacerbate the underlying disease." Bracke v. Baza'r, supra, 293 Or at 250; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (later employment conditions must have actually contributed to a worsening of the condition). A claimant must suffer more than a mere increase in symptoms. Timm v. Maley, 134 Or App 245, 249 (1995); see Bracke 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").

Considering his long-standing hearing loss and the extent of his employment exposure, the issue of whether claimant's bilateral hearing loss actually worsened during his employment at Pope & Talbot presents a complex medical question. Therefore, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

There are three medical opinions on causation. Dr. Chowning, otolaryngologist, has treated claimant since 1974. He concluded that claimant's major hearing loss occurred while employed by James River from approximately 1983 to 1989. (Ex. 48). Dr. Chowning compared the audiogram of November 10, 1989, which found 8 percent loss in the right ear and 5.5 percent loss in the left ear with the audiogram of April 9, 1982, which revealed zero percent hearing loss in both ears. (Id.)

In his December 15, 1994 report, Dr. Chowning reported that claimant's audiograms taken from 1990 to present "showed only a slight worsening of his hearing loss." (Ex. 51). Dr. Chowning compared claimant's November 10, 1989 hearing test with the July 18, 1994 hearing test and concluded there was not a significant change. Dr. Chowning explained:

> "[T]he audiogram of November 10, 1989, average six frequencies, 0.5 through 6 kilohertz, right ear 40.8 decibels, left ear 39.2 decibels. Audiogram, July 18, 1994, right ear 40.8 decibels, left ear 42.5 decibels. As you can see, there was no change in his hearing in the right ear and only an increased loss of 2.7 decibels in his left ear. This, in my opinion, is not a significant change. The percentage loss actually improves very significantly during this same period of time in the right ear from 8% to 3.75% and only a 0.75% increase in the left ear from 5.5% to 6.25%. The reason for the improvement in percentage loss is due entirely to the presbycusis factor." (Id.)

Dr. Chowning concluded that claimant's "exposure at Pope and Talbot was of no significant consequence in his overall hearing loss." (Id.) Dr. Chowning also compared claimant's November 10, 1989 audiogram with the March 2, 1994 audiogram and found no change in his hearing from 1989 to 1994. (Ex. 52).

James River asserts that, although Dr. Chowning related claimant's hearing loss to claimant's employment with James River, he failed to account for the fact that the audiogram was performed in November 1989, approximately seven months after Pope & Talbot came on the risk. James River argues that, because Dr. Chowning stated the major change in hearing occurred through 1989, and Pope & Talbot was on the risk for a major portion of that year, it "seems to reason" that claimant's employment during 1989 contributed to his hearing loss. James River acknowledges that there is no specific medical opinion addressing the seven months in 1989 and it asserts that it was not clear that any of the experts in this case were aware of this change in coverage.

Dr. Ediger, audiologist, noted in his report that claimant began employment for Pope and Talbot on May 1, 1989. Dr. Ediger compared claimant's 1989 hearing tests (done in March and in November 1989) to his June 14, 1994 hearing test and found that claimant's hearing had not declined from 1989 to 1994. (Ex. 50). Dr. Ediger concluded that claimant's employment at Pope & Talbot had not caused claimant's hearing loss to increase. (Id.) Although Dr. Ediger believed that the major cause of claimant's hearing loss was presbycusis, rather than industrial noise exposure, his opinion is relevant for purposes of deciding whether claimant's hearing loss worsened during his employment with Pope & Talbot. In light of Dr. Ediger's report, we are not persuaded by James River's argument that claimant's employment with Pope & Talbot in 1989 actually contributed to his hearing loss.

The remaining expert opinion is not helpful for purposes of assigning responsibility. Mr. Fairchild, audiologist, found that claimant had significant and substantial hearing changes from 1984 to 1994 and he believed that the employer for that period was responsible. (Ex. 47). Since Mr. Fairchild apparently assumed that claimant had only one employer during this time period, his opinion is not sufficiently detailed for purposes of assigning responsibility.

Based on the opinions of Drs. Chowning and Ediger, we conclude that claimant's later employment conditions at Pope & Talbot did not actually contribute to the cause of, aggravate, or exacerbate claimant's hearing loss. See Bracke v. Baza'r, supra; Oregon Boiler Works v. Lott, supra. We agree with the ALJ that claimant's industrially-caused hearing loss substantially worsened during the time he was employed by James River and that it did not worsen thereafter. Therefore, James River is responsible for claimant's bilateral hearing loss condition.

Unreasonable Denial

Claimant argues that the ALJ erred by declining to award a penalty for Brooks Willamette's (Brooks') allegedly unreasonable compensability denial. Claimant asserts that, at the time Brooks issued its first denial, three reports were in existence, all of which agreed that claimant's claim was caused in major part by industrial exposure.

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 considered in the light of all the evidence available. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Claimant was employed with Brooks from August 1965 to February 1970. (Tr. 24). Brooks issued a denial of compensability and responsibility on October 6, 1994 on the basis that claimant's hearing loss could be due to non-work-related exposure while in the military from 1955 to 1959. (Ex. 41). The denial was amended on October 20, 1994. (Ex. 44). Brooks continued to deny compensability of claimant's hearing loss at hearing. (Tr. 9, 16).

At the time Brooks issued its first denial, Mr. Fairchild had reported that claimant began working in 1970 with some hearing loss which did not exceed the loss expected for his age. (Ex. 36). However, Mr. Fairchild reported that since 1970, claimant's hearing had worsened faster than expected from aging and became worse in the 1980's. Mr. Fairchild concluded that claimant's hearing loss was due to work exposure. (Id.) Dr. Chowning concurred with Mr. Fairchild's report. (Ex. 38). Since claimant did not work for Brooks after 1970, we conclude that, in light of Mr. Fairchild's report, Brooks had a legitimate doubt regarding its liability for the claim. Consequently, we do not consider Brooks' denial to have been unreasonable. Accordingly, we decline to award a penalty under ORS 656.262(11)(a).

Attorney Fees

Claimant argues that the ALJ erred by declining to award an attorney fee associated with American's withdrawal of its denial of compensability prior to hearing. American contends that there is no evidence that claimant's attorney was instrumental in obtaining a rescission of its compensability denial.

After the ALJ's order, the legislature enacted Senate Bill 369. 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 (July 26, 1995). Since the ALJ's order was not final, the amended version of ORS 656.386(1) applies to this case.

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. Or Laws 1995, ch 332, § 43(1) (SB 369, § 43(1)). 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."

American issued a denial on September 30, 1994, denying compensability and responsibility of claimant's hearing loss claim. (Ex. 40). On November 14, 1994, subsequent to claimant's request for hearing, American withdrew its compensability denial and denied responsibility only. (Ex. 46; Tr. 9).

Claimant's hearing loss claim constituted a "denied claim" since American expressly denied compensability of the claim. We conclude that claimant's request for hearing was sufficiently instrumental to serve as the basis of an attorney fee award pursuant to ORS 656.386(1). See Gates v. Liberty Northwest Ins. Corp., 131 Or App 164 (1994); Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994) (claimant's counsel entitled to carrier-paid fee under ORS 656.386(1) when carrier rescinded compensability portion of denial before hearing regarding responsibility for claim); see also Kerry L. VanWagenen, 46 Van Natta 1786 (1994) (request for hearing preserved the claimant's right to challenge the employer's denial and was sufficient to warrant an assessed fee under 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 pre-hearing services concerning the rescission of American's compensability denial is $500, to be paid by American. 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.

Finally, claimant argues that the ALJ should have awarded the fee requested in the Petition for Attorney Fees, which was $3,287.50. 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. In reaching this conclusion, we have particularly considered the time devoted to the denial 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. We further note that a portion of claimant's counsel's services were devoted to his unsuccessful request for the assessment of a penalty.

Claimant is also entitled to a fee on Board review. Since Brooks-Willamette's denial also included compensability, both compensability and responsibility were decided by the ALJ. Therefore, by virtue of the Board's de novo review authority of the ALJ's order, ORS 656.295(6), compensability remained at risk on review as well. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53 (1992), mod 119 Or App 447 (1993). James River's appeal to the Board placed claimant's award at risk. Consequently, claimant's counsel is entitled to an assessed attorney fee under ORS 656.382(2) for services on Board review, payable by James River.

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 $100, to be paid by James River. 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 further note that claimant is not entitled to an attorney fee for services on review concerning his unsuccessful cross-request regarding the penalty issue. Finally, claimant is not entitled to an attorney fee for his counsel's efforts on review in securing an attorney fee award. Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The ALJ's order dated March 14, 1995 is reversed in part and affirmed in part. For pre-hearing services regarding the compensability issue, claimant's attorney is awarded $500, to be paid by American Can Company. The ALJ's order is otherwise affirmed. Claimant's attorney is also awarded $100 for services on Board review, to be paid by James River.

---



In the Matter of the Compensation of
**FRANK DiCARLO, Claimant**
WCB Case No. 94-11569
ORDER ON REVIEW
Svoboda & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's aggravation/surgery claim for a left knee condition. On review, the issues are compensability and, if compensable, aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the last sentence of the seventh paragraph on page 2. We do not adopt her findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable injury to his left knee in 1988. He filed a claim for a twisted knee. Dr. Carter diagnosed claimant's condition as a torn medial meniscus. During surgery to repair that condition, claimant was also diagnosed with preexisting degeneration in the left knee. There is no claim acceptance in the record. The insurer paid benefits for the knee injury. The claim was closed with an award of 18 percent scheduled permanent disability, which did not include an award for preexisting degenerative changes.

Applying Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), the ALJ found that claimant's compensable injury was a material contributing cause of his worsened left knee condition and that the worsening had been established by objective findings. The ALJ concluded that claimant's left knee surgery was compensable and that claimant had established a compensable aggravation claim as of the time of surgery. Accordingly, the ALJ set aside the insurer's denial.

The insurer argues that the issue before the ALJ was the compensability of a specific medical procedure, not a claim for aggravation. Before we address the insurer's argument regarding the scope of its denial, we must identify the current condition that is the object of the present claim and decide whether it is a compensable condition.

Dr. Carter, claimant's treating physician, diagnosed claimant's current condition as osteoarthritis, a degenerative condition. (Ex. 27-2). Because claimant was diagnosed with a preexisting degenerative condition at the time of the 1988 surgery for his compensable injury, our first task is to determine whether this condition is an accepted condition.

There is no evidence that the insurer accepted the preexisting degenerative condition as a part of the 1988 claim. The insurer's payment of medical bills, even if the treatment related to the degenerative condition, does not constitute an acceptance of the degenerative condition. Amended ORS 656.262(10)[1]; see Olson v. Safeway Stores, Inc., 132 Or App 424, 427 (1995). Moreover, although claimant was previously awarded 18 percent scheduled permanent disability, the award was limited to disability resulting from the torn medial meniscus and ensuing surgery, and did not include consideration of the degenerative knee condition. (See Exs. 12, 13, and 15). Thus, even under the law existing prior to the enactment of the June 7, 1995 statutory amendments, claimant's prior permanent disability award would not preclude the insurer from contesting claimant's degenerative knee condition. See Olson v. Safeway Stores, Inc., supra.[2]

Because claimant sought treatment for a condition which was not previously accepted, he must establish the compensability of that condition under ORS 656.005(7)(a). See Beck v. James River Corp., 124 Or App 484 (1993), rev den 318 Or 478 (1994) (ORS 656.005(7)(a) applies to initial determinations of the compensability of a condition, i.e., to claims for new injuries or conditions different from an already accepted claim, rather than to claims for continued medical treatment of a compensable condition under ORS 656.245(1)); Jocelyn v. Wampler Werth Farms, supra (An aggravation is a worsening of a compensable condition). (Emphasis added). Moreover, because claimant has a compensable left knee injury and a preexisting condition in the left knee, our next inquiry is whether the injury and the preexisting condition combined.[3]

Dr. Carter opined that both claimant's preexisting degenerative changes and the injury and subsequent surgery combined to produce claimant's current osteoarthritic condition. (Exs. 22, 22A). Based on that persuasive opinion from claimant's treating physician, we conclude that claimant must prove that the compensable injury is the major contributing cause of his disability or need for treatment of the combined condition. See ORS 656.005(7)(a)(B).

During the period of worsening from 1989 until 1994, Dr. Carter concluded that the worsened degeneration in the medial compartment of claimant's left knee was a consequence of the original injury and the subsequent meniscectomy. (Exs. 16 and 17). However, in 1994, he changed his opinion after reviewing his original operative report, explaining that the degenerative change found during the 1988 arthroscopy would be expected to gradually worsen and that the probability of a partial medial meniscectomy leading to progressive degenerative changes over a six year period was not great. Dr. Carter ultimately determined that both the preexisting changes in the medial compartment and the injury and partial meniscectomy "probably contribute[d] in an equal fashion" to claimant's current left knee condition. (Exs. 22, 22A and 27).

Dr. Mayhall, who also had a complete medical record, including the finding of preexisting degeneration in the medial compartment, concluded that claimant's worsened left knee condition was related to the tear of the medial meniscus and degenerative changes which resulted from the tear as well as the residual torn posterior horn remnant. (Exs. 10 and 18-5). Dr. Mayhall did not discuss the relative contribution of the preexisting degenerative condition.

The causation issue is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). We are more persuaded by Dr. Carter's reasoned opinion than that of Dr. Mayhall. Somers v. SAIF, 77 Or App 259 (1986). Dr. Carter was claimant's long-standing attending physician and performed the 1988 surgery. Because of this advantageous position, we give significant probative value to Dr. Carter's observations. Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

---

[1] Or Laws 1995, ch 332, §§ 28, 66(5)(b) (SB 369, §§ 28, 66(5)(b)).

[2] Amended ORS 656.262(10) provides that payment of permanent disability benefits pursuant to a determination order or litigation order does not preclude a carrier from subsequently contesting the compensability of the condition rated therein, where the condition has not been formally accepted. See SB 369, §§ 28, 66(5)(b). Inasmuch as we have found that the previous award did not include permanent disability for claimant's degenerative condition, we need not determine the applicability of the amended statute.

[3] Since our decision would be the same under either version of ORS 656.005(7)(a)(B), we need not decide which version is applicable.

Accordingly, we are not persuaded that the accepted 1988 injury was the major contributing cause of claimant's current combined condition. Consequently, we conclude that claimant's current osteoarthritic condition is not compensable under either version of ORS 656.005(7)(a)(B). Inasmuch as claimant's current condition is not compensable, disability and treatment relating to the current condition are not compensable. In light of such circumstances, we need not address the insurer's remaining contentions.

ORDER

The ALJ's order dated January 21, 1995 is reversed.[4] The insurer's August 24, 1994 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[4] The ALJ upheld that portion of the insurer's denial "regarding the right knee." The insurer correctly contends that the right knee was not involved in this case. (See Exs. 18-2 and Tr. 2).



In the Matter of the Compensation of
**JOHN Q. EMMERT, Claimant**
WCB Case Nos. 91-14932 & 91-07717
ORDER ON REMAND
Craine & Love, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Emmert v. City of Klamath Falls, 135 Or App 209 (1995). The court reversed our order in John Q. Emmert, 46 Van Natta 997 (1994), which upheld the SAIF Corporation's denial of claimant's coronary artery disease, arrhythmia condition and hypertension. Reasoning that the notice of acceptance (which used codes that stood for "unclassified" and "chest, including ribs, breast bone, and internal organs of the chest") had not specified a particular condition, the court concluded that the acceptance must be interpreted as pertaining to claimant's severe chest pain claim. Since such an acceptance constitutes an acceptance of the medical cause or causes of the symptoms, the court determined that SAIF had accepted the condition or conditions that caused claimant's severe chest pain. Because we had not found what caused claimant's chest pain, the court has remanded for reconsideration.

The relevant facts are as follows. In March 1981, claimant experienced chest pain for which he was hospitalized. Claimant filed a claim for "severe chest pains." He was diagnosed as suffering an acute myocardial infarction (MI) superimposed on coronary artery disease (CAD). SAIF accepted the claim as a disabling injury classified by code designations ("999 430") meaning "unclassified" and "chest, including ribs, breast bone and internal organs of the chest."

In approximately 1991, claimant began receiving medical treatment for cardiac arrhythmia and hypertension, which were considered to be due to his prior MI and/or CAD. SAIF issued a denial of claimant's CAD, vascular disease, arrhythmia, hypertension, and related problems as not being caused in major part by the compensable 1981 injury. (Ex. 53).

The ALJ (formerly Referee) found that SAIF did not accept claimant's CAD in 1981. The ALJ also found that neither claimant's compensable MI nor his work activities were either a material or the major contributing cause of his need for treatment beginning in 1991. Based on those findings, the ALJ concluded that claimant's CAD, arrhythmia and hypertension conditions were not compensable. Claimant requested review of the ALJ's order.

On review, we affirmed and adopted the ALJ's order. John Q. Emmert, supra. Specifically, we agreed with the ALJ that SAIF accepted only the acute MI, not the underlying CAD. We reasoned that because SAIF did not accept a particular condition, it was appropriate to rely on contemporaneous medical records to determine what condition SAIF accepted. The contemporaneous hospital records diagnosed claimant's condition as an acute MI. (Exs. 4, 5, 13). Subsequently, Dr. Schaefer, consulting

cardiologist, described claimant's condition as "[CAD] status post-acute anteroseptal [MI]," noting that claimant's MI was caused in part by work-related stress superimposed on his preexisting CAD. (Ex. 18). Two weeks later, SAIF accepted the claim. (Ex. 20). In light of the contemporaneous, specific diagnosis of MI, we were not persuaded that Dr. Schaefer's opinion explaining the interrelationship between claimant's CAD and MI meant that SAIF had accepted both the MI and the CAD conditions. Because we found that claimant had failed to prove the compensability of his CAD condition, we upheld SAIF's denials. Claimant appealed our order.

The court reversed our decision. Emmert v. City of Klamath Falls, supra. The court concluded that SAIF had not accepted a particular condition; it simply accepted claimant's claim. The claim was for "severe chest pains." The court reasoned that since the acceptance was not limited in any way, it must be interpreted as constituting an acceptance of the claim as filed. Relying on Georgia Pacific v. Piwowar, 305 Or 494 (1988), the court held that, since SAIF had accepted a claim for symptoms of a disease or injury (severe chest pain), it had accepted the condition or conditions that caused the symptoms. Because we did not make a determination about what caused claimant's severe chest pain, the court has remanded for reconsideration, directing us to make that determination. Accordingly, we proceed with our reconsideration.

Here, claimant was hospitalized with chest pain in March 1981. His condition was diagnosed as an acute MI. (Exs. 4, 5). Subsequently, he underwent cardiac testing by cardiologist Dr. Schaefer, which revealed single vessel coronary artery disease. (Ex. 16). Dr. Schaefer described claimant's condition as "coronary artery disease status post-acute anteroseptal myocardial infarction." (Ex. 18-1). Dr. Schaefer noted that claimant had experienced ischemic cardiac pain shortly before his acute MI. He explained that claimant's occluded artery was most likely due to coronary atherosclerosis, a chronic, degenerative disorder which had developed over a period of years. He further explained that claimant's acute MI developed when claimant's work stress was superimposed on his preexisting coronary artery disease. Dr. Schaefer opined that claimant's acute work stress, superimposed on his already impaired cardiac circulation, contributed to the acute MI. (Ex. 18).

Based on Dr. Schaefer's opinion, we find that claimant's chest pain in March 1981 was caused by both his underlying coronary artery disease and the acute myocardial infarction. Therefore, because CAD was one of the conditions that caused claimant's symptoms of severe chest pain, CAD was one of the conditions SAIF accepted in 1981. Piwowar, supra; Emmert, supra. Having once accepted the claim for coronary artery disease, SAIF cannot thereafter deny the claim. Bauman v. SAIF, 295 Or 788 (1983). Consequently, SAIF's denial must be set aside.

Inasmuch as claimant has prevailed finally after remand from the Court of Appeals, he is entitled to an assessed attorney fee for his counsel's services before every prior forum. ORS 656.388(1); 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, on review and before the court is $7,500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs, and claimant's counsel's attorney fee request for services at hearing and on Board review), the complexity of the issues, the value of the interest involved, the skill and standing of counsel, and the risk that counsel may go uncompensated.

Accordingly, on reconsideration of our May 24, 1994 order, we reverse the ALJ's June 11, 1993 order. The SAIF Corporation's denials of May 23 and October 10, 1991 are set aside, and the claim is remanded to SAIF for processing in accordance with law. For services before all prior forums, claimant's attorney is awarded a $7,500 fee, to be paid by SAIF.

IT IS SO ORDERED.

In the Matter of the Compensation of
**LANA M. FORD-FRYOU, Claimant**
WCB Case Nos. 94-03920 & 93-15120
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian 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 myofascial pain syndrome. On review, the issue is compensability.

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

Claimant relies on the reports of Dr. Lee, treating physician, to establish the compensability of her myofascial pain syndrome.[1] Dr. Lee initially concluded that, based on a history of claimant having been taken off work for three weeks when the syndrome initially manifested itself, the syndrome "probably is the job related condition with incomplete recovery." (Ex. 29). In his final report, Lee stated that it was his medical opinion that claimant's work at SAIF's insured "probably was the major contributing cause of her disability and need for treatment." (Ex. 41). He explained that claimant's condition "probably has been mostly with muscle irritation and activation of trigger points due to repetitive activities at [SAIF's insured]." (Id.) Lee issued that report in response to a letter from claimant's counsel that asked Dr. Lee to assume, among other things, that claimant constantly had to answer a telephone and clean cabinets and computer screens. (Ex. 39A)

We are not persuaded by Dr. Lee's reports. First, when claimant's right upper extremity condition initially manifested itself, she was taken off work for three days, not three weeks. (Ex. 4). Second, there is insufficient evidence to support the telephone and cleaning assumptions on which Dr. Lee's final report is based. In the absence of an accurate history regarding claimant's work activities and disability, we conclude that Dr. Lee's reports are insufficient to meet claimant's burden of proof. E.g., Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (unexplained medical report discounted). That conclusion finds support in the fact that Dr. Lee did not begin treating claimant until nearly a year after she left her position with SAIF's insured. E.g., Bruce Hardee, 46 Van Natta 2261, 2262-63 (1994) (Board discounted opinion of physician who did not begin treating claimant until 10 months after injury).

In sum, for the reasons stated in the ALJ's order, as supplemented here, we agree that claimant has failed to establish the compensability of her myofascial pain syndrome.

ORDER

The ALJ's order dated March 17, 1995 is affirmed.

---

[1] The parties dispute the existence of claimant's myofascial pain syndrome. We will assume, without deciding, that claimant has that condition.

**Board Member Gunn dissenting.**

Notwithstanding several reports from Dr. Lee, treating physician, relating claimant's myofascial pain syndrome to her work activities, the majority concludes that claimant has failed to establish the compensability of that condition. Because I find the majority's analysis incorrect, I dissent.

I thought that it was this Board's policy to defer to the reports of treating physicians, Weiland v. SAIF, 64 Or App 810 (1983), and to accept causation opinions even if they lack the so-called "magic words." Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992). The Board appears to have abandoned those policies here.

Dr. Lee is the treating physician. He concluded that claimant's disability and need for treatment were caused, in major part, by her work activities. (Ex. 41). I find no reason to not defer to that opinion. Moreover, I find Dr. Lee's reference to "disability and need for treatment," as opposed to claimant's myofascial condition, is not such a departure from the "magic words" of causation so as to render his opinion unpersuasive.

The majority concludes that Dr. Lee's opinions are based on an inaccurate history. I disagree. That Lee may have mistakenly recorded the amount of time (three weeks instead of three days) that claimant initially took off because of her condition is of little importance; I find nothing in the medical record that justifies the magnification of that discrepancy into a basis for discounting all of Dr. Lee's reports.

I reach the same conclusion regarding the telephone and cleaning issue. The letter on which Dr. Lee's final report is based asked him to assume that claimant performed many different work functions. I agree with the majority that there is insufficient evidence to support the assumptions regarding claimant's telephone use and cleaning activities. However, there is sufficient evidence to support the remainder of the assumptions stated in the letter. Again, I find nothing in this record that warrants the elevation of the telephone/cleaning issue to a basis for rejecting Dr. Lee's entire opinion.

Finally, I am not persuaded that the fact that Dr. Lee became claimant's treating physician over a year after she left the employ of SAIF's insured is a basis for rejecting Lee's opinions. For the reasons stated above, I would find that, based on his access to a sufficiently complete and accurate history of claimant's condition and work activities, and his physical findings, Dr. Lee was in as good a position as any physician could be to render an opinion about the cause of claimant's myofascial condition.

Because the majority relies on several untenable grounds to conclude that claimant's myofascial pain syndrome is not compensable, I respectfully dissent.

---

October 25, 1995 Cite as 47 Van Natta 2071 (1995)

In the Matter of the Compensation of
**DONALD R. KOEHN, Claimant**
WCB Case No. 93-07238
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Spangler's order which dismissed its request for hearing from a Director's order under former ORS 656.327(1) for lack of jurisdiction. On review, the issue is jurisdiction. We affirm.

## FINDINGS OF FACT

This is a procedurally complex case. A brief recitation of the background of this claim would be beneficial.

On March 15, 1993, the Director issued a proposed "Final Order" pursuant to former ORS 656.248, finding that the employer had no obligation to reimburse claimant for an additional $960 for the costs of hearing aids for an accepted hearing loss condition. The Director, however, issued another "Final Order" on May 14, 1993, setting aside the prior order and remanding the case to the Medical

Review Unit for processing. The Director reasoned that the reimbursement issue was a medical treatment dispute under former ORS 656.327(1).[1]

On June 10, 1993, pursuant to ORS 656.327(1), the Director issued a "Proposed and Final Order Concerning a Bona Fide Medical Services Dispute," wherein the Director ordered the employer to reimburse claimant in full for the hearing aids that he purchased. Subsequently, on June 21, 1993, the employer requested judicial review of the Director's May 14, 1993 order remanding the claim to the Medical Review Unit. The employer requested a hearing on June 23, 1993, contesting the Director's June 10, 1993 order requiring it to reimburse claimant for the full price of his hearing aids for his accepted hearing loss condition.

The ALJ dismissed the employer's June 23, 1993 hearing request by November 3, 1993 order, as supplemented and republished in a December 8, 1993 Order on Reconsideration. The ALJ reasoned that the Hearings Division had no jurisdiction over the employer's hearing request while the case was pending before the Court of Appeals. The employer requested Board review of the ALJ's order. That order is the subject of the present proceedings.

Additional developments, however, occurred after the ALJ's decision. In February 1994, the Director withdrew the May 14, 1993 order to reconsider several issues. In an April 14, 1994 "Order on Reconsideration," the Director held that the employer was not required to reimburse the additional $960 for claimant's hearing aids. The Director reasoned that the medical services issue arose out of ORS 656.248, not ORS 656.327. The "Order on Reconsideration" was not appealed.

Finally, the employer withdrew its petition for judicial review inasmuch as the April 14, 1994 reconsideration order had resolved the reimbursement issue in its favor. The court dismissed the request for judicial review on May 12, 1994.

## CONCLUSIONS OF LAW AND OPINION

As previously noted, the ALJ's order dismissing the employer's request for hearing from the Director's June 10, 1993 "327" order for lack of jurisdiction, is the subject of our review. While we agree with the ALJ that the Hearings Division lacked jurisdiction over the medical services dispute, our reasoning differs from the ALJ's.

The Director's June 10, 1993 order, which is the subject of these proceedings, was issued pursuant to former ORS 656.327(1). That statute, however, was amended by Senate Bill 369 on 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." 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. Thomas Abel, 47 Van Natta 1571 (1995); Walter L. Keeney 47 Van Natta 1387 (1995).

---

[1] Former ORS 656.327(1) provided:

"(a) If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer or self-insured employer shall so notify the parties and the director.

"(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. Appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the board within 30 days after issuance of the order. The board shall set aside or remand the order only if the board finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding in the order when the record, reviewed as a whole, would permit a reasonable person to make that finding. The decision of the board is not subject to review by any other court or administrative agency.

"(c) The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section."

Consequently, because the order at issue concerns ORS 656.327 and there is no dispute regarding the compensability of claimant's underlying claim for his accepted hearing loss condition, exclusive jurisdiction over this case now rests with the Director. Walter Keeney, supra. In that case, neither we nor the Hearings Division have jurisdiction over it.[2] Therefore, the ALJ properly dismissed the employer's hearing request regarding the Director's order issued pursuant to ORS 656.327, although our reasoning differs from that of the ALJ.

ORDER

The ALJ's order dated November 3, 1993, as reconsidered on December 8, 1993, is affirmed.

[2] The employer requests that we "set aside" the Director's June 10, 1993 order rather than "refer" it back to the Director. The employer notes that the Director has already performed a review pursuant to ORS 656.327 and alleges that he will be bound by his April 14, 1994 reconsideration order. However, we cannot comply with the employer's request, inasmuch as we no longer have jurisdiction to set aside a Director's order. Walter Keeney, supra. Rather, it is incumbent on the parties to present their respective positions to the Director, who is statutorily authorized to address medical service disputes such as this one. Likewise, what, if any, action is appropriate is a matter for the Director to determine.

---



In the Matter of the Compensation of
**KURT KONRAD, JR., Claimant**
WCB Case No. 94-13283
ORDER ON REVIEW
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Hazelett's order that affirmed an Order on Reconsideration awarding 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of the left knee. On review, the issue is extent of scheduled permanent disability.

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

At hearing, claimant asserted that he was entitled to additional disability based on OAR 436-35-230(13)(b) (WCD Admin. Order 17-1992). That rule provides:

> "A value of 5% of the leg shall be combined with other impairment values, including chronic condition as in (a) above, if there is a diagnosis of more extensive chondromalacia, arthritis, or degenerative joint disease and one or more of the following:
>
> "(A) Grade IV chondromalacia
>
> "(B) Secondary strength loss
>
> "(C) Chronic effusion; or
>
> "(D) Varus or valgus deformity less than that specified in subsection (4) of this rule."

According to claimant, he proved the existence of grade IV chondromalacia and chronic effusion in his left knee.

For the reasons discussed by the ALJ, we agree that there is no persuasive evidence of grade IV chondromalacia. With regard to chronic effusion, claimant's treating physician, Dr. Sulkosky, indicated that claimant's "chondral defect" "will also cause intermittant [sic] and periodic swelling of the left knee[.]" (Ex. 26).

We find such evidence is insufficient to prove entitlement to additional impairment. First, Dr. Sulkosky described the chondral defect as a "pre-arthritic lesion," which is different from "a diagnosis of more extensive chondromalacia, arthritis, or degenerative joint disease" required by the rule. Furthermore, we find that Dr. Sulkosky provided only a prediction of swelling, which falls short of showing the existence of "chronic effusion." Thus, we conclude that there is no basis for awarding an additional award based on OAR 436-35-230(13)(b).

ORDER

The ALJ's order dated March 21, 1995 is affirmed.

---

October 25, 1995 Cite as 47 Van Natta 2074 (1995)

In the Matter of the Compensation of
**JEAN E. OTTO, Claimant**
WCB Case No. 94-04891
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) found claimant's bilateral tendinitis condition claim was prematurely closed; and (2) assessed a penalty and related attorney fee for an allegedly unreasonable claim closure pursuant to former ORS 656.268(4)(f). On review, the issues are premature claim closure and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On January 19, 1993, claimant was examined for the insurer by Dr. Coletti, orthopedic surgeon, and Dr. Fabricius, chiropractor. (Ex. 4).

On February 19, 1993, the insurer accepted bilateral wrist tendinitis. (Ex. 5).

On August 20, 1993, claimant was examined for the insurer by Dr. Button, hand and arm surgeon. (Ex. 11).

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We adopt and affirm the ALJ's opinion on this issue, with the exception of the first paragraph on page 4.

Penalty for Unreasonable Claim Closure

Relying on opinions by its medical examiners, the insurer issued an August 27, 1993 Notice of Closure declaring claimant medically stationary on August 26, 1993. Claimant requested reconsideration. A March 16, 1994 Order on Reconsideration found claimant medically stationary on August 20, 1993, based on a preponderance of medical opinion.

Claimant requested a hearing regarding premature claim closure, penalties and attorney fees.[1]

---

[1] At hearing, claimant identified the theories on which she sought penalties as follows: "If the Notice of Closure is set aside, that would be unreasonable claims processing, and if not, the fact that the attending physician did not rate impairment in this case and the claim was closed without any award of permanent disability would be unreasonable resistance to payment of compensation." (Tr. 1, 2).

The ALJ concluded that the insurer's issuance of the Notice of Closure was premature. See former ORS 656.268(1).[2] The ALJ further concluded that the Notice of Closure was unreasonable because the insurer failed to request and obtain a closing examination by, or with the concurrence of, the attending physician, in violation of former ORS 656.245(3)(b)(B)[3] and OAR 436-30-020. The insurer argues that neither the statutes nor the rules required that a worker's medically stationary status be made only by the attending physician, and that its reliance on the medical examiners was reasonable. We agree.

Claimant is entitled to a penalty under former ORS 656.268(4)(f) for an insurer's unreasonable Notice of Closure without authorization to do so under ORS 656.268(4)(a).[4] Brenda G. Chaney, 46 Van Natta 2340 (1994); Cindy A. Schrader, 46 Van Natta 175 (1994); see also Dominic R. Gordon, 42 Van Natta 2487 (1990). Former ORS 656.268(4)(a) provides that the insurer may close the claim when the worker's condition has become medically stationary and the worker has returned to work or the worker's attending physician releases the worker to return to regular or modified employment. Here, the attending physician had released claimant to modified employment. (Ex. 9). However, at the time the insurer closed the claim, neither the statutes nor the rules required that the decision regarding medically stationary status be made only by the attending physician. See former ORS 656.268; former OAR 436-30-020(1).[5] Former OAR 436-30-035(1) provides:

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

Former OAR 436-30-035(2) provides:

> "When there is a conflict in the medical opinions as to whether or not a worker is medically stationary, more weight shall be given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning."

Former OAR 436-30-035(3) provides:

> "Where there is not a preponderance of medical opinion stating the worker is or is not medically stationary, deference shall generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference shall be given to the opinion of the physician with the greatest expertise in, and understanding, of the worker's condition."

OAR 436-30-035(6) provides in part: "A worker is medically stationary on the date so specified by a physician." (Emphasis added.)

---

[2] The 1995 Legislature made numerous changes to the Workers' Compensation Law. Generally, those amendments apply to all claims and causes of action existing on the effective date of the Act, and the Act is intended to be fully retroactive unless a specific exception applies. Or Laws 1995, ch. 332, § 66 (SB 369, § 66); Volk v. America West Airlines, 135 Or App 565 (1995). No exception applies to amended 656.268(1). Because the amended portion of the statute is not relevant to the facts of this case, under either version the result is the same.

[3] Renumbered ORS 656.245(2)(b)(B) without a change in language. SB 369, §§ 25, 66.

[4] As noted supra, ORS 656.268 was amended by SB 369. Amended ORS 656.268(4)(f) has no change in language. The amendment to ORS 656.268(4)(a) is not relevant here. See SB 369, §§ 30, 66. Consequently, under either version of the statute, the result is the same.

[5] We are cognizant that, effective January 1, 1995, new rules were adopted by the Department restricting the "medically stationary" status determination to the attending physician, or with the attending physician's concurrence. See OAR 436-30-020(2) and 436-30-035(5), WCD Admin Order 94-059. Because the issue is the reasonableness of the insurer's action closing the claim prior to the promulgation of these rules, their retroactive applicability is not at issue here.

Here, prior to closing the claim, the insurer had received two reports from three physicians, (an orthopedic surgeon, a chiropractor and a hand surgeon), that declared claimant medically stationary. Under these circumstances, we conclude that the insurer's Notice of Closure was reasonable and that a penalty is not warranted. See Maria R. Porras, 42 Van Natta 2625 (1990) (penalty and attorney fee not appropriate when the carrier's reliance on a former rule was reasonable). Consequently, we reverse that portion of the ALJ's order that assessed a penalty and attorney fee for unreasonable claim processing.

Claimant's attorney is entitled to an assessed attorney fee for prevailing over the employer's request for review on the premature closure 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 premature closure issue is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 18, 1994 is affirmed in part and reversed in part. Those portions of the order that assessed a penalty pursuant to former ORS 656.268(4)(f) and an attorney fee pursuant to former ORS 656.382(1) are reversed. Claimant's attorney is awarded $1,200 for services on Board review, to be paid by the insurer. The remainder of the order is affirmed.

**Board Member Hall concurring in part and dissenting in part.**

I concur in the majority's decision that the claim was prematurely closed. I dissent on the issue of whether the closure was reasonable and, thus, whether a penalty should be assessed.

The majority concludes that the insurer's claim closure was not unreasonable because, at the time of claim closure, neither the statutes nor the rules required that the decision regarding medically stationary status be made only by the attending physician. Claimant asserts that, because the insurer did not request the attending physician to rate claimant's impairment, that the closure was unreasonable. Because of the importance of the attending physician's opinion in this case on the medically stationary issue, I would find that it was unreasonable to close the claim without seeking information from the attending physician. I, therefore, respectfully dissent.

I recognize that neither the statutes nor the rules in effect at the time of claim closure technically required that claimant's medically stationary status be made only by the attending physician. Nevertheless, there are other rules that clearly reflected the role of the attending physician in closing claims. At the time of closure, former OAR 436-30-020(3) provided that a condition precedent to an insurer closure was information in a closing examination report sufficient to determine the extent of permanent disability. See former OAR 436-30-020(2); 436-30-020(3) and 436-30-030(5)(b). Former OAR 436-30-030(5)(b) provided that the required closing examination report be pursuant to OAR 436-10-080. OAR 436-10-080 describes the determination of impairment by the attending physician, or concurred in by the attending physician. Here, the insurer closed the claim without requesting or obtaining a closing examination, in violation of those provisions.

Moreover, in the face of a claim with an attending physician, it is unreasonable to ignore or fail to even solicit an opinion from the attending physician on the medically stationary issue, an issue that the attending physician would be in the best position to evaluate and where the attending physician's opinion should be given deference.

Here, the insurer's failure to obtain claimant's attending physician's opinion regarding whether claimant was medically stationary makes a difference in the outcome of this case, thus illustrating my point. Consequently, even though the insurer was technically not required to obtain the attending physician's opinion on claimant's medically stationary status, I conclude that the insurer's failure to do so was unreasonable in this case and that a penalty pursuant to ORS 656.268(4)(f) should be assessed.

In the Matter of the Compensation of
**VICTOR ROBLES, Claimant**
WCB Case Nos. 94-06437 & 93-10321
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order which: (1) set aside its partial denials of claimant's preexisting low back degenerative disease; and (2) awarded a $2,000 attorney fee for claimant's counsel's services in obtaining a rescission of a denial prior to hearing. The insurer also contends that if the Board reverses the ALJ's compensability decision, then claimant's attorney fee on that issue should be reduced by up to $2,000. 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

Claimant sustained a low back injury on August 5, 1993 when he fell down stairs at work. The insurer accepted the claim as a disabling lumbar strain. (Ex. 21). Later, the insurer also accepted an "L5-S1 disc." (Ex. 84). Claimant received conservative treatment for his low back conditions.

A bone scan ordered by Dr. Poulson in January 1994 revealed right-sided L5-S1 degenerative arthropathy, presumably osteoarthrosis. (Ex. 62). In a partial denial issued March 2, 1994, the insurer denied compensability of any "right L5-S1 degenerative arthropathy or osteoarthrosis." (Ex. 74). Specifically, the insurer denied that the degenerative disease was causally related to claimant's August 1993 industrial injury, or that work activities were the major contributing cause of that condition. (Id.). In a later partial denial issued August 5, 1994, the insurer reiterated its denial of right-sided L5-S1[1] degenerative arthropathy or osteoarthrosis, and indicated that it was also accepting "an L5-S1 disc condition." (Ex. 83). Claimant requested a hearing, contending that the L5-S1 arthropathy or osteoarthrosis condition was compensable.

In order to establish a compensable injury, claimant must prove that an accidental injury at work was a material contributing cause of his disability or need for treatment. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Alternatively, in order to prove a compensable occupational disease, claimant must show that work activities were the major contributing cause of his disability or need for treatment. ORS 656.802.

In light of the nature of claimant's condition and its potential relationship either to a specific work incident or to work activities generally, we find that the question of causation is medically complex and requires expert medical opinion to resolve. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). It is claimant's burden to prove the compensability of his condition by a preponderance of the evidence. ORS 656.266; Hutcheson v. Weyerhaeuser, 288 Or 51, 55 (1979). Medical evidence must be expressed in terms of reasonable medical probability, rather than mere possibility, in order to establish a causal connection. Gormley v. SAIF, 52 Or App 1055, 1059-60 (1981).

Claimant's initial treating physician, Dr. Poulson, did not specifically address the compensability of the right-sided L5-S1 degenerative condition, as distinguished from the accepted left-sided L5-S1 herniated disc. Therefore, Dr. Poulson did not offer an opinion as to the relationship, if any, between the right-sided L5-S1 arthropathy or osteoarthrosis and the 1993 work incident, the accepted claim arising out of that incident, or work activities generally.

---

[1] The denial reads "L4-S1" (Ex. 83), but the parties stipulated that it should read "L5-S1." Opinion and Order at 2.

Dr. Mata, claimant's subsequent treating physician, opined that the August 1993 work injury may have worsened claimant's preexisting degenerative disease in his lower back. (Ex. 85-4). However, an opinion expressed in terms of possibility, rather than medical probability, is insufficient to carry claimant's burden of proof. See Gormley, supra.

Accordingly, we conclude that claimant has failed to carry his burden of proving either that the 1993 work incident was a material contributing cause of his right-sided L5-S1 arthropathy or osteoarthrosis, or that work activities were the major contributing cause of that condition. Therefore, the insurer's partial denials of the right-sided L5-S1 arthropathy or osteoarthrosis will be reinstated and upheld.

In so holding, we reject claimant's argument on review that in accepting the "L5-S1 disc," the insurer accepted all pathology at that level. In light of the specific denial the insurer issued shortly before its acceptance, we find that the insurer did deny the specific condition described as "right L5-S1 degenerative arthropathy or osteoarthrosis." (See Exs. 83, 84). Nevertheless, we agree that the insurer's acceptance of an "L5-S1 disc" was general. Thus, we interpret the insurer's denial narrowly as pertaining solely to the identified condition: right L5-S1 degenerative arthropathy or osteoarthrosis. Accordingly, our decision upholding the insurer's denial is strictly limited to that condition. In other words, we interpret the insurer's acceptance as encompassing the L5-S1 disc, except for the specific condition identified in its partial denials.

Attorney Fees

The ALJ awarded claimant a $2,000 attorney fee for his counsel's services in obtaining a pre-hearing rescission of the denial of his L5-S1 herniated disc. The insurer contends that the attorney fee award is excessive. We affirm the ALJ's award.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $2,000 is a reasonable fee in this case. We particularly note the factors identified by the ALJ, including the time devoted to the case, the expertise of claimant's counsel, the value to claimant of the interest involved, and the risk that claimant's attorney's efforts might go uncompensated. We also specifically note, as did the ALJ, claimant's counsel's participation in a lengthy deposition and other evidence-gathering relevant to the issue involved in the denial. Accordingly, we affirm the ALJ's attorney fee award for claimant's counsel's services in obtaining rescission of the L5-S1 disc denial.

The ALJ awarded claimant a total attorney fee of $3,000. Given that $2,000 of the fee was allocated to claimant's counsel's services in obtaining rescission of a denial, the remainder must be allocated to claimant's counsel's services regarding compensability of the right-sided L5-S1 degenerative condition. Because we have found that condition not compensable, we reverse that portion of the ALJ's attorney fee award which awarded claimant a fee of $1,000 for his counsel's services regarding compensability of the right-sided L5-S1 degenerative condition.

ORDER

The ALJ's order dated January 4, 1995 is affirmed in part and reversed in part. That portion of the ALJ's order which set aside the insurer's partial denials of claimant's right-sided L5-S1 degenerative condition is reversed. The insurer's partial denial of March 2, 1994 is reinstated and upheld. The ALJ's attorney fee award in the amount of $1,000 is reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
**DELORES LOVING, Claimant**
WCB Case No. 94-10671
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its "back-up" denial of claimant's claim for bilateral plantar fasciitis; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are "back-up" denial, compensability and penalties. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the Findings of Ultimate Fact. The pertinent facts are as follows:

Claimant has worked as a stocker for the employer for five years. She developed pain in both of her feet in January 1994. On February 4, 1994, claimant sought treatment with Dr. Irvine. Dr. Irvine diagnosed bilateral plantar fasciitis, and referred claimant to a physician in the employer's managed care organization (MCO).

The employer accepted claimant's claim for plantar fasciitis on March 17, 1994. After it issued this acceptance, the employer received records from claimant's March 8, 1994 treatment with Dr. Kennedy, a podiatrist in the employer's MCO. In this initial treatment, Dr. Kennedy took the position that claimant's condition was due to the abnormal structure of her foot and micro tearing of the plantar fascia, and not necessarily her work situation.

In reliance on Dr. Kennedy's March 8, 1994 chart note, the employer issued a "back-up" denial on July 21, 1994.

## CONCLUSIONS OF LAW AND OPINION

### Propriety of the "Back-up" Denial

Under ORS 656.262(6), if a carrier accepts a claim in good faith and "later obtains evidence" that the claim is not compensable, it may revoke its acceptance of a claim and issue a denial as long as the denial is issued no more than two years after the date of the initial acceptance. If the worker requests a hearing on the "back-up" denial, the carrier has the burden of proving the claim is not compensable.[1]

In this case, the ALJ determined that although the employer did not receive Dr. Kennedy's March 8, 1994 chart note until after it accepted the claim, the chart note was not "later obtained evidence" within the meaning of ORS 656.262(6). Relying on CNA Ins. Co. v. Magnuson, 119 Or App 282 (1993), the ALJ reasoned that Dr. Kennedy's opinion was not based on any new factual information not known to the employer at the time of acceptance, and therefore it was only a "reevaluation" of claimant's condition, which does not constitute "later obtained evidence." The ALJ also noted that because the employer was aware before it accepted the claim that claimant had been referred to an MCO physician, it could have obtained Dr. Kennedy's chart note prior to the time it accepted the claim.

On review, the employer challenges that ALJ's characterization of Dr. Kennedy's report as a "reevaluation" of earlier obtained evidence. The employer argues that Dr. Kennedy's report is a report

---

[1] ORS 656.262(6) was amended by SB 369. Or Laws 1995, ch 332 § 28(6)(a) (SB 369, § 28(6)(a)). The amended version changed the burden of proof in "later obtained evidence" cases from "clear and convincing" to "a preponderance of the evidence." Because SB 369 is intended to be retroactive and since no relevant exceptions to this retroactivity requirement are present, we apply the amended version of ORS 656.262(6)(a) in this case. See Volk v. America West Airlines, 135 Or App 565 (1995).

from a new physician which incorporates both historical information and new, first-hand information based on that physician's examination of claimant. The employer also argues that it had no reason nor any obligation to seek out Dr. Kennedy's opinion before accepting the claim, and that it acted reasonably once it received Dr. Kennedy's note indicating claimant's condition was not compensable.

We need not decide in this case whether Dr. Kennedy's report constitutes "later obtained evidence" for purposes of ORS 656.262(6) because even if it does, we would find that the employer has failed to sustain its burden of proof on the noncompensability of claimant's condition.

Subsequent to his March 8, 1994 assessment, Dr. Kennedy indicated that the major contributing cause of claimant's foot pain was her work activities. (Ex. 11). In a supplemental report, Dr. Kennedy explained why his opinion had changed. He initially did not ask claimant about when her pain subsided. When he subsequently learned that claimant did not experience pain on weekends and vacations, he concluded that work was the major causative agent. He further explained that the long hours of standing on a hard surface had a cumulative effect: over time the foot structure gives way and the pain begins. (Ex. 18).

Dr. Marble, who examined claimant at the employer's request, opined that claimant's problems resulted from the broadness of her feet, and the fact that she is active and obese. Dr. Marble noted that he could not ascribe claimant's work as the major cause of her complaints because she had worked in the same capacity for the prior four years without complaint. Unlike Dr. Kennedy, Dr. Marble does not address the fact that claimant's pain subsided when she was off of work.

Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). When the medical evidence is divided, 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).

Here, we see no persuasive reason not to defer to the opinion of treating Dr. Kennedy, who had the opportunity to observe the claimant over an extended period of time. Although his current medical opinion differs from his original assessment, we find his change of opinion to be reasonable in light of his explanation. See Kelso v. City of Salem, 87 Or App 630, 633 (1987). Therefore, his initial March 8, 1994 chart note does not undermine his current medical opinion that the major cause of claimant's condition is the hard surface and long hours of standing at her job, rather than her weight and foot structure.

Consequently, we find that the employer has not established by a preponderance of the evidence that claimant's plantar fasciitis is not compensable. Amended ORS 656.262(6)(a). We therefore affirm the ALJ's ultimate conclusion that the employer's "back-up" denial must be set aside.

Penalty

The ALJ determined that claimant was entitled to a penalty because the employer's "back-up" denial was unreasonable under Darwin G. Widmar, 46 Van Natta 1018 (1994), aff mem Alexsis Risk Management v. Liberty Northwest Ins. Co., 134 Or App 414 (1995) and Ralph E. Murphy, 45 Van Natta 725 (1993).

On review, the employer argues that the ALJ incorrectly equated the impropriety of "back-up" denial under ORS 656.262(6) with the "unreasonableness" standard of amended ORS 656.262(11)(a) (formerly numbered ORS 656.262(10)(a)). The employer argues that an incorrect "back-up" denial should not automatically trigger penalties in the absence of a truly unreasonable decision to issue the denial.

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." Amended ORS 656.262(11)(a). The standard for determining unreasonable resistance to the 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) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). 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 employer at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

In this case, the employer may have had a legitimate doubt about its liability at the time it issued the "back-up" denial. It received an unsolicited chart note by treating Dr. Kennedy indicating that claimant's condition was not necessarily work-related and, based on that report, the employer could have had a colorable argument that this report constituted "later obtained evidence" under ORS 656.262(6).[2] We need not resolve that question, however, because any legitimate doubt about liability that the employer may have had was destroyed when the employer subsequently received Dr. Kennedy's July 20, 1994 letter. See Brown v. Argonaut Ins. Co., supra (continuation of the denial in light of new medical evidence becomes unreasonable if the new evidence destroys any legitimate doubt about liability).

In his July 20, 1994 report, Dr. Kennedy indicated that the major contributing cause of claimant's pain was her work. Dr. Kennedy also explained why his opinion had changed from his original assessment:

> "Although she has a foot type which could be more susceptible to plantar fasciitis, she has never experienced this pain before and once she is off work, to include weekends and vacations, her pain is gone. Since not all people with this foot type get plantar fasciitis and since the pain is only caused by her being at work and on these hard surfaces, it is my opinion that the major contributing cause of her pain is work." (Ex. 11).

Given Dr. Kennedy's well-explained change of opinion and the absence of any other evidence at that time which indicated that claimant's condition was not work-related, we conclude that the employer's continuation of the "back-up" denial was not supported by a legitimate doubt regarding its liability for the claim. Consequently, we consider the denial unreasonable. Dr. Marble's report, which related claimant's condition to her foot structure and weight, does not reestablish a reasonable foundation for the "back-up" denial. This report was subsequently generated at the employer's request and was essentially a reevaluation of claimant's unchanged condition. It does not, therefore, constitute "later obtained evidence." See John J. Rice, supra. Under these circumstances, we affirm the ALJ's penalty award.

Attorney Fee On Review

Claimant's attorney is entitled to an assessed fee for services on review regarding the "back-up" 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 issue is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services devoted to the penalty issue. Saxon v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated "March 14, 1994(sic)"[3] is affirmed. For services on review regarding the "back-up" denial issue, claimant's attorney is awarded $1,000, to be paid by the employer.

---

[2] See, e.g., Debra L. Rollini, 45 Van Natta 960 (1993) (no basis to assess a penalty for an unreasonable "back-up" denial where the employer received an anonymous call concerning the authenticity of claimant's injury claim, but could not prove under former ORS 656.262(6) that the claim was not compensable); but see John J. Rice, 46 Van Natta 984 (1994) (a "post-acceptance" insurer-arranged medical opinion did not constitute "later obtained evidence" where the claimant's condition had not changed and the later medical opinion related to the same circumstances known at the time of claim acceptance); Darwin G. Widmar, supra, aff mem Alexsis Risk Management v. Liberty Northwest Insurance Corporation, supra, (indicating in dicta that a subsequently obtained doctor's report was not "later obtain[ed] evidence" because the carrier was aware that this doctor had been treating the claimant and could have obtained his records before accepting the claim).

[3] Inasmuch as the hearing was convened on December 1, 1994, we conclude that the date stated on the ALJ's order contains a typographical error. In other words, the ALJ's order issued on March 14, 1995, not March 14, 1994.

In the Matter of the Compensation of
**ALAN E. NIX, Claimant**
WCB Case No. 94-00546
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys

Reviewed by Board Members Neidig, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that found that he was not a subject worker. On review, the issue is subjectivity. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

In July 1993, claimant injured his right shoulder when he was thrown from a horse and landed on his shoulder. (Ex. 1). On November 23, 1993, the Department of Consumer and Business Services found that claimant was not a subject worker of Dr. Block, veterinarian, at the time of the alleged injury. (Ex. 3). Claimant requested a hearing on the Department's subjectivity order. See OAR 438-06-038. The ALJ applied the "right to control" test and concluded that claimant was not a "worker."

Claimant argues that the ALJ misapplied the "right to control" test and erred by not addressing all of the criteria in ORS 670.600.

When deciding whether a person comes under the workers' compensation law, the first inquiry is whether the person is a "worker" under ORS 656.005(30)[1] and the judicially created "right to control" test and, if so, whether the worker is "nonsubject" under one of the exceptions in ORS 656.027. S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 614, 630-31 (1994). If the relationship between the parties cannot be established by the "right to control" test, it is permissible to apply the "nature of the work" test. Id. at 622 n 6.

The principal factors to be considered under the "right to control" test are: (1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. Castle Homes, Inc. v. Whaite, 95 Or App 269, 272 (1989). None of those factors is dispositive; rather, they are to be viewed in their totality. Cy Investment, Inc. v. Natl. Council on Comp. Ins., 128 Or App 579, 583 (1994).

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

With respect to the first factor, the pertinent consideration is Dr. Block's control over the method of performance, as opposed to control over the result to be reached. See id.

Dr. Block owned a licensed training track for race horses and was in the business of raising and training horses. (Tr. 8). Dr. Block also boarded horses. Dr. Block asked claimant to exercise some of the horses. (Tr. 11, 12). Dr. Block testified that claimant set his own consideration and the parties agreed that claimant would receive $5 per ride. (Tr. 14, 20).

Claimant testified that he could only ride Dr. Block's horses in the afternoon. (Tr. 21). Dr. Block said that the arrangement was that claimant would ride in Washington in the morning and ride for Dr. Block in the afternoon. (Tr. 53). Claimant had been exercising horses in Washington, working for six or seven trainers. (Tr. 17, 48, 49). That work ended because the track was rained out. (Tr. 19). Claimant hoped that those horses would be "going back to work" again when the track was suitable. (Tr. 48). At the time claimant was working for Dr. Block, claimant also had an arrangement to do work for one other horse owner at the same location. (Tr. 27).

---

[1] We note that ORS 656.005(28) was renumbered to ORS 656.005(30). Or Laws 1995, ch 332, § 1 (SB 369, § 1).

Claimant testified that Dr. Block told him what to do, how fast to go, how far to go, and if he needed to go through the starting gates. (Tr. 23, 65). Dr. Block agreed that he told claimant about each horse and what stage of training they were in, including the type of saddle being used. (Tr. 54). Dr. Block told him how far he wanted each horse to be ridden. (Tr. 14). Dr. Block also told him the peculiarities of each horse and told him he did not have to ride any horse he did not want to. (Tr. 54).

Dr. Block testified that claimant set his own schedule and they worked around claimant's schedule. (Tr. 13, 59). On one day, although claimant was supposed to work on a Monday, he did not return until Tuesday. (Tr. 55). Dr. Block testified that, on the day of the injury, he was skeptical about claimant's use of a flat saddle with one of the horses, but claimant assured him he could handle the horse. (Tr. 55). Dr. Block testified that claimant was hired to "put the race in these horses." (Id.)

Claimant initially testified that he never rode unless Dr. Block was there and he never decided how to exercise one of the horses by himself. (Tr. 22, 25, 26). However, claimant later acknowledged that he rode one day when Dr. Block was not present. (Tr. 50). Claimant worked for Dr. Block only a few days before he was injured.

Claimant argues that Dr. Block exercised control over him because he told claimant how to exercise each horse, what type of saddle to use and how far to ride each horse. Claimant contends that the situation was analogous to a teaching situation in that Dr. Block advised claimant of his expectations and claimant attempted to achieve them to Dr. Block's satisfaction.

The ALJ found, and we agree, that Dr. Block's input was informational in nature and designed to assist claimant in carrying out his exercise duties in a safe manner. Based on claimant's testimony, the type of instruction Dr. Block provided is customary in this type of business. Claimant testified that a trainer tells him how he wants the horse to go and will usually tell him the peculiarities of a horse so that he could decide whether he wanted to ride the horse. (Tr. 40).

Claimant also testified that Dr. Block gave him the impression that he had respect for claimant's abilities. (Tr. 67). Claimant did not feel that Dr. Block was an expert in exercising horses, but he was trying. (Tr. 25). In light of claimant's testimony, we are not persuaded by his argument that Dr. Block exercised control over the method of claimant's performance.

Moreover, although claimant asserts that Dr. Block exercised control over him, claimant acknowledged that he rode one day when Dr. Block was not there. In addition, claimant set his own schedule and was not required to adhere to it. Flexibility in scheduling is generally not indicative of employee status. See McQuiggin v. Burr, 119 Or App 202 (1993). Furthermore, the fact that claimant also exercised horses for other people suggests that he was not an employee.

Under these circumstances, we are not persuaded that Dr. Block exercised direct control over claimant's method of performance. Consequently, the first factor is not indicative of an employee-employer relationship.

Method of Payment

The ALJ found that the method of payment was on a per ride basis and that there was no evidence of payroll deductions or other indicia of employer-employee status. When payment is by quantity, rather than by unit of time, the method of payment factor is neutral. Kaiel v. Cultural Homestay Institute, 129 Or App 471, 476, rev den 320 Or 453 (1994). We agree with claimant that this factor is inconclusive.

Furnishing of Equipment

Claimant argues that the essential equipment was provided by Dr. Block, or, alternatively, he contends that this factor is not relevant because both parties provided essential equipment.

Claimant provided his own safety equipment, including a riding helmet, chaps and whip. (Tr. 20). Claimant testified that he used his own helmet because if the helmet did not fit properly, it could cause more damage. (Id.) He also testified that the chaps had to fit correctly to save his legs from wear and tear from buckles and saddles. (Id.) Claimant testified that the trainers supply the saddle, the bridle and the horse. (Tr. 40). Here, Dr. Block provided the saddle, bridle, brushes and horses. (Tr. 23).

If claimant had furnished all of his own equipment, that factor could be indicative of independent contractor status. See Reforestation General v. Natl. Council on Comp. Ins., 127 Or App 153, 169 (1994). Here, however, since both parties provided equipment, we find that this factor is inconclusive in determining claimant's "worker" status.

Right to Fire

We also find that the "right to fire" factor is inconclusive. Claimant testified that the time period of employment was "sort of an indefinite deal." (Tr. 32). Claimant's understanding was that if Dr. Block needed him and if he was doing a good job, he would keep working for at least 60 to 90 days. (Tr. 32, 33). Dr. Block testified that he "didn't have to ride [claimant] on my horses if I didn't want to, but [claimant] -- when he showed up and rode the horses, he was an excellent exercise rider." (Tr. 61). Dr. Block said that there was "no reason to fire him as long as he showed up." (Id.)

In summary, we find the "right to control" test does not establish whether claimant was a "worker" under ORS 656.005(30). When the evidence under the "right to control" test is insufficient to establish the relationship between the parties, application of the "nature of the work" test is permissible. S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra, 318 Or at 622 n.6; Woody v. Waibel, 276 Or 189, 197-98 (1976).

Nature of the Work

Under the "nature of the work" standard, several factors are considered. They include: (1) the character of the claimant's work; i.e., how skilled it is, how much of a separate calling it is and the extent to which it may be expected to carry its own accident burden; and (2) the relationship of claimant's work to the employer's business; i.e., how much it is a part of the employer's regular work, whether it is continuous or intermittent and whether the duration is sufficient to amount to the hiring of continuing services, as distinguished from contracting for completion of a particular job. Woody v. Waibel, supra, 276 Or at 195.

The modern tendency is to find employment when the work being done is an integral part of the regular business of the employer and when the worker, relative to the employer, does not furnish an independent business or professional service. 1B Larson, Workmen's Compensation Law 8-193, § 45.00 (1995). The line is crossed to independent contractorship when the service is part of a general professional service held out to the public. Id. at 8-255, § 45.32(c).

Claimant worked part time and set his own schedule. Claimant was not required to ride only when Dr. Block was present. That evidence suggests that claimant was not an employee. See McQuiggin v. Burr, supra.

Moreover, claimant exercised horses for other people, which suggests that the services claimant provided constituted a separate business or enterprise. As we discussed earlier, before working for Dr. Block, claimant had been exercising horses in Washington, working for six or seven trainers. That work ended because the track was rained out. Dr. Block testified that the arrangement was that claimant would ride in Washington in the morning and ride for Dr. Block in the afternoon. Claimant testified that he could only ride Dr. Block's horses in the afternoon and he apparently hoped to go back to work in Washington when the track was suitable. In addition, while claimant was working for Dr. Block, claimant also had an arrangement to do work for one other horse owner at the same location. Those facts indicate that claimant operated an independent business, which is indicative of independent contractorship. See 1B Larson, supra, at 8-237, § 45.32(c).

Based on all the evidence, we conclude that, under the "right to control" and the "nature of the work" tests, claimant was not a worker. Because we have found that claimant was not a subject worker, we need not determine whether any of the exceptions to coverage listed in ORS 656.027 apply. See S-W Floor Cover Shop v. Natl. Council on Comp. Ins., supra, 318 Or at 630. Accordingly, we conclude that claimant was not a "worker" when he was injured.

ORDER

The ALJ's order dated February 28, 1995 is affirmed.

**Board Member Hall dissenting.**

The majority erroneously concludes that the "right to control" test does not establish that claimant was a "worker." The majority also errs by addressing whether claimant rode for others in the course of analyzing the "right to control" factors. Because I disagree with the majority's conclusion that claimant was not a "worker," I respectfully dissent.

The test for determining "control" is based not on the actual exercise of control, but on the right to control. S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 614, 622 (1994). In this case, Dr. Block clearly had the right to control claimant's work activities. Dr. Block was responsible for caring for the horses and thus retained control over the handling of the horses, including claimant's riding. Dr. Block told claimant how to exercise each horse, what type of saddle to use and how far to ride each horse. The fact that Dr. Block could fire claimant without suffering any liability also supports the conclusion that claimant was a subject worker.

---

October 26, 1995 Cite as 47 Van Natta 2085 (1995)

In the Matter of the Compensation of
**NORVAL W. PARK, Claimant**
WCB Case Nos. 94-02420, 93-11637 & 93-05792
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys
Garrett, Hemann, et al, Defense Attorneys
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Gunn and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Daughtry's order that upheld Safeco Insurance Company's denial of his current low back condition claim. On review, the issues are scope of acceptance and compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the last two paragraphs and with one modification. We change the first sentence in the fourth paragraph to reflect that claimant was diagnosed with a low back strain and grade I spondylolisthesis of the L5-S1 level.

## CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back in September 1982 while working for Safeco's insured. He was diagnosed with a low back strain and grade I spondylolisthesis of the L5-S1 level. An October 28, 1986 Opinion and Order awarded 50 percent permanent disability for claimant's "back condition." (Ex. 25).

Claimant worked for Allied Auto Supply from 1985 to 1993. Claimant's back continued to bother him. In 1990, claimant was treated for a "flare up" in his back. In 1993, claimant had more frequent back pain and he was treated by Dr. Lewis. Since claimant's spondylolisthesis was more symptomatic and disabling, Dr. Lewis recommended a decompression and fusion at L5-S1. (Ex. 37).

At hearing, the ALJ found that Safeco had accepted a strain in 1982. The ALJ concluded that claimant did not meet his burden of proving that the 1982 injury was the major contributing cause of his current disability and need for treatment.

On review, claimant argues that Safeco is precluded from denying that his spondylolisthesis is part of his compensable claim. Citing Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995), claimant contends that part of his unscheduled permanent disability award was for his preexisting spondylolisthesis. According to claimant, since Safeco did not appeal the Opinion and Order awarding additional permanent disability, it is now precluded from denying compensability of his spondylolisthesis.

Safeco responds that Messmer v. Deluxe Cabinet Works, supra, is distinguishable and, in any event, amended ORS 656.262(10) effectively overrules Messmer. Or Laws 1995, ch 332, § 28(10) (SB 369, § 28(10)).

We must first determine the scope of Safeco's acceptance. The ALJ found that, although there was no written acceptance, the contemporaneous medical evidence indicated that the accepted condition was a strain. The ALJ found that the 1982 injury was diagnosed as a strain and there was no showing that the underlying spondylolisthesis condition was treated. The ALJ rejected claimant's argument that Safeco had accepted claimant's spondylolisthesis. We disagree with the ALJ's reasoning and conclusion.

If a carrier accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms. Georgia Pacific v. Piwowar, 305 Or 494(1988). When the acceptance does not identify the specific condition, we look to the contemporaneous medical records to determine what condition was accepted. Timothy Hasty, 46 Van Natta 1209 (1994); Cecilia A. Wahl, 44 Van Natta 2505 (1992).

In Emmert v. City of Klamath Falls, 135 Or App 209 (1995), the claimant argued that because the carrier had previously accepted his "severe chest pains" claim, the carrier was precluded from subsequently denying the coronary artery disease because the disease had been the cause of the chest pains. Reasoning that the notice of acceptance (which used codes which stood for "unclassified" and "chest, including ribs, breast bone, and internal organs of the chest") had not specified a particular condition, the court concluded that the acceptance must be read as constituting an acceptance of the claim as filed, which was for severe chest pain. Because the Board did not determine what caused claimant's chest pain, the court remanded for reconsideration.

Here, claimant was injured on September 23, 1982 when he was shoveling dirt. He stated on the "801" form that he "snapped something in back" and the part of his body affected was "lower back." (Ex. 9). The claim was deferred as a disabling injury on the "801" form.

A chart note dated September 27, 1982, apparently from Dr. Weeks, diagnosed low back strain. (Ex. 5). A chart note dated September 28, 1982 described "grade 1 spondylolisthesis of the L5-S1 level." (Id.) Dr. Weeks referred claimant to Dr. Anderson, orthopedic surgeon.

Dr. Anderson examined claimant on September 29, 1982 and noted that claimant had had treatments for his back at least 12 times in the past year and frequently it would take 2 weeks for him to be relieved of symptoms. (Ex. 8). Dr. Anderson's impression was "[s]pondylolisthesis with osteoarthritic lumbosacral spine." (Id.) He recommended conservative treatment and advised claimant that surgery could be necessary.

On October 18, 1982, Dr. Anderson reported that claimant was having fewer muscular symptoms but continued to have the catching sensation in his back. (Ex.8). Dr. Anderson believed claimant had made reasonable progress. Claimant apparently was concerned because in the past he had had chiropractic manipulation and would be well within a day or two. (Id.) Dr. Anderson reported that "in [his] experience with spondylolisthesis and muscle spasm it doesn't respond that rapidly and I feel his progress has been normal or even a little faster than normal." (Id.) Claimant was to return for another examination in six weeks. On November 1, 1982, Safeco indicated on a "1502" form that it had accepted the claim. (Ex. 11).

The foregoing medical reports indicate that claimant had been diagnosed and treated for spondylolisthesis and that claimant's spondylolisthesis condition was contributing to his back pain.[1] By accepting claimant's claim that he "snapped something in [his] back," Safeco's acceptance was not limited to a specific diagnosis, such as a low back strain. By not including an adequate degree of specificity in its acceptance, Safeco accepted all the causes of claimant's back symptoms, including the spondylolisthesis condition. See Georgia Pacific v. Piwowar, supra; Emmert v. City of Klamath Falls, supra.

[1] We note that the October 28, 1986 Opinion and Order that decided claimant's extent of disability described claimant's accepted condition as a "back condition." (Ex. 25). Contrary to Safeco's assertion that the order did not refer to claimant's spondylolisthesis, the order discussed the medical reports diagnosing claimant's spondylolisthesis condition.

We find that claimant's current spondylolisthesis condition is the same as the prior accepted condition. Therefore, Safeco's May 7, 1993 and August 4, 1993 denials that denied claimant's current condition constituted "back-up" denials of compensability. Insofar as the Safeco's denials are an attempt to back-up deny the spondylolisthesis condition, they are invalid because they were issued more than two years after claim acceptance and the denials were not based on fraud, misrepresentation or other illegality by claimant. See amended ORS 656.262(6)(a). SB 369, § 28(6). Consequently, we conclude that Safeco's "back-up" denials are invalid and we set them aside.

Because we have concluded that claimant's spondylosisthesis condition was accepted by Safeco, it is not necessary to address claimant's argument that Messmer v. Deluxe Cabinet Works, supra, applies to this case.[2]

Claimant's counsel is entitled to attorney fees for services at hearing and on review concerning the issue of compensability. 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 is $4,000, to be paid by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

## ORDER

The ALJ's order dated September 26, 1994 is reversed. Safeco's denials of compensability are set aside and the claim is remanded to Safeco for processing in accordance with law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $4,000, to be paid by Safeco.

---

[2] We note that our decision is based on the fact that claimant's current spondylolisthesis condition was accepted in 1982, and our decision is not based on claimant's assertion that he was later awarded permanent disability benefits for his preexisting spondylolisthesis condition. For that reason, we need not address whether amended ORS 656.262(10) applies to this case. (SB 369, § 28(10).

Furthermore, there is no need to remand this case for the parties to comply with amended ORS 656.262(6)(d), which provides, 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, § 28(6)(d). Since Safeco has contested whether claimant's spondylolisthesis condition has been accepted or is compensable, we conclude that it would not achieve substantial justice to remand this case for compliance with amended ORS 656.262(6)(d).

In the Matter of the Compensation of
**BUDDY R. REYNOLDS, Claimant**
WCB Case No. 94-10182
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

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

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

Under ORS 656.005(7)(a), claimant must prove both elements of the work-connection inquiry, the "in the course of employment" element and the "arising out of" element. Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1993). In this case, claimant's injury happened in the course of his employment because his fall occurred at work. The pivotal issue is whether claimant has also established the "arising out of" element, i.e., the causal connection between his injury and the employment.

In upholding SAIF's denial, the ALJ found that, on the entire record, it was just as likely claimant's injury occurred because his right knee gave way due to his preexisting knee weakness as it was that he caught his toe on a protruding drain cap in the employer's parking lot. We agree.

On the 801 Form, completed the day of his injury, claimant reported that his "knee went out" while taking out the garbage. He told the emergency room physician that he had a twisting sensation in his right knee and his knee gave out. Claimant did not mention tripping or catching his toe, and the emergency room report noted that he had no other injuries from the fall. Claimant similarly reported to his treating physician, Dr. Thompson, that his knee gave way, and did not describe tripping over any object on the parking lot surface. He indicated that he had experienced intermittent knee laxity as a result of a prior right knee injury and anterior cruciate ligament reconstruction surgery.

At hearing, claimant testified that he could not remember exactly how his fall occurred. He only remembered falling forward, twisting his knee, and hitting the ground. He further testified that on or about September 10, 1994, when he and his wife returned to the area of his fall, seeing the drain cap caused him to recall that he caught his toe.

We find it significant that, even after claimant allegedly remembered that he had caught his toe, he did not report this information to Dr. Thompson. Dr. Thompson testified that he specifically questioned claimant regarding the circumstances of the fall on October 4, 1994, prior to claimant's arthroscopic surgery, and that claimant maintained that his knee had given out.

On this record, we cannot find that a preponderance of the evidence supports claimant's contention that his fall resulted from tripping over the drain cap.[1] Accordingly, claimant has failed to establish that his injury was sufficiently related to his employment to be compensable. See Norpac Foods, Inc. v. Gilmore, supra; James Hoffman, 47 Van Natta 394 (1995).

ORDER

The ALJ's order dated March 31, 1995 is affirmed.

---

[1] Claimant argues on review that in the absence of a specific adverse credibility finding, his testimony at hearing should be considered more reliable than his conflicting statements in the medical record. Like the ALJ, we do not decide this case on the basis of claimant's credibility or lack thereof, but on his failure to prove that his injury was work-connected by a preponderance of the evidence. See ORS 656.005(7)(a); ORS 656.266. We note that even at hearing, claimant did not unequivocally testify that his injury resulted from a hazard or condition associated with his work. At one point, claimant stated that he could not testify as to "exactly" what happened when he fell because he "honestly" did not know. Under further questioning, he testified only that he felt he "tripped over something" because he remembered "catching [his] toe." In the absence of affirmative proof that his injury was, in fact, related to his work environment, his claim is not compensable. See Ruben G. Rothe, 45 Van Natta 369 (1993).

In the Matter of the Compensation of
**ELIZABETH A. SHIELDS, Claimant**
Own Motion No. 95-0147M
OWN MOTION ORDER
Gary L. Tyler, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

On September 7, 1993, the self-insured employer voluntarily reopened claimant's compensable 1984 cervical injury claim for the payment of temporary disability compensation. Claimant's aggravation rights on that claim expired on August 25, 1991.

On November 11, 1993, the employer issued a Notice of Closure, which terminated payment of temporary disability to claimant. Claimant had not undergone surgery or inpatient hospitalization, nor had the Board, under its own motion authority, authorized the payment of temporary disability compensation to claimant under this claim. Claimant requested a hearing with the Hearings Division concerning her entitlement to further temporary disability benefits from November 11, 1993 through the present. (WCB Case No. 93-14248).

By Opinion and Order dated January 13, 1995, Administrative Law Judge (ALJ) McCullough dismissed claimant's hearing request, concluding that the Hearings Division did not have jurisdiction over the temporary disability issue in this case. Further, the ALJ concluded that jurisdiction rested with the board under its "own motion" authority. Claimant requested Board review of ALJ McCullough's order, and in an order issued on today's date, the Board affirmed ALJ McCullough's order. However, as claimant is requesting temporary disability benefits, we treat this request as a request for own motion relief, and proceed to consider claimant's request.

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

On September 7, 1993, Dr. Brett, claimant's treating physician, recommended that claimant undergo surgery for her compensable cervical condition, opining that surgery was related to her original work injury. The employer voluntarily reopened claimant's 1984 claim, and began paying temporary disability compensation from the date claimant was taken off work.

Following Dr. Brett's surgery recommendation, claimant was evaluated by several other surgeons, and doubts were expressed regarding the advisability of surgery. By the end of 1993, claimant had not had the surgery.

In January 1994, claimant was involved in a motor vehicle accident which caused a worsening of her cervical condition. Following the accident, she returned to see Dr. Brett, who again recommended surgery. However, Dr. Brett further indicated that claimants need for surgery was due to the motor vehicle accident. That surgery was finally performed in March 1994.

The employer voluntarily paid claimant temporary disability compensation beginning the date Dr. Brett took her off work. As cited previously, we are only authorized to grant temporary disability benefits from the date a claimant is actually hospitalized or undergoes surgery. Claimant did not undergo surgery until March of 1994. In this or any case, the insurer/employer is permitted by ORS 656.278(4) to voluntarily reopen an own motion claim, and it is within the employer's discretion to do so. See OAR 438-12-030(2); Allen E. Orton, 42 Van Natta, 924 (1990). However, subsequent authorization of such benefits will not be granted by the Board unless the claim qualifies for own motion relief under ORS 656.278 and the Board's rules. Here, the payment of temporary disability benefits to claimant were made prior to her surgery date. As a result, we are unable to authorize the employer's gratuitous payment of temporary disability compensation from September 7, 1993 through November 10, 1993, prior to claimant's surgery. See ORS 656.278(1)(a); Wausau Ins. Companies v. Morris, 103 Or App 270 (1990); Tamara Frolander, 45 Van Natta 968 (1993).

Furthermore, because Dr. Brett opined that the March 1994 surgery was not a result of a work-related injury, and because the employer has not accepted the March 1994 surgery and claimant's current cervical condition as compensable, we are unable to authorize temporary disability compensation beginning in March of 1994. See Id. Accordingly, claimant's request for own motion relief is denied.

Finally, claimant requests a penalty and associated attorney fee based on the employer's "unreasonable termination of temporary disability compensation after November 10, 1993." Inasmuch as we have found that there was no compensation due at the time of the employer's alleged delay, the employer did not unreasonably resist the payment of compensation. Consequently, we are not authorized to assess a penalty or related attorney fee.

IT IS SO ORDERED.

---



In the Matter of the Compensation of
**ROY L. SUTTON, Claimant**
WCB Case No. 94-03770
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order which upheld the SAIF Corporation's denial of claimant's injury claim for an atrial flutter. On review, the issue is compensability.

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

Claimant contends that Dr. Kremkau has identified certain underlying factors which predispose claimant to atrial flutter. Therefore, claimant argues that these predisposing factors are not preexisting conditions or causes for the purpose of determining causation of claimant's atrial flutter. We disagree.

Subsequent to the ALJ's order, effective June 7, 1995, the legislature enacted Senate Bill 369, amending ORS 656.005. Or Laws 1995, ch 332, § 1 (SB 369, § 1).[1] The legislature added ORS 656.005(24), which states: "'Preexisting condition" 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 injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273." Accordingly, the factors referred to by Dr. Kremkau qualify as preexisting conditions and, thus, properly are considered when analyzing causation of claimant's atrial flutter.[2]

ORDER

The ALJ's order dated March 8, 1995 is affirmed.

---

[1] Section 1 of Senate Bill 369 retroactively applies to this case. SB 369, § 66; Volk v. America West Airline, 135 Or App 565 (1995) (retroactively applying amended ORS 656.386(1) pursuant to § 66(1)).

[2] While compelled to add atrial flutters to the ever expanding list of preexisting conditions under the current version of ORS 656.005(24), Board Member Gunn would note that the predisposing conditions which are used to reach that conclusion could not legally prohibit medical treatment under a health plan. In other words, the definition of preexisting condition under ORS 743.730(19) is a condition for which medical advice, diagnosis, care or treatment is recommended or received during the specified period. This dichotomy between the two statutory definitions could raise questions for providers who are health insurers under ORS 743.730. Although there is an exemption under ORS 740.702 for individual plans, no exemptions appear to exist for small employers who are covered by a health plan or an MCO.

In the Matter of the Compensation of
**DALE A. WARREN, Claimant**
WCB Case No. 94-07798
ORDER ON RECONSIDERATION
Dobbins, et al, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our Order on Review in this matter, issued May 24, 1995. In that order, we reversed Administrative Law Judge (ALJ) Baker's order that declined to award temporary disability benefits. In doing so, we relied on SAIF v. Mize, 129 Or App 636, 639-40 (1994), and concluded that SAIF is bound by the express language of its acceptance, which accepted claimant's lumbar strain as a nondisabling injury, not an occupational disease. Because the claim was accepted as an injury, we found that, pursuant to ORS 656.210(2)(b)(A), claimant's temporary total disability (TTD) benefits are based on his at-injury wage.

On reconsideration, SAIF argues that we erred in relying on SAIF v. Mize, supra, in concluding that claimant's lumbar strain was accepted as an injury. SAIF argues that claimant's lumbar strain is an occupational disease and, as such, his TTD benefits should be based on his wage at the time of medical verification that he was unable to work due to the occupational disease pursuant to ORS 656.210(2)(b)(B).

On June 8, 1995, we withdrew our order for reconsideration. Claimant was granted 14 days within which to respond. Inasmuch as that 14-day period has expired and no such response has been forthcoming, we proceed with our reconsideration.

SAIF notes that we adopted the ALJ's findings of fact, which included a finding that "[t]here was no specific incident or accident." (Opinion and Order, page 1). However, the adopted findings also included a finding that "[t]he claim was accepted November 19, 1993 for nondisabling injury." Id. In order to make our findings clear, we further supplement the ALJ's findings of fact as follows: SAIF accepted claimant's lumbar strain as a nondisabling injury. (Ex. 6).

With that further supplementation, we adhere to our prior reasoning that, based on the Mize decision, SAIF is bound by the express language of its acceptance, which explicitly accepted the lumbar strain as a nondisabling injury. Therefore, we continue to find that, pursuant to ORS 656.210(2)(b)(A), claimant's TTD benefits are calculated using his at-injury wages. Accordingly, we continue to find that claimant is entitled to: (1) temporary partial disability (TPD) benefits from May 31, 1994 (the date he was medically restricted to working only 30 hours per week) through June 2, 1994; and (2) TTD benefits as of June 3, 1994 (the date he was laid off while he remained medically restricted to working only 30 hours per week). These benefits are to continue until SAIF may terminate them in accordance with the law.

We have found claimant entitled to temporary disability benefits as enumerated above. It is up to SAIF to process the claim, which includes determination of the correct rate of TPD.

Accordingly, we withdraw our May 24, 1995 order. On reconsideration, as supplemented herein, we republish our May 24, 1995 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**DAVID F. IERULLI, Claimant**
WCB Case No. 94-05929
ORDER ON REVIEW
Frank J. Susak, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Balasubramani's order that: (1) found that claimant's injury claim was not time barred; and (2) set aside its denial of that claim. On review, the issues are timeliness and whether claimant's injury arose out of and occurred in the course of his employment.

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

Claimant, a loan officer, drives to "open houses" on weekends to prospect realtors for the employer. Claimant was injured in a motor vehicle accident (MVA) while on his way to deliver information to a realtor (Jones). The ALJ reasoned that claimant's activity of taking data to Mr. Jones was a benefit to the employer, was contemplated by the employer, was an ordinary risk of employment, and was acquiesced in by the employer. The ALJ further found that if the activity resulted in business for the employer, claimant would have been paid a commission, and that claimant was not on a personal mission. Therefore, citing Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985), the ALJ concluded that claimant's activity at the time of the MVA arose out of and in the course of his employment.

Subsequent to the ALJ's order, the court issued its opinion in First Interstate Bank of Oregon v. Clark, 133 Or App 712, rev den 321 Or 429 (1995). In Clark, the court reiterated that the legal framework for determining whether an injury "arose out of" and "in the course of" employment included two prongs: (1) whether the injury occurred in the course of employment (considering time, place and circumstance); and (2) whether a causal connection existed between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994). The court concluded that the factors identified in Mellis should no longer be used as an independent and dispositive test of work-connection. Nonetheless, depending on the circumstances, the court further concluded that some or all of the Mellis factors would remain helpful inquiries under the Norpac Foods two-prong analysis. 133 Or App at 717. In view of Clark, we apply the two-prong analytical framework set forth in Norpac Foods, and consider any helpful Mellis factors.

We begin by examining whether claimant's injury arose "in the course of" employment. Generally, injuries sustained while traveling to and from an employee's regular place of employment are not considered to have occurred in the course of employment. SAIF v. Reel, 303 Or App 210 (1987). There are, however, exceptions to this "going and coming" rule.

One exception is the "traveling employee" rule. Claimant's job involved travel to contact business prospects/clients. Where travel is a part of employment, risks incident to travel are covered by the workers' compensation law even though the employee may not be working at the time of injury. Furthermore, employees whose work entails travel away from the employer's premises are within the course and scope of employment continuously during the trip, except when a distinct departure on a personal errand is shown. Proctor v. SAIF, 123 Or App 326, 330 (1993), citing 1A Larson, Workmen's Compensation Law 5-275, § 25.00 (1990).

The insurer asserts that: "That claimant may have made visits to open houses or worked in his office earlier would not establish that claimant was within the course of his employment at the time of the accident." (App. Br. at 10). Essentially, the insurer's argument is that claimant is not credible. The ALJ, however, found claimant credible. The finding of credibility is central. The ALJ observed claimant's attitude, appearance and demeanor while testifying, and the credibility finding is based on those observations. Under the circumstances, we defer to the ALJ 's demeanor-based credibility finding. See International Paper Co v. McElroy, 101 Or App 61 (1990). Moreover, on review, we find claimant's testimony was plausible, internally consistent and was corroborated by his attorney/father, former co-

worker Emery, and Mr. Jones.[1] Claimant was injured while traveling to deliver data to a client of the employer. Inasmuch as there is no evidence claimant was on a personal errand when the accident occurred, he has satisfied the "in the course of employment" element of the work-connection test.

Next, we consider whether claimant's injury "arose out of" his employment. 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.

Because claimant was injured while traveling to deliver information to a client, we find that claimant's conditions of employment put him in a position to be injured. Accordingly, claimant has established a causal link between the injury and his employment, thus satisfying the "arising out of employment" element of the work-connection test.

In sum, we agree that claimant's injury arose out of and occurred in the course of his employment. Therefore, we affirm the ALJ's decision setting aside the insurer's denial of claimant's claim.

Claimant is entitled to an attorney fee for his counsel's 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 Board 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 April 14, 1995 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the insurer.

---

[1] We recognize, as did the ALJ, that claimant initially reported this accident as nonwork-related to a private insurance carrier. That factor weighs against credibility. However, the evidence may prove a compensable injury, despite false statements by a claimant on related issues, where the evidence is, nevertheless, persuasive to establish that a compensable injury occurred. Taylor v. Multnomah School District #1, 109 Or App 499, 501 (1991); Mashadda v. Western Employers Insurance, 75 Or App 93, 96 (1985); Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985). Notwithstanding claimant's initial representation of the injury as nonwork-related (following the advice of two attorneys), we find the evidence persuasive that the MVA arose out of and occurred in the scope of claimant's employment.

---



In the Matter of the Compensation of
**BOYD H. McKIBBEN, Claimant**
WCB Case No. 94-11513
ORDER OF DISMISSAL
Alan L. Ludwick (Saif), Defense Attorney

Claimant, pro se, has requested Board review of Administrative Law Judge (ALJ) Nichols' September 6, 1995 order that dismissed his hearing request regarding a Director's September 14, 1994 order which had found claimant eligible for vocational assistance. We have reviewed the request to determine whether we have authority to proceed with our review of the ALJ's order. Because the record does not establish that the other parties to this proceeding timely received notice of claimant's request, we dismiss.

## FINDINGS OF FACT

A hearing was conducted on September 5, 1995 before ALJ Nichols. The issues at that hearing were the SAIF Corporation's appeal of a Director's vocational assistance order (WCB Case No. 94-11513) and claimant's appeal of an Order on Reconsideration (WCB Case No. 95-01772). At the hearing, the ALJ separated the two cases.

On September 6, 1995, the ALJ issued an Order of Dismissal in WCB Case No. 94-11513. Reasoning that jurisdiction over SAIF's appeal of the Director's vocational assistance order rested with the Director, the ALJ concluded that the Board lacked authority to consider the vocational assistance question. Parties to that order were claimant, One MCK Logging Co., and SAIF. The order contained a statement explaining the parties' rights of appeal, including a notice that copies of any request for Board review must be mailed to the other parties within the 30-day appeal period.

On September 25, 1995, the ALJ issued an Opinion and Order in WCB Case No. 95-01722. The ALJ affirmed the Order on Reconsideration "in all respects." Parties to that order were claimant, One MCK Logging Co., and SAIF. The order contained a statement explaining the parties' rights of appeal, including a notice that copies of any request for Board review must be mailed to the other parties within the 30-day appeal period.

On October 4, 1995, the Board received claimant's September 30, 1995 letter to the ALJ. Referring to the "appeal proceedings in the matter of Vocational Assistance," claimant requested paper work "to appeal the hearing held September 5, 1995." Specifically, claimant asserted that "I do not agree with the division [sic] made September 5, 1995 and wish to appeal that decision." Claimant's letter, which was not mailed by certified mail, did not indicate that copies had been provided to the other parties.

On October 10, 1995, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review of the ALJ's September 6, 1995 order in WCB Case No. 94-11513, as well as the ALJ's September 25, 1995 order in WCB Case No. 95-01772. Receipt of that acknowledgment constitutes SAIF's and its insured's first notice of claimant's request for Board review.

## CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.298(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2).

The failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or App 47, 51 (1985); Argonaut Insurance v. King, 63 Or App 847 (1983). All parties to the ALJ's order must be served or receive notice, even if the appealing party makes no claim as to the excluded party. Kelsey v. Drushella-Klohk NCE, 128 Or App 53, 57 (1994); Mosley v. Sacred Heart Hospital, supra.

Here, the 30th day after the ALJ's September 6, 1995 order was October 6, 1995. Therefore, the last day in which to timely file a request for review was Friday, October 6, 1995. Anita L. Clifton, 43 Van Natta 1921 (1991). Assuming for the sake of argument that claimant's letter to the ALJ constitutes a request for Board review, the request was timely filed because it was received by the Board on October 4, 1995. See OAR 438-05-046(1)(b).

However, the record fails to establish that all of the other parties to the proceeding before the ALJ were either provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, the record indicates that SAIF's and its insured's first notice occurred when they received a copy of the Board's October 10, 1995 letter acknowledging claimant's request for Board review.

Under such circumstances, we conclude that notice of claimant's request was not provided to all of the other parties within 30 days of the ALJ's September 6, 1995 order.[1] Consequently, we lack jurisdiction to review the ALJ's order. See ORS 656.289(3); 656.295(2).

---

[1] In the event that claimant can establish that he provided notice of his request for Board review to SAIF or its insured (One MCK Logging Co.) within 30 days of the ALJ's September 6, 1995 order, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Since our authority to reconsider this order expires within 30 days from the date of this order, claimant must file his written submission as soon as possible.

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

Accordingly, the request for Board review is dismissed.[2]

IT IS SO ORDERED.

[2] This dismissal order only pertains to the ALJ's September 6, 1995 order in WCB Case No. 94-11513. Our decision today has no effect on WCB Case No. 95-01722, which pertains to the ALJ's September 25, 1995 Opinion and Order.



In the Matter of the Compensation of
**DOUGLAS SCALES, Claimant**
WCB Case No. TP-95006
THIRD PARTY DISTRIBUTION ORDER
Gatti, Gatti, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant has petitioned the Board for approval of a third party compromise. ORS 656.587. We approve the settlement.

## FINDINGS OF FACT

While working as a taxi cab driver, claimant's cab was struck from behind by another automobile. Claimant received treatment in the emergency room, where he was diagnosed with a cervical strain and lumbar strain. The SAIF Corporation accepted the injury claim and processed it to closure. Following claim closure, claimant was awarded 13 percent (41.6 degrees) unscheduled permanent disability by an August 18, 1994 Order on Reconsideration. To date, SAIF's lien totals $6,585.31.

Claimant, through his legal counsel, filed a cause of action against a third party. Following negotiations, including a written settlement demand package, additional settlement letters, and a mediation between claimant, his representative, and the third party insurer, the third party insurer ultimately offered $9,500 to settle the claim.

The third party insurer declines to increase the amount of its settlement offer, contending that the medical care claimant received was excessive and/or unrelated to the injuries sustained in the motor vehicle accident. The basis of this contention is that the impact caused by the accident was insignificant and resulted in minimal damage to the vehicles. In addition, the third party insurer relies on the fact that jury verdicts are low with soft tissue, minimal impact motor vehicle accident cases.

Claimant has agreed to settle the action for $9,500. SAIF has declined to approve the settlement. Contending that claimant has not established why he would not prevail in his third party action, SAIF asserts that the settlement is unreasonable because it will not receive full reimbursement for its entire lien.

## FINDINGS OF ULTIMATE FACT

The third party settlement offer of $9,500 is reasonable.

CONCLUSIONS OF LAW

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

A paying agency's failure to recover full reimbursement for its entire lien is not determinative as to whether a third party settlement is reasonable. See Catherine Washburn, 46 Van Natta 74, on recon 46 Van Natta 182 (1994); Jill R. Atchley, 43 Van Natta 1282, 1283 (1991); John C. Lappen, 43 Van Natta 63 (1991). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Catherine Washburn, supra; Jill R. Atchley, supra; Kathryn I. Looney, 39 Van Natta 1400 (1987).

SAIF objects to the settlement on the basis that claimant has failed to show why he would not prevail in his action against the third party. Yet, it is not incumbent on claimant to establish whether he would prevail at trial. Rather, our review is confined to a determination of whether the proposed compromise of claimant's third party action is reasonable.

Furthermore, we have previously held that, as the prosecutor of his third party action, a claimant is aware of the potential weaknesses of his case, as well as the statutory distribution scheme and his lienholders. See Kathleen I. Steele, 45 Van Natta 21 (1993). Considering this accessibility to vital factual information and relevant statutory prerequisites, we have reasoned that the claimant is in the best position to make an informed and reasoned decision regarding the appropriateness of a settlement offer. Id. Moreover, with that knowledge, the claimant has the capacity to accurately calculate what his eventual net recovery will be, should he accept such an offer. Id.

Consequently, although there may be reasons to proceed with litigation, we conclude that claimant and his counsel are in the best position to weigh the risks of litigation versus the certainty of a settlement. See e.g. Karen A. King, 45 Van Natta 1548 (1993); John C. Lappen, supra (Paying agency's arguments that the claimant should have proceeded with litigation were not supported by the record, and in any event, costs attributable to further litigation would have been deducted from any third party recovery before the remainder would become subject to the paying agency's lien).

The fact that SAIF would not recover full reimbursement of its entire lien is likewise not determinative. In the event that the $9,500 settlement is allocated in accordance with the statutory distributory scheme, SAIF stands to recover approximately $4,222.22, while its asserted lien amounts to $6,585.31.[1] In other words, SAIF would receive approximately 64 percent of its lien. We have

---

[1] We reach this general estimate of SAIF's approximate recovery of $4,222.22 by reviewing ORS 656.593(1), the statutory formula for distribution of a third party recovery obtained by judgment. Under ORS 656.593(1)(a), litigation costs and attorney fees are initially disbursed. Then, the worker receives at least 33 1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency is paid the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Any remaining balance is paid to the worker. ORS 656.593(1)(d).

In making this approximate calculation, we emphasize that we are not reaching a determination of a "just and proper" distribution of third party settlement proceeds. Since we have not been requested to make such a determination, it would be inappropriate to render such a ruling. Rather, we apply this analysis merely for illustration purposes in responding to SAIF's concerns regarding its proportionate share of a $9,500 settlement. Assuming the absence of litigation expenses, a general distribution under ORS 656.593(1) would be as follows:

| | |
|---|---|
| Settlement | $9,500.00 |
| 1/3 Attorney Fee | - 3,166.67 |
| Subtotal | $6,333.33 |
| Claimant's 1/3 Share | - 2,111.11 |
| Remaining Balance (SAIF's Share) | $4,222.22 |

previously held that failure to fully satisfy a paying agency's lien does not equate with a determination that a third party compromise is not reasonable. See Denita I. Cleveland (Hall), 44 Van Natta 466, 468 (1992); Catherine Washburn, supra; Jill R. Atchley, supra; John C. Lappen, supra (settlement approved despite paying agency's recovery of 25 percent of its asserted lien).

Accordingly, after reviewing the parties' respective positions, as well as the record (particularly the third party insurer's contentions that the accident caused minimal soft tissue damage for which jury awards are traditionally very low, and that claimant received excessive and unrelated medical treatment, which also might reduce the amount of any jury award), we conclude that the proposed settlement is reasonable. We, therefore, approve the settlement. ORS 656.587.

IT IS SO ORDERED.

---



In the Matter of the Compensation of
**RICHARD G. SHIELDS, Claimant**
WCB Case No. 94-09444
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order which: (1) set aside its denial of claimant's left leg condition; and (2) assessed a penalty/under former ORS 656.262 (10) for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW

### Compensability

Claimant sustained an off-work motorcycle accident in September 1993 which resulted in a crush injury to his left leg, including severe comminuted open fractures of the left tibia and fibula. (Ex. 1). Dr. James, claimant's attending orthopedic surgeon, repaired the fractured tibia with a plate. (Id.). On January 20, 1994, x-rays revealed "some slight increased callus over the past six weeks in both the tibia and fibula, but still not completely healed in by any means and certainly isn't completely calcified." (Ex. 2-4).

On March 3, 1994, claimant fell down some stairs at work carrying sheetrock, and fractured the plate in his tibia. (Ex. 2-4 to 2-5; Tr. 16-19). X-rays on March 4, 1994 revealed nonunion of the left tibia. (Ex. 2-5). Dr. James prescribed a walking cast hoping that the compressive forces of weightbearing would heal the fracture without further surgery. (Id.). In June 1994, Dr. James performed surgery to remove the plate and other hardware from claimant's tibia. (Ex. 4A-1 to 4A-2).

On July 1, 1994, SAIF issued a denial of claimant's left leg condition, diagnosed as "left distal tibia fracture." (Ex. 6). Claimant requested a hearing.

The ALJ found that claimant's fall at work was at least a material contributing cause of the plate fracture. He also found that the plate fracture combined with the preexisting, incompletely healed tibia fracture, and that the plate fracture was the major contributing cause of the prolongation of the healing process. Accordingly, the ALJ found the resultant condition compensable under former ORS 656.005(7)(a)(B).

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 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). We conclude that the result would not change as we find that claimant has established that her condition is compensable under both former and amended ORS 656.005(7)(a)(B). Consequently, we need not address which version of the statute should apply to this case.

The medical evidence establishes that claimant's preexisting left leg condition - an incompletely healed tibia fracture - combined with the work injury to cause or prolong his current disability and need for treatment. (Ex. 4A-1, 5). Therefore, in order to establish the compensability of the "combined" condition, claimant must prove that the work injury was the major contributing cause of his disability due to the combined condition, or the major contributing cause of the need for medical treatment of the combined condition. Amended ORS 656.005(7)(a)(B), SB 369 § 1.

Because claimant's work injury combined with a preexisting incompletely healed fracture, we find that the causation question is medically complex. Therefore, we require expert medical opinion to resolve it. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Dr. James, the attending orthopedist, and Dr. McKillop, an orthopedist who conducted a file review at SAIF's request, offered medical opinions.

Dr. McKillop opined that although the fall at work most likely caused the plate fracture, "[t]he fracture of the plate is not really the most important problem this man has. The most important problem is the non-union, and the fracture of the plate is secondary." (Ex. 9-20). The non-union of the tibia fracture was already present before claimant fell down the stairs. (Ex. 9-18). Dr. McKillop explained that claimant most likely eventually would have needed surgery for the non-union, regardless whether the plate fractured or not; the plate fracture simply advanced the timing of the treatment. (Ex. 9-21).

Dr. James opined in a concurrence letter that it was medically probable that the major cause of claimant's condition, diagnosed as the fractured plate and non-union of the left tibia, for which his office provided medical treatment on and after March 4, 1994, was the March 3, 1994 work injury when claimant fell down stairs carrying sheetrock. (Ex. 7-1). He adhered to this opinion in his deposition testimony. (Ex. 10-27). He explained that surgery to remove the plate and other hardware revealed that most of the fracture had healed well, but that the mid-portion, where the plate had fractured, still had some microscopic motion. Dr. James characterized the tibia fracture as a delayed union site, rather than a non-union site. (Ex. 10-6; see also Ex. 9 at 29-30). He retained hope that further healing would occur without a bone graft. (Ex. 10-6 to -7). Dr. James expressed the opinion that most likely, if claimant had not fallen at work, the tibia fracture would have eventually healed. (Ex. 10-10). He further opined that once the plate fractured, that increased the likelihood of delayed union of the original tibia fracture. (Ex. 10-26). Considering Dr. James' express causation opinion, in light of his testimony as a whole, we find that his opinion persuasively establishes that the work injury was the major contributing cause of claimant's combined condition, as well as his disability and need for treatment due to the combined condition.[1]

When medical opinions differ, we generally give greater weight to the treating doctor's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find no reason not to defer to the treating doctor's opinion in this case. Moreover, we find Dr. James' opinion more persuasive than Dr. McKillop's because Dr. James' opinion is based in part on his observation of

[1] We recognize that, at one point in his deposition, Dr. James opined that "the original injury was the primary cause of [claimant's] whole problem." (Ex. 10-18). However, reading this statement in context, we conclude that Dr. James was referring to claimant's eventual need for a bone graft, rather than the condition and need for treatment immediately following the March 3, 1994 work injury. (Id.). The compensability of the bone graft surgery is not specifically before us.

claimant's fracture during surgery. Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988) (give great weight to opinion based on first-hand exposure to and knowledge of condition). Accordingly, we conclude, based on Dr. James' opinion, that claimant's left leg condition is compensable.

Penalty and Attorney Fees

The ALJ found that SAIF's denial was unreasonable and, therefore, assessed a penalty (shared equally by claimant and his counsel) under former ORS 656.262(10).[2] We disagree.

A denial is not unreasonable when, in light of all the evidence available to the carrier at the time of the denial, the carrier has a legitimate doubt as to its liability. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). Here, at the time of its July 1, 1994 denial, SAIF had received written comments from Dr. James in which he opined that claimant's current findings had combined with his preexisting condition to cause or prolong his current need for treatment, but he did not give an opinion as to whether the preexisting condition was the major contributing cause of claimant's current need for treatment. (Ex. 5). In addition, Dr. James explained to SAIF's claims representative that the fall probably broke the plate in claimant's leg, thereby increasing the stress on his healing fracture and causing it to go to a delayed or nonunion state. (Ex.4A at 2-3; see also Ex. 5A). Under these circumstances, we find that SAIF had a legitimate doubt as to its liability, since Dr. James implicated the role of a preexisting condition in claimant's current need for treatment, but he did not give an opinion as to what he believed was the major contributing cause of claimant's current need for treatment. Accordingly, we conclude that SAIF's denial was not unreasonable and a penalty is not warranted.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review devoted to penalty issue.

ORDER

The ALJ's order dated March 3, 1995 is affirmed in part and reversed in part. That portion of the ALJ's order which assessed a penalty under former ORS 656.262(10) to claimant and his counsel is reversed. The remainder of the ALJ's order is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the SAIF Corporation.

---

[2] Pursuant to Senate Bill 369, former ORS 656.262(10) has been renumbered to ORS 656.262(11), but the provision itself was not amended. SB 369, § 28.

**Member Hall concurring in part and dissenting in part.**

I agree that claimant's left leg condition is compensable, and to that extent I concur with the majority. However, I believe that a penalty is warranted for SAIF's unreasonable denial, and to that extent I respectfully dissent.

A denial is not unreasonable only when, in light of all the evidence available to it, the carrier has a legitimate doubt as to its liability. Brown, supra. I believe that given the evidence available to it at the time of denial, SAIF had no legitimate doubt of its liability in this case.

While Dr. James' written comments may not have explained the role of the preexisting condition in claimant's current need for treatment, his subsequent telephone conference with SAIF's representative erased any legitimate doubt SAIF might have had as to its liability. (See Ex. 4a, 5). On June 29, 1994, following SAIF's receipt of his written comments, Dr. James had a "long conference" with SAIF's representative. (Ex. 4A-2). Dr. James' chart note indicates that he explained, in response to SAIF's questions, that the only thing that could have caused the plate in claimant's leg to break was the

torsional and angular force on his leg due to his fall down the stairs. He further explained that once the plate broke, it placed increased stress on the preexisting, healing fracture, causing the fracture to go to a delayed or nonunion state. (Ex. 4A at 2-3). Dr. James indicated that he answered all the SAIF representative's questions. (Ex. 4A-2). Thereafter, on July 1, 1994, SAIF issued its denial.

Under these circumstances, I would find that any questions SAIF may have had regarding the role of a preexisting condition in claimant's current need for treatment were fully answered by Dr. James in the telephone conference on June 29, 1994. Dr. James fully explained the mechanism of injury, the cause of the plate breaking, and the interplay between claimant's preexisting fracture and the work injury. The SAIF representative's notes do not indicate any remaining unanswered questions regarding the major contributing cause of claimant's current need for treatment. (See Ex. 5A). Thus, I would conclude that at the time of its denial, SAIF had no legitimate doubt that the work injury was the major contributing cause of claimant's current need for treatment. Therefore, I would affirm the ALJ and find that a penalty and related attorney fee are warranted under amended ORS 656.262(11).

---



In the Matter of the Compensation of
**WENDY YOURAVISH, Claimant**
Own Motion No. 94-0619M
OWN MOTION ORDER OF ABATEMENT
Jon C. Correll, Claimant Attorney
Liberty Northwest, Insurance Carrier

Claimant requests reconsideration of our October 12, 1995 Own Motion Order Reviewing Carrier Closure, in which we affirmed the insurer's June 3, 1995 Notice of Closure of the above claim.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The insurer 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
**STEVEN J. ANDERSON, Claimant**
WCB Case Nos. 94-13179 & 94-13178
ORDER ON REVIEW
Thomas J. Flaherty, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the insurer's denial of his consequential psychological condition. The insurer has requested that the record be "reopened" to include supplemental medical reports. 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.

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

Remand

On review, the insurer has submitted for consideration two supplemental reports from Dr. Blair, who is treating claimant's respiratory condition. The insurer contends that the test results that are the subject of these two reports were not available at the time of hearing and that these reports are significant in that they are evidence that claimant's psychological condition is not compensably related to his work injuries.

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 referee. 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).

Although these particular medical reports were not available at the time of the hearing, we are not persuaded that the substantive matters contained in the reports were unobtainable with the exercise of due diligence prior to the hearing. In addition, Dr. Blair's findings are already in the record, along with those of other treating and examining physicians. Moreover, we see no compelling reason to remand because these additional reports are not likely to affect the outcome in this case. In other words, based on the record as presently developed, we agree with the ALJ that claimant has failed to establish that his psychological condition is caused in major part by his chemical exposure injuries at work.

Compensability

The only medical evidence relating claimant's depression to his chemical exposure injuries at work is the conclusory opinion of Dr. Maletzsky. Although Dr. Maletzsky opined that claimant's work injury is the cause of claimant's current psychiatric symptoms, his reports provide no explanation or foundation for this opinion. Dr. Maletzsky's unexplained opinion is therefore entitled to little weight. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); see also Marta I. Gomez, 46 Van Natta 1654 (1994) (least weight given to conclusory, poorly analyzed opinions). Accordingly, we conclude that claimant has failed to sustain his burden of proof. ORS 656.005(7)(a)(A); ORS 656.266.

ORDER

The ALJ's order dated March 8, 1995 is affirmed.

In the Matter of the Compensation of
**JEAN M. GORDON, Claimant**
WCB Case No. 94-06925
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
David L. Jorling, Defense Attorney

Claimant requests reconsideration of our October 12, 1995 Order on Review which modified that portion of an Administrative Law Judge's (ALJ's) order that increased claimant's scheduled permanent disability award for loss of binocular vision from both eyes from 9.75 percent (29.25 degrees), as awarded by an Order on Reconsideration, to 100 percent (300 degrees). Specifically, in lieu of the ALJ's award of 100 percent (300 degrees) scheduled permanent disability for loss of binocular vision, we awarded claimant 100 percent (100 degrees) scheduled permanent disability for loss of monocular vision. In her request for reconsideration, claimant argues that we erred in our interpretation of the standards. In addition, by separate written communication, claimant contends that, in light of the passage of Senate Bill 369, Or Laws 1995, ch 332 § 17 (SB 369, § 17), claimant's permanent partial disability award should be paid at the higher rate of $347.51 per degree, rather than $305 per degree, as set forth in former ORS 656.214(2).

Extent of Scheduled Permanent Disability

In our order, we found that, pursuant to OAR 436-35-260(4), claimant has an impairment rating of 100 percent resulting from her binocular diplopia condition. We also determined that, pursuant to OAR 436-35-260(4), the 100 percent impairment value represents 100 percent impairment of one eye (100 degrees), not 100 percent impairment of both eyes (300 degrees).

On reconsideration, claimant argues that we should apply OAR 436-35-260(4)(b) so that it awards her 100 percent of binocular visual loss (300 degrees). In support of this argument, claimant cites ORS 656.214(2)(i), the statute which provides for the rating for partial loss of vision in both eyes as "that proportion of 300 degrees which the combined binocular visual loss bears to normal combined binocular vision." Claimant argues that our interpretation of OAR 436-35-260(4) violates ORS 656.214(2)(i). We disagree.

The record establishes that claimant has 100 percent impairment due to a binocular diplopia condition. However, it does not establish that she has 100 percent binocular visual loss. In this regard, there is no medical evidence that claimant has lost 100 percent of her binocular vision. In addition, claimant is able to drive a car and perform various activities of daily living, including performing her regular job, which involves detailed statistical work using a standard computer. Thus, the medical evidence and claimant's abilities do not support a finding that claimant has 100 percent binocular visual loss. Because claimant has not established 100 percent binocular visual loss, it is not inappropriate to decline to award her 300 degrees for such a loss.

In addition, to the extent that claimant argues that we have rated her binocular diplopia as monocular diplopia, we disagree. The standards provide for ratings for monocular and binocular diplopia. In rating monocular diplopia, OAR 436-35-260(5) provides:

> "[t]o the extent that glare disturbances or monocular diplopia causes visual impairment are not reflected in visual acuity, visual field or ocular motility, the losses for visual acuity, visual fields or ocular motility will be combined with an additional 5% when in the opinion of the physician the impairment is moderate, 10% if the impairment is severe."

Thus, monocular diplopia is rated at a maximum of 10 percent impairment. However, in rating claimant's condition, we applied OAR 436-35-260(4), which provides the ratings for binocular diplopia. Under that rule, we determined that claimant is entitled to 100 percent impairment. Thus, we properly rated claimant's binocular diplopia condition. Moreover, for the reasons detailed in our initial order, we continue to find that such impairment represents 100 percent impairment of one eye (100 degrees).

Rate of Scheduled Permanent Disability

The sole issue on review was the extent of scheduled permanent disability. On reconsideration, claimant raises an issue that pertains not to the extent of disability, but rather to the self-insured employer's eventual actions in processing the claim, i.e., the rate at which the permanent partial disability award modified on review shall be paid.

Because the employer has yet to process the claim in response to our order, any ruling regarding the applicable rate for claimant's permanent disability benefits would be premature and advisory in nature. See, e.g., James J. Sheets, 44 Van Natta 400 (1992). If claimant subsequently disagrees with the employer's actions in paying the permanent disability award granted by our order, she may seek a hearing concerning that matter. See ORS 656.283(1). The issue will be ripe at that time. David J. Aronson, 47 Van Natta 1948 (1995).

Accordingly, we withdraw our October 12, 1995 order. On reconsideration, as supplemented herein, we republish our October 12, 1995 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

**Board Member Gunn dissenting.**

For the reasons previously expressed in my dissenting opinion, I continue to disagree with the majority's conclusion that claimant's impairment should be valued as a loss of vision in one eye rather than both eyes.

---

October 30, 1995 Cite as 47 Van Natta 2103 (1995)

In the Matter of the Compensation of
**DENNIS C. GROSS, Claimant**
WCB Case No. 94-09087
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) upheld the self-insured employer's denial of claimant's psychological condition claim; (2) upheld the employer's denial of proposed medical services; (3) declined to assess penalties for allegedly unreasonable claims processing; and (4) declined to reimburse claimant for costs in procuring additional medical reports. On review, the issues are compensability, jurisdiction, and, potentially, medical services, penalties, and reimbursement for medical reports. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Preliminary Issue

At hearing, the employer's attorney offered a surveillance videotape of claimant's activities and the testimony of the investigator who performed the surveillance. The evidence was admitted without objection. (Tr. 11). The employer then offered medical reports from physicians who had viewed the videotape and provided opinions regarding claimant's condition based on his activity on the videotape. The employer's counsel indicated that the documents also were offered only for impeachment purposes. (Id. at 14). The ALJ admitted the reports (Exhibits 28-32) "for impeachment purposes only." (Id. at 16).

The ALJ subsequently reconsidered her ruling, finding that the medical reports "have to be considered substantive evidence, and not strictly impeachment." (Id. at 20). The ALJ also continued the hearing to allow claimant to submit the videotape to his treating physicians. (Id. at 22-23).

On review, claimant asserts that the ALJ erred in considering the exhibits as substantive evidence and that they should be considered only for impeachment purposes. Claimant further contends that he successfully rebutted such evidence with medical reports from the treating and consulting physicians.

The disputed reports discuss the cause of claimant's mental and physical conditions and not just claimant's credibility. Thus, we agree with the ALJ that the evidence properly is considered as substantive, and not impeachment, evidence. Consequently, we disagree with claimant that the reports should be considered only for purposes of evaluating claimant's credibility.

Compensability of Psychological Condition

We adopt and affirm the relevant portion of the ALJ's order.

Compensability of Medical Services

Dr. Grimm, claimant's consulting orthopedic surgeon, proposed surgery to treat a tarsal tunnel syndrome on claimant's right foot. The employer denied the surgery on the basis that it was neither reasonable nor necessary. The ALJ found that the more persuasive evidence showed that the proposed surgery was not reasonable and necessary. Claimant challenges this conclusion, asserting that he proved the medical services for his compensable condition are appropriate.

Subsequent to the ALJ's order, the legislature amended ORS 656.327(1) to provide that, "[i]f an injured worker, an insurer or self-insured employer or the Director believes that medical treatment * * * 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[.]" Or Laws 1995, ch 332, § 41 (SB 369, § 41). The new law also added ORS 656.245(6) providing that, "[i]f 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." SB 369, § 25. Finally, amended ORS 656.704(3) provides that a "matter concerning a claim" for purposes of Board review does not include disputes arising under ORS 656.245 and 656.327. SB 369, § 50.

These provisions retroactively apply to cases currently pending before the Board. Newell v. SAIF, 136 Or App 280, 283 (September 6, 1995); Walter L. Keeney, 47 Van Natta 1387 (1995). Pursuant to these sections, the Director has exclusive jurisdiction over matters concerning compensability of medical services under ORS 656.327(1). Newell v. SAIF, supra; Walter L. Keeney, supra, 47 Van Natta at 1389.

The dispute here concerns whether the proposed surgery for claimant's compensable condition is reasonable and necessary. Hence, it falls under ORS 656.327(1). Consequently, exclusive jurisdiction of this matter now rests with the Director. In view of this conclusion, we vacate that portion of the ALJ's order concerning this issue.

Penalties

Claimant also contends that he is entitled to penalties for late processing of his claims for the psychological condition and proposed surgery. Because we have agreed with the ALJ that the psychological condition is not compensable, there is no basis for awarding a penalty for this claim. ORS 656.262(11)(a). Furthermore, because we do not have jurisdiction to decide the medical services claim, it follows that authority to consider any accompanying penalty regarding this issue likewise rests with the Director. SB 369, § 42d(5); Lynda J. Zeller, 47 Van Natta 1581 (1995).

Reimbursement for Medical Reports

Claimant next argues that the medical reports he solicited to rebut the surveillance tape and the employer's medical reports qualify as compensable diagnostic services and, thus, he should be reimbursed for the costs in procuring the reports. We agree with the ALJ that such costs are not compensable. We have held that medical services performed to determine whether or not a causal relationship exists are compensable. E.g., Charles W. Womack, 44 Van Natta 2407 (1992). We also have distinguished such services with reports generated for purposes of litigation, finding those costs not to be compensable since such reports were not provided for medical treatment. E.g., Kenneth D. Nichols, 45 Van Natta 1622, 1624 (1993).

Here, it is clear that the reports solicited by claimant were for purposes of litigation. Claimant requested the reports after the employer produced the surveillance tape at hearing; his statements at hearing indicate that he wanted to submit the videotape to his treating physicians in order to provide evidence that would limit any damage by the surveillance tape. The content of the reports discuss the surveillance tapes, finding such evidence to have little or no impact on the physicians' previous opinions that claimant suffered great pain and was in need of treatment.

Under such circumstances, we find no basis that the reports qualify as diagnostic services and consider them as having been solicited and generated solely for purposes of litigation. Consequently, claimant is not entitled to be reimbursed for the costs of procuring the reports. Kenneth D. Nichols, supra.

ORDER

The ALJ's order dated March 13, 1995 is vacated in part and affirmed part. Those portions concerning the propriety of medical services and penalties/attorney fees for allegedly unreasonable claims processing of such medical services claim are vacated. Claimant's request for hearing regarding those issues is dismissed for lack of jurisdiction. The remainder of the order is affirmed.

---

October 30, 1995 Cite as 47 Van Natta 2105 (1995)

In the Matter of the Compensation of
**JOHN H. KIRKPATRICK, Claimant**
WCB Case Nos. 94-12835, 94-09869, 94-12834 & 94-11678
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Crumme's order which: (1) set aside its denial of responsibility for claimant's "new injury" claim for a right shoulder condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of responsibility for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "findings of fact" with the exception of the second sentence of finding #18.[1]

---

[1] At the time of hearing, the ALJ decided this case as an "Arbitrator." Subsequent to the ALJ's order, the Legislature amended ORS 656.307. See Or Laws 1995, ch 332, § 36 (SB 369, § 36). Under the former version of the statute, the Board reviewed an "Arbitrator's" order for errors of law. Pursuant to amended ORS 656.307(2), the Board reviews the ALJ's order de novo. No party disputes SAIF's contention that amended ORS 656.307(2) applies. Therefore, we apply the amended statute and review this matter de novo. See Volk v. America West Airlines, 135 Or App 565, 573 (1995); Dan J. Anderson, 47 Van Natta 1929 (1995).

## CONCLUSIONS OF LAW AND OPINION

On or about January 16, 1989, while the employer was insured by Liberty, claimant sustained a compensable right shoulder injury accepted as a disabling right shoulder strain. Claimant ultimately received 10 percent unscheduled permanent disability for this injury.

Coverage of the employer changed to SAIF on July 1, 1993. On June 17, 1994, claimant was smoothing some concrete with a board when he felt a snap and pain in the right shoulder. Claimant was initally diagnosed with tendonitis of the right shoulder. On August 31, 1994, claimant underwent athroscopic surgery on his right shoulder. Both Liberty and SAIF denied responsibility for claimant's current right shoulder condition. On October 24, 1994, Liberty was designated paying agent pursuant to ORS 656.307.

At hearing, the ALJ determined that claimant's current right shoulder condition "essentially involved the same condition" as the accepted 1989 injury. Therefore, the ALJ applied ORS 656.308 in resolving the dispute concerning responsibility for claimant's right shoulder condition. The ALJ found that claimant had sustained a "new compensable injury" on June 17, 1994 while SAIF insured the employer. In reaching this conclusion, the ALJ relied on the medical opinion of the only physician to comment on the causation issue, claimant's attending physician, Dr. Lundsgaard.

On review, SAIF contends that the ALJ erred in finding that Liberty had sustained its burden of proving that the June 17, 1994 incident was the major contributing cause of claimant's "combined condition" under amended ORS 656.005(7)(a)(B). SAIF asserts that the ALJ improperly considered the precipitating cause of claimant's need for medical treatment to be the major contributing cause of claimant's combined condition. See Dietz v. Ramuda, 130 Or App 397 (1994), rev allowed 320 Or 492 (1994); Alec Snyder, 47 Van Natta 838 (1995). We agree.

Senate Bill 369 was enacted on June 7, 1995 and amends ORS 656.005(7)(a)(B) and ORS 656.308(1).[2] 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 Liberty is responsible for claimant's current right shoulder condition under either version of those statutes.

Liberty remains responsible for claimant's future compensable medical services and disability relating to the accepted 1989 right shoulder condition unless it establishes that claimant sustained a "new compensable injury involving the same condition" while working during SAIF's coverage. SAIF v. Drews, 318 Or 1 (1993).[3] To establish a new injury, Liberty must show that claimant's employment activity on June 17, 1994 was the major contributing cause of claimant's disability or need for medical treatment. SAIF v. Drews, 318 Or at 9.[4] We conclude that Liberty has failed to meet that burden based on Dr. Lundsgaard's medical opinion.

---

[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, 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."

[3] No party disputes the ALJ's finding that claimant's current right shoulder condition involves the "same condition" as that accepted by Liberty in 1989.

[4] We note SAIF's contention that, based on Dietz v. Ramuda, 130 Or App 397 (1994), the inquiry under ORS 656.005(7)(a)(B) is whether the June 1994 incident is the major contributing cause of claimant's combined condition, not simply the major cause of the immediate need for treatment. However, 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. See Dale E. Weitman, 47 Van Natta 1396, 1397 n. 2 (1995), on recon 47 Van Natta 1527 (1995).

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 this case, we find Dr. Lundsgaard's medical opinion insufficient to carry Liberty's burden of proof.

In both U-Haul of Oregon v. Burtis, 120 Or App 353 (1993) and Dietz, supra, the court held that the proper analysis under 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. Hence, the application of ORS 656.005(7)(a)(B) is largely dependent on an evaluation of the medical evidence in each case. See Lance A. Banaszek, 47 Van Natta 361 (1995).

In Alec Snyder, supra, we rejected the opinion of a physician who noted that the claimant was asymptomatic for about a year before an August 1993 incident and who opined that claimant would not have needed treatment in the absence of the August 1993 incident. We concluded that the doctor employed a "but for" analysis; that is, but for the August 1993 incident, claimant would not have required treatment. We reasoned that that analysis is essentially the same "precipitating cause" analysis that was rejected by the Dietz court. We emphasized that the mere fact that an incident precipitated symptoms does not mean that the incident was the major cause of those symptoms. Because the physician employed a "but for" analysis, rather than weighing the relative contribution of different causes, we concluded that the opinion was not well reasoned and, hence, not persuasive.

In this case, we find that Dr. Lundsgaard also employed a "but for" analysis similar to the one we rejected in Snyder. Dr. Lundsgaard initially opined in a letter to SAIF on October 13, 1994 that claimant's "problems" related to his 1989 injury and that there was no "substantial" new injury. (Ex. 30). In a letter to Liberty on the same date, Dr. Lundsgaard once again identified the 1989 injury as the primary factor in claimant's current right shoulder condition, stating that the "major problem" that claimant was going to have now and in the future was related to the 1989 injury. (Ex. 31). Dr. Lundsgaard was ultimately deposed.

In his deposition, Dr. Lundsgaard testified that the majority of claimant's "problems" were related to his initial injury in 1989. However, Dr. Lundsgaard also testified regarding the affect of the second injury in 1994, stating: "I personally think that the second injury was the cause for [claimant] needing treatment at this point in time because I don't think he would have been here in '94 had he not had the second injury at that point because he hadn't returned." (Ex. 34-18).

Although Dr. Lundsgaard testified that the 1994 injury caused claimant's immediate need for treatment, it is also clear that Dr. Lundsgaard believed that "but for" the second injury on June 17, 1994, claimant would not have needed treatment. As previously noted, this is the same kind of analysis we disapproved of in Snyder, supra.[5] Therefore, we do not consider Dr. Lundsgaard's opinion with respect to the affect of the June 1994 injury to be sufficient to satisfy Liberty's burden of proving that the June 1994 injury is the major contributing cause of claimant's disability or medical treatment under either former or amended ORS 656.005(7)(a)(B).

Accordingly, we disagree with the ALJ's finding that responsibility for claimant's right shoulder condition had shifted to SAIF. We, thus, reverse the ALJ's order.[6]

Claimant has submitted a respondent's brief on review. However, compensability was not litigated at hearing and claimant's TTD rate is the same under the SAIF claim as it is under the Liberty claim. (Ex. 33). Because claimant's compensation was not at risk of disallowance or reduction, claimant's attorney is not entitled to an attorney fee for services on Board review. See ORS 656.382(2); Long v. Continental Can Co., 112 Or App 329 (1992); Rito N. Nunez, 45 Van Natta 25, 26 (1993); Riley E. Lott, 43 Van Natta 209, 212 (1991); aff'd Oregon Boiler Works v. Lott, 115 Or App 70 (1992).

---

[5] Although Snyder was a compensability case, the Dietz analysis on which our decision in Snyder was based is applicable in a responsibility context. See Larry W. Gange, 46 Van Natta 2237 (1994).

[6] Claimant requests a remand for a new hearing should we find that Senate Bill 369 changed the legal standard for shifting responsibility. Given our finding that Liberty failed to sustain its burden of proof under either version of ORS 656.005(7)(a)(B), we decline to remand this matter.

ORDER

The ALJ's order dated April 27, 1995 is reversed. Liberty's denial of responsibility is set aside and the claim is remanded to it for processing. SAIF's denials of responsibility are reinstated and upheld. The ALJ's assessed fee award of $2,450 shall be paid by Liberty, rather than SAIF.

---



In the Matter of the Compensation of
**SHAWN C. MANN, Claimant**
WCB Case No. 93-15239
ORDER ON REVIEW
Galton, Scott & Colett, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Hall, Christian and Neidig.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Poland's order that: (1) found that it was not authorized to stay payment of "pre-litigation order" temporary disability benefits pending its appeal of an Arbitrator's responsibility decision; and (2) assessed a penalty for an allegedly unreasonable failure to pay those benefits. On review, the issues are stay of compensation and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and stipulated facts, with the following correction.

The parties stipulated that, pending appeal of the Arbitrator's November 30, 1993 decision, SAIF timely paid appropriate benefits that accrued from the date of that decision.

CONCLUSIONS OF LAW AND OPINION

Stay of Compensation

With the following supplementation, we adopt and affirm the ALJ's reasoning and conclusion concerning this issue.

On November 2, 1993, the Director issued an order under ORS 656.307 (.307 order) designating Sedgwick James (Sedgwick) the paying agent. Sedgwick paid temporary disability benefits from September 2, 1993 through November 22, 1993.[1] A November 30, 1993 Arbitrator's decision found SAIF responsible for claimant's current low back condition. SAIF timely requested Board review of the Arbitrator's decision. On August 10, 1994, we affirmed the Arbitrator's decision. SAIF did not appeal, and our order became final. Within 14 days of our order becoming final, SAIF paid all "pre-litigation order" temporary disability benefits due from May 10, 1993 through November 30, 1993.

Claimant requested a hearing seeking penalties for SAIF's failure to pay temporary disability benefits from May 10, 1993 through November 30, 1993, pending appeal of the Arbitrator's November 1993 decision.

The ALJ found that the differential between SAIF's higher temporary disability rate and Sedgwick's lower rate was compensation which SAIF properly stayed under ORS 656.313(1)(a). The ALJ, however, found that claimant's entitlement to "pre-litigation order" temporary disability benefits (payable at the lower rate) were not stayed under ORS 656.313(1). Finding that SAIF's conduct was unreasonable, the ALJ also assessed a 25 percent penalty based on the compensation which was not lawfully stayed.

---

[1] Because OAR 436-60-150(5) allows TTD payments to be paid every two weeks and in 7-day arrearage, Sedgwick's next TTD payment would have become due after the Arbitrator's decision.

SAIF contends that ORS 656.313(1)(a)[2] is clear on its face and that issuance of a .307 order does not provide for an exception to the compensation that can be stayed pending appeal. Under SAIF's interpretation, ORS 656.313(1)(a) would allow it to stay the full amount of compensation (not merely the differential) for the period of temporary disability benefits paid under the .307 order, pending appeal of the responsibility dispute. We must, therefore, determine whether the obligation to pay temporary disability benefits under ORS 656.307 conflicts with ORS 656.313(1)(a).

In construing statutes, when several statutory provisions are involved, a construction should be adopted that gives effect to all of them, if possible. Burt v. Blumenauer, 84 Or App 144, 147 (1987).

ORS 656.307 provides that in responsibility cases, the Director "shall, by order, designate who shall pay the claim, if the employers and insurers admit that the claim is otherwise compensable. Payments shall begin in any event as provided in ORS 656.262(4)." OAR 436-60-180(13) provides that "[t]he designated paying agent shall process the claim as an accepted claim through determination unless relieved of the responsibility by an order of the arbitrator. *** The payment of temporary disability due shall be for periods subsequent to periods of disability already paid by any insurer."

The purpose of a .307 order is to permit a claimant to receive compensation notwithstanding a continued dispute over responsibility for the claim. See Ronnie E. Taylor, 45 Van Natta 905 (1993). Thus, a .307 order insures a claimant benefits, at the minimum entitlement level, pending resolution of the responsibility dispute. The .307 order entitles a claimant to benefits, but it does not determine who is ultimately responsible for compensation under the claim.

Here, Sedgwick was the designated paying agent under the ".307" order because its claim had the lower TTD rate. As the designated paying agent, it was responsible for processing the claim as an accepted claim until the Arbitrator issued her November 30, 1993 decision finding SAIF responsible for the claim. SAIF then stepped into the shoes of the designated paying agent for claims processing purposes. See Rick Fawver, 41 Van Natta 894 (1989)(pending appeal of the responsibility dispute, the then-responsible insurer processed the claim on behalf of the insurer ultimately found responsible). As such, SAIF was obligated to pay, at a minimum, temporary disability at the lower rate.

When responsibility was ultimately determined, SAIF became responsible for the full amount of benefits. SAIF would have to pay the temporary disability paid under the .307 order at its higher rate. Thus, it follows that SAIF is entitled to stay, pending appeal of the Arbitrator's decision, compensation which it would be responsible for under the claim; i.e., the difference in the temporary disability rates. Otherwise, we would be creating an obligation for SAIF to pay the difference pending appeal. To do so, would nullify SAIF's right to stay compensation pursuant to ORS 656.313(1)(a). See Shannon K. Hartshorn, 46 Van Natta 18 (1994).

To require SAIF to pay the "pre-arbitrator's order" temporary disability (i.e., the temporary disability paid pursuant to the .307 order) at the lower rate allows claimant to continue receiving temporary disability benefits pursuant to the .307 order. Under ORS 656.313(1)(a), SAIF would be entitled to stay the difference in the "pre-arbitrator's order" temporary disability benefits that it otherwise would have ultimately been responsible for. Therefore, there is no necessary conflict between ORS 656.307 and ORS 656.313 and effect can be given to both statutes.

Penalty

We adopt that portion of the ALJ's order which assessed SAIF a penalty for SAIF's unreasonable failure to pay temporary disability pending its appeal of the prior ALJ's "307" order.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services on review concerning the temporary disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4)

---

[2] ORS 656.313(1)(a) states that "[f]iling by an employer or the insurer of . . . a request for Worker's Compensation Board review . . . 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 applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the temporary disability issue is $1,000 payable by the SAIF Corporation. 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 have not considered claimant's counsel's efforts expended concerning the penalty issue. See Saxton v. SAIF, 80 App 631 (1986).

ORDER

The ALJ's order dated January 25, 1995 is affirmed. For services on Board review, claimant's attorney is awarded $1,000 to be paid by the SAIF Corporation.

**Board Chair Neidig Concurring In Part And Dissenting In Part.**

I agree with that portion of the majority's opinion which finds that a carrier must pay the lower temporary disability rate pending its appeal of an ALJ's "307" order. However, because I disagree with that portion of the majority's opinion which finds Saif's failure to pay "pre-ALJ order" temporary disability to have been unreasonable, I must respectfully dissent.

The majority adopts the ALJ's determination that, when the provisions of ORS 656.313(1) were read in conjunction with ORS 656.262(2), ORS 656.307 and the administrative rules, SAIF had no legitimate doubt regarding its obligation to pay temporary disability pending its appeal of the ALJ's order. I would disagree.

Until the majority's decision today, no case has addressed the application of the stay provisions of ORS 656.313 in conjunction with the appeal of an ALJ's "307" order. The apparent conflict between the two statutes (ORS 656.313(1) and ORS 656.307) has now been thoroughly analyzed in the majority'S opinion. As indicated above, I concur with the majority's ultimate conclusion regarding the interplay of those two provisions. Nonetheless, in light of the apparent inconsistency between the two statutes, as well as the lack of regulatory guidance or case precedent, I do not consider it unreasonable for SAIF to have relied on the broad authorization provided in ORS 656.313 to stay the payment of "pre-litigation order" temporary disability pending its appeal Of that litigation order. Consequently, I do not consider it appropriate to assess SAIF a penalty for its conduct in processing this claim.

---



In the Matter of the Compensation of
**RAFAEL B. MESTA, Claimant**
WCB Case No. 94-13268
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order which upheld the insurer's denial of claimant's occupational disease claim for his hernia condition. On review, the issue is compensability.

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

Claimant started working for the employer on April 11, 1991. (Tr. 4). Claimant began to have pain in his left groin region within the first 6 months of his employment. (Tr. 7). In October 1993, claimant sought treatment for his left groin condition from Dr. Shames, who diagnosed claimant's condition as an umbilical hernia. (Ex. 1). Dr. Cary, on referral from Dr. Shames, diagnosed claimant's condition as left internal ring hernia. (Ex. 2B). In January 1994, Dr. Cary performed surgery on claimant's left groin area. Dr. Cary's surgical findings were weakness in the area of the Spieghel, with fatty tissue protruding through and large lipoma of the cord coming through the internal ring. (Ex. 2C-1).

The ALJ found that the medical evidence did not support a finding that claimant's hernia condition was caused by his work activities. In so doing, the ALJ relied on the opinion of Dr. Cary, treating surgeon.

On review, claimant contends that the ALJ erred by not relying on the opinion of Dr. Shames, treating physician. Specifically, claimant asserts that Dr. Shames' opinion is dispositive because it is based on an alleged conversation with Dr. Cary and upon Dr. Shames' own research of hernias.

Because the evidence reveals that the symptoms that culminated in claimant's current condition had a gradual onset, we analyze that condition as an occupational disease. See Valtinson v. SAIF, 56 Or App 186 (1982). To prove a compensable occupational disease, claimant must prove that his work activities were the major contributing cause of the onset or worsening of his hernia condition. ORS 656.802(2);[1] Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991). Due to the number of potential causes of claimant's condition, the causation question is medically complex and resolution of the issue requires expert medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Uris v. Compensation Department, 247 Or 420, 424 (1967). Medical opinions that are well-reasoned and explained and based on complete and accurate histories are given greater weight. Somers v. SAIF, 77 Or App 259 (1986). Additionally, 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 physician, Dr. Shames.

Dr. Shames initially diagnosed claimant's condition as an umbilical hernia. (Ex. 1). Dr. Shames believed that claimant's hernia was a congenital defect made worse by his obesity and heavy lifting. In a discussion with claimant's attorney, Dr. Shames stated that he would have trouble relating claimant's work as the "primary" factor that caused claimant's need for surgery. (Ex. 3-2). Dr. Shames explained that to advance a primary cause opinion one of two things would need to occur: Either a surgeon with experience in treating umbilical hernias and their consequences might be able to offer such an opinion, or he would have to research the etiology of "these things" (hernias) himself. In a concurrence letter written by claimant's attorney, Dr. Shames stated that he talked with Dr. Cary, surgeon, and both he and Dr. Cary believed that the major cause of claimant's need for surgery was his work activity. (Ex. 4-1).

Dr. Cary, treating surgeon, did not find an "umbilical hernia" when he operated on claimant. Dr. Cary found claimant's condition to be an internal ring defect with retroperitoneal fat protruding through the internal ring forming a "lipoma." (Exs. 2C; 9 -17, 18, 19). Dr. Cary stated that a lipoma is known to all surgeons as a "classic mimicker" of a hernia. (Ex. 9-18). Dr. Cary explained that claimant's obesity predisposes him to heavy retroperitoneal fat and it is this fat that came through the internal ring defect to cause claimant's lipoma. (Ex. 9-19). Dr. Cary, opined that he could not relate claimant's work activities to either the cause of claimant's internal ring defect or to its worsening. (Ex. 9-17).

Here, we find Dr. Shames' opinion unpersuasive because it is both contradictory and conclusory. For instance, Dr. Shames admits that to relate claimant's condition to his work he would defer to a surgeon's opinion or research the etiology of hernias himself. In these respects, Dr. Cary unequivocally stated that he never talked to Dr. Shames about claimant's condition or cause thereof. (Ex. 9-4). Further, on deposition, it is apparent that Dr. Shames was unfamiliar with the types of hernias found by Dr. Cary. (Ex. 8-16, 17). However, Dr. Shames, without explanation or familiarity, opined that claimant's hernia condition was probably caused by his work. Dr. Shames' opinion was not based on any research (that he previously believed was needed to advance such a causation opinion) but on the fact that hernias in general are caused by intra-abdominal wall pressure. (Ex. 8-17). Further, Dr. Shames stated that he was at a loss as to what percentage claimant's hernia was due to either his work, obesity or "bad luck" since they are all related. (Ex. 8-11). Therefore, we find Dr. Shames opinion to be unexplained, contradictory and thus unpersuasive. See Kelso v. City of Salem, 87 Or App 630 (1987); Somers v. SAIF, supra.

---

[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). The outcome would be the same under either the former or amended versions of ORS 656.802.

In contrast, considering Dr. Cary's advantageous position as claimant's treating surgeon, his accurate history, and his well-reasoned opinion, we find his conclusions persuasive. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). Dr. Cary operated on claimant and found that claimant's condition was caused by retroperitoneal fat protruding through the internal ring defect. Dr. Cary explained that claimant's obesity predisposed him to his hernia condition. Finally, Dr. Cary believed that neither he nor any other physician could opine as to the cause of claimant's condition and need for surgery. Consequently, claimant has failed to establish that his hernia condition and need for medical treatment were caused by his work. Accordingly, claimant does not have a compensable claim.

ORDER

The ALJ's order dated March 27, 1994 is affirmed.

---



In the Matter of the Compensation of
**LAWRENCE E. MILLSAP, Claimant**
WCB Case No. 94-09828
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the insurer's denial of claimant's current low back condition and his aggravation claim for a low back condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, aggravation, penalties, and attorney fees.

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

We replace the last sentence of the sixth paragraph of the findings of fact with the following. Following their January 18, 1989 examination of claimant, examining physicians Drs. Holm, Rich, and McKillop diagnosed recurrent lumbar strain, multiple lumbar strains, superimposed upon L3-L4 degenerative disc disease, L3-4 disc protrusion and degenerative lumbar canal stenosis. (Ex. 36-4). They opined that the compensable July 14, 1988 work injury led to a worsening of the L3-4 degenerative disc disease and was probably responsible for the disc protrusion at L3-4. (Ex. 36-5).

We add the following findings of fact. By Stipulation dated December 29, 1988, the insurer rescinded its denial of August 31, 1988 and accepted the July 14, 1988 work incident as a compensable new injury. (Ex. 35A-2). The stipulation stated that the insurer "acknowledges that the condition being accepted is an increased disc herniation at L3-4 as noted by Dr. John Misko [treating physician]." Id.

At hearing and on review, claimant seeks compensation for a L4-5 stenosis condition either as an aggravation of the accepted injury to the L3-4 disc or as a consequential condition caused by the accepted injury. (Tr. 5, 8). In addition, in his closing arguments at hearing, claimant raised the following issues: (1) the scope of acceptance contained in the December 29, 1988 Stipulation, contending that the insurer accepted all underlying pathologies in claimant's back by that stipulation; and (2) preclusion, contending that, under Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), the insurer is precluded from denying the L4-5 stenosis condition because it did not dispute an extent award for L3-4 stenosis surgery. On review, claimant renews his arguments regarding the issues of scope of acceptance and preclusion.

The insurer argues that claimant may not raise new issues in his closing arguments. 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.

---

[1] Subsequent to the date of the ALJ's order, the legislature enacted Senate Bill 369, which amends ORS 656.273. Or Laws 1995, ch 332, § 31 (SB 369, § 31). Here, we need not resolve the applicability of these amendments because, under either version of the statute, the result would be the same.

Schilthuis, 43 Van Natta 1396, 1399 (1991); Edward A. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2133 (1989).

Claimant does not contend that the preclusion issue was raised before the closing arguments. (Claimant's Reply Brief, page 2). In any event, the record would not support such a contention. However, he argues that the scope of acceptance issue was necessarily before the ALJ because a "determination of what conditions have been accepted is a necessary part of the determination of whether there has been an aggravation." (Claimant's Reply Brief, page 1). However, prior to the closing arguments, claimant explicitly stated that the accepted condition was a "herniation or worsening of a herniation at L3-4" and that he was arguing that that condition had worsened requiring surgery at L4-5, establishing an aggravation or, alternatively, that his current condition is a consequential condition that requires surgery. (Tr. 8). An ALJ's scope of review is limited to issues raised by the parties. Michael R. Petkovich, 34 Van Natta 98 (1982). Given claimant's representations, we do not find that the scope of acceptance made by the stipulation was placed at issue during the hearing.

Even if the claimant's scope of acceptance argument could be characterized as a different theory of compensability of the L4-5 stenosis condition, rather than a separate issue, because this "theory" was not pleaded before or during the hearing, we conclude that the employer would be prejudiced if we resolved this case based on the late-raised theory. Larry L. Schutte, supra; Gunther H. Jacobi, 41 Van Natta 1031 (1989); see Donald A. Hacker, 37 Van Natta 706 (1985) (fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and such an opportunity does not exist if there is no notice that the issue is in controversy). Accordingly, we conclude that the issues of the preclusive effect, if any, of the insurer's failure to dispute an extent award for L3-4 stenosis surgery[2] and the scope of acceptance made by the December 1988 stipulation were not properly before the ALJ. Therefore, we decline to address these issues on review.

ORDER

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

---

[2] We note that Senate Bill 369 amended ORS 656.262(9), renumbered ORS 656.262(10), to provide that a carrier is not precluded from subsequently contesting the compensability of a condition for which it previously paid permanent disability benefits, unless the condition has been formally accepted. (SB 369, § 28 (10)). However, because we find that claimant did not properly raise the issue of any preclusive effect regarding the insurer's failure to dispute the earlier extent award, we need not determine the applicability of this amendment.

---



In the Matter of the Compensation of
**BALDOMERO C. CONTRERAS, Claimant**
WCB Case No. 94-14262
ORDER ON REVIEW (REMANDING)
Willner & Associates, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that: (1) found that he did not establish good cause for his untimely hearing request from the insurer's denial; and (2) dismissed claimant's hearing request as untimely. In his brief, claimant seeks remand for additional evidence. On review, the issues are evidence, remand, and, if the hearing request is timely, compensability. We remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not established good cause for his failure to timely request a hearing from the insurer's denial. At the hearing, claimant testified that he called a toll free number for the insurer which was listed on the denial. The ALJ found that claimant made such a phone call. Claimant spoke to a female, Spanish-speaking employee of the insurer. After the phone conversation, claimant testified that he had the impression that the denial would be rescinded and that his medical bills would be paid. Claimant did not know the name of the person to whom he spoke on the phone. The insurer's claims examiner testified that there were two Spanish speaking, female employees working for the insurer at the time claimant says that he called.

When claimant attempted to testify regarding the substance of his conversation with the insurer's representative, the insurer's counsel objected on hearsay grounds. The ALJ upheld the hearsay objection. Claimant did not make an offer of proof.

On review, claimant argues that this matter should be remanded to the ALJ for claimant's testimony regarding the substance of the phone conversation. The insurer opposes claimant's motion for remand.

ALJs are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the ALJ's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

In this case, we conclude that it does not serve the interests of substantial justice to exclude testimony concerning the substance of claimant's phone conversation with the insurer's employee. Reliance on a misleading statement of a carrier's claims representative can constitute good cause. See Voorhies v. Wood, Tatum, Mosser, 81 Or App 336, rev den 302 Or 342 (1986) (good cause established where claims supervisor erroneously advised a claimant that mailing of a request for hearing on the 60th day would protect his rights). Thus, in this particular case, to establish good cause based on such grounds, claimant must put forth persuasive evidence that the insurer's representative misled him into believing that the denial would be rescinded. If such testimony is excluded, such circumstances establishing good cause cannot be shown. Under these circumstances, we find it was error for the ALJ to exclude the evidence concerning good cause.

We may remand to the ALJ for further evidence taking if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). In the absence of the substance of the conversation claimant had with an employee of the carrier, we are unable to determine whether good cause for failing to timely appeal the denial has been established. Under such circumstances, we find the record incompletely developed concerning the good cause issue and conclude that remand is justified. ORS 656.295(5).

In reaching this conclusion, we acknowledge the insurer's contention that remand is not reasonably likely to affect the outcome of this case because the medical evidence does not support the compensability of claimant's claim. After considering the observations expressed in the medical record, we are unable to conclude that is indisputable that claimant's claim would fail. Consequently, we cannot say that remanding for further development on the good cause issue would not be reasonably likely to affect the ultimate outcome of this case. Accordingly, we reject the insurer's argument.

Finally, we recognize the insurer's assertion that claimant has not established due diligence in seeking introduction of the excluded testimony because he failed to present an offer of proof. Admittedly, it is customary for parties to present offers of proof following an adverse evidentiary ruling. Such a practice permits us to proceed with our review should we subsequently overturn the ALJ's ruling. Nevertheless, no Board precedent requiring such an offer exists. In light of such circumstances, we do not consider claimant's failure to present an offer of proof to be fatal to his current request for remand. However, as a result of this decision, we may look unfavorably on such future requests where a party neglected to take advantage of an offer of proof.

In conclusion, this matter is remanded to ALJ Neal to conduct further proceedings which would allow for the taking of further evidence from both parties concerning claimant's conversation with the insurer's employee. The further proceedings may be conducted in any manner which will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

ORDER

The ALJ's order dated March 1, 1995 is vacated. This matter is remanded to ALJ Neal for further proceedings consistent with this order.

---



In the Matter of the Compensation of
**JOHN F. O'NEALL, JR., Claimant**
WCB Case Nos. 94-10204 & 94-06831
ORDER ON REVIEW
Max Rae, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order which: (1) set aside its denials of claimant's new low back injury claim; and (2) determined that claimant's Grade 1 spondylolisthesis was a compensable component of the low back injury claim. Claimant cross-requests review of those portions of the ALJ's order which: (1) upheld the insurer's denial of his aggravation claim for a mid-back condition; and (2) declined to award a penalty for the insurer's allegedly unreasonable denial of his low back injury claim. Claimant also moves to strike that portion of insurer's reply brief which allegedly raises a new issue. On review, the issues are motion to strike, compensability, aggravation and penalties.

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

The ALJ found that claimant had sustained a compensable low back injury on March 4, 1994 that worsened his preexisting spondylolisthesis condition. Claimant moves to strike that portion of the insurer's reply brief which contends that, should we affirm the ALJ's compensability determination, its responsibility for claimant's low back condition should cease under ORS 656.005(7)(a)(B) in July 1994. Claimant asserts that we should not consider the insurer's argument because the only issue before the ALJ was the "threshold compensability" of the March 4, 1994 incident, not continuing responsibility for claimant's low back condition under ORS 656.005(7)(a)(B).

We agree with claimant that, both in his recorded closing argument and during the hearing, he raised only the narrow issue of whether his lifting incident on March 4, 1994 resulted in a need for medical treatment. (Tr. 7). The insurer did not object to claimant's characterization of the issue either at hearing or during the closing argument. Thus, we have not considered the insurer's alternative argument regarding the issue of whether claimant's low back condition remains compensable under ORS 656.005(7)(a)(B).

In reaching this conclusion, we distinguish our decision in Pedro C. Rodriguez, 47 Van Natta 871 (1995). In Rodriguez, the ALJ set aside the insurer's denial of the claimant's initial injury claim, but upheld the denial insofar as it pertained to the claimant's "current back/neck" condition. We rejected claimant's argument that the ALJ should only have decided whether the initial injury had occurred, and not whether the claimant's current condition was compensable.

In reaching this conclusion, we noted that the insurer had denied the claimant's back/neck "condition," and that the claimant had agreed with the ALJ's statement that the issues were whether an injury occurred as the claimant had alleged, as well as whether the injury was compensable. In our view, the ALJ's statement of issues, with which the claimant had agreed, raised the questions of whether an injury had occurred, and whether the claimant' s current condition was compensable.

In this case, the insurer did deny claimant's "current low back condition of lumbarized S1 with spondylolilsthesis." (Ex. 34). However, the denial alleged that this condition was not due in major part to a specific incident or claimant's work exposure. Given the denial's reference to a specific incident and claimant's explicit contention at hearing and during closing argument that the claim involved "threshold compensability" and was a "threshold case," statements with which the insurer did not disagree, we conclude that the only issue raised at hearing was whether an initial compensable injury on March 4, 1994 had occurred.

In finding that claimant sustained a compensable low back injury on March 4, 1994, the ALJ concluded that claimant's spondylolisthesis could not constitute a preexisting condition for the purposes of ORS 656.005(7)(a)(B) because it "predisposed" claimant to injury. See Portland Adventist Medical Center v. Buckallew, 124 Or App 141 (1993). Thus, the ALJ applied a material contributing cause standard in determining that claimant had sustained his burden of proving that he suffered a compensable injury. Alternatively, the ALJ found that, even if ORS 656.005(7)(a)(B) were applicable, claimant had proved that the March 4, 1994 incident was the major contributing cause of his need for medical treatment.

We agree with the ALJ's finding that claimant's spondylolisthesis "predisposed" claimant to injury. (Exs. 39-14; 40-23). We note, however, that, with the passage of Senate Bill 369, the legislature has now defined "preexisting condition" to mean 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."[1] ORS 656.005(24) (emphasis added).

Inasmuch as claimant's spondylolisthesis condition "predisposed" claimant to a need for treatment and preceded the onset of an initial claim for an injury, it likely qualifies as a "preexisting condition" under the 1995 legislative amendments to ORS Chapter 656. If so, amended ORS 656.005(7)(a)(B) is applicable.[2]

However, we need not definitively determine the applicability of the 1995 legislative amendments to this claim. We agree for the reasons cited by the ALJ that claimant's March 4, 1994 low back injury claim is compensable under either a material or major causation standard.[3]

The ALJ also found the insurer responsible for claimant's spondylolisthesis as a compensable component of the March 4, 1994 injury. On review, the insurer contends that the medical evidence is insufficient to establish claimant's compensable injury caused or worsened claimant's preexisting spondylolisthesis. We disagree.

There are two relevant medical opinions: those of Dr. Tiley, claimant's attending physician, and Dr. Fuller, an examining physician. Dr. Fuller opined that the March 4, 1994 incident was consistent with a symptomatic flare-up of claimant's preexisting spondylolisthesis which did not worsen the underlying pathology. (Exs. 39-34). On the other hand, Dr. Tiley considered the March 1994 incident to have been both a symptomatic flare-up as well as an "actual" worsening of the underlying condition. (Ex. 40-37). Dr. Tiley opined that the work incident likely resulted in some subtle destabilization, at least temporarily, of the lumbar vertebrae, causing a painful lumbar disc. (Ex. 40-46, 47).

The ALJ deferred to Dr. Tiley's opinion, finding that it was the best reasoned and most persuasive. We find no persuasive reason not to defer to the opinion of the attending physician, Dr. Tiley. See Weiland v. SAIF, 64 Or App 810 (1983). Thus, we conclude that claimant has sustained his burden of proving that the March 4, 1994 work incident was the major contributing cause of claimant's current spondylolisthesis condition. See ORS 656.005 (7)(a)(B). Accordingly, we affirm the ALJ's order.

---

[1] ORS 656.005(24) applies retroactively to this claim by virtue of Section 66 of Senate Bill 369, which provides that the "Act applies to all claims or causes of action existing or arising on or after the 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." See Volk v. America West Airlines, 135 Or App 565 (1995). No exception for ORS 656.005(24) is stated in Senate Bill 369.

[2] Inasmuch as no exception for retroactive application of amended ORS 656.005(7)(a)(B) is stated in Senate Bill 369, the amendments to that provison were also effective on passage of Senate Bill 369. See Volk v. America West Airlines, supra. 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."

[3] Our determination makes it unnecessary to address claimant's challenges to the retroactive application of Senate Bill 369 under Article 1, Section 10 of the Oregon Constitution and the Americans with Disabilities Act.

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 attorney fee for claimant's attorney's services on review regarding the insurer's appeal is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues raised by the insurer's appeal (as represented by claimant's appellate briefs), the complexity of the issues, and the value of the interests involved.

ORDER

The ALJ's order dated December 14, 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
**JO W. ORMAN, Claimant**
Own Motion No. 91-0707M
OWN MOTION ORDER ON RECONSIDERATION
Darris K. Rowell, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our August 11, 1995 Own Motion Order that assessed 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. With its request for reconsideration, SAIF makes several arguments in support of its contention that we erred in assessing that penalty.

On September 11, 1995, we withdrew our August 11, 1995 order for reconsideration and allowed claimant an opportunity to respond to SAIF's arguments. We have received claimant's response to SAIF's motion. In addition, with that response, claimant cross-requests reconsideration of that portion of our order that declined to award procedural temporary disability benefits from July 10, 1990 through March 9, 1993.

We first address claimant's cross-request. On reconsideration, claimant renews her argument that Lebanon Plywood v. Seiber, 113 Or App 651 (1992), is distinguishable from this case and that Georgia-Pacific v. Piwowar, 305 Or 494 (1988), requires a finding that she is entitled to the requested temporary disability benefits. We fully addressed this argument in our initial order. We continue to be unpersuaded by claimant's argument and have nothing further to add to our initial order in regard to this argument.

We proceed to address SAIF's request that we reverse our prior penalty assessment. SAIF argues that claimant untimely requested Board action to enforce our October 16, 1992 Own Motion Order, as reconsidered on November 25, 1992.[1] SAIF contends that claimant could have raised this enforcement issue at the time of her unsuccessful 1993 challenge of SAIF's claim closure and her failure to do so bars her from now raising that issue. Essentially, SAIF argues that claimant is barred by claim preclusion from requesting the Board to enforce the October 16, 1992 Own Motion Order. After reconsidering the facts of this case, we agree with SAIF that the current enforcement claim is barred by claim preclusion.

On September 29, 1992, the Board affirmed an Opinion and Order that both upheld SAIF's denial of claimant's psychological condition and found SAIF responsible for psychological treatment as a

---

[1] SAIF actually makes two contentions regarding this "timeliness" argument. In addition to its claim preclusion argument, SAIF argues that amended ORS 656.319(6) applies to this claim and bars claimant's action regarding the alleged claims processing error because claimant filed her request for hearing more than two years after the alleged inaction occurred. Or Laws 1995, ch 332, § 39(6) (SB 369, § 39(6)). Claimant responds that amended ORS 656.319(6) does not apply to her claim. Because we find that claimant's claim is barred by claim preclusion, we need not decide whether amended ORS 656.319(6) applies to her claim.

necessary prerequisite for medical care for claimant's accepted neck, shoulders, and upper back injuries. By Own Motion Order dated October 16, 1992, as reconsidered November 25, 1992, the Board authorized the reopening of claimant's claim to provide temporary disability compensation beginning July 7, 1990, the date claimant was hospitalized for treatment of her psychological condition.

In February 1993, claimant requested a hearing with the Hearings Division seeking enforcement of the Own Motion Order dated October 16, 1992, as reconsidered November 25, 1992. By order dated March 22, 1993, Administrative Law Judge (ALJ) T. Lavere Johnson dismissed claimant's hearing request. The ALJ found that enforcement of the Own Motion Order was within the Board's own motion jurisdiction and, therefore, the Hearings Division was without subject matter jurisdiction. On August 5, 1993, the Board issued an order affirming and adopting the ALJ's order. On December 14, 1994, the Court of Appeals affirmed the Board's order, holding that original jurisdiction to enforce own motion orders lies with the Board in its own motion jurisdiction, not with the Hearings Division. Orman v. SAIF Corp., 131 Or App 653 (1994).

In the meantime, on March 9, 1993, SAIF closed the own motion claim with an award of temporary total disability from July 7, 1990 through July 10, 1990. SAIF declared claimant medically stationary as of July 10, 1990. On May 6, 1993, claimant requested review of SAIF's closure by the Board in its own motion jurisdiction. By Own Motion Order Reviewing Carrier Closure dated August 10, 1993, as reconsidered on September 9, 1993 and November 29, 1993, the Board affirmed the March 9, 1993 Notice of Closure. That order was not appealed and has become final by operation of law. In her request for review of SAIF's closure and her requests for reconsideration of the Own Motion Order Reviewing Carrier Closure, claimant raised only the issue of premature closure. Claimant did not request enforcement of the October 16, 1992 Own Motion Order, as reconsidered on November 25, 1992.

On January 23, 1995, claimant requested a hearing with the Hearings Division, again raising, among several other issues, the issue of enforcement of the October 16, 1992 Own Motion Order, as reconsidered on November 25, 1992. By order dated May 15, 1995, ALJ Daughtry concluded, inter alia, that the Hearings Division did not have jurisdiction over the own motion enforcement issue. Claimant requested review. (WCB Case No. 95-01178).

On June 5, 1995, claimant submitted a petition to the Board in its own motion jurisdiction requesting enforcement of the Board's October 16, 1992 Own Motion Order, as reconsidered on November 25, 1992. It is from that petition that we issued the August 11, 1995 Own Motion Order assessing the penalties that are currently at issue on reconsideration.

"Claim preclusion" bars a plaintiff who has prosecuted one action against a defendant through to a final judgment from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, and where the plaintiff seeks a remedy additional or alternative to the one sought in the first, and is of such a nature as could have been joined in the first action. Rennie v. Freeway Transport, 294 Or 319, 323 (1982). In addition, to have preclusive effect, the final judgment in the prior litigation must be a judgment on the merits of the claim. Id. at 294 Or 330. Claim preclusion bars future litigation not only of every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980). Claim preclusion does not require actual litigation of an issue, but does require the opportunity to litigate, whether or not used. Drews v. EBI Companies, 310 Or 134 (1990).

Here, in May 1993, claimant requested that the Board in its own motion jurisdiction review SAIF's March 9, 1993 closure of claimant's claim. Subsequently, the Board issued an order on the merits of the claim and affirmed the closure. The Board had previously authorized the reopening of claimant's own motion claim by the October 16, 1992 Own Motion Order, as reconsidered on November 25, 1992. It was on this same factual transaction that, in June 1995, claimant requested the Board in its own motion jurisdiction to enforce the October 16, 1992 Own Motion Order, as reconsidered on November 25, 1992. This enforcement action could have been brought at the same time as the request for review of carrier closure. Thus, claimant had the opportunity to litigate the enforcement action before the proper forum at the time the propriety of the March 9, 1993 claim closure was being litigated. Under these circumstances, we conclude that the current enforcement action is barred by claim preclusion.

In reaching this conclusion, we are aware that claimant attempted to bring the enforcement action regarding the own motion order in the Hearings Division, a forum without jurisdiction to enforce an own motion matter. In addition, to have preclusive effect, the final judgment in the prior litigation must be a judgment on the merits of the claim.

> "Thus, where a court dismisses a plaintiff's action on a matter of procedure -- e.g., improper venue, lack of jurisdiction, or nonjoinder of an essential party -- without ruling as to the substantive validity of plaintiff's claim for relief, that dismissal will not generally be res judicata so as to preclude subsequent action based on the same claim. See Restatement ( Second) of Judgment section 20 [(1981)]."

Rennie v. Freeway Transport, supra at 294 Or 330-331.

The point is that the determination made by ALJ Johnson in March 1993 and later affirmed by the Board and the Court of Appeals that the Hearings Division did not have jurisdiction to enforce on own motion order, did not preclude claimant from bringing the enforcement action before the proper forum. In other words, if claimant had raised this enforcement action before the Board in its own motion jurisdiction at the time she requested review of SAIF's March 1993 Notice of Closure, claim preclusion would not have barred that action. See Hellesvig v. Hellesvig, 294 Or 769, 776 n.5 (1983). However, that is not the case here. Claimant did not raise the enforcement issue when she requested "Own Motion" Board review of the March 1993 closure. Furthermore, the Board reached a decision on the merits in that case and affirmed the claim closure. Therefore, for the reasons discussed above, claimant is barred by claim preclusion from now bringing the enforcement action.[2]

Accordingly, on reconsideration, and in lieu of our August 11, 1995 Own Motion Order, we hold as follows. Claimant is precluded from bringing an enforcement action regarding the October 16, 1992 Own Motion Order, as reconsidered on November 25, 1992. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---

[2] We note that SAIF makes several additional arguments in support of its request that we reverse the penalty assessed in our August 11, 1995 Own Motion Order. However, because we find that claimant is precluded from bringing the enforcement action, we need not address SAIF's remaining arguments.

---



In the Matter of the Compensation of
**BRUCE W. ARCHER, Claimant**
WCB Case No. 94-07703
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order which upheld the SAIF Corporation's denial of his bilateral knee injury claim on the ground that the injury did not occur while it was providing coverage for its insured (Westfall Construction). Claimant contends that the claim should be remanded for consolidation with WCB Case # 94-15344, which concerns Westfall's appeal of an order of noncompliance issued by the Department. In its brief, Westfall asserts that the ALJ had no jurisdiction over the issues at hearing and that, alternatively, the case should be remanded for further proceedings to determine whether SAIF is responsible for claimant's injury either as a guaranty insurer or as a statutory claim processor for Westfall. On review, the issues are compensability, jurisdiction and remand.

We deny the motions for remand and adopt and affirm the ALJ's order with the followi ng supplementation.

Claimant, a roofer, filed a bilateral knee injury claim resulting from an incident in which he fell through a rotted section of roof while performing his work activities. SAIF, which insured the employer after November 16, 1993, denied the claim on the ground that the claim was not timely filed and that the injury occurred prior to its coverage of the employer.[1] The ALJ upheld SAIF's denial, reasoning that claimant failed to prove that his injury occurred on or after November 16, 1993.

On review, Westfall (unrepresented at the hearing, but now represented) contends that the Hearings Division had no jurisdiction over the issues at hearing. Westfall alleges that there was no "matter concerning a claim" since the real issue was "coverage." Alternatively, Westfall seeks remand for a determination of responsibility.

Claimant also seeks remand. Claimant agrees with Westfall that the case is really about "responsibility" and asserts that the matter should be remanded to be joined with separate proceedings in WCB # 94-15344. In that case, Westfall is contesting the Department's October 28, 1994 order finding it in noncompliance with Oregon workers' compensation law from October 28, 1993 through November 16, 1993. Alternatively, claimant contends that the ALJ erred in finding that he failed to establish that his injury occurred after November 16, 1993.

Turning to Westfall's jurisdictional argument first, we note that no party raised an issue regarding jurisdiction at the hearing. Notwithstanding the parties' failure to contest jurisdiction at hearing, the issue of subject matter jurisdiction may be raised at any time during the course of litigation. Schlect v. SAIF, 60 Or App 449 (1982); Dena M. Smith, 38 Van Natta 147 (1986), aff'd Smith v. Ridgepine Inc., 88 Or App 147 (1987). Accordingly, we consider Westfall's argument that the ALJ lacked jurisdiction because there was no "matter concerning a claim." See ORS 656.704(3).

A "matter concerning a claim" is one in which a worker's right to receive compensation, or the amount there of, is directly at issue. ORS 656.704(3); Douglas Fredinberg, 45 Van Natta 1619, 1620 (1993). A claimant's right to receive compensation is directly at issue when a denial of compensation is issued, regardless of whether or not claimant appeals. Walter D. Hutsell, 46 Van Natta 1268 (1994).

In this case, a denial of compensation was issued by SAIF when it alleged that claimant's bilateral knee injury claim was not compensable on the ground that it occurred prior to its coverage of Westfall. By reason of SAIF's denial, claimant's right to receive compensation is directly at issue. As a result of the ALJ's decision, claimant may not receive any compensation for his injury in November 1993 insofar as his claim pertains to SAIF's status as a guaranty insurer for Westfall. Consequently, we hold that claimant's hearing request regarding SAIF's denial constitutes a "matter concerning a claim."

We are mindful that a finding that claimant failed to prove that his injury occurred after SAIF assumed insurance coverage does not necessarily mean that claimant will not receive compensation for his injury. In other words, in the event that Westfall is finally determined to be a noncomplying employer, and when the Department eventually refers the claim for processing under ORS 656.054, SAIF (or some other "assigned claims agent" under amended ORS 656.054) may be ultimately responsible for the processing of claimant's injury claim. However, notwithstanding its noncompliance finding, the Department apparently has not referred the claim to an "assigned claims agent" for processing on behalf of the alleged noncomplying employer. Moreover, even if the claim is referred to SAIF (or some other statutory claims processor), it is not a foregone conclusion that claimant will receive compensation because that processor must investigate the claim to determine its response to the claim.

In conclusion, we find that the Hearings Division had jurisdiction to determine the merits of SAIF's denial. Thus, we now proceed to address the remand requests from Westfall and claimant.

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

In this case, we conclude that there is no compelling basis to remand. At hearing, counsel for claimant and SAIF explicitly agreed that the only issue was when claimant's injury occurred. (Trs. 13, 14). Westfall now raises for the first time an issue regarding responsibility, asserting that SAIF should have disclaimed responsibility and advised claimant of other parties that SAIF believed were responsible

[1] SAIF did not assert the timeliness defense at hearing.

for his claim. Westfall now argues that a remand is required so that this matter may be examined in both a compensability and responsibility context.

We disagree with Westfall's contention in light of its failure to raise a responsibility issue at hearing. We recognize that Westfall was unrepresented at hearing. However, extensive discussions were held regarding Westfall's right to counsel. (Tr. 7). Despite those admonitions, Westfall agreed to proceed without representation. Id. Given the parties' express agreement that the only issue at hearing was the date of injury, we find no good cause or compelling basis to remand for a determination of responsibility. Kienow's Food Stores v. Lyster, supra. Therefore, we deny Westfall's motion.

We next address claimant's motion for remand/consolidation with WCB Case No. 94-15344. As previously noted, Westfall has requested a hearing to address the issue of its alleged noncomplying status prior to November 16, 1993. Expressing concern that the ALJ's order may be subject to "collateral attack" in the other proceeding, claimant seeks consolidation to insure that all parties will be present at one proceeding in which to determine responsibility for his injury.

We reject claimant's request. The Department's order finding Westfall in noncompliance had issued by the time of the hearing. Despite his awareness of the order, claimant did not object to proceeding with the hearing on the issue of the date of injury. Even though Westfall had indicated that it had appealed the order finding it in noncompliance with workers' compensation law, claimant did not request consolidation with the noncomplying employer case. Under these circumstances, we conclude that claimant has also failed to establish "good cause" or other compelling basis to justify remand.[2] Id.

## ORDER

The ALJ's order dated March 7, 1995 is affirmed.

---

[2] We acknowledge claimant's concern about the potential for inconsistent rulings. However, our decision declining claimant's request for consolidation with the separate noncomplying employer proceedings will not necessarily result in inconsistent rulings. Our finding that claimant failed to prove that an injury occurred during SAIF's coverage of Westfall does not preclude claimant from proving that an injury occurred during the alleged period of noncompliance prior to November 16, 1993 and receiving the same benefits as he would from a claim against a carrier-insured employer. An injury occurring during a period of noncompliance is processed in essentially the same manner as a claim made by a worker employed by a carrier-insured employer. See ORS 656.054(1).

---



In the Matter of the Compensation of
**RONNA F. DUFF, Claimant**
WCB Case Nos. 94-09876 & 94-04702
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Meyers, Radler, 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) Bethlahmy's order that: (1) set aside its denial of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS) condition; and (2) found that claimant's right CTS surgery was reasonable and necessary treatment related to the compensable CTS claim. On review, the issues are compensability and medical services. We affirm in part and vacate in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. Claimant did not appeal the employer's September 9, 1992 denial of her claim for right CTS.

## CONCLUSIONS OF LAW AND OPINION

### Compensability of Right CTS Claim

Relying on the opinion of Dr. Brett, claimant's treating surgeon, the ALJ found that claimant had established a pathological worsening of her right CTS condition, which was caused in major part by claimant's work activities. On that basis, the ALJ set aside the employer's denial of claimant's claim for an occupational disease relating to her work activity since September 9, 1992. We adopt the ALJ's reasoning and conclusions regarding this issue with the following supplementation.

Claimant did not appeal the employer's September 9, 1992 denial of right CTS. An uncontested denial bars future litigation of the denied condition unless the condition has changed and claimant presents new evidence to support the claim that could not have been presented earlier. Popoff v. J. J. Newberrys, 117 Or App 242 (1992); Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560, 563-64 (1989), rev den 309 Or 645 (1990). A worsening of the denied condition is considered a "changed" condition. See Kepford v. Weyerhaeuser, 77 Or App 363, 365, rev den 300 Or 722 (1986). Thus, claimant is barred from seeking recovery for the right CTS that was the subject of the unappealed September 9, 1992 denial, unless that condition worsened following that denial.

We agree with the ALJ that claimant has established that, following the September 1992 denial, the right CTS pathologically worsened due to her work activities. Therefore, claimant has established a compensable occupational disease claim. Consequently, we need not address claimant's alternative argument presented on review that, pursuant to Georgia-Pacific v. Piwowar, 305 Or 494 (1988), the employer accepted the right CTS condition when it accepted "right hand numbness" on September 4, 1992.

### Medical Services

On review, the employer argues that, because the underlying right CTS condition is not compensable, claimant is not entitled to surgery for that condition. Thus, on review, the employer is making a causation argument in disputing the compensability of the CTS surgery.[1] We have found claimant's right CTS condition compensable. Therefore, the surgical treatment directed at that condition is compensable. Furthermore, Dr. Brett's reports establish that the surgical treatment was directed at the right CTS condition.

In deciding the appropriateness of the right CTS surgery, the ALJ simply stated that "[c]laimant's surgery was reasonable and necessary treatment" and found that it related to the September 9, 1992 claim, rather than the June 10, 1992 claim. To the extent that the ALJ decided the reasonableness and necessity of the right CTS surgery, we find that the ALJ did not have jurisdiction to address that issue.

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[2], 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. We have recently held that the amendments to ORS 656.327(1) apply retroactively to all claims or causes of action arising on or after the effective date of the Act. Walter L. Keeney, 47 Van Natta 1387 (1995). Thus, the Director now has exclusive jurisdiction over ORS 656.327(1) medical services disputes. Id. Therefore, to the extent that the ALJ decided the appropriateness of the CTS surgery, the ALJ did not have jurisdiction to address that issue, and we vacate that portion of her order. Lynda J. Zeller, supra; Walter L. Kenney, supra.

---

[1] Subsequent to the ALJ's order, Senate Bill 369 (SB 369) was enacted. Or Laws 1995, ch 332 (SB 369). The bill added ORS 656.245(6), which provides that review of a disapproved medical service claim is with the Director pursuant to ORS 656.245, 656.260, or 656.327 "[i]f a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim[.]" [Emphasis added]. SB 369, § 25. Because the employer issued a formal denial of the compensability of the underlying claim, i.e., claimant's occupational disease claim for right CTS (Ex. 28A), we retain jurisdiction to review this aspect of the dispute even though it involves a claim for medical services. Id; Lynda J. Zeller, 47 Van Natta 1581 (1995).

[2] ORS 656.260 concerns managed care organizations, which are not at issue here.

Attorney Fees on Review

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issues is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 20, 1994 is vacated in part and affirmed in part. To the extent that the ALJ's order addressed the appropriateness of the carpal tunnel syndrome surgery, that portion of the ALJ's order is vacated. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the self-insured employer.

**Board Member Gunn specially concurring.**

I agree that: (1) claimant has established a compensable occupational disease claim regarding the right CTS condition; (2) we have jurisdiction over the employer's causation argument in disputing the compensability of the right CTS surgery; and (3) the CTS surgery was causally related to and directed at the compensable right CTS condition. I also agree that, if the employer disputes the reasonableness and necessity of the CTS surgery, resolution of that dispute is with the Director. Amended ORS 656.327(1); Walter L. Keeney, 47 Van Natta 1387 (1995). I write only to note the lack of administrative economy and the delays in reaching a final decision regarding medical service issues that the legislature has brought about by splitting jurisdiction of those issues between the Hearings Division and the Director.

In the Keeney decision, I concurred in part and dissented in part. A portion of my dissent was directed at the precise problem that the current case presents; namely that, under Senate Bill 369, both the Hearings Division and the Director have jurisdiction over different aspects of the same medical services case. Prior to Senate Bill 369, the parties could choose to resolve the entire dispute regarding a medical service issue at the Hearings Division, which had the authority to resolve medical treatment issues regarding both causation and appropriateness of treatment. That option is no longer available. In its place, Senate Bill 369 directs that all appropriateness of treatment issues must be resolved by the Director.

Thus, contrary to the stated objectives of the Workers' Compensation Law to reduce litigation "to the greatest extent practicable" and to provide "sure, prompt and complete medical treatment for injured workers," the split-jurisdiction system created by Senate Bill 369 actually creates more litigation and delays the provision of medical services. ORS 656.012(2)(a), (b). This case demonstrates that fact. Here, the statutes in effect as of the date of hearing allowed the parties to resolve the medical services dispute in one forum, the Hearings Division. Now, under Senate Bill 369, if the employer disputes the reasonableness and necessity of the CTS surgery, it must take that dispute to the Director. However illogical I find that result, it is the obvious intent of the legislature. Therefore, I have no option but to follow it. Accordingly, I concur with this decision.

In the Matter of the Compensation of
**RHONDA L. HITTLE, Claimant**
WCB Case No. 94-06276
ORDER ON REVIEW
Max Rae, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) determined that a registered nurse (RN) was, and a veterinarian was not, qualified to serve as an expert witness in this case; (2) excluded from evidence documents pertaining to tuberculosis (TB); (3) limited claimant's cross-examination of the RN witness; (4) upheld the self-insured employer's denial of claimant's injury claim related to a positive TB skin test; and (5) upheld the employer's denial of claimant's occupational disease claim for TB exposure. Claimant filed a supplemental brief, alleging that the retroactive application of Oregon Laws 1995, chapter 332 (SB 369), to this claim violates certain constitutional and statutory provisions. The employer asserts that claimant's supplemental arguments are frivolous, and therefore, warrant the imposition of a penalty. On review, the issues are evidence, remand and, alternatively, compensability and penalties. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Evidence/Remand

Claimant argues that the ALJ erred by: (1) ruling that her veterinarian witness was not qualified to testify as an expert regarding claimant's TB claims; (2) excluding certain documents pertaining to TB; (3) ruling that the employer's RN witness was a qualified expert witness; and (4) limiting claimant's cross-examination of the RN witness. We need not address those issues because, even if we considered the veterinarian's testimony and the contents of the excluded documents, and excluded the RN's testimony, for the reasons explained below, we agree with the ALJ that neither of claimant's claims is compensable.

### Compensability -- Injury Claim

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

Claimant asserts that her allegedly[1] positive TB skin test was a compensable injury. She argues that, because the skin test, which involved the subcutaneous injection of test material in her forearm, occurred at work and was a sudden event, her reaction to the test is a compensable injury. She refers us to Kelly Barfuss, 44 Van Natta 239 (1992), in support of her position. We disagree with claimant's line of reasoning.

A compensable injury is "an accidental injury * * *; an injury is accidental if the result is an accident, whether or not due to accidental means[.]" ORS 656.005(7)(a) (emphasis added). Any worker "'who undesignedly and unexpectedly suffer(s) a hurt, without reference to whether the cause of the injury itself was accidental,' meets the requirement of an 'accidental' injury." Mathel v. Josephine County, 319 Or 235, 241 (1994) (quoting Olson v. State Ind. Acc. Com., 222 Or 407, 413 (1960)).

As the ALJ properly concluded, claimant's skin test was neither undesigned nor unexpected; she knowingly and voluntarily underwent the procedure. Therefore, the test itself was not accidental. Mathel, supra, 319 Or at 241. Moreover, because claimant's positive reaction was not an undesigned or unexpected result of the test, her reaction also was not accidental. Id. Accordingly, we agree with the ALJ that claimant's skin test injury claim fails.

---

[1] The employer contests claimant's assertion that the TB test was positive, because no one "read" the test within the specified time. In view of our conclusion that claimant's injury claim fails, we do not address that issue.

Kelly Barfuss, supra, does not aid claimant. That case involved an accidental needle stick injury. Here, neither claimant's needle stick skin test, nor her reaction to the test, was accidental. Consequently, Barfuss is distinguishable.

In sum, for the reasons set forth in the ALJ's order, as supplemented here, we agree with the ALJ's decision to uphold the employer's denial of claimant's skin test injury claim.

Compensability -- Occupational Disease

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

Claimant asserts that her TB exposure is a compensable occupational disease. We disagree. Although claimant, a county jail corrections officer, worked with a population that is at higher risk than the general population for developing TB, there is no evidence that, during the relevant time, she came into contact with anyone at work who had active TB.[2] (See Exs. 2, 4-2; Tr. 35, 51). On this record, claimant has established only that she had an increased risk of being exposed to TB at work; there is insufficient evidence that she actually was exposed to the disease at work. Therefore, claimant's TB occupational disease claim fails. Tamara D. Hergert, 45 Van Natta 1707 (1993) (TB claim held not compensable when claimant had not affirmatively proved any exposure to TB in the course of her employment); see John A. Hoffmeister, 46 Van Natta 1688, on recon 46 Van Natta 1891 (1994) (Hepatitis C exposure claim held not compensable when evidence failed to establish incidence of disease in population with which claimant interacted at work), aff'd mem Hoffmeister v. City of Salem, 134 Or App 414 (1995). Accordingly, we affirm the ALJ's decision upholding the employer's denial of claimant's occupational disease TB claim.

Supplemental Arguments

In conducting our review of this case, we have acknowledged claimant's supplemental briefs, in which she contends that certain sections of SB 369 violate Article I, section 10, of the Oregon Constitution and the Americans With Disabilities Act (ADA), 42 USCA § 12101 et seq. 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 her TB claims are compensable.

We do not address those arguments because, even under the material contributing cause standard, claimant's occupational disease claim fails for lack of evidence that she was exposed to TB at work. Moreover, her injury claim fails for reasons that, as explained above, have nothing to do with the material contributing cause standard. Thus, even if we agreed with claimant's constitutional and ADA arguments, we would continue to find that the record does not establish the compensability of either of her claims.

Penalties

The employer asserts that claimant's supplemental arguments are frivolous and, therefore, warrant the imposition of a penalty under ORS 656.390. We disagree.

ORS 656.390(1) gives us the authority to impose an appropriate sanction against an attorney who files a frivolous request for review. "'[F]rivolous' means the matter is not supported by substantial evidence or the matter isinitiated without reasonable prospect of prevailing." ORS 656.390(2)[3]; see Westfall v. Rust International, 314 Or 553 (1992) (defining "frivolous" under former ORS 656.390).

---

[2] Some, but not all, inmates in the facility in which claimant worked were tested for TB exposure. Some of the inmates had positive TB skin tests, which reveals their exposure to someone with active TB; no inmate, however, tested positive for active TB.

[3] ORS 656.390(2) was added to the Act by SB 369, § 45. Because that section is not excluded from the general retroactivity provisions of the bill, see SB 369, § 66, it applies to this case. See Volk v. America West Airlines, 135 Or App 565 (1995) (SB 369 applies to matters for which the time to appeal the Board's decision has not yet expired, or if appealed, has not been finally resolved on appeal).

Here, claimant's request for review was not frivolous. She raised colorable arguments regarding the evidentiary record and applicable legal standards. Moreover, to the extent that her supplemental brief constitutes a "request," we are not inclined to find it frivolous.

Although claimant raised the constitutional and ADA arguments for the first time on review, it is within our discretion to address them. Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991). Further, claimant's supplemental arguments are sufficiently developed so as to create a reasonable prospect of prevailing on the merits.[4] Consequently, although we reject claimant's supplemental arguments, we do not find them legally frivolous. Accordingly, we do not impose a sanction under ORS 656.390(1).

In sum, for the reasons set forth in the ALJ's order, as supplemented here, we affirm the ALJ's order in its entirety.

ORDER

The ALJ's order dated February 2, 1995 is affirmed.

[4] The employer refers us to a case that concluded that a former version of the Workers' Compensation Act (which gave workers and employers the option of accepting or rejecting the Act's coverage) did not violate Article I, section 10, of the Oregon Constitution. Evanhoff v. State Industrial Acc. Com., 78 Or 503 (1915). The employer also asserts that claimant's ADA argument raises a federal preemption question, over which this Board lacks jurisdiction. In the absence of specific controlling authority that directly applies to the matters at issue, the employer's arguments do not persuade us that claimant has no reasonable prospect of prevailing on the merits of her supplemental arguments.

**Board Member Gunn concurring in part and dissenting in part.**

I write to express my views regarding claimant's evidentiary arguments and her occupational disease claim.

On the basis of its conclusion that neither of claimant's claims is compensable, the majority declines to address claimant's arguments regarding the expert status of the registered nurse (R.N.) and veterinarian witnesses in this case. I find neither witness an "expert" for purposes of evaluating claimant's tuberculosis (T.B.) claims. Both witnesses lack the medical expertise necessary to render their testimony probative regarding the cause of claimant's positive T.B. test. Accordingly, I agree with the ALJ's decision to disqualify the veterinarian, and would have done the same regarding the R.N.[1]

Next, I disagree with the majority's analysis regarding the merits of claimant's occupational disease claim.[2] The majority concludes that, based on lack of evidence that claimant came into contact with specific persons at work who had active T.B., her occupational disease claim fails.

That standard imposes an almost insurmountable burden on claimant. In "exposure" cases such as this, I would find it sufficient that claimant established that: (1) her work involved a heightened risk of contracting a particular disease; (2) she was exposed to the disease; and (3) the exposure is the major contributing cause of a positive test for the disease and need for medical services. See John A. Hoffmeister, 46 Van Natta 1689, 1691 (Member Gunn, dissenting), on recon 46 Van Natta 1891 (1994), aff'd mem Hoffmeister v. City of Salem, 134 Or App 414 (1995).

All three of those elements are satisfied here. First, no one seriously disputes that claimant's work involves a heightened risk of contracting T.B.; why else would the employer perform routine T.B. testing? Second, claimant's positive T.B. test reveals her exposure to persons with that disease. Last, I would find that, in view of the first two elements, and because there is absolutely no evidence that claimant was ever exposed to T.B. away from work, claimant's work activities were the major contributing cause of her positive T.B. test and need for medical services.

Because the majority concludes otherwise, I dissent.

[1] In view of that conclusion, I find it unnecessary to address claimant's arguments regarding the ALJ's limitations on cross-examination of the R.N.

[2] Although claimant does not have active T.B., I find that her T.B. exposure constitutes a "disease" for purposes of her occupational disease claim.

In the Matter of the Compensation of
**JON T. MARS, JR., Claimant**
WCB Case No. 92-01535
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
David L. Runner (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. SAIF v. Mars, 129 Or App 103, rev allowed 320 Or 325 (1994), rev dismissed 321 Or 418 (1995). The court reversed our prior order, Jon T. Mars, Jr., 45 Van Natta 536 (1993), that modified a Director's order which found that the Director lacked jurisdiction to review claimant's eligibility for vocational assistance. Citing to Harsh v. Harsco Corp., 123 Or App 383 (1993), rev den 318 Or 661 (1994), the court has remanded for reconsideration.

## FINDINGS OF FACT

We adopt the "Findings of Fact" as contained in the Administrative Law Judge's (formerly Referee's) order.

## CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable injury to his right knee in 1982. In September 1991, following expiration of claimant's "aggravation rights," we reopened the claim pursuant to our own motion authority. SAIF denied claimant's subsequent request for vocational assistance and claimant requested administrative review by the Director to determine his eligibility for such benefits.

The Director issued an Order of Dismissal finding a lack of jurisdiction to review the matter, reasoning that our Own Motion reopening of the claim could not be a basis for awarding vocational assistance. The ALJ affirmed the Director's order.

On review, we found that the Director had jurisdiction to determine claimant's eligibility for vocational services. Further concluding that the Director's rules which prevented workers whose aggravation rights had expired from being eligible for vocational assistance contravened the relevant statute, we modified the Director's order and instructed the insurer to provide claimant the same vocational assistance benefits he would receive if his aggravation rights had not expired. Jon T. Mars, Jr, supra.

The Court of Appeals reversed and remanded, citing to Harsh v. Harsco Corp., supra. In that case, the court held that "the only benefits available to a claimant whose aggravation rights have expired are those referred to in ORS 656.278(1)." 123 Or App at 387. Because that statute was limited to providing only certain medical services and temporary disability benefits, and not vocational assistance, the court concluded that the Director was correct in denying the claimant's vocational assistance following expiration of his aggravation rights.[1] Id.

The Supreme Court, after initially allowing the petition for review in this case, dismissed its review as having been improvidently granted. Thus, we proceed with our reconsideration pursuant to the Court of Appeals' decision.

Subsequent to the court's decision, the Legislature amended ORS 656.283(2) by charging the Director "with the duty of creating a procedure for resolving vocational assistance disputes in the manner prescribed in this subsection." Or Laws 1995, ch 332, § 34(2) (SB 369, § 34(2)). Based on the retroactive application of this statute, we have held that exclusive jurisdiction over vocational assistance disputes rests with the Director. Ross M. Enyart, 47 Van Natta 1540 (1995). Therefore, in Enyart, we vacated the ALJ's order and dismissed claimant's hearing request for lack of jurisdiction.

---

[1] Board member Gunn points out that this decision confirms Judge Buttler's concurrence in Colclasure v. Washington County School District No. 48-I, 117 Or App 128, 125 (1992): "[c]oncededly, the statutory process dictated by ORS 656.283(2) is peculiar and, perhaps, unfair to claimants. However, that is a question for the legislature to resolve.

Because no order or decision in this case has become final, amended ORS 656.283(2) applies to this case. SB 369, § 66; see Manuel Altamirano, 47 Van Natta 1499, 1500 (1995) (Board applied amended statute on remand rather than court's holding). Inasmuch as we have held that the statute places exclusive jurisdiction to resolve vocational assistance disputes with the Director, we conclude that we lack jurisdiction to consider the vocational assistance matter in this case.

Accordingly, on reconsideration, we vacate the ALJ's June 24, 1992 order, and dismiss claimant's hearing request from the Director's order.

IT IS SO ORDERED.

---



In the Matter of the Compensation of
**MARK E. HART, Claimant**
WCB Case No. 94-13216
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of his bilateral hernia condition. On review, the issue is compensability.

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

The ALJ found that the medical evidence preponderated "ever so slightly" in favor of a finding that claimant has a hernia condition. The ALJ analyzed the claim as an occupational disease and concluded that claimant did not meet his burden of proving that his hernia condition was due in major part to his work exposure.

Claimant argues that the material contributing cause standard applies and he contends that his testimony establishes that he suffered a compensable injury. Claimant asserts that he first felt pain in his groin area in mid-August when he slipped during work. Claimant testified:

> "And I felt some pain and I bent over for a little bit, about five minutes, and then walked around and got back inside the truck and just kept driving. It hurt for about 15, 20 minutes and over the course of an hour, it kind of gradually went away and I was busy and still had about 50 stops to make and kind of forgot about it." (Tr. 5, 6)

Claimant did not report this incident to the employer and did not seek any medical treatment.

Claimant's testimony at hearing is inconsistent with the history documented in the medical reports. Dr. Hirons examined claimant on August 26, 1994 and reported that claimant "had no discomfort or untoward incidences [sic] while working for [the employer]." (Ex. 3). Dr. Hirons found some generousness to the inguinal opening on the right side but was "not very impressed" with claimant having a hernia. (Id.) Dr. Hirons thought that "there would be the possibility of an argument over whether or not it was related to his work at [the employer's], as there was no specific incident of injury or awareness of pain syndrome." (Id.)

Dr. Hoversten reported that claimant had been working for the employer doing deliveries "from 10 to 14 hours a night, stepping in and out of a truck with very high steps multiple times each day." (Ex. 5). Dr. Hoversten did not document any specific incidents at work where claimant had slipped or had any groin pain.

Dr. Bender examined claimant on behalf of the insurer. Although Dr. Bender referred to an incident when claimant slipped at work, his report indicated that claimant did not feel an acute onset of pain in the groin area. Dr. Bender reported:

> "[Claimant], while he was employed at [the employer] did not have any injury that could have provoked a hernia. He does recollect one incident when he slipped on the steps of his delivery truck, hung onto the door handle and became somewhat stretched out. This accident, however, would not produce any increased stress to the inguinal areas and he did not feel any acute onset of pain in those areas." (Ex. 8).

Dr. Bender did not find evidence of inguinal hernias during his exam and he concluded that there was no history of an injury that would have provoked a hernia. (Id.)

Claimant does not adequately explain why the medical reports are inconsistent with his testimony of a specific injury with immediate onset of pain. In any event, even if we analyze the claim as an injury and apply a material contributing cause standard, the medical evidence does not support an injury theory of causation.

Since claimant did not seek treatment in connection with the August work incident and in light of the other possible causes of his bilateral hernia condition, we consider the causation issue to be a complex question. Therefore, we rely on expert medical opinion to resolve the issue. 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).

Although claimant argues that we should defer to his treating physician, Dr. Hoversten, Dr. Hoversten's opinion does not support an injury theory of causation. Rather, Dr. Hoversten relied on an occupational disease theory. Dr. Hoversten reported:

> "In view of the fact that he had had a pre-employment physical examination that showed he did not have inguinal hernias present prior to being employed by [the employer], I must assume that the activities he performed while employed by [the employer] were the direct cause of his now-diagnosable bilateral inguinal hernias." (Ex. 7).

Dr. Hoversten agreed that the heavy work activity claimant performed at the employer could have made a "condition that was asymptomatic and non-diagnosable become symptomatic and in need of treatment." (Id.)

Even if we analyze claimant's claim as an occupational disease, we are not persuaded by Dr. Hoversten's conclusory opinion. Dr. Hoversten "assumes" that claimant's work activities caused the bilateral hernia condition since the pre-employment exams did not show that condition. Dr. Hoversten's opinion establishes, at most, the possibility, not the probability, of a causal connection between claimant's hernia condition and his employment. See Miller v. SAIF, 60 Or App 557 (1982); Gormley v. SAIF, 52 Or App 1055 (1981). Furthermore, Dr. Hoversten relied heavily on a temporal relationship between claimant's symptomatology and the alleged work exposure. The temporal relationship, in and of itself, is insufficient to establish medical causation. See Allie v. SAIF, 79 Or App 284 (1986).

Dr. Hirons reported that, although claimant's work conditions may have caused his hernia condition, it was equally possible that his condition pre-existed his employment (and was overlooked by the first pre-employment physical) or was caused by non-work activities. (Ex. 9). Although Dr. Bender did not find evidence of a hernia condition, he also concluded that there was no history of an injury that would have provoked a hernia. (Ex. 8).

We conclude that claimant has not sustained his burden of proving that his work activity was a material or major contributing cause of his bilateral hernia condition. Accordingly, we affirm the ALJ's order.

## ORDER

The ALJ's order dated February 27, 1995 is affirmed.

**Board Member Hall specially concurring.**

Claimant urges the Board to accept his sworn testimony regarding the events surrounding his injury, rather than accepting the "history" contained in various medical reports. While ultimately I find

insufficient evidence to support this claim,[1] I write separately to express my view concerning claimant's sworn testimony.

At hearing, a claimant has been sworn to tell the truth and is subject to cross-examination, including impeachment by prior inconsistent statements. Unless claimant is found to be a non-credible witness, or unless there are other grounds to find claimant less persuasive, it is reasonable to accord claimant's sworn testimony of events greater weight than the history of events recorded in medical reports. After all, medical reports are admitted into the record in a workers' compensation proceeding under a statutory exception to the hearsay rule.[2]

Certainly arguments can be made (and usually are) on both sides of this issue. For example, a claimant's history given to a physician immediately after an injury and before any litigation may be more reliable. On the other hand, histories taken by physicians are primarily taken to aid diagnosis, not litigation, and during a medical examination, a claimant may not fully explain the history of symptoms or comprehend the importance of providing full details. In addition, claimants are not given the opportunity to review chart notes and correct mistakes. In my view, it is reasonable to accept a claimant's sworn testimony regarding the events surrounding an injury as more probative than hearsay histories recorded in medical reports.

---

[1] The record contains only one medical report that evaluated claimant's "injury" history. However, Dr. Bender reported that the accident would not produce any increased stress to claimant's inguinal areas and he concluded that there was no history of an injury that would have provoked a hernia. (Ex. 8). Furthermore, the medical opinion most favorable to claimant, that of Dr. Hoversten, is couched in terms of possibility, not probability, and is not sufficient to meet claimant's burden of proof.

[2] ORS 656.310(2) provides, in part: "The contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein; so, also, shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical and surgical reports consents to submit to cross-examination."

---



In the Matter of the Compensation of
**JOYCE M. RAMIREZ, Claimant**
WCB Case Nos. 94-11822 & 94-11457
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Walace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its current condition denial of claimant's low back condition. On review, the issue is compensability.

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

---

[1] The insurer submits that because "claimant presented herself for surgery with a preexisting condition," SB 369 § 1(24) supports its position that claimant's current condition and need for treatment are not related to the compensable 1985 work injury. ORS 656.005(24) provides: "'Preexisting condition' means any injury, disease . . . or similar condition that contributes or predisposes a worker to a 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." Or Laws 1995, ch 332, § 1(24) (SB 369 § 1(24)).

The insurer apparently argues that the original industrial injury itself may constitute a "preexisting condition" where a claim for further medical services is presented. We do not agree with that reading of the statute. Moreover, the insurer's invocation of ORS 656.005(24) notwithstanding, the gist of its argument is not that claimant's current condition and need for treatment are due to a "preexisting condition," but rather that her current condition is the result of intervening trauma. We therefore do not find application of a "preexisting condition" analysis appropriate in this instance. In any event, were we to apply a "preexisting condition" analysis, on this record, we would find, as did the ALJ, that claimant has established that the compensable injury of October 1985 is the major contributing cause of her current condition and need for surgery.

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 $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 25, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the insurer.

---



In the Matter of the Compensation of
**AMY L. WATERS, Claimant**
WCB Case No. C5-01989
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Haynes and Hall.

On July 21, 1995, the Board acknowledged the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

On July 24, 1995, the Board noted that part of the consideration underlying the CDA was waiver by the insurer of its "lien on any recovery of benefits by the claimant as to a third-party claim." The Board asked for an addendum containing information whether a third party settlement or judgment had been reached and, if so, the amount of such settlement.

On October 17, 1995, we received an addendum stating that the insurer had a lien in the amount of $18,252.98 which it could recover from the third party settlement proceeds. The document further provided that such amount, in combination with a lump sum payment of $1,000, gave a total consideration of $19,252.98. There was no information whether a third party settlement had been achieved and its amount.

Generally, we disapprove CDAs in which consideration for the agreement consists of the carrier's reduction of a lien, but the CDA contains no provision indicating that a third party settlement or judgment has been achieved. E.g., Kenneth Hoag, 43 Van Natta 991 (1991). We reach this conclusion because the "value" of any consideration flowing to the claimant as a result of the CDA where no third party settlement has been achieved is not "presently ascertainable." Id.

We have distinguished such cases, however, from those that also provide a lump sum payment to the claimant along with a waiver of a lien. Howard S. Johnson, 47 Van Natta 1049 (1995). Specifically, we have found that, when the CDA provides for a lump sum payment, there is an "amount to be paid claimant" that is "presently ascertainable." Furthermore, when that amount by itself, whether or not the claimant achieves an increased portion of any third party settlement proceeds because the carrier agreed to reduce or eliminate its lien, is sufficient to qualify the CDA as not unreasonable as a matter of law, we approve the disposition. Id.

We find that this case falls under the latter category. In particular, because the CDA provides for a lump sum payment of $1,000 and that amount by itself is sufficient for the disposition to not be unreasonable as a matter of law, we approve it.

In conclusion, we hold that the CDA is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1). Therefore, the parties' CDA is approved. Claimant's attorney fee of $250 also is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
**ROSEMARY MINARD, Claimant**
WCB Case No. 95-01603
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order which found that claimant's claim was prematurely closed. In the event that we do not find claimant's claim prematurely closed, claimant contests the Order on Reconsideration, which did not award permanent disability for a neck and upper back injury. On review, the issues are premature claim closure and permanent disability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt his ultimate findings of fact in regard to claimant's claim being prematurely closed.

## CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable injury on May 19, 1994. The SAIF Corporation, on June 6, 1994, accepted a claim for "cervicaothoracic strain." (Ex. 21). On July 8, 1994, claimant began treating with Dr. Steinhauer, who diagnosed neck, upper back and left peri-scapular strains. (Ex. 26). He ordered physical therapy and released claimant to part-time light duty work.

Claimant returned to Dr. Steinhauer on July 12, 1994, who continued the physical therapy. (Ex. 30). On July 22, 1994, Dr. Steinhauer found restricted cervical ranges of motion with crepitus in left shoulder abduction. (Ex. 32). Dr. Steinhauer noted that there would be a delay in claimant reaching medically stationary status due to her going to Arizona. Id.

Responding to an August 3, 1994, letter from SAIF, Dr. Steinhauer stated that claimant was expected to be medically stationary by August 12, 1994. However, Dr. Steinhauer could not officially determine the date until she returned to his office. (Ex. 37).

On August 4, 1994, claimant went to Arizona to stay with her terminally ill mother. While in Arizona, she began treating with Dr. Baird, who found full range of motions in claimant's cervical and shoulder regions. (Ex. 40). Dr. Baird did not respond to SAIF's letter which asked Dr. Baird to fill out an attending physician form and whether he thought claimant was medically stationary. (Ex. 46). Claimant remained in Arizona until September 26, 1994.

Upon returning to Oregon, claimant was instructed by SAIF, to see Dr. Steinhauer on September 27, 1994. (Ex. 53). His examination found no nodules or areas of spasms in claimant's left scapular region. Additionally, he reported that claimant had full range of motion in her shoulders and no crepitus on her left side. Claimant informed Dr. Steinhauer that Dr. Baird recommended 6 more weeks of therapy. Dr. Steinhauer did not perform a closing examination, because claimant informed him that she was going to seek a new attending physician. Dr. Steinhauer noted that he had no medical reason to change his opinion that claimant was medically stationary by August 12, 1994.

Claimant was examined by Dr. Quarum, on behalf of SAIF, on October 3, 1994. (Ex. 56). Dr. Quarum found tenderness at the left scapula and mid-trapezius area with right and left cervical bending limited to 35 degrees. He reported that claimant had no permanent impairment. Dr. Quarum diagnosed cervical/thoracic strain by history. He agreed with Dr. Steinhauer that claimant was medically stationary.

SAIF closed claimant's claim on October 4, 1994, noting a medically stationary date of August 12, 1994. (Ex. 57). Claimant requested reconsideration.

Claimant was examined by Dr. Takacs on October 13, 1994, who diagnosed chronic cervical-thoracic strain/somatic dysfunction with mild upper extremity overuse syndrome and mild left thoracic

outlet syndrome. (Ex. 59A-2). Dr. Takacs opined that claimant was medically stationary in regard to her cervical-thoracic strain, but that some palliative care would be appropriate for her thoracic outlet syndrome.

On December 5, 1994, Dr. Takacs treated claimant's cervical-thoracic dysfunction and thoracic outlet syndrome. He did not believe that claimant was medically stationary (in regard to these conditions) at that time. (Ex. 64A). On January 10, 1995, Dr. Takacs pronounced claimant to be medically stationary. (Ex. 66 A).

On January 13, 1995, Dr. Watson, medical arbiter, reported that claimant's cervical-thoracic strain had resolved. (Ex. 67-4). He found no objective evidence of impairment and believed that claimant could resume her regular work. Dr. Watson who did not offer an opinion on when claimant became medically stationary.

Dr. Turner, on referral by Dr. Takacs, diagnosed somatic dysfunction in the cervical, thoracic and rib regions. (Ex. 69A). He treated claimant with osteopathic manipulation. On April 29, 1995, Dr. Turner believed that claimant was not medically stationary based on her condition improving after six visits to his office. He believed that, if she were medically stationary, claimant's impairment would be minimal. (Ex. 72).

On January 31, 1995, an Order on Reconsideration found claimant to be medically stationary on September 27, 1994, and affirmed the October 4, 1994 closure, in all other respects. Claimant requested a hearing.

The ALJ found that claimant's claim was prematurely closed. In so doing, the ALJ relied on the medical opinions of Drs. Baird and Takacs.

On review, SAIF contends that the medical evidence supports a finding that claimant's claim was not prematurely closed. We agree.

It is claimant's burden to prove that her claim was prematurely closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). In determining whether claimant has carried this burden, we examine medical evidence available at the time of closure, as well as evidence thereafter, except that which pertains to changes in claimant's condition subsequent to closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). The propriety of the closure turns on whether claimant was medically stationary at the time of the October 4, 1994, Notice of Closure. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). "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, we find that claimant's compensable condition was medically stationary when the October 4, 1994, Notice of Closure issued. On August 4, 1994, Dr. Steinhauer projected that claimant would be medically stationary on August 12, 1994. In September 27, 1994, (prior to claim closure) Dr. Steinhauer stated that he had no medical reason to change claimant's medically stationary date of August 12, 1994. See James Canton, 44 Van Natta 2435 (1992) (a projection of when a claimant might be medically stationary is unacceptable unless a subsequent report confirms that the claimant achieved medically stationary status as projected).

The October 3, 1994 report of Dr. Quarum agreed with Dr. Steinhauer's medically stationary findings. As such, we find that the preponderance of the persuasive medical evidence supports a conclusion that claimant's claim was not prematurely closed on October 4, 1994. In making this decision, we find the opinions of Drs. Baird, Takacs and Turner, unpersuasive for the following reasons.

Dr. Baird does not advance an opinion in regard to claimant's medically stationary status. Although claimant testified that Dr. Baird recommended six weeks of physical therapy upon her return to Oregon, there is no report to substantiate this recommendation. Further, the recommending of physical therapy in and of itself does not support a finding that claimant was not medically stationary. Don M. Boldman, 44 Van Natta 1809 (1992) (although some improvement was to be expected from physical therapy, that improvement was insufficient to alter the claimant's medically stationary date);

Bobby G. Todd, 42 Van Natta 2421 (1993) (further testing and recommendations of physical therapy do not necessarily represent that further improvement could have been reasonably expected at claim closure).

We also find Dr. Takacs' opinion unpersuasive because he was not able to advance an opinion as to whether claimant was medically stationary as of October 4, 1994, the date of claim closure. Sullivan v. Argonaut Ins. Co., supra. Similarly, we do not rely on the opinion of Dr. Turner, because his opinion as to claimant's stationary status appears to be based on subsequent improvements, rather than claimant's condition at the time of closure. Scheuning v. J. R. Simplot & Company, supra.

Based on the persuasive opinions authored by Drs. Quarum and Steinhauer, we conclude that claimant was medically stationary on the date of closure. ORS 656.266. Consequently, her claim was not prematurely closed.

Alternatively, claimant requests that she be awarded permanent disability. Based on the following reasoning, we affirm the Order on Reconsideration which did not award permanent disability.

With the exception of a medical arbiter, findings concerning a claimant's impairment can be made only by the attending physician at the time of claim closure. Dennis E. Conner, 43 Van Natta 2799 (1991). Medical evidence regarding permanent impairment must come from the findings of the attending physician or other physicians with whom the attending physician agrees. See Roseburg Forest Products v. Owen, 129 Or App 442 (1995); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). Reports of insurer-arranged medical examiners are not admissible for the purpose of rating impairment unless those findings are ratified by the claimant's attending physician. See OAR 436-35-007(8 ); Tektronix, Inc. v. Watson, 132 Or App 483 (1995) (attending physician rated claimant's impairment where he incorporated the findings of the consulting physician and noted that claimant had no significant impairment).

Here, the medical arbiter, Dr. Watson, did not find any signs of permanent impairment. Additionally, regardless of whether Dr. Baird or Dr. Steinhauer was the attending physician at claim closure (as there was a dispute) neither physician's reports support an award of permanently disability. Dennis E. Conner, supra. For instance, Dr. Baird found full range of motion in claimant's shoulders and cervical region. He believed that claimant would "get over" her industrial injury with manipulative treatment. Dr. Baird did not report any permanent impairment as a result of claimant's industrial accident. Similarly, Dr. Steinhauer's reports do not support an award of permanent impairment As such, claimant has not proven entitlement to a permanent disability award.

ORDER

The ALJ's order dated May 30, 1995 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is reversed.

---

November 2, 1995 Cite as 47 Van Natta 2134 (1995)

In the Matter of the Compensation of
**WALTER J. REZNICSEK, Claimant**
Own Motion No. 93-0572M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Scott McNutt, Claimant Attorney
John M. Pitcher, Defense Attorney

The self-insured employer has requested reconsideration of our August 2, 1995 Own Motion Order Reviewing Carrier Closure which: (1) affirmed its' December 1, 1994 Corrected Notice of Closure; and (2) assessed a penalty equal to 25 percent of the procedural temporary disability benefits due between April 18, 1994 and December 1, 1994 for the employer's unreasonable failure to pay those benefits. In order to fully consider the employer's motion, we abated our order and allowed claimant an opportunity to respond. Claimant has not responded. After considering the employer's motion and memorandum in support, we issue the following order.

The employer contends that: (1) we lacked jurisdiction under ORS 656.278 to consider the penalty issue; (2) it was improper for us to have raised the penalty issue *sua sponte;* and (3) we erred in assessing a penalty. After conducting our reconsideration, we modify our prior order.

The Board, and not the Hearings Division, has jurisdiction over issues emanating from an own motion order. See Orman v. SAIF, 131 Or App 653 (1994); Darlene M. Welfl, 44 Van Natta 235 (1992); David L. Waasdorp, 38 Van Natta 81 (1986). Inasmuch as claimant's procedural entitlement to temporary disability emanates from our order which reopened his claim, we have jurisdiction to consider whether a penalty is appropriate in this matter.

With regard to the employer's contention that it was improper for us to raise the penalty issue, we note that it is within the Board's discretion to address an issue not raised by the parties. See e.g. Destael v. Nicolai Companies, 80 Or App 596 (1986). Moreover, as noted above, the Board has the authority under ORS 656.278 to address issues relating to an own motion order. Consequently, we are not persuaded by the employer's contention.

Nevertheless, because claimant did not request us to find the employer's conduct unreasonable, nor did he request a penalty, we conclude that we should not have exercised our authority to assess a penalty. See Frank L. Korkow, 47 Van Natta 1481 (1995). Consequently, we modify our original order and decline to award a penalty for the employer's failure to pay procedural temporary disability benefits between April 18, 1994 and December 1, 1994.[1]

Finally, we note that the employer's motion contained certain statements pertaining to the Board's review of this matter. While the Board welcomes appropriate motions addressing errors that need corrections, we expect parties to conduct themselves in a professional manner with respect for the forum.

On reconsideration, as modified herein, we adhere to and republish our August 2, 1995 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

[1] We note that, although the employer was statutorily obligated to pay temporary disability compensation between June 24, 1994 and July 1, 1994 when it closed the claim, the employer did not do so. However, because claimant did not specifically ask for a penalty associated with that week of unpaid temporary disability benefits, we choose not to assess a penalty.

---

November 3, 1995 Cite as 47 Van Natta 2135 (1995)

In the Matter of the Compensation of
**MICHAEL BLAIR, Claimant**
WCB Case No. C5-02927
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Coons, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

By order dated October 20, 1995, the Board disapproved the parties' claim disposition agreement (CDA). We did so based on our finding that the CDA, in providing that claimant's waiver of the 30-day "cooling off" period was irrevocable, exceeded the statutory provisions of amended ORS 656.236 and was, therefore, unreasonable as a matter of law. In disapproving the CDA, we advised the parties that they may move for reconsideration of our order by submitting an addendum removing the offending language.

On October 25, 1995, the parties submitted an addendum removing the offending language. Specifically, the parties modified paragraph 17 on page 3 of the CDA to remove the language which provided that claimant's waiver was "irrevocable." As amended by the addendum, we find that the parties' CDA is consistent with the provisions of amended ORS 656.236.

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 Laws 1995, ch 332, § 24(1)(a) (SB 369, § 24); OAR 438-09-020(1). Therefore, the parties' claim disposition agreement is approved. An attorney fee of $5,875, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

---

November 3, 1995 Cite as 47 Van Natta 2136 (1995)

In the Matter of the Compensation of
**GARY M. BROWN, Claimant**
WCB Case No. 94-09415
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

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

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

Finding that none of the doctors who provided an opinion regarding the medical causation of claimant's condition had a complete and accurate history, the ALJ concluded that claimant had failed to prove "medical" causation and, therefore, failed in carrying his burden of establishing compensability. On review, claimant contends that there is no indication that knowledge of the 1991 motorcycle accident which injured his low back or review of the 1991 x-rays showing preexisting L5-S1 spondylolisthesis would have changed the doctors' opinions.

Such knowledge may or may not have changed the doctors' opinions. Because, however, the doctors were unaware of, and therefore, were precluded from considering other potential causes that could have contributed to claimant's condition, their opinions are not sufficient to meet claimant's burden of proving that the work injury was the major contributing cause of his low back condition. See, e.g., Pamela A. Burt, 46 Van Natta 415 (1994).[1]

ORDER

The ALJ's order dated May 23, 1995 is affirmed.

---

[1] Claimant notes that fault and "wrongdoing" have no place in Workers' Compensation Law. Our decision is not intended to punish claimant for failing to report his prior medical history. Rather, the question is whether there is sufficient persuasive medical evidence to carry claimant's burden of proof. On This record, we conclude there is not.

In the Matter of the Compensation of
**ANGELA L. KING, Claimant**
WCB Case No. 94-15074
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Emmons, Kropp, et al, Attorneys
Michael Fetrow (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside an Order on Reconsideration classifying claimant's hand injury 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 Sharman R. Crowell, 46 Van Natta 1728 (1994), and George J. May, 46 Van Natta 2499 (1994), the ALJ found that claimant's claim should be classified as disabling because claimant was restricted to modified work.

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."

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.

In this case, claimant was released to, and returned to, modified employment. She was paid her full salary and was not entitled to any temporary disability. Because no temporary disability 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).

The medical evidence in the record does not establish a reasonable expectation that permanent disability will result from claimant's injury. Claimant's treating physicians, Drs. Lewis and Welch, concurred with examining physician Goby's assessment that claimant would improve to a point that she

---

[1] Since there is no 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 (July 26, 1995) Walter L. Keeney, 47 Van Natta 1387 (1995).

[2] Although constrained to adhere to the Board's holding in Maldonado, Member Gunn refers the parties to his concurring and dissenting opinion in that case.

could perform her present job without limitations. (Exs. 40, 42, 43). The medical arbiter panelsimilarly concluded that claimant would have no permanent impairment as a result of her injury. (Ex. 48). We conclude, therefore, that claimant's claim cannot be classified as disabling.[3]

ORDER

The ALJ's order dated April 21, 1995, as amended April 27, 1995, is reversed. The Order on Reconsideration is affirmed. The ALJ's attorney fee award is reversed.

---

[3] In a footnote in her respondent's brief, claimant contends that if the Guzman decision is reversed or overruled as a result of the amendments to ORS 656.005(7)(c), we should remand this case to the ALJ so that claimant may have "a meaningful opportunity to be heard" on the new statutory standard. We disagree. We may remand for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or some other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Here, claimant does not indicate what, if any, additional evidence she could present which would alter our decision. Further, she does not contend, nor do we find, that the record is incompletely or insufficiently developed. Finally, since the issue at hand is one of statutory construction rather than fact, we conclude that remand is unnecessary.

---

November 6, 1995 Cite as 47 Van Natta 2138 (1995)

In the Matter of the Compensation of
**HARLEY J. GORDINEER, Claimant**
WCB Case Nos. 94-04853, 94-00533 & 93-14467
ORDER ON REVIEW
David C. Force, Claimant Attorney
Schwabe, et al, Defense Attorneys
Alan Ludwig (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Christian, Hall and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that directed it to recalculate claimant's rate of temporary disability compensation based on an hourly wage of $12.28, rather than $8. Cigna Insurance Company cross-requests review of those portions of the ALJ's order that: (1) set aside its denial of responsibility for claimant's claim for the current low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of responsibility for claimant's "new injury" claim for the same condition. Cigna contends, alternatively, that SAIF should be found responsible for the low back condition, though no claim for that condition was filed against SAIF. Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to assess a penalty for SAIF's allegedly unreasonable refusal to recalculate his temporary disability rate; (2) set aside Cigna's responsibility denial for his current low back condition; (3) upheld Liberty's responsibility denial for the same condition; (4) declined to award claimant's counsel an assessed attorney fee under ORS 656.386(1) for services at hearing concerning the responsibility issue; (5) declined to order Liberty to pay claimant additional temporary disability benefits under the accepted claim for a right eye injury; and (6) declined to assess a penalty for Liberty's allegedly unreasonable refusal to pay temporary disability benefits. On review, the issues are temporary disability, responsibility, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

In lieu of the ALJ's finding that claimant did not sustain a new compensable low back injury on October 3, 1993, we find that the September 28, 1993 accident, which occurred while Liberty's insured was on the risk, was the major contributing cause of claimant's subsequent low back condition and resultant disability and need for treatment.

In lieu of the ALJ's finding that Cigna and Liberty issued disclaimers of responsibility for claimant's current low back condition, we find that both insurers issued denials of responsibility for the condition.

## CONCLUSIONS OF LAW AND OPINION

### Temporary Disability Rate

We adopt and affirm the ALJ's conclusions and opinion regarding this issue and the related penalty issue.

### Responsibility

The issue is whether claimant, who has a prior accepted low back injury claim with Cigna's insured, sustained a new compensable low back injury on September 28, 1993, while working for Liberty's insured, so as to shift responsibility for his low back condition from Cigna to Liberty, pursuant to ORS 656.308(1).[1] The ALJ concluded that claimant had not sustained a new compensable low back injury on September 28, 1993, reasoning that there was insufficient evidence to prove that the 1993 accident was the major contributing cause of claimant's subsequent low back condition and resultant disability and need for treatment. Based on our review of the record, we disagree with the ALJ's conclusion and opinion.

We begin with a brief summary of relevant facts. Claimant, a log truck driver, has a history of low back problems dating back to January 1979, when he suffered a low back strain while working for Cigna's insured. At that time, claimant was also diagnosed with preexisting spondylolisthesis of L5 on S1. A year later, diagnostic studies revealed degenerative disc disease at L4-5 and L5-S1. In April 1981, claimant underwent surgery to remove herniated discs at L4-5 and L5-S1 on the left. However, due to chronic back instability, he underwent surgery again in February 1983 for discectomy and interbody fusions at L4-5 and L5-S1.

About a year after the 1983 surgery, diagnostic studies revealed pseudarthrosis at L4-5. Claimant ultimately received a total award of 85 percent unscheduled permanent disability for his low back condition. He eventually returned to regular truck driving work for SAIF's insured. In May 1986, claimant suffered a compensable left shoulder and back strain. The 1986 claim was closed with no permanent disability award. Although claimant continued to have periodic low back and left leg pain, he nevertheless returned to regular log truck driving.

In October 1991, after performing heavy lifting at work, claimant developed low back pain which radiated through the left leg. He was diagnosed with a low back strain and treated conservatively. After about three weeks, his low back condition returned to its "baseline" (i.e., pre-October 1991) level of chronic pain. Claimant's medical treatment in October 1991 was his last treatment for low back symptoms prior to October 1993. During that two-year interval, claimant continued to work as a truck driver for different employers, and he was examined once by Dr. Woolpert at SAIF's request in March 1992. In that examination, claimant reported low back pain and some pain, numbness and tingling through the left leg; however, those symptoms were not deemed to require treatment. Dr. Woolpert indicated that claimant was doing "reasonably well" at that time, though he anticipated further worsening of the degenerative disc disease over time.

On August 24, 1993, claimant began working for Liberty's insured as a full-time log truck driver. Prior to his employment, claimant underwent a physical examination by the employer's doctor, and was found to be medically qualified to perform work with a lifting limitation of 20 pounds.

On September 28, 1993, while loading his truck, claimant was struck across the right shoulder and right eye by a branch. He recoiled and fell to the ground, with his hand over his right eye. He had the immediate onset of severe right eye pain and increased back pain. Because there was no one present to assist him, he drove his truck to his original destination in Springfield and unloaded. After his truck was reloaded, he drove back to the employer's yard and reported the accident to his supervisor, Rick Nelson.

---

[1] Subsequent to the parties' briefing in this case, ORS 656.308 was amended by the 1995 Legislature. Or Laws 1995, ch 332, § 37 (SB 369, § 37). We need not decide whether amended ORS 656.308 applies to this case because we find that the result in this case would be the same under either the former or amended version of the statute.

Nelson drove him to Dr. Ewing, where his eye was examined and diagnosed with a corneal abrasion. Although claimant also had back pain, he was most concerned about his eye condition; therefore, he did not report his back pain to Dr. Ewing on September 28, 1993 or during the follow-up visit on September 29, 1993. Claimant was released from work and referred for an ophthalmological consultation with Dr. Cox. Claimant's eye condition eventually improved with treatment. Cigna accepted the eye injury claim.

On October 5, 1993, claimant saw Dr. Peter and, for the first time, reported increased low back pain and left leg symptoms since the September 28 accident. Dr. Peter diagnosed a lumbar strain. Diagnostic studies of the back revealed no changes from previous studies; severe degenerative disc disease was present at L4-5 and L5-S1, with retrolisthesis of L5 on S1. When conservative treatment failed to yield improvement, claimant was referred to Dr. Kitchel, orthopedic surgeon. Dr. Kitchel diagnosed lumbar pseudarthrosis and performed lumbar fusion surgery on July 6, 1994. Claimant filed claims against Cigna and Liberty for his current low back condition. Both insurers denied responsibility for the condition.

Under ORS 656.308(1), Cigna, as the insurer with the last accepted claim for claimant's low back condition, remains responsible for disability and treatment relating to that condition unless claimant sustained a "new compensable injury involving the same condition." Cigna and claimant contend that claimant sustained such a new injury on September 28, 1993 and that responsibility for the low back condition therefore shifted to Liberty as of that date. We agree.

In determining whether a "new compensable injury" has been proven, we apply the criteria in ORS 656.005(7), including the limitations in subparagraphs (A) and (B). SAIF v. Drews, 318 Or 1, (1993). Here, the ALJ found that the September 28, 1993 injury combined with claimant's preexisting low back condition to cause disability and the need for treatment. Hence, the ALJ applied the "major contributing cause" standard under ORS 656.005(7)(a)(B). On review, the parties do not dispute the application of the "major contributing cause" standard; therefore, we apply the same standard.[2]

The medical evidence is divided between the opinions of Drs. Kitchel and Peter, which support the finding of a new compensable injury, and the contrary opinion of Dr. Farris. Dr. Kitchel, treating orthopedic surgeon, opined that, although claimant had preexisting back problems dating back to 1979, the September 28, 1993 injury was the major contributing cause of his subsequent need for treatment, including surgery. (Exs. 109, 113, 117-12). In his deposition, Dr. Kitchel explained that, prior to the September 28, 1993 accident, claimant had chronic intermittent back symptoms due to pseudarthrosis, which probably existed since the 1983 surgery, but that claimant neither required surgery nor was disabled from performing his regular truck driving job. As a result of the accident, however, Dr. Kitchel noted that low back symptoms were continuous and required surgery. (Ex. 117-9, 117-10).

Dr. Peter, treating physician, concurred with Dr. Kitchel's opinion. (Ex. 110). In his deposition, Dr. Peter expressly deferred to Dr. Kitchel regarding the cause of claimant's need for surgery in July 1994. (Ex. 116-21).

Dr. Farris, orthopedic surgeon, examined claimant at Liberty's request in February 1994. He opined that the major contributing cause of claimant's current back condition was the 1979 injury and the subsequent surgeries in 1981 and 1983. He reasoned that claimant has had chronic back symptoms for many years and that the September 1993 accident caused, at most, a temporary symptomatic worsening, and did not cause a material worsening of the lumbar spine condition. (Ex. 107A-6).

The ALJ declined to rely on the opinions of Drs. Kitchel and Peter because he found that claimant's history regarding the September 1993 accident was not credible. He based his credibility finding on: (1) the discrepancies in history that claimant provided to Dr. Peter, Dr. Kitchel and at hearing; (2) the conflict between claimant's testimony that he immediately reported his back injury to his supervisor, Nelson, and the testimony of Nelson that he did not recall any mention of a back injury; and (3) claimant's one-week delay in reporting his back pain to doctors.

---

[2] Subsequent to the parties' briefing in this case, ORS 656.005(7)(a)(B) was amended by the 1995 Legislature. SB 369, § 1. However, we need not decide whether amended ORS 656.005(7)(a)(B) applies to this case, because we conclude that the result would be the same under either the former or amended version of the statute.

In our view, the discrepancies in history noted by the ALJ were not significant enough to support his credibility finding. Claimant told Dr. Peter that he was struck in the right eye by a log and fell off towards the left side into a pile of logs. (Ex. 101-3). Claimant later told Dr. Kitchel that he was struck in the face with a branch and that his back snapped into an extended position, causing an immediate onset of low back pain. (Ex. 105-1). At hearing, claimant testified that a branch struck his right eye and that he fell on the left side of his back. (Tr. 37). He further testified that he fell onto a new road with a lot of rocks and limbs. (Tr 37).

There are discrepancies concerning the surface of the ground where claimant fell; he told Dr. Peter he fell down a hill onto a pile of logs, but he testified at hearing that he fell onto a new road with rocks and limbs. However, it is clear in all three histories that, when the branch struck claimant in the eye, it caused him to recoil suddenly. Dr. Kitchel relied on that particular history ("hyperextending the back") as the mechanism of the injury which triggered the onset of low back symptoms. That history is entirely consistent with the histories claimant gave Dr. Peter and the ALJ at hearing.[3]

Turning to the conflict between the testimonies of claimant and Nelson regarding his report of a back injury, we find that claimant was not certain about whether he reported his back pain to Nelson. On cross-examination, claimant testified that he "believe[d]" he told Nelson about the back injury. (Tr. 71). Given claimant's uncertainty, we do not find that Nelson's testimony sufficiently impeached claimant's credibility.

Finally, on the issue of claimant's one-week delay in reporting his back pain to doctors, we find that claimant had a reasonable explanation for the delay. He testified that, immediately after the accident, he was concerned that he had lost his right eye. (Tr. 37, 42). When he saw Dr. Ewing, he recalled that the doctor was also very concerned about his eye. (Tr. 41). After the corneal abrasion was diagnosed and claimant was referred to an ophthalmologist for further care, he then saw Dr. Peter on October 5, 1993, and reported his back pain. Claimant told Dr. Peter that, although he had back pain at the time of his earlier visits to Dr. Ewing, his main issue of concern at that time was his eye condition. (Ex. 101-3).

Because claimant was most concerned about his eye condition when he initially sought treatment, we find that claimant's one-week delay in reporting his back pain to doctors was reasonable and is insufficient to support the ALJ's credibility finding. Accordingly, for the aforementioned reasons, we reject the ALJ's finding that claimant's history concerning the September 1993 accident was not credible.

We turn now to the medical evidence. Where the medical evidence is divided, we tend to give greater weight to the opinion of the treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In addition, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Here, we are most persuaded by the opinion of Dr. Kitchel, the treating orthopedic surgeon. As the treating surgeon, he had the best opportunity to evaluate claimant's back condition first-hand. His opinion was based on a complete understanding of the progression of claimant's condition since the 1979 injury. In addition, his opinion was well-reasoned. Although he was aware that claimant has had low back problems since the 1979 injury, he noted that, for two years prior to the September 1993 accident, claimant's symptoms were intermittent and neither required treatment nor resulted in disability. Indeed, claimant was able to perform regular full-time truck driving work prior to the accident. After the accident, however, Dr. Kitchel found that claimant's symptoms were continuous and unbearable and required surgery. For those reasons, he opined that the September 1993 accident was the major contributing cause of claimant's subsequent disability and need for treatment.

---

[3] We are mindful that Dr. Peter based his causation opinion on the fact that claimant fell down a hill and landed on his back onto a pile of logs. (Ex. 116-32). We note, however, that Dr. Peter expressly deferred to Dr. Kitchel's expertise concerning the cause of claimant's need for surgery. Unlike Dr. Peter, Dr. Kitchel did not rely on any history of a fall; rather, he relied on the history that claimant's back was hyperextended as he recoiled from the branch. As we noted above, that history is not refuted by other evidence in the record.

Dr. Farris, on the other hand, examined claimant only once, and focused entirely on the fact that claimant has had chronic back symptoms since 1979. He did not address the fact that claimant was able to work and did not require back treatment for two years prior to the accident. Although Dr. Kitchel initially concurred with Dr. Farris' opinion, (Ex. 108A-1), his concurrence was not thoroughly explained and preceded the back surgery he eventually performed. After performing the surgery, and considering the absence of treatment and disability for two years prior to the accident, Dr. Kitchel reversed his opinion. (Ex. 117-20). Based on our review of Dr. Kitchel's opinion and reasoning, we conclude that his opinion is most persuasive. Accordingly, based on his opinion, we find that the September 1993 accident was the major contributing cause of claimant's subsequent low back condition and resultant disability and need for treatment. See ORS 656.005(7)(a)(B).

Inasmuch as we find that claimant sustained a new compensable injury involving his low back condition on September 28, 1993, we conclude that responsibility for the low back condition shifted to Liberty as of that date. See ORS 656.308(1); SAIF v. Drews, supra. Liberty's responsibility denial shall be set aside.[4]

Attorney Fee Pursuant to ORS 656.386(1)

At hearing, claimant requested an assessed fee award of $10,822.50 for services rendered at hearing on the responsibility issue. The ALJ denied the request, reasoning that, inasmuch as both Cigna and Liberty had conceded compensability, no assessed fee was authorized under ORS 656.386(1). On review, claimant contends that his counsel is entitled to an assessed fee under ORS 656.386(1), because Cigna and Liberty reserved the right to assert that responsibility should be assigned to SAIF (as the insurer of Oceanway Transport), against which claimant did not file a claim for his current back condition. We agree.

By letter dated December 8, 1993, Liberty denied responsibility for claimant's low back condition.[5] The letter stated, in pertinent part:

> "Based on the information currently available, it does appear your [low back] condition may be the result of your work exposure previous to your employment with [our insured].
>
> "* * * *
>
> "Listed below are the names and addresses of each employer, and its insurer, as well as the possible dates of injury or occupational exposure, which may be responsible for your current condition:
>
> "[List of potentially responsible employers].
>
> "After review of the investigation material available, it appears that your condition is compensable; however, responsibility may rest with one of the employers identified above.
>
> "Therefore, this letter represents a denial of responsibility for your current condition.

---

[4] Because we have concluded on the merits that Liberty is responsible for claimant's current low back condition, we need not address the issue of whether Liberty's responsibility disclaimer was untimely and whether Liberty is therefore barred from asserting that another insurer is responsible for the condition.

[5] The ALJ referred to the denial letters issued by Liberty and Cigna as "disclaimers." However, both letters expressly stated: "This is a denial of your claim for benefits." In addition, both letters included "notice of hearing" provisions. See OAR 438-05-053(4). Therefore, we find that the letters are denials, rather than disclaimers, of responsibility. We point out, in response to Member Haynes' dissent, that these documents were "denials" of compensation even under amended ORS 656.386 (1) in that, if sustained, claimant would not be entitled to compensation. ORS 656.586 (1) now difines a denied claim as a claim which the carrier refused to pay on the express ground the claim "is not compensable or otherwise does not give rise to an entitlement to any compensation." (Emphasis added).

"I have requested a designation of paying agent pursuant to ORS 656.307." (Ex. 104A).

On March 17, 1994, Cigna also issued a letter denying responsibility for the low back condition, stating:

> "Based on the information available, we deny responsibility for your current low back condition as it appears that your condition is the result of subsequent injury that occurred on 9/28/93 while you were employed by [Liberty's insured].
>
> "Listed below are the names and addresses of each employer and its insurer, as well as the possible dates of injury or occupational exposure which may be responsible for your current condition:
>
> "[List of potentially responsible employers]." (Ex. 108).

At hearing, all parties agreed that Cigna and Liberty were conceding compensability and denying responsibility only. (Tr. 11-13). At the same time, however, both insurers expressly reserved the right to assert that SAIF, as insurer of Oceanway Transport, is "responsible." Inasmuch as claimant did not file a claim for his current back condition against SAIF, all parties understood that if SAIF was determined to be "responsible," claimant would effectively be denied compensation for his condition. (Id.) Thus, Cigna and Liberty were asserting an "empty chair" defense.

Because claimant would receive no compensation if Cigna and Liberty prevailed in establishing that SAIF was "responsible," we find that there was an issue of compensability, i.e., whether claimant was entitled to receive compensation for his condition. Hence, this case is distinguishable from the cases cited by the ALJ: Multnomah County School Dist. v. Tigner, 113 Or App 405 (1992); Paul J. LaFrance, 45 Van Natta 1991 (1993); and John L. Law, 44 Van Natta 1619 (1992) (on reconsideration). In those cases, not only did the insurers deny responsibility only, but all potentially responsible insurers were joined in the responsibility proceeding. The joinder of all potentially responsible insurers ensured that the claimant would receive compensation from at least one of those insurers as a result of the responsibility determination. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod 119 Or App 447 (1992).

Because we find that claimant's entitlement to any compensation turned on the responsibility determination, we conclude that claimant has established his entitlement to an assessed fee under ORS 656.386(1) for services rendered at hearing.[6] 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 concerning the denial issue is $8,000, payable by Liberty. 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 counsel may go uncompensated.

Temporary Disability For Eye Claim

At hearing, claimant requested an award of temporary disability benefits from Liberty for the period beginning December 8, 1993, as well as assessment of a penalty for Liberty's allegedly unreasonable refusal to pay those benefits. The ALJ denied claimant's request, reasoning that claimant had not carried his burden of proving entitlement to such benefits as a result of the accepted eye claim.

---

[6] Subsequent to the parties' briefing in this case, ORS 656.386(1) was amended by the 1995 Legislature. SB 369, § 43. As amended, ORS 656.386(1) now provides that an assessed fee may be awarded if claimant finally prevails against a "denied claim." The amended statute defines the term "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." We need not decide if amended ORS 656.386(1) applies to this case because we find that claimant's low back claim would satisfy the definition of a "denied claim" for the following reason. Inasmuch as both Cigna and Liberty expressly denied responsibility for the claim, and acknowledged at hearing that claimant would not receive compensation if they successfully established that responsibility should be assigned to SAIF, we find they were effectively asserting that claimant's condition "[did] not give rise to an entitlement to compensation."

Because we are setting aside Liberty's denial of the low back claim, and it is undisputed that claimant was disabled by the low back condition during the aforementioned time period, we need not decide whether claimant is entitled to an award of temporary disability benefits under solely the eye claim. However, we must decide whether a penalty should be assessed against Liberty for its allegedly unreasonable refusal to pay temporary disability benefits under the eye claim for the period beginning December 8, 1993.

The issue is whether Liberty was authorized to terminate temporary disability benefits under the accepted eye claim prior to December 8, 1993. Termination of temporary disability benefits is authorized under the circumstances set forth in ORS 656.268(3).

Subsequent to the parties' briefing in this case, ORS 656.268(3) was amended by the 1995 Legislature. SB 369, § 30. Subsection 66(1) of SB 369 sets forth 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 656.268(3).

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 1387 (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). Furthermore, we do not find that retroactive application of amended ORS 656.268(3) to this case would produce an absurd or unjust result or would clearly be inconsistent with the purposes and policies of the Workers' Compensation Law. See Ida M. Walker, 43 Van Natta 1402 (1991); Bryan L. Dunn, 43 Van Natta 1673 (1991) (retroactive application of law expanding claim processing period from 60 to 90 days would not produce absurd or unjust result); compare Rick A. Webb, 47 Van Natta 1550 (1995) (retroactive application of aggravation claim filing requirements under amended ORS 656.273(3) would produce an absurd and unjust result). Accordingly, we conclude that amended ORS 656.268(3) applies to the present case.

Amended ORS 656.268(3)(b) provides that temporary disability benefits may be terminated when "[t]he attending physician advises the worker and documents in writing that the worker is released to return to regular employment." Here, Dr. Cox, who was treating claimant for his eye condition, completed a Work Status Report on October 4, 1993, stating that claimant was released to work (without restrictions) on October 4, 1993. (Ex. 99A-3).[7]

Claimant argues that the aforementioned work release was ineffective because it was not signed by claimant. Although former ORS 656.268(3)(b) required that the attending physician "give" the worker a written release for regular work, amended ORS 656.268 merely requires that the physician "advise" the worker of the work release and document the release in writing. We find that those requirements were met on October 4, 1993.

On April 9, 1994, claimant returned to the Eugene Clinic with recurrent right eye problems. He was released from work on that date. (Ex. 108AA-1).[8] Claimant treated with Dr. Cox and was later

---

[7] In his Cross-Appellant's brief, claimant stated that Exhibit 99A was furnished untimely as an exhibit. (Cross-App. Br. at p. 30). Insofar as claimant is objecting to the timeliness of submission of Exhibit 99A, we conclude that claimant has waived any such objection by failing to make an objection to the exhibit at hearing. (Tr. 3, 9).

[8] Exhibit 108AA, which consists of three one-page work status reports issued by the Eugene Clinic, was initially submitted by claimant on July 14, 1994 (date of original hearing) as Exhibits 108A, 108B and 108E. Although those reports were admitted into evidence without objection, they were apparently omitted from the final revised exhibit list, but were included in the Board review file. We have restored those exhibits to the revised exhibit list and renumbered them as Exhibit 108AA, pages 1 through 3.

released for work (without restrictions) on April 30, 1994. (Exs. 108AA-3, 115). That release was documented in writing and signed by claimant. (Ex. 108AA-3). Based on those documents, we conclude that Liberty was required to pay claimant temporary disability benefits for the period from April 9, 1994 through April 30, 1994. Liberty has offered no explanation for its failure to do so; therefore, we find that its failure was unreasonable. Accordingly, Liberty is assessed a penalty equal to 25 percent of the amount of temporary disability benefits due and owing claimant for the period from April 9, 1994 through April 30, 1994. The penalty shall be paid in equal shares to claimant and his attorney.

Attorney Fee on Board Review

Cigna cross-requested Board review and asserted the same "empty chair" defense that it (and Liberty) asserted at hearing, arguing that responsibility should be assigned to SAIF. Inasmuch as a claim for the current low back condition was not filed against SAIF, and SAIF was not joined as a potentially responsible insurer, we find that Cigna's assertion placed claimant's entitlement to compensation at risk. See Dennis Uniform Manufacturing v. Teresi, supra. Therefore, we conclude that claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on review concerning the denial issue, payable by Cigna. See 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 fee for claimant's attorney's services on review concerning the denial issue is $1,000, payable by Cigna. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's cross-respondent's brief), the complexity of the issue, and the value of the interest involved.

Claimant's attorney is also entitled to an assessed fee under ORS 656.382(2) for services on review concerning the temporary disability rate issue. 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 temporary disability rate issue is $500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 29, 1994 is reversed in part and affirmed in part. That portion of the order that set aside Cigna's responsibility denial and upheld Liberty's responsibility denial is reversed. Cigna's responsibility denial is reinstated and upheld. Liberty's responsibility denial is set aside, and claimant's claim for his current low back condition is remanded to Liberty for processing according to law. For services at hearing on the responsibility issue, claimant's counsel is awarded an assessed fee of $8,000, payable by Liberty. Liberty is assessed a penalty equal to 25 percent of the amounts of temporary disability benefits due and owing for the period from April 9, 1994 through April 30, 1994. The penalty shall be paid in equal shares to claimant and his counsel. The ALJ's order is otherwise affirmed. For services on review, claimant's counsel is awarded assessed fees of $1,000, payable by Cigna, and $500, payable by SAIF.

**Board Member Hall concurring in part and dissenting in part.**

I concur with the majority's decision in all respects but one. Liberty should be assessed a penalty for its refusal to pay temporary disability benefits under the accepted eye claim. There clearly was no existing law which authorized Liberty's refusal. The majority, however, applies the current, amended law retroactively to find that Liberty acted properly, rather than applying the law in effect at the time of Liberty's refusal. Because I believe this result is absurd and unjust, I dissent.

It is a fundamental principle that the reasonableness of a carrier's conduct is judged on the basis of the information available to the carrier at the time of its conduct. See Brown v. Argonaut Insurance Co., 93 Or App 588, 591 (1988). The information available to the carrier includes a working knowledge of its claim processing obligations under the applicable law and the understanding that its failure to carry out those obligations exposes it to potential liability for penalties.

Here, Liberty failed to pay benefits due and owing under the law then in effect (in December 1993), and has no reasonable explanation for its failure. By definition, Liberty's failure is unreasonable and should result in a penalty assessment. However, the majority has effectively excused Liberty by applying the current law, which took effect June 7, 1995, to its conduct two years earlier. This result is absurd and certainly unjust. In my view, Liberty should be held to nothing less than the standard in effect at the time of its conduct. For its failure to conform to that standard, it should be penalized. For this reason, I must dissent on this issue.

**Board Member Haynes concurring in part and dissenting in part.**

I dissent from only that portion of the majority's decision that awarded claimant's counsel an assessed fee under ORS 656.386(1) for services rendered at hearing on the responsibility issue. It is undisputed that counsel for both Cigna and Liberty expressly conceded compensability of the low back condition at hearing. Their only dispute was over which carrier was responsible for the condition. Hence, claimant's entitlement to compensation was never in question.

The courts have held that, if a carrier denies responsibility, but not compensability, (i.e., whether the condition was caused by an industrial injury), ORS 656.386(1) is not the applicable attorney fee statute. Short v. SAIF, 305 Or 541, 545 (1988); Multnomah County School Dist. v. Tigner, 113 Or App 405, 408-409 (1992). Although Short and Tigner were decided under the former version of ORS 656.386(1), the amended version of the statute is even more compelling in my view. Amended ORS 656.386(1) now defines a "denied claim" as a claim which a carrier refuses to pay on the express ground the claim "is not compensable or otherwise does not give rise to an entitlement to any compensation." Here, claimant's entitlement to compensation was not disputed. Yet, the majority reasons that, because one of the potentially responsible carriers (SAIF) was not joined in the responsibility proceeding, the remaining carriers' responsibility denials effectively placed claimant's compensation at risk.

I submit that claimant's compensation was placed at risk by claimant's own refusal to file a claim against SAIF. There is no question that Cigna and Liberty notified claimant that SAIF's insured, Oceanway Transport, was a potentially responsible carrier. (See Exs. 104A, 108). Yet, claimant declined to file a claim against SAIF. Thus, it is because of claimant's own refusal to act that his compensation was placed at risk. This is not an appropriate basis for awarding claimant's attorney a carrier-paid fee and it is certainly not authorized under the terms of either the former or amended version of ORS 656.386(1). For this reason, I dissent from that portion of the majority's order. Otherwise, I concur in the remaining portions of the majority's decision.

---



In the Matter of the Compensation of
**ELMER HITCHCOCK, Claimant**
WCB Case No. 94-06186
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that upheld the SAIF Corporation's denial of claimant's current condition after August 4, 1994. In its respondent's brief, SAIF challenges that portion of the ALJ's order that set aside its denial of claimant's current condition before August 4, 1994. On review, the issue is compensability. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant has preexisting venous insufficiency. As a result of a June 1988 industrial injury, SAIF accepted a claim for left leg ulcers, cellulitis and phlebitis. A June 1989 Determination Order awarded

permanent disability for Class 4 "vascular damage." On April 12, 1994, SAIF issued a partial denial for claimant's current condition based on the lack of a causal relationship between the current need for treatment of left leg ulcers and the June 1988 injury.

The ALJ first determined that SAIF was not precluded, pursuant to Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995), from denying the left leg ulcers. The ALJ further concluded that claimant's need for treatment was compensable through August 4, 1994, and set aside the denial to the extent that it pertained to claimant's condition before August 4, 1994. Finding that claimant's need for treatment after that date was in major part caused by the preexisting venous insufficiency, the ALJ upheld the denial for treatment after August 4, 1994.

Claimant asserts that the ALJ improperly treated the denial as prospective and that it should be set aside in its entirety. According to SAIF, because claimant failed to prove compensable his need for treatment of the left leg ulcers under ORS 656.005(7)(a)(B), the denial should be upheld in its entirety.[1]

The record shows that claimant's left leg ulcers were caused by a combination of the abrasions that resulted from the June 1988 industrial injury and claimant's preexisting venous insufficiency condition. (Exs. 7, 9-2, 14-7). Thus, we agree with SAIF that compensability properly is determined under ORS 656.005(7)(a)(B). That statute 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."[2]

In March 1989, claimant's initial treating physician, Dr. Nickels, indicated that claimant's "underlying vascular problems * * * resulted in the slowing of his healing from the injury." (Ex. 7). In June 1992, examining vascular surgeon, Dr. Moneta, found "long-standing venous insufficiency" in the lower limbs. (Ex. 9-2). Dr. Moneta also found that, although the ulcers initially could be attributed to the industrial accident, claimant's continuing need for treatment was in major part caused by his preexisting venous insufficiency. (Id.) Dr. Nickels concurred. (Ex. 10).

In August 1994, Dr. Moneta reexamined claimant, finding that the ulcers had healed, but claimant continued to experience swelling in his left leg. (Ex. 12-3). Dr. Moneta explained that persons with chronic venous disease, like claimant, "are very likely to have significant problems with injury to their ankle areas * * * because the [condition] renders the nutritional status of the skin poor and the actual microvascular blood supply to the skin poor as well." (Id. at 1). Dr. Moneta attributed claimant's symptoms to chronic venous disease. (Id.) During a deposition, Dr. Moneta reiterated that the major contributing cause of claimant's ulcers was his preexisting condition because it prevented the lesions from healing. (Ex. 13-9).

---

[1] Claimant asserts that this argument "does not have merit" because SAIF "did not appeal the Opinion and Order." We understand claimant to argue that SAIF cannot challenge any portion of the ALJ's order because it did not file a formal cross-request for review. We will consider "informal" requests for review provided in a party's brief if the original request for hearing has not been withdrawn. E.g., Eder v. Pilcher Construction, 89 Or App 425 (1988); Rocky L. Coble, 43 Van Natta 1907, on recon 43 Van Natta 2288, 2289 (1991), aff'd on other grounds Coble v. T.W. Kraus & Sons, 116 Or App 62 (1992); Kenneth Privatsky, 38 Van Natta 1015 (1986). Thus, inasmuch as claimant did not withdraw his request for review, we will consider SAIF's argument raised in its respondent's brief.

[2] The statute was amended by Oregon Laws 1995, ch 332, § 1. The former version of ORS 656.005(7)(a)(B) provided:

> "If a compensable injury combines with a preexisting disease or condition to or 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 the need for treatment."

Inasmuch as none of the specific exceptions prevent retroactive application of the amended law, we analyze this case under the present version of ORS 656.005(7)(a)(B). Or Laws 1995, ch 332, § 66(1); Volk v. America West Airlines, 135 Or App 656 (1995) (retroactively applying amended ORS 656.386(2)).

Claimant's current treating surgeon, Dr. Cox, reported that, although claimant had preexisting chronic venous disease, the ulcerations were in major part caused by the June 1988 trauma. (Ex. 12A). Dr. Cox also indicated that "healing can be a major problem" when a person with chronic venous disease experiences trauma. (Id., 14-7).

We find more persuasive Dr. Moneta's opinion that the major contributing cause of claimant's ulcers was his preexisting venous insufficiency or disease. Dr. Moneta explained how such a condition causes symptoms in the lower extremity and prevents lesions from healing. Dr. Cox, although apparently agreeing that chronic venous disease can prevent ulcers from healing, did not explain why, in claimant's case, the industrial accident was the major contributing cause for claimant's continuing need for treatment.

For these reasons, we defer to Dr. Moneta's opinion. See Somers v. SAIF, 77 Or App 259 (1986). Based on this opinion, we conclude that claimant failed to prove that his continuing need for treatment was caused in major part from his compensable injury. Thus, SAIF's denial should be upheld in its entirety.[3]

Citing Messmer v. Deluxe Cabinet Works, supra, claimant also contends that the denial should be set aside with regard to the venous insufficiency condition. In that case, the court held that claim preclusion barred the carrier from later arguing that a noncompensable condition was not part of the compensable claim because it had not appealed a Determination Order which awarded compensation for residuals of surgery for the noncompensable condition. 130 Or App at 258. Here, according to claimant, the June 1989 Determination Order awarded compensation for his venous insufficiency and, because SAIF did not appeal, it is precluded from now arguing the compensability of the condition.

We agree with the ALJ that this case is distinguishable from Messmer. The evaluator's worksheet accompanying the Determination Order awarded 50 percent scheduled permanent disability for "Class 4 Vascular damage." We find it unlikely, based on the common meaning of the terms, that "vascular damage" refers to venous insufficiency. We also agree with the ALJ that, based on the applicable standards, the "vascular damage" award was for claimant's ulcers and we adopt that portion of the ALJ's order. Consequently, because we conclude that the Determination Order did not award compensation for venous insufficiency, we find Messmer to be inapplicable to this case.[4]

Finally, claimant asserts that retroactive application of the new law to this case violates his rights under "section 10 and 21 of the Oregon Constitution" and "the 14th amendment and Section 10 of Article 1 of the United States Constitution." Claimant also asserts that the new law is preempted by the "American [sic] with Disabilities Act" (ADA). Finally, claimant contends that, if law different from that in Messmer is applied, he is entitled to remand for the opportunity to relitigate his case under the new law. For the following reasons, we find claimant's assertions to be without merit.

First, because claimant's preexisting condition combined with his compensable injury, his claim would come under both former and amended ORS 656.005(7)(a)(B). As we previously explained, since the medical evidence is not sufficient to prove that the compensable injury is the major contributing cause of his need for treatment, his claim fails under either version of the statute. Thus, because the result is the same, the new law does not change any of claimant's "rights" under the old law. Furthermore, inasmuch as we find Messmer to be inapplicable, this part of our decision also is not changed by the new law. Thus, we conclude that any amendment to the holding in Messmer is not relevant to this case and does not entitle claimant to remand.

## ORDER

The ALJ's order dated March 31, 1995 is reversed in part and affirmed in part. That portion of the order setting aside SAIF's denial for the period before August 4, 1994 is reversed. SAIF's denial is reinstated and upheld in its entirety. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

---

[3] Consequently, we need not address whether, under the ALJ's analysis, SAIF's denial was improperly prospective.

[4] As SAIF notes, ORS 656.262(10) now provides that payment of permanent disability benefits awarded by a determination order cannot preclude the carrier from "subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." Inasmuch as we have found that the Determination Order did not award benefits for the venous insufficiency condition, the statute is not relevant to this case.

In the Matter of the Compensation of
**KATHLEEN D. (FENNELL) KIDWELL, Claimant**
WCB Case No. 94-06591
ORDER ON REVIEW
Michael B.Dye, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Marshall's order that set aside its partial denials of claimant's left knee injury claim. In its brief, the insurer contends that res judicata bars claimant's left knee claim. On review, the issues are res judicata and compensability. We affirm.

## FINDINGS OF FACT

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

On April 6, 1993, Dr. Bright noted minor crepitus in the lateral aspect of claimant's left knee. (Exs. 4-5 and 10-2).

On January 4, 1994, the parties entered into a stipulation regarding claims processing violations. The parties did not stipulate to settle all issues raised or raisable at that time. (Ex. 24A).

The insurer provides coverage for OHD Service Corporation (OHD), the prior employer, as well as Bakery Specialties, the employer in the instant case.

## CONCLUSIONS OF LAW AND OPINION

### Res Judicata

The ALJ concluded that, because the February 10, 1994 Disputed Claim Settlement (DCS) took place between claimant and OHD, a prior employer, neither claim nor issue preclusion applies here to preclude claimant from asserting a claim against Bakery Specialties for her left knee injury. We agree that claimant is not precluded from asserting a left knee injury claim, but for different reasons.

Claimant sustained a compensable, nondisabling injury to her left knee in 1989, when employed by OHD. On October 27, 1992, when employed by Bakery Specialties, claimant slipped at work. Following the incident, claimant experienced low back and left thigh pain. The insurer accepted a nondisabling lumbar strain injury. Shortly thereafter, claimant began experiencing increased left knee symptoms.

In May 1993, OHD denied claimant's current left knee condition on the basis that it was no longer related to the 1989 compensable injury. Claimant requested a hearing and the matter was resolved by a February 10, 1994 DCS in which OHD's denial was upheld. (Ex. 26).

On October 7, 1993, claimant filed a request for hearing alleging claims processing violations by Bakery Specialties for failure to provide claims information timely. On January 4, 1994, claimant and Bakery Specialties entered into a stipulation regarding the claims processing violations. (Ex. 24A). The stipulation did not contain language indicating that the parties agreed to settle all issues raised or raisable at that time. (Id.). On January 20, 1994, claimant submitted unpaid medical bills for services rendered in October and November 1993 to the insurer, to be paid under the 1992 Bakery Specialties claim. On March 31, 1994, the insurer, on behalf of Bakery Specialties, denied claimant's left knee condition. Claimant requested a hearing on the denial.

At hearing and on review, the insurer has consistently contended that claimant is precluded by the January 4, 1994 stipulation between claimant and itself, on behalf of Bakery Specialties, from asserting that her current left knee condition is a part of her 1992 claim. (Tr. 5, 13; Appellant's Brief at 4). Specifically, the insurer contends that claimant could have raised the issue of the compensability of her left knee condition at the time of the stipulation, and because she failed to do so, her left knee claim is barred. We disagree.

The doctrine of res judicata precludes litigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 38, 50, modified 305 Or 468 (1988). Both issue and claim preclusion apply to worker's compensation proceedings. Drews v. EBI Companies, 305 Or 134 (1990). The general rule of claim preclusion bars the litigation of a claim based on the "same factual transaction" that was or could have been litigated between the parties in a prior proceeding. It does not require actual litigation of an issue; nor does it require that the determination of the issue be essential to the final result reached in the proceeding. Only the opportunity to litigate is required. Id.

In Drews, the issue was whether a wage rate dispute was barred by claim preclusion rules where a claimant had failed to raise the rate of TTD at a hearing which opened an aggravation claim. The Court looked at the workers' compensation statutes to aid it in determining whether the aggravation claim was a separate claim to which claim preclusion applies and to determine whether the finality requisite for claim or issue preclusion had attached. The Court concluded that an aggravation claim was a "claim" for claim preclusion purposes, but that the finality required to invoke claim preclusion had not attached. Consequently, the claimant was not barred from raising the rate of TTD issue by claim preclusion.

Here, in contrast to Drews, finality has attached to the stipulation. Proctor v. SAIF, 68 Or App 333, 335-36 (1984) (An ALJ's order approving a stipulation and dismissing a claimant's request for hearing is a "judgment" within the meaning of claim or issue preclusion rules). Consequently, our next inquiry is whether the claim in this case is the "same factual transaction" that was at issue in the stipulation. We conclude that it was not.

The matter memorialized in the parties' January 4, 1994 stipulation merely settles the parties' dispute over a procedural claims processing matter by allowing claimant's attorney a fee. The matter before us in the instant case is the compensability of claimant's current left knee condition in relation to her 1992 injury. Although the stipulation recited that claimant sustained a compensable injury on October 27, 1992 that was accepted and processed by the insurer, we find no language in the stipulation that expressly settles the issue of the compensability of claimant's left knee condition in relation to that claim. Moreover, claimant had been treating for her left knee condition in relation to her accepted 1989 left knee claim. There is no evidence that claimant was aware that bills relating to her left knee condition were outstanding at the time of the stipulation. (See Ex. 25). Finally, and of most importance, there is no language in the stipulation that memorializes the parties' agreement to settle all issues raised or raisable at the time of the stipulation.

We conclude that the factual transaction, as intended by the parties, was limited to the procedural claims processing matter. Moreover, the absence of language in the stipulation agreeing to settle all issues raised or raisable permits us to infer that the parties agreed, in effect, that claimant could raise the compensability matter at a subsequent time.

Compensability

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

The insurer contends that, because claimant has a preexisting left knee condition due to her 1989 left knee injury, and she is obese, Section 3 of SB 369[2] governs the compensability matter. Specifically, the insurer contends that the medical services for claimant's left knee are solely directed to her preexisting 1989 left knee injury "and/or" her obesity and that the 1989 left knee condition was not pathologically worsened by the 1992 back strain.

---

[1] Applying former ORS 656.005(7)(a)(B), the ALJ concluded that claimant has established that the October 27, 1992 incident is the major contributing cause of her current left knee condition and need for treatment. Subsequent to the ALJ's order, but prior to briefing in this case, the legislature revised the workers' compensation law, including amendments to ORS 656.005(7)(a)(B). Or Laws 1995, ch 332 (SB 369). We do not find it necessary to address the applicability of the amended statute here because, were we to do so, the analysis and outcome would remain the same.

[2] Section 3 provides in pertinent part: "In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless: (1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition." SB 369, § 3 (emphasis added).

Claimant has a preexisting compensable left knee condition diagnosed as a strain that occurred as a result of a twisting injury at a prior employer. In addition, claimant is 5 feet 5 inches tall and weighs about 265 pounds.

In order to determine the applicability of the aforementioned statute, we must decide what condition is being claimed and whether it is preexisting. Claimant's current left knee condition[3] has been diagnosed by Dr. Poulson as torn medial and lateral menisci, involving both anterior and posterior horns of the semilunar cartilages. Based on the findings of a normal knee in July 1992 and crepitus in the left knee subsequent to the 1992 injury, Dr. Poulson opined that the meniscus tears were a new pathology that arose from the 1992 injury. (Ex. 35).

Claimant's current left knee condition was also diagnosed by Dr. Neuburg as torn lateral and medial menisci of uncertain age. Dr. Neuburg opined that claimant's left knee injury may have resulted in some internal derangement, with further internal derangement as a result of the 1992 injury. (Ex. 19). We interpret Dr. Neuberg's opinion to indicate that claimant's current left knee condition may have been a combination of the 1989 and 1992 injuries.

Dr. Bright, who had examined claimant prior to the 1992 injury, opined that at the time of the 1989 injury, claimant had sustained a sprain of the left knee which through the years "obviously" culminated into tears of the ligaments and cartilage of the left knee. (Ex. 23). Dr. Hansen, who had treated claimant subsequent to the 1989 injury, also opined that it was possible that claimant may have had a mild disruption of the cartilage in her knee as a result of the 1989 injury. (Ex. 24). Dr. Dordevich, rheumatologist, who examined claimant for the insurer, also opined that claimant's current left knee complaints are the direct result of the 1989 injury, based on claimant's history of ongoing knee symptoms. (Ex. 29).

We do not find the opinions of Drs. Neuberg, Bright, Hansen or Dordevich persuasive. None of these doctors adequately explains the relationship between claimant's preexisting left knee condition, which was diagnosed as a left knee strain, and her current meniscus tears. Moreover, there is no evidence that Drs. Bright and Hansen considered the possible effects of claimant's 1992 injury on the meniscus tears.

Instead, we are more persuaded by the opinion of Dr. Poulson and find his opinion to be more reasoned and consistent with the record. He based his opinion on a comparison of knee findings made before and after the 1992 injury by Drs. Snider and Bright. These findings indicate that claimant's knee condition was normal in July 1992 and exhibited evidence of derangement in April 1993 and are consistent with Dr. Poulson's opinion. Because we find Dr. Poulson's opinion to be better reasoned and based on complete information, we find it more persuasive than those of the aforementioned doctors. Somers v. SAIF, 77 Or App 259 (1986).

Based on Dr. Poulson's persuasive opinion, we conclude that claimant's current left knee condition is torn medial and lateral menisci. Given that claimant's preexisting condition was identified as a left knee strain, we are not persuaded that claimant's disability is solely related, or her need for medical services is solely directed to her preexisting strain condition. Consequently, we conclude that § 3 of SB 369 is not applicable to this case.[4]

---

[3] Claimant also has a left thigh condition, diagnosed as meralgia paresthetica, that arose after her 1992 injury. There is no record evidence that the compensability of the thigh condition has been raised by the parties.

[4] Although claimant has been diagnosed with obesity, there is no evidence that claimant has made a claim for such a condition or that her disability is solely related to, or her need for medical services are solely directed to, that condition. If we interpret the insurer's contention to mean that claimant's obesity combined with her 1989 strain injury to cause her current symptoms, the argument fails. Although Dr. Bright opined prior to the 1992 injury that claimant's ongoing symptoms were due to her obesity, there is no medical evidence that claimant's obesity is involved in the meniscus tears. Moreover, even if claimant's disability or need for medical services was solely directed to her worsened strain condition, Dr. Poulson's persuasive report (Ex. 35) establishes that claimant's left knee condition has pathologically worsened.

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 May 3, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

---

November 6, 1995 Cite as 47 Van Natta 2152 (1995)

In the Matter of the Compensation of
**ELIZABETH A. O'BRIEN, Claimant**
WCB Case No. 94-07547
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Bethlahmy's order which: (1) found that it was obligated to accept claimant's disc herniations, pursuant to a prior ALJ's order; and (2) awarded an assessed attorney fee. On review, the issues are claims processing and attorney fees.

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

Claimant sustained a compensable injury in December 1990. Completing a "801" form, claimant identified her injuries as "bruises, strain and two herniated discs." The employer accepted the claim. (Ex. 1).

In January 1991, claimant began treating with Dr. Irvine. (Ex. 6B-5). In February 1991, a MRI revealed no evidence of nerve impingement with minimal disc herniation at C4-5 and C5-6. (Ex. 6B-8). In March 1992, claimant's claim was closed by Determination Order. (Ex. 4).

Claimant resumed treating with Dr. Irvine in July 1992 because of "renewed" radicular pain. According to Dr. Irvine, a November 1992 MRI showed significant disc herniation at C4-5 with nerve impingement on the spinal sac. (Ex. A-2). Dr. Irvine opined that claimant's C4-5 disc herniation had worsened and that the major cause of claimant's worsened cervical condition was her compensable injury. (Exs. A-2; 6B-28).

On April 12, 1993, the insurer's denial stated that claimant's current condition was not a compensable worsening of her industrial injury of December 1990. It also denied that claimant's industrial injury was the major contributing cause of her ongoing condition. (Ex. 5). Claimant requested a hearing.

In December 1993, a prior ALJ found that claimant's accepted cervical condition was a material cause of her current condition. The prior ALJ's order also found that claimant's industrial injury caused her C4-5 disc bulges. Finally, based on the medical reports of Drs. Irvine and Denekas, as well as the MRI evidence, (which revealed disc herniations) the prior ALJ's order concluded that claimant's accepted condition had worsened. The prior ALJ set aside the insurer's denial and remanded the claim to the insurer for acceptance of claimant's current condition and aggravation claims. (Ex. 7-8).

On December 16, 1993, the insurer issued a letter stating that it was accepting claimant's condition as C4-5 and C5-6 disk bulges. (Ex. 8). On January 11, 1994, claimant requested that the insurer amend its acceptance to specifically accept her cervical spondylosis at C4-5 with radicular compression, mild spondylotic changes at C5-6, secondary cervical radicular syndrome, and central disc herniations at C4-5 and C5-6. (Ex. 11). When the insurer declined to amend its acceptance, claimant requested a hearing in this case.

The ALJ determined that the insurer's aggravation denial (which was set aside by the prior ALJ's order) included claimant's disc herniations. Therefore, the ALJ concluded that the insurer's "post-order" acceptance encompassed claimant's disc bulges and herniations at C4-5 and C5-6. Finally, the ALJ awarded claimant's attorney a carrier-paid attorney fee for her counsel's services in clarifying the compensable conditions.

On review, the insurer contends that the ALJ erred in finding that claimant's disc herniations were compensable. According to the insurer, the prior ALJ's order did not obligate it to accept claimant's disc herniations. On the contrary, the insurer asserts that the prior ALJ's order specifically directed it to accept claimant's condition as "disc bulges."

Initially, we note that the prior ALJ's order specifically addressed the compensability of claimant's disc bulges in the section labeled "Disk Condition." However, the prior ALJ's order also addressed the compensability of claimant's "worsened condition." Relying on the opinions of Drs. Irvine and Denekas and supported by the disc herniation changes in claimant's cervical spine as evidenced by the MRI films, the prior ALJ's order found that claimant's condition had worsened. Therefore, because the insurer was ordered to accept claimant's current condition and aggravation claims, we conclude that the prior ALJ's order had the effect of ordering the acceptance of claimant's disc herniations. We base our conclusion on the following reasoning.

The facts of this case are similar to those presented in King v. Building Supply Discount, 133 Or App 179 (1995). In King, the claimant filed a claim for a heart attack. The carrier issued a written denial which denied not only the heart attack claim, but also the claimant's preexisting CAD. At hearing, the ALJ found that the heart attack was compensable and the denial was set aside "in its entirety," and remanded to the carrier for processing. The ALJ's order was not appealed. Later, the carrier issued a denial of the CAD. The court held that the carrier was precluded by the prior ALJ's order from contesting the compensability of the CAD. While noting that no claim had been previously made for the CAD, the court found that the carrier specifically denied the disease, and thus, framed the issue for litigation before the prior ALJ. The court reasoned that, had the carrier's denial been upheld and the claimant later sought compensation for that denied condition, a denial of that future claim would have been upheld. Inasmuch as the ALJ's order had set aside the denial in its entirety, the court concluded that the ALJ's order had the effect of ordering the acceptance of the CAD. Id.

Here, claimant's cervical pain was attributed to "low grade disc herniations and secondary radicular symptoms." (Ex. 1-1). The initial MRI ordered by Dr. Irvine revealed minimal disc herniations with no significant nerve impingement. Subsequent to the closure, Dr. Irvine ordered another MRI as a result of "renewed" radicular symptoms. According to Dr. Irvine, the subsequent MRI revealed increased disc herniation with nerve impingement. Dr. Irvine opined that claimant's current symptoms were almost entirely due to her disc herniation.

When presented with these reports, the insurer issued a denial of claimant's current condition and aggravation claims. Thereafter, at the prior hearing, claimant asserted that the medical reports of Drs. Irvine, Denekas and Berkeley supported compensability of her worsened condition. The insurer responded by contending that claimant had a normal cervical cord with no nerve root impingement and that her condition had not worsened. (Ex. 6B-45). The prior ALJ's order set aside the insurer's denial in its entirety. The insurer did not appeal the prior ALJ's order.

Under these circumstances, we agree with the ALJ that compensability of claimant's disc herniation condition has been previously litigated. At the prior hearing, both the insurer and claimant contested the compensability of claimant's worsened current condition. According to Dr. Irvine, claimant's November 1992 MRI revealed significant disc herniation with nerve root impingement. He opined that the cause of claimant's worsened condition was her disc herniation at C4-5. The insurer contended that claimant's cervical cord was normal with no nerve root impingement. (Ex. 6-45). The prior ALJ's order set aside the insurer's denial, ordering it to accept and process claimant's claim for her current worsened condition.

In conclusion, we find that the prior ALJ's order which set aside the insurer's current condition and aggravation denial had the effect of ordering the acceptance of claimant's disc herniations. See King v. Building Supply Discount, supra. Accordingly, because the insurer did not contest the prior ALJ's order, it is now precluded from litigating the compensability of claimant's disc herniation condition.

Attorney Fees

The ALJ awarded claimant's counsel a carrier-paid attorney fee for clarifying the compensability of claimant's disc herniations. We affirm.

On review, the insurer contends that the ALJ's attorney fee award was inappropriate because claimant's counsel did not receive additional compensation for claimant. Specifically, the insurer contends that, if the December 1993 order obligated it to accept claimant's disc herniations, then its acceptance letter should also be interpreted as accepting this condition. As such, according to the insurer, claimant's attorney did not assist claimant in obtaining additional compensation beyond that which the insurer had already accepted. We disagree.

Amended ORS 656.262(6)(d) prohibits a worker from alleging a "de facto" denial at any hearing or other proceeding if the worker did not provide a written objection to the carrier's notice of acceptance. 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. 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."

At hearing, claimant stated that the issues were a "de facto" denial (i.e. the scope of the accepted conditions ordered by the prior ALJ's order), penalties and attorney fees. (Tr. 2, 3). Specifically, claimant contended that she requested (in writing) that the insurer accept her spondylotic changes at C5-6, secondary cervical radicular syndrome and central disc herniations at C4-5 and C5-6. (Tr. 2; Ex. 11). The insurer responded to claimant's contention, asserting that it was not ordered by the prior ALJ to accept claimant's disc herniations. (Tr. 3, 19).

Here, claimant objected to the insurer's notice of acceptance. (Ex. 11). Claimant requested (in writing) that the insurer accept, among other things, her disc herniations. The insurer declined to do so. Claimant requested a hearing, regarding the insurer's refusal to modify its acceptance. At hearing, the insurer challenged claimant's contention that her disc herniations were compensable, arguing that the prior ALJ's order had not pertained to the herniations.

In light of such circumstances, we find that the insurer refused to pay compensation for claimant' disc herniations on the express ground that the herniations were not compensable or otherwise did not give rise to an entitlement to any compensation. Consequently, we hold that claimant's disc herniations constituted a "denied claim." Amended ORS 656.386(1); Guillermo Rivera, 47 Van Natta 1723 (1995). Inasmuch as claimant has established the compensability of that denied claim, a carrier-paid fee was appropriate. See Amended ORS 656.386(1).

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability of claimant's disc herniations. 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 claim processing issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 27, 1995 is affirmed. For services on review claimant's counsel is awarded $1,500, payable by the insurer.

In the Matter of the Compensation of
**RALPH I. PINGLE, Claimant**
WCB Case No. 94-10640
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside its partial denial of claimant's mileage reimbursement claim for travel to his attending physician's office; and (2) assessed a penalty for an allegedly unreasonable denial. Claimant cross-requests review of that portion of the order that declined to assess an attorney fee. On June 26, 1995, we approved the parties' Claim Disposition Agreement (CDA), in which claimant released all present, past and future rights to benefits, except medical services under ORS 656.245, related to his bilateral elbow and shoulder conditions. Because the parties acknowledge, and we agree, that their mileage reimbursement dispute is not subject to resolution under the CDA, we proceed with our review. 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, under Charles M. Andersen, 43 Van Natta 463 (1991), the employer was obligated to reimburse claimant for his actual mileage in traveling to his attending physician's office. We do not address that issue, because we lack jurisdiction over this matter.

Medically-related travel expenses were "other related services" within the meaning of former ORS 656.245(1)(c). E.g., Susan A. Lowry-Puls, 43 Van Natta 1106, 1107 (1991). The 1995 Legislature amended ORS 656.245. Or Laws 1995, ch 332, § 25 (SB 369, § 25). ORS 656.245(1)(d), a new subsection, now limits a carrier's liability for out-of-pocket expense reimbursement related to a worker's travel to receive care from the attending physician. SB 369, § 25. For the following reasons, we do not address the effect of ORS 656.245(1)(d) on this case.

Amended ORS 656.245(6) provides that, if a claim 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 [.]" SB 369, § 25 (emphasis added). That statute applies retroactively to medical services disputes that arose under former ORS 656.245. Thomas L. Abel, 47 Van Natta 1571, 1572 (1995) (citing Volk v. America West Airlines, 135 Or App 565, 573 (1995)). Under amended ORS 656.245(6), the Director now has exclusive jurisdiction over medical services disputes arising under the former and amended versions of ORS 656.245, except for cases in which a formal denial of a worker's underlying claim is disputed. Id. at 1573.

This is a medical services travel expense case that arose under former ORS 656.245. As such, it is now governed by amended ORS 656.245. Because this is not a dispute regarding the formal denial of claimant's underlying claim for his compensable conditions, under amended ORS 656.245(6), the Director now has exclusive jurisdiction over this matter. Thurman Mitchell, 47 Van Natta 1971 (1995). Accordingly, we vacate the ALJ's decision concerning the medical services issue. Moreover, because we are without authority to award penalties or attorney fees for matters arising under the Director's jurisdiction, SB 369, § 42d(5), we vacate the ALJ's penalty award and attorney fee analysis. See, e.g., Thomas L. Abel, supra, 47 Van Natta at 1573.

Claimant asserts that the retroactive application of SB 369 to this matter violates his constitutional due process rights. Because we lack jurisdiction over this matter, we are not inclined to address that argument. See, e.g., Mary S. Leon, 45 Van Natta 1023, 1024 (1993) (because Board lacked jurisdiction over former ORS 656.245(1)(b) dispute, it lacked authority to address the claimant's equal protection and due process arguments); 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). Nevertheless, we have considered, and now reject, claimant's due process arguments.

Relying on Thornton v. Hamlin, 41 Or App 363, rev den 288 Or 1 (1979), claimant asserts that he has an "accrued right of action" in the benefits that the ALJ awarded him. Therefore, he asserts, due process prohibits the Legislature from depriving him of that right. Thornton is inapposite. That case did not involve a due process challenge to a retroactive statute; rather, it concerned whether, in the first instance, the legislature intended a statute to apply retroactively. That is not the issue here. In any event, by amending ORS 656.245, the Legislature did not deprive claimant of any right; instead, it simply changed the forum before which the parties must now litigate this mileage reimbursement dispute. For these reasons, we reject claimant's arguments under Thornton.[1]

Claimant also asserts that, under Carr v. SAIF, 65 Or App 110 (1983), rev dismissed 297 Or 83 (1984), he has a "a constitutional right to due process as he has a property interest in the workers' compensation benefits." Carr is inapposite. There, the Director terminated the claimant's temporary disability benefits without holding a hearing or offering him an opportunity to be heard. Here, no one has terminated claimant's benefits; further, amended ORS 656.245's Director review process affords claimant an opportunity to air his complaints about this dispute. On that ground alone, claimant's arguments under Carr fail.

We also note that Carr is a procedural due process case. Claimant has not identified what particular process he believes is constitutionally defective. Moreover, his argument assumes that, if this case is presented to the Director, he will be deprived of the benefits that the ALJ awarded him. There is no evidence to support that assumption. In the absence of evidence of a constitutionally infirm process that has already deprived claimant of some benefit, we reject his arguments under Carr v. SAIF.

ORDER

The ALJ's order dated December 30, 1994 is vacated. Claimant's hearing request is dismissed.

---

[1] Claimant may be arguing that he has a vested right in the benefits the ALJ awarded him and that the Legislature may not deprive him of that right without violating due process. If that is the case, we reject that argument outright. Because an order regarding claimant's benefits has yet to become final, claimant's entitlement to such benefits has not yet matured into a vested right. See, e.g., State ex rel v. Kiessenbeck, 167 Or 25, 30 (1941) (the first and essential quality of a judgment or decree that gives rise to a vested right is that it be a final determination of the rights of the parties); see also Roberts et al v. State Tax Com., 229 Or 609, 614 (1962) ("vested right" is an immediate right to present enjoyment, or a present fixed right to future enjoyment). For that reason, a "vested right" argument will fail.

---



In the Matter of the Compensation of
**DOROTHY D. VANDERZANDEN, Claimant**
WCB Case No. 94-15363
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the self-insured employer's denial of claimant's current low back condition and her proposed surgery request. On review, the issues are compensability, jurisdiction, and proposed surgery. We reverse in part and vacate in part.

FINDINGS OF FACT

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

The first sentence of the eighth paragraph should read: "On April 2, 1992, claimant returned to Dr. Nash.

On November 29, 1983, Dr. Rosenbaum, examining neurosurgeon, related claimant's condition to the June 6, 1983 compensable low back injury, noting that claimant had an initial tear in her annulus at the time of the work injury and "an eventual extrusion of her disc in October [1983] causing her back and leg pain." (Ex. 14-2). Dr. Bergquist, claimant's then-treating physician, concurred. (Ex. 17). Both Drs. Rosenbaum and Bergquist recommended surgery to correct the herniated disc at L5-S1. (Exs. 17, 20, 22). On January 18, 1984, Dr. Bergquist performed a left L5-S1 hemilaminotomy and discectomy. (Ex. 23).

The January 1984 surgery provided only a few days of pain relief, then claimant's back and left leg symptoms returned to pre-operative levels. On January 30, 1985, claimant began treating with Dr. Nash, neurosurgeon. (Ex. 69). Dr. Nash diagnosed a recurrent L5-S1 disc. On November 11, 1985, Dr. Nash performed a secondary lumbar laminotomy, subtotal medial facetectomy, L5-S1, left, and discectomy, L5-S1, left. (Ex. 96).

## CONCLUSIONS OF LAW AND OPINION

On November 28, 1994, the employer issued a partial denial of claimant's current low back condition and medical services related to that condition, including a proposed surgery. (Ex. 140). At hearing, the issues included both compensability and the reasonableness and necessity of the proposed surgery. (Tr. 2). However, in rendering his opinion, the ALJ focused solely on the reasonableness and necessity issue without addressing the compensability issue. The ALJ concluded that the proposed surgery was not reasonable and necessary and upheld the November 28, 1994 denial in its entirety. On review, claimant again raises the issues of compensability of the current low back condition and the appropriateness of the proposed surgery. We address each issue separately.

### Compensability

Given the fact that claimant compensably injured her low back in 1983 and subsequently underwent two compensable surgeries at the L5-S1 level, the compensability of claimant's current low back condition presents a complex medical question the resolution of which depends on expert medical opinion. Barnett v. SAIF, 122 Or App 279 (1993); Uris v. Compensation Department, 247 Or 420 (1967). The medical opinion regarding the compensability of claimant's current low back condition comes from two physicians: Dr. Nash, treating neurosurgeon, and Dr. Wilson, examining neurologist.

Dr. Wilson examined claimant twice: on May 7, 1992, regarding a previous proposed low back surgery request, and on November 17, 1994, regarding the current issues of compensability and appropriateness of the current proposed surgery. (Ex. 138). Dr. Wilson did not have any x-rays or CT scans available during his November 17, 1994 examination. Following that examination, Dr. Wilson stated that claimant's work activity was not the major contributing cause of these diagnosed conditions. (Ex.138-7).

During his deposition, Dr. Wilson reviewed 1994 x-rays and CT scans and acknowledged that both of claimant's previous surgeries were at the L5-S1 level, with no surgery at the L4-5 level as he had previously indicated. Dr. Wilson opined that claimant's present symptoms were not due to the accepted 1983 low back strain injury claim or to the two prior back surgeries, but rather were due to nonorganic causes. Although he was not sure why claimant had pain, Dr. Wilson found no evidence to suggest the cause was S1 nerve root compromise. (Ex. 143-27).

Based on May 1994 CT scans, x-rays, and claimant's examination, Dr. Nash (who had examined claimant "15 or 20" times since 1985) diagnosed "lumbar radiculopathy due to an L5-S1 foraminal stenosis, there is also associated broad-based disc at the L4-5 level." (Ex. 141-2). Noting that claimant had nerve root compromise caused by the compensable injury and the subsequent surgeries related to that injury, Dr. Nash opined that the major contributing cause of claimant's current low back condition was the work injury and the resulting surgical removal of the disc. (Ex. 142-35).

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reasons not to rely on the opinion of Dr. Nash, a physician who has treated claimant since 1985 when he performed the 1985 surgery. To the contrary, Dr. Nash's opinion that the 1983 work injury damaged the S1 disc, resulting in subsequent surgeries at L5-S1 is supported by the contemporaneous medical record. In contrast, Dr. Wilson appears to confine the 1983 work injury to a

low back strain, a conclusion which is not supported by the record. In this regard, in November 1983, Dr. Rosenbaum, examining neurosurgeon, related claimant's then-need for surgery to correct a L5-S1 herniated disc to the June 6, 1983 compensable low back injury. (Ex. 14-2). Dr. Bergquist, claimant's then-treating physician, concurred. (Ex. 17). On January 18, 1984, Dr. Bergquist performed a left L5-S1 hemilaminotomy and discectomy. (Ex. 23). In addition, Dr. Nash performed a second surgery in 1985 due to a recurrent herniated disc at L5-S1.

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).

Here, Dr. Nash persuasively opined that claimant's current low back condition was caused in major part by the compensable 1983 low back injury and the resulting surgical treatment of that injury. Based on Dr. Nash's opinion, we find that claimant's current low back condition is compensable.

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 for prevailing over the employer's denial of her current low back condition is $3,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Jurisdiction over Proposed Surgery

The employer denied compensability of claimant's current low back condition and proposed surgery on the basis that they were not a consequence of the compensable injury. (Ex. 140). As discussed above, we have found claimant's current low back condition compensable. The ALJ found that the proposed low back surgery was not reasonable and necessary treatment. Based on the reasoning discussed below, we find that the Director has exclusive jurisdiction of the dispute concerning the reasonableness and necessity of the proposed surgery.

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. See Newell v. SAIF, 136 Or App 280 (1995).

Here, although the claim for surgery was initially denied on the basis that the underlying current low back condition was not compensable, we have concluded that claimant's current low back condition is compensable. Therefore, the medical service dispute regarding proposed surgery no longer pertains to the compensability of claimant's underlying claim. Rather, the remaining issue to be decided is whether the proposed surgery requested by Dr. Nash 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. Lynda J. Zeller, 47 Van Natta 1581 (1995).

ORDER

The ALJ's order dated April 14, 1995 is vacated in part and reversed in part. Those portions of the order which pertained to the issue of the appropriateness of the proposed surgery are vacated and claimant's request for hearing on that issue is dismissed for lack of jurisdiction. Those portions of the order which upheld the self-insured employer's denial of claimant's current low back condition are reversed. The employer's denial of claimant's current low back condition is set aside, and the claim is remanded to the employer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded $3,000, payable by the employer.

In the Matter of the Compensation of
**FREDDY VASQUEZ, Claimant**
WCB Case No. 94-05352
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order which affirmed an Order on Reconsideration of Final Determination of his Inmate Injury Fund claim, awarding 21 percent (28.35 degrees) scheduled permanent disability for a left foot (ankle) condition. On review, the issue is extent of scheduled permanent disability.

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

The ALJ held that, pursuant to ORS 655.515, injured inmates are entitled to the same benefits as other injured workers, but not necessarily the same procedures for payment of those benefits. Thus, the ALJ concluded that claimant was not entitled to a medical arbiter examination upon demand. We agree.

We have previously recognized that the statutory scheme for review of determinations for claims under the Inmate Injury Fund does not envision claim closure pursuant to ORS 656.268. Instead, we have noted that ORS 655.525 provides for review of determination actions in accordance with the procedures set forth in ORS 656.283 to 656.304. Victor L. Stewart, 45 Van Natta 1626, 1627 n.1 (1993). ORS 656.283 authorizes an ALJ to apply the disability standards adopted by the Director and to evaluate the extent of permanent disability. ORS 656.295 authorizes the Board to apply the disability standards and to rate the extent of permanent disability. Only the Director may appoint a medical arbiter under ORS 656.268. ORS 656.268(7). Neither the Board nor its Hearings Division is authorized to appoint a medical arbiter.

In injured inmate cases, claim processing is performed by the SAIF Corporation on behalf of the Department of Administrative Services. ORS 655.520. SAIF also has no authority to appoint a medical arbiter.

Accordingly, we find no error in the ALJ's refusal to refer this claim to a medical arbiter.

ORDER

The ALJ's order dated November 23, 1994 is affirmed.

**Board Member Gunn dissenting.**

Because I believe an injured inmate is entitled to examination by a medical arbiter, I respectfully dissent.

ORS 655.515 provides that for an injured inmate, with certain exceptions not applicable here, "benefits shall be paid in the same manner as provided for injured workers under the workers' compensation laws of this state[.]" For injured workers, the payment of benefits for permanent disability is determined by the extent of permanent disability rated under the Director's disability standards. The extent of disability rating, in turn, is determined, at least in part, by the extent of impairment measured by an attending physician, or by a medical arbiter. Under ORS 656.268(7), an injured worker is entitled to a medical arbiter examination, if the basis for objection to claim closure is "disagreement with the impairment used in rating of the worker's disability[.]" The medical arbiter examination findings can be critical in determining the extent of a worker's disability, which in turn determines the amount of his benefits for permanent disability.

Because of the critical role played by the medical arbiter in evaluating extent of permanent disability, denying an injured inmate access to a medical arbiter examination is tantamount to denying the inmate the payment of benefits in the same manner as provided for injured workers under ORS Chapter 656. I believe such a result is contrary to the language and spirit of ORS 655.515. Accordingly, I would remand this claim to the Director for appointment of a medical arbiter.

The majority relies for its position on a footnote in a prior Board decision, Victor L. Stewart, supra. I do not believe that either our decision or our footnote in that case mandates the result reached by the majority in this case. First, in Stewart, we did not decide the question of whether the inmate was entitled to a medical arbiter examination. Instead, the initial question before us was whether the Hearings Division and Board had jurisdiction to consider the inmate's hearing request when the inmate had not first obtained reconsideration by the Director.[1] We held that, pursuant to ORS 655.525, we had jurisdiction to review the final determination of the inmate's claim. Therefore, because we did not decide in Stewart whether an inmate is entitled to a medical arbiter examination, our decision in that case does not determine the outcome in this case.

Second, our footnote in Stewart spoke only to the proper procedure for review of injured inmate determination actions under ORS 655.525. We did not address the inmate's entitlement to benefits under ORS 655.515. Therefore, I do not believe our decision in Stewart is determinative of the issue involved in this case.

Accordingly, because I do not believe our prior decision mandates the outcome reached by the majority in the present case, and because I believe that, in order to receive benefits in the same manner as any injured worker under ORS Chapter 656, an injured inmate is entitled to an examination by a medical arbiter, I respectfully dissent.

---

[1] In Stewart, the claimant had sought reconsideration before the Appellate Unit and the Evaluation Section of the Department, but both forums declined to consider the claimant's request for lack of jurisdiction. Thereafter, the claimant filed a request for hearing before the Board's Hearings Division.

---

November 6, 1995 Cite as 47 Van Natta 2160 (1995)

In the Matter of the Compensation of
**DONNA M. WILSON, Claimant**
WCB Case No. 94-10507
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of claimant's ankle injury claim. On review, the issue is whether claimant's injury arose out of and occurred in the course of her employment. We affirm.

## FINDINGS OF FACTS

Claimant works as a secretary/bookkeeper for an accountant. On Friday, May 27, 1994, at approximately ten minutes before the end of the work day, claimant went to her employer's office to ask if she could leave early. Her employer told her that she could leave. Happy because of the upcoming long weekend and because she could leave early to check on her son at the orthodontist, claimant did a skip step around a corner on the way to her office; in the process, she tore her Achilles tendon. (Tr. 7-8).

The insurer denied the claim on the ground that the injury did not occur within the course and scope of employment.

## CONCLUSIONS OF LAW AND OPINION

Parenthetically, we note that claimant has requested oral argument. We ordinarily do not entertain oral argument. OAR 438-11-015(2 ). However, we may grant such a request if a case presents an issue that could have a substantial impact on the workers' compensation system. See Ruben G. Rothe, 45 Van Natta 369 (1993). Here, through their extensive appellate briefs, the parties have availed themselves of the opportunity to fully address the issues for determination. Inasmuch as the parties' respective positions regarding these issues have been thoroughly defined, we are unpersuaded that oral

argument would appreciably assist us in reaching our decision. Furthermore, claimant concedes that this is a very fact-bound case and thus unlikely to have a significant impact on the workers' compensation system. In addition, recent court and Board decisions have answered most of the issues raised on review. Consequently, we decline to grant claimant's request.

Relying on Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), the ALJ found that skipping was not an integral part of claimant's job and that claimant's skipping because she was happy to leave work early was not a risk connected with her employment. The ALJ further found that claimant's injury occurred independent of any physical conditions at work. The ALJ, therefore, concluded that claimant's injury did not arise out of her employment. We agree.

In Norpac Foods, Inc. v. Gilmore, supra, the Court stated that, to establish the compensability of an injury, the claimant must show that the injury: (1) occurred in "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. As the Court explained, neither element is dispositive; rather, "all the circumstances" must be considered to determine if the claimant has satisfied the work-connection test.[1] Id. at 366, 369.

The parties do not dispute the "in the course of employment" element. The dispute concerns whether claimant's injury "arose out of" her employment. In determining whether a causal connection existed between the injury and the employment, we consider whether the conditions of claimant's employment put her in a position to be injured. Henderson v. S.D. Deacon Corp., 127 Or App 333, 338-39 (1994).

In Henderson, the court concluded that the claimant's conditions of employment put her in a position to be injured (when she attempted to step out of an elevator) based on the employer's knowledge of her repeated use of the elevator to go to and from her workplace, the lack of alternative means to arrive and leave her workplace, the unavailability of lunch facilities at the workplace, and the employer's preference that claimant leave the building for lunch. Id. at 339; see also Mark Hoyt, 47 Van Natta 1046 (1995)(the claimant's conditions of employment put him in a position to be injured by a knife where the claimant and the co-worker were on a mandatory lunch break in the employer's lunchroom, which was the only practical choice for such a break; the workers generally carried and used knives to assist them in completing their work duties, and the employer had acquiesced in this practice).

Here, claimant was injured when she skipped around a corner at work. Other than the injury occurring on the employer's premises, we find no risk connected with claimant's employment.[2] The employer did not contemplate or expect claimant to skip around the corner nor had he seen claimant skip in the office. Skipping was not the usual means for claimant to go to her office. The decision to skip was claimant's, not the employer's. Other than the fact that claimant was "happy" because she could leave work early, there was no condition associated with her work to cause the injury.[3] See William F. Gilmore, on remand, 46 Van Natta 999 (1994); see also, Kevin G. Robare, 47 Van Natta 318 (1995)(risk of injury was personal where the claimant choked on water and passed out and where risk was not related to any premises hazard or to work activities); Denise C. Smith, 46 Van Natta (1994)(the claimant's use of employer parking lot, where injury occurred, was solely for her husband's convenience; injury did not arise out of employment).

---

[1] 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). Rather, the factors were helpful inquiries in considering the totality of the circumstances to determine if a sufficient work connection was shown.

[2] Claimant argues that "locomoting" herself within the office to perform a specific job duty is within the ambit of conditions of employment. Perhaps, if claimant had used her usual means of ambulation, we may have agreed. Furthermore, the record does not persuasively establish that claimant was returning to her office to transfer the phones to the answering service.

[3] Contrary to the dissent's assertions, we are not opposed to "happy" workers. That the work environment may impact how a worker expresses her mood, does not negate the fact that the risk of injury was personal. Particularly where, as here, the employer had no knowledge of, and did not anticipate, how claimant would express her happiness.

Accordingly, we conclude that claimant's injury did not result from an act which was an ordinary risk of, or incidental to, her employment and, therefore, did not "arise out of" her employment. Claimant has failed to establish that the injury was sufficiently related to her employment to be compensable.

ORDER

The ALJ's order dated December 30, 1994 is affirmed.

**Board Member Gunn dissenting.**

Happy workers are, obviously, legally not allowed by the majority. According to the majority, being happy at work is not a risk related to work. I would find that being happy is an anticipated risk of employment, such that claimant's employment put her in a position to be injured. Therefore, I respectfully dissent.

Generally, injuries occurring on the employer's premises arise out of and in the course of employment, unless an exception applies. Chris T. Singelstad, 46 Van Natta 894 (1994). Exceptions taking a worker outside the course of employment include where the claimant has: engaged in horseplay (ORS 656.005(7)(b)(B)); consumed alcohol and/or drugs (ORS 656.005(7)(b)(C)); or engaged in some other misconduct. As these exceptions illustrate, the prohibited activity is not expected or part of the claimant's employment. Compare Agripac v. Zimmerman, 97 Or App 512 (1989)(injury from jumping off loading dock sufficiently work related when employer acquiesced in conduct where claimant had jumped on several occasions in the presence of supervisory personnel without reprimand).

The majority finds that the employer did not expect claimant to skip in the office. Claimant, like other workers, is a human being with feelings, moods, attitudes, etc. Expressions of these moods, be it anger, sadness, or happiness, are to be expected in the workplace. Likewise, physical manifestations of these moods should also to be expected. Workers should not have to behave or act like a "Commander Data" (the android in "Star Trek, The Next Generation") in order to be entitled to workers' compensation benefits when injured.

Moreover, unlike the above stated exceptions to the general rule, claimant did not engage in any prohibited activity that would take her outside the course of her employment. The employer only prohibited claimant from skipping in the view of clients. At the time of claimant's injury, there were no clients in the office. Thus, claimant's chosen means of transporting herself within the work place was not unexpected and should not, in itself, take her outside the course of employment.

In addition, the employer told claimant that she could leave work early. A worker looking forward to a long weekend would be expected by an employer to be happy. Claimant expressed her elation by doing a skip. Absent other evidence that non-work related factors were the cause of claimant's injury, claimant's physical expression of her mood should not be the determinative factor in denying compensability.

In the Matter of the Compensation of
**KIM E. DANBOISE, Claimant**
WCB Case No. 94-14711
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Gunn, Christian and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that awarded claimant 21 percent (67.2 degrees) unscheduled permanent disability for a back injury, whereas an Order on Reconsideration had granted no permanent disability. On review, the issue is extent of unscheduled permanent disability. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Low Back Impairment

The ALJ concluded that, based on the medical arbiters' range of motion findings, claimant had established a 5.5 percent low back impairment. SAIF asserts that,, because the ALJ's conclusion was necessarily based on an inadmissible "post-reconsideration" supplemental arbiter report, claimant has failed to establish a ratable low back impairment. We disagree.

The medical arbiters initially found that "[l]umbar motions by double inclinometer in the maximums were flexion 36 degrees, extension 0 degrees, straight leg raising on the right 50 degrees, on the left also 50 degrees. Total sacral motion was 6 degrees. Therefore, lumbar flexions are invalid. Right lateral bend was 10 degrees, left was 12 degrees." (Ex. 35-2; emphasis added). An Order on Reconsideration issued, awarding claimant no permanent disability benefits. Thereafter, one of the arbiters issued a supplemental report, clarifying that claimant's lateral bend ranges of motion were valid. (Ex. 38).

In rating a worker's impairment, we may not consider a supplemental medical arbiter's report, unless the arbiter's examination or initial report is incomplete. Daniel L. Bourgo, 46 Van Natta 2505, 2508 (1994). Here, there is insufficient evidence that the arbiters' examination or initial report was incomplete. Therefore, the rating of claimant's low back impairment must be made without considering the supplemental arbiter's report.

On this record, we find the initial arbiters' report sufficient to support the ALJ's impairment findings. The report states that claimant's lumbar flexion range of motion findings are invalid; it does not impugn the validity of the lateral bend findings. Therefore, in the absence of any contrary evidence, we find that the lateral bend findings in the initial arbiters' report are persuasive evidence of claimant's lumbar impairment. Because we reach that conclusion without considering the supplemental arbiter's report, we reject SAIF's argument regarding that report.

Claimant is entitled to 3 percent rating for his loss of right lateral flexion, and 2.6 percent rating for his loss of right lateral flexion. OAR 436-35-360(21). Rounding the 2.6 figure to 3, OAR 436-35-007(10), (11), and adding the values for loss of motion, OAR 436-35-360(22), claimant's ratable lumbar impairment is 6 percent.

For these reasons, we affirm the ALJ's conclusions regarding claimant's low back impairment.

### Cervical Impairment

The ALJ concluded that, based on the medical arbiters' findings, claimant has established that his cervical impairment is due to his compensable injury. SAIF disputes that conclusion, arguing that there is insufficient evidence that claimant's cervical impairment was related to his compensable injury. We disagree.

To be entitled to permanent disability compensation for his cervical impairment, claimant must establish that the impairment is due to his compensable injury. ORS 656.214(2). If a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury, and does not attribute the impairment to causes other than the compensable injury, we will construe the findings as showing that the claimant's impairment is due to the compensable injury. Edith N. Carter, 46 Van Natta 2400 (1994); David J. Schafer, 46 Van Natta 2298 (1994).

Here, the medical arbiters found diminished cervical range of motion. (Ex. 35-2). Those findings are consistent with claimant's compensable cervical strain. Because the panel did not attribute the cervical findings to causes other than the compensable injury, we construe the findings as showing that claimant's cervical impairment was due to his compensable injury. Edith N. Carter, supra; David J. Schafer, supra. Accordingly, we affirm the ALJ's conclusions regarding claimant's cervical impairment.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 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 March 29, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the SAIF Corporation.

**Board Member Haynes concurring in part and dissenting in part.**

I agree with the majority's reasoning and conclusions regarding claimant's low back impairment. I write to express my disagreement with its analysis concerning claimant's cervical impairment.

Relying on Edith N. Carter, 46 Van Natta 2400 (1994) and David J. Schafer, 46 Van Natta 2298 (1994), the majority reasons that, "[i]f a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury, and does not attribute the impairment to causes other than the compensable injury, we will construe the findings as showing that the claimant's impairment is due to the compensable injury." 47 Van Natta at 2164. Because I believe that that conclusion conflicts with a clear statutory mandate, I disagree with it. Moreover, to the extent that they support the majority's conclusion, I would disavow Carter and Schafer.

David J. Schafer, supra., concerned the claimant's entitlement to unscheduled permanent disability for loss of use or function of the right knee. In addition to a compensable knee condition, the claimant had a noncompensable inflammatory disease. The medical arbiter reported that the claimant had reduced knee range of motion, but did not relate those findings to the compensable injury. The Board concluded, "In the absence of evidence that the arbiter rated impairment due to causes other than the compensable injury," the arbiter's impairment findings were "due to" the claimant's compensable injury. 46 Van Natta at 2299.

The Board concluded likewise in Edith N. Carter, supra. There, the issue was the claimant's entitlement to unscheduled permanent disability for a cervical and shoulder condition. The medical arbiter measured the claimant's range of motion, finding that the claimant was "status post cervical and right shoulder strain," but did not attribute those findings to any particular cause. 46 Van Natta at 2401.

The insurer asserted that the arbiter's report did not prove entitlement to permanent disability, because it did not indicate that the claimant's impairment was "due to" her accepted condition. Citing David J. Schafer, the Board disagreed, concluding that, because the arbiter's diagnosis was consistent with the claimant's accepted conditions, he referred only to those conditions, and he referred to no other potential causes of the claimant's impairment, the report was "most reasonably construed as showing that [the] claimant's limited range of motion was due to the accepted conditions." 46 Van Natta 2401.

In my view, both Schafer and Carter run afoul of ORS 656.214(2). That statute provides, in part, "When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury." (Emphasis added). In view of that provision, and the requirement that a worker adduce direct medical evidence of impairment, see, e.g., ORS 656.726(3)(f)(B) ("Impairment is established by a preponderance of the medical evidence based upon objective findings[.]"), I believe that there must be at least some direct medical evidence that the impairment is due to the claimant's industrial injury. That conclusion comports with ORS 656.266, which provides that the worker has the burden of proving the nature and extent of any disability resulting from a compensable condition. See former OAR 436-35-007(l) (since amended by WCD Order Admin Order 95-060 (August 23, 1995) (temp)) ("A worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the accepted injury and/or its accepted conditions." (emphasis added)).

In Schafer and Carter, the records supported, at most, an inference that the claimants' impairments were "due to" their industrial injuries. There was no direct evidence that any medical expert had actually considered the cause of their impairments. Lacking such evidence, I believe that Schafer and Carter failed to establish the "due to" element of ORS 656.214(2) and that the Board decisions to the contrary were erroneous.[1] I would disavow them.[2]

Here, there is no direct evidence that claimant's cervical impairment is the result of his compensable injury; none of the treating or examining physicians ever attributed that impairment to any particular source. Under ORS 656.214(2), claimant has failed to establish that his cervical impairment is related to his compensable injury. Accordingly, I would reverse the ALJ's findings and conclusions regarding the cervical condition. Because the majority concludes otherwise, I dissent.

---

[1] As stated earlier, Schafer states that, "In the absence of evidence that the arbiter rated impairment due to other causes than the compensable injury," the "due to" element had been satisfied. 46 Van Natta at 2299. The Board assumed that the arbiter rated impairment solely related to the compensable injury to conclude that the impairment was due to the injury. That is patent circular reasoning. For that additional reason, I find Schafer insufficient to support claimant's cervical permanent disability award.

[2] A handful of other Board decisions have followed the Schafer/Carter reasoning. Marvin L. Thrasher, Sr., 47 Van Natta 915, 917 n 2 (1995); David B. Weirich, 47 Van Natta 478, 480 n 1 (1995); Harold J. Lawrence, 46 Van Natta 2356, 2358 (1994). To the extent that they address the "due to" issue, I would disavow them, too.

---

November 8, 1995 Cite as 47 Van Natta 2165 (1995)

In the Matter of the Compensation of
**DAVID L. BLACK, Claimant**
WCB Case No. 94-02972
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) dismissed claimant's request for hearing for lack of jurisdiction; (2) did not address claimant's challenge to the SAIF Corporation's alleged "de facto" denials of claimant's claims for proposed medical services, including continued treatment to be provided by Dr. Fitzgerald; and (3) did not award penalties and attorney fees for SAIF's allegedly unreasonable claim processing. On review, the issues are jurisdiction and, if the Hearings Division has jurisdiction, medical services, penalties and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the last sentence, with the following supplementation.

The Director's April 10, 1994 "Proposed and Final Order Concerning a Medical Services Dispute" (finding that the electric lift prescribed by Dr. Fitzgerald is not a medical service) was not appealed.

The Director's April 22, 1994 "Proposed and Final Order Change of Attending Physician Dispute" (directing claimant to select a new attending physician from those within the MCO, i.e., not Dr. Fitzgerald--whom the MCO had decredentialed) was not appealed.

## CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the Hearings Division lacked jurisdiction over claimant's medical services claim because the services at issue were not prescribed by claimant's attending physician. We reach the same result, but base our decision on the following reasoning.

The threshold issue is whether the Hearings Division has authority to address claimant's challenge to his MCO's disapproval (which claimant characterizes as SAIF's "de facto" denials). Specifically, claimant contends that he should be permitted to continue treating with Dr. Fitzgerald and that SAIF is responsible for his claim for an electric lift (as prescribed by Dr. Fitzgerald).

We have recently held that, under the unambiguous mandatory language of amended ORS 656.260(6)[1], the Director has exclusive jurisdiction over all MCO medical services disputes. Ronald R. Streit, 47 Van Natta 1577 (1995). In reaching this conclusion, we looked to the text and context of amended ORS 656.260(6).[2]

Here, because neither the Hearings Division nor the Board[3] has jurisdiction over the MCO's denial of claimant's claim for medical services, claimant's request for hearing was properly dismissed.[4] Accordingly, we do not address the medical services issue.[5] See David L. Black, 47 Van Natta 1704 (1995) (Jurisdiction to decide whether medical treatment is reasonable and necessary rests with the Director). Likewise, because the remaining issues are contingent upon the resolution of the medical services issue, we are without authority to address the accompanying penalty and attorney fee issues. See SB 369, §42b(5).

## ORDER

The ALJ's order dated September 16, 1994 is affirmed.

---

[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, supra.

[3] In Ronald R. Streit, 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 limitation, it applied retroactively. See Newell v. SAIF, 136 Or App 280 (1995); 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).

[5] The result would be the same under the law existing before the 1995 amendments to ORS Chapter 656. See former ORS 656.260(6) ("[A]uthorization for medical services to be provided by other than an attending physician pursuant to ORS 656.245(3) shall be subject solely to review by the Director or the Director's designated representative." (Emphasis added)); compare Job G. Lopez, 47 Van Natta 193 (1995); see also Robin L. Smith, 47 Van Natta 423, 425 (1995); Ronald D. Robinson, 44 Van Natta 1657 (1992) (A dispute involving a change in attending physician is not "a matter concerning a claim" over which the Hearings Division has jurisdiction).

**Board Member Gunn dissenting.**

My notion of substantial justice is offended by the lack of due process afforded to this injured worker. Because I would remedy this injustice by asserting jurisdiction to review this medical services dispute, I dissent.

Claimant compensably fractured his left foot in 1977 and subsequently developed numerous complications, including severe reflex sympathetic dystrophy in the left leg, traumatic arthritis in the left foot, and severe depression. He has also struggled with preexisting obesity, weighing in excess of 300 pounds. Despite near constant medical treatment, as well as psychiatric treatment, claimant's functional ability continued to deteriorate, and he was granted permanent total disability benefits in 1980.

In 1991, claimant began developing chronic right leg pain, in addition to left leg pain, due to progressive reflex sympathetic dystrophy. He became less mobile, spending more time in bed, and was more depressed. When he did go out, he often required the use of two canes. In 1993, the sympathetic dystrophy began migrating to claimant's arms, rendering him more disabled and dependent on a motorized wheelchair for mobility. In an effort to increase claimant's mobility, Dr. Fitzgerald, the attending physician, requested authorization for an electric lift for the wheelchair for use in claimant's van, to enable him to drive on his own to doctors' appointments and for other activities. Dr. Duncan, claimant's treating psychiatrist, concurred with Dr. Fitzgerald's request, opining that increased mobility would decrease claimant's depression.

Despite these doctors' opinions that the electric lift is reasonable and necessary for claimant's recovery from the compensable injury and its sequela, the Medical Director at that time--a registered nurse--concluded that the lift is not even a "medical service" which can be approved for claimant's condition. The Medical Director's order was not appealed. However, my obligation to effect substantial justice compels me to note that the Medical Director's decision in this case, which denies what medical doctors have prescribed for claimant's physical and psychiatric recovery from his compensable injury, is the kind of decision that is produced by administrative review.

When the 1990 Legislature instituted administrative review of medical services disputes (via Senate Bill 1197), its intent was to have doctors, rather than lawyers and Board members, making decisions about the appropriateness of proposed medical care for injured workers. The Legislature envisioned a review process in which a medical doctor, appointed to be the Department's Medical Director, would review treatment proposed by the worker's own medical doctor(s). Presumably, the Medical Director would be uniquely qualified, by training, experience and expertise, to decide the often complex medical issues involved in treatment.

In principle, this administrative review process should have worked to ensure the administration of proper medical care and the denial of inappropriate or unnecessary care. Unfortunately, we have yet to retain a medical doctor as Medical Director for more than one year. Instead, these medical treatment decisions have been left in the hands of nurses or any passing bureaucrat. The end result in this case is that claimant, who has the potential for medical improvement with increased mobility, is denied that potential for improvement by a bureaucrat, in direct contradiction of medical opinion. Moreover, this decision is typical of the bureaucratic approach to problem solving. Instead of viewing the reasonableness and necessity of the electric lift under the unique circumstances of this particular case, the bureaucrat categorically denies the lift as not falling within the definition of a "medical service."

The recent expansion of administrative review jurisdiction over medical services disputes (under Senate Bill 369) causes me great concern that more decisions like the one made in this case will be made in the future. As jurisdiction is shifted from contested case determinations to those by fiat of bureaucratic regulation, all participants will lose. Workers will be denied medical treatment they need to improve and hopefully return to work, and employers will be subject to greater bureaucratic interference in their businesses.

For these reasons, and because I doubt the administrative review process provides the parties with due process sufficient to withstand constitutional scrutiny, I dissent.

In the Matter of the Compensation of
**MICHAEL J. BOLLWEG, Claimant**
WCB Case Nos. 94-13669, 94-12982, 93-06799 & 94-12981
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Thomas J. Dzieman (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer (City of Gold Hill) requests review of those portions of Administrative Law Judge (ALJ) Howell's order that: (1) found that claimant was not a subject worker of Rogue Community College pursuant to former ORS 656.046(1); and (2) set aside its "back-up" denial of claimant's claims for injuries to his right eye, knees, low back, and left shoulder. On review, the issues are subjectivity and "back-up" denial.

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

Gold Hill asserts that claimant is an employee of Rogue Community College pursuant to former ORS 656.046(1) arguing that the 1993 amendments to ORS 656.046(1) support its assertion. However, as noted by the ALJ, this matter is governed by the former version of ORS 656.046(1) and therefore the 1993 amendments are not applicable. Moreover, we have previously rejected a similar interpretation of the former statute in Michael C. Steelman, 46 Van Natta 1852, 1853 (1994). Accordingly, we agree with the ALJ's conclusion that claimant was not a subject worker of Rogue Community College.

Gold Hill also contends that since it did not discover that claimant was not a "subject worker" until after it issued its acceptance, the ALJ erred in concluding that its "back-up" denial was not based on new evidence. We disagree.

In Ralph E. Murphy, 45 Van Natta 725 (1993) we held that the legislative history behind ORS 656.262(6) supported an interpretation that evidence in support of a "back-up" denial must be obtained or discovered after acceptance of the claim. Such new evidence does not include a new analysis or legal conclusion based on the same information the carrier knew, or should have known, at the time of acceptance. Id. at 727.

Here, the evidence upon which Gold Hill based its "back-up" denial is the factual information, i.e., that claimant was injured while he was an unpaid trainee registered at Rogue Community College's Professional Skills Training Program. It is from this information that Gold Hill drew the legal conclusion that claimant was not a subject worker. However, this information was known to Gold Hill at the time it issued its acceptance. A later analysis of the same information, or a later legal conclusion based on the same facts does not constitute "later-obtained evidence" under ORS 656.262(6). Ralph E. Murphy, supra at 727. Consequently, Gold Hill was not statutorily entitled to issue a "back-up" denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 Gold Hill. 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 April 19, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by Gold Hill.

In the Matter of the Compensation of
**DARCY L. BORGERDING, Claimant**
WCB Case No. 94-12762
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Bostwick, 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) Otto's order that: (1) set aside its denial of compensability of claimant's chronic urticaria and angioedema as an invalid "back-up" denial; (2) awarded an assessed attorney fee pursuant to ORS 656.386(1); and (3) awarded a $500 attorney fee under ORS 656.382(1) for allegedly unreasonable resistance to the payment of compensation. On review, the issues are compensability and attorney fees.

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

It is the law of the case that the condition denied by the employer in its October 21, 1994 denial, identified as "chronic idiopathic utecaria [sic] and angioedema" is the same condition accepted by the employer in 1991 as "allergies to red spruce and fir." Darcy L. Borgerding, 47 Van Natta 976, n.1 (1995) ("we find that the 'urticaria' and 'angioedema' diagnoses merely describe the same condition/symptoms which the employer accepted under the original claim."). We therefore affirm the ALJ's determination to set aside the October 21, 1994 denial as a procedurally improper "back-up" denial under ORS 656.262(6).

Claimant's attorney is entitled to an assessed fee for services on review concerning the employer's denial. 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 $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. Claimant is not entitled to an attorney fee award for services devoted to the attorney fee issues. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 15, 1995, as ammended May 2, 1995, is affirmed. For services on review, claimant's attorney is awarded $750, to be paid by the employer.

In the Matter of the Compensation of
**EDWARD F. EBERT, Claimant**
WCB Case No. 94-15103
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Jeffrey R. Gerner (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order which affirmed the Order on Reconsideration's award of 21 percent (67.2 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

Claimant's claim was closed by Notice of Closure on August 29, 1994. Accordingly, we apply WCD Admin. Order 93-056 when rating the extent of claimant's unscheduled permanent disability.

The ALJ concluded that the specific vocational preparation (SVP) value to be used in calculating the extent of claimant's unscheduled permanent disability is 7. The ALJ assigned that figure because claimant worked as a finish carpenter for approximately three and three-fourths years during the five years prior to the time of determination. The DOT for finish carpenter (860.381-022) states that the SVP is 7, which requires a training time of "2+ years - 4 years."

Claimant argues that, because he has not completed employment as a finish carpenter for the maximum period of 4 years, he has not met the SVP for finish carpenter. In support of his argument, claimant relies on OAR 436-35-300(3)(b)(A), which provides: "A worker is presumed to have met the SVP training time after completing employment with one or more employers in that job classification for the maximum period specified in the table in section 4 of this rule." (Emphasis added).

Thus, claimant contends that he is not presumed to have met the SVP because he has not worked the maximum period of 4 years. SAIF argues that the rule sets out a rebuttable presumption. That is, if claimant has worked less than 4 years, but more than 2 years, he can rebut the inference that he was actually proficient and able to perform the work. We agree with SAIF's contention.

OAR 436-35-300(3)(b)(A) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. See Michael W. Davison, 42 Van Natta 1820 (1990). The DOT provides that, for an SVP of 7, the length of time to proficiency is "over 2 years up to and including 4 years." Dictionary of Occupational Titles, Vol. II, at 1009 (4th ed. 1991). (Emphasis added).

In Davison, the employer argued that the claimant should be assigned an SVP of 7 because the claimant had operated an automotive body shop. We held that, since the claimant had not reached the minimum requirement because he had not worked at the job of autobody repairer for over two years, he did not meet the SVP required for that job. Michael W. Davison, supra.

Here, there is no evidence that claimant is not proficient and unable to perform the work. Claimant has worked as a finish carpenter for four different construction companies between July 1988 and April 1992. (Ex. 13-3, 4). His job duties included finish carpentry work at several motels and grocery stores, and responsibility for all the finish carpentry work on the Portland Convention Center. Id. Accordingly, we agree with the ALJ that claimant is entitled to an SVP value of 7.

ORDER

The ALJ's order dated April 5, 1995 is affirmed.

In the Matter of the Compensation of
**HARLEY J. GORDINEER, Claimant**
WCB Case Nos. 94-04853, 94-00533 & 93-14467
ORDER OF ABATEMENT
David C. Force, Claimant Attorney
Schwabe, et al, Defense Attorneys
Alan Ludwig (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

On November 6, 1995, we issued an Order on Review, which (among other things) set aside Liberty Northwest's denial of claimant's "new injury" claim for his current low back condition, as well as found Liberty Northwest responsible for a $8,000 attorney fee under ORS 656.386(1) for claimant's counsel's services at hearing. On our own motion, we withdraw our prior order for reconsideration. Specifically, we intend to consider the effect, if any, amended ORS 656.308(2)(c) has on claimant's attorney fee award for services at hearing.

To further assist us in our examination of this question, the parties are granted an opportunity to file supplemental briefs. To be considered, each of those briefs 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
**BRIAN A. HASKIE, Claimant**
WCB Case No. 94-05862
ORDER ON REVIEW
Bostwick, et al., Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Herman's order that dismissed his request for hearing. With his brief, claimant has submitted additional evidence. We treat the submission of additional evidence as a motion for remand to the ALJ. On review, the issues are the propriety of the dismissal order and remand.

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

On May 16, 1995, the Board approved a Claim Disposition Agreement (CDA) in which claimant released his right to "temporary disability benefits, permanent disability benefits, whether partial or total, vocational rehabilitation benefits, further disability benefits in any form in conjunction with any aggravation claim or claim for Own Motion relief, all rights to survivor's benefits, death benefits and burial benefits, and further benefits of any kind regarding his claim whether for currently existing conditions or not, other than his right to medical services for the compensable injury which is expressly retained along with any entitlements to preferred worker status." In return, claimant, who was represented by an attorney, received $5,000, (less a $1,250 attorney fee). Claimant's May 5, 1994 hearing request had raised issues of unilateral termination of temporary disability benefits, penalties and attorney fees. Finding that all the matters raised by the hearing request had been resolved pursuant to the CDA, the ALJ dismissed claimant's hearing request.

We find no error in the ALJ's order. Because the CDA, either directly or indirectly, pertained to all benefits addressed by claimant's hearing request, the issues raised by that request became moot. In other words, claimant is not entitled to any of the benefits listed in his hearing request. Consequently, the ALJ properly dismissed the hearing request. See Russell C. Terry, 47 Van Natta 304 (1995).

Claimant contends that his former attorney did not advise him of the terms of the CDA.[1] Yet, by signing the CDA, claimant stipulated that he had been "fully informed of all legal, medical,

[1] If claimant is challenging the legal advice offered by his counsel, that is a matter for another forum.

vocational and financial consequences" of the CDA. Moreover, we approved the CDA in a final order pursuant to ORS 656.236, which is not subject to further review. ORS 656.236(2). In any event, such an order would not issue if we found that agreement unreasonable as a matter of law, or based on an intentional misrepresentation of material fact, or if claimant had requested that the Board disapprove the agreement within 30 days from the date it was submitted to the Board. ORS 656.236(1). Accordingly, we find no basis for setting aside the CDA.

We find an additional ground for affirming the ALJ's dismissal order. In a March 29, 1995 letter, claimant personally wrote to the Hearings Division requesting dismissal of his case. We find this case analogous to those cases in which a claimant's attorney withdraws a hearing request on behalf of the claimant. In such cases, we have affirmed an ALJ's dismissal order where the claimant did not dispute that his then-attorney had authority to act on his behalf or that the ALJ dismissed the hearing request in response to the attorney's request. See, e.g., David R. Robertson, 47 Van Natta 687 (1995). Here, claimant, himself, requested the dismissal of his case. Under such circumstances, we find no reason to alter the ALJ's dismissal order.

Claimant also raises arguments concerning penalties which were assessed by the Department on April 7, 1994. The penalty issue raised by claimant was not raised in claimant's hearing request and it is not within our authority to address that issue.

Finally, claimant has submitted additional evidence with his briefs on review. We treat the submission of this evidence as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985).

The Board's review is limited to the record developed by the ALJ. We may remand to the ALJ for the taking of additional evidence if we determine that the record 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. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Here, it has not been shown that the additional material submitted by claimant was unobtainable at the time of hearing. In addition, the additional material is not reasonably likely to affect the outcome of the case, i.e., consideration of the additional material will not alter our decision to affirm the ALJ's dismissal order. Accordingly, the motion for remand is denied.

ORDER

The ALJ's order dated June 6, 1995 is affirmed.

---

November 8, 1995 Cite as 47 Van Natta 2172 (1995)

In the Matter of the Compensation of
**DANIEL K. KELIIHELEUA, Claimant**
WCB Case No. 94-14979
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order which authorized the SAIF Corporation to offset previously paid temporary disability compensation from claimant's award of permanent disability. Claimant contends that the temporary disability compensation is properly characterized as interim compensation and is not subject to offset. On review, the issue is interim compensation.

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

Claimant sustained compensable neck and right shoulder injuries in October 1993, which SAIF accepted as disabling. Claimant was declared medically stationary on March 29, 1994. On April 22, 1994, claimant's attending physician authorized temporary disability due to an off-work shoulder injury, and SAIF began paying temporary disability benefits. On July 7, 1994, the claim was closed by a Notice of Closure which approved the deduction of overpaid temporary disability benefits from claimant's unpaid permanent disability award.

Claimant contends that the temporary disability compensation paid from April to June 1994 is properly characterized as interim compensation for an aggravation claim that claimant is not required to repay. The ALJ held that the compensation paid from April to June 1994 was temporary disability, not interim compensation, and was subject to repayment. We agree with the ALJ.

ORS 656.273(6) authorizes the payment of interim compensation on an aggravation claim, pending the carrier's acceptance or denial of that claim. Peterson v. JEV Inc., 115 Or App 525, 527 (1992); Greg W. Koenig, 46 Van Natta 977, 979 (1994). By definition, an aggravation claim is a claim for additional compensation after the last award or arrangement of compensation. ORS 656.273(1). Here, however, claimant's alleged worsening occurred prior to claim closure, while the claim was still open. Therefore, claimant's claim could not have been for an aggravation, and no interim compensation was due under ORS 656.273(6). Peterson, supra, 115 Or App at 528; see also Terrance N. Chase, 44 Van Natta 1555 (1992), aff'd mem 121 Or App 206 (1993) (no claim made for new condition; therefore, only basis for compensation was temporary disability on an open claim, which was subject to offset).

ORDER

The ALJ's order dated April 7, 1995 is affirmed.

---

November 8, 1995 Cite as 47 Van Natta 2173 (1995)

In the Matter of the Compensation of
**ROBERT L. KUNZ, SR., Claimant**
WCB Case No. 95-01617
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Daughtry's order which set aside its denial of claimant's occupational disease claim for a binaural hearing loss condition. On review, the issue is compensability.

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

Claimant worked in a paper mill from 1956 until his retirement in 1994. Claimant testified that the paper mill was very noisy from the various saws (i.e., 10 foot ban saw, 11 foot slasher saw) operating simultaneously. (Tr. 13).

From 1954-57 claimant was in the National Guard. Each year during this time, claimant would spend two weeks at "camp" where he fired 20 mortar rounds over a 3 day period. (Tr. 24). He testified that he would cover his ears with his hands when firing the mortars and that he did not have any noticeable pain or hearing loss afterwards. (Tr. 25).

Claimant has hunted since 1956. (Tr. 26). In preparation for the hunting season, claimant fired 10-15 rounds to "sight-in" his rifle. (Tr. 26). For approximately the last 15 years, claimant wore hearing protection while sighting in his rifle (Tr. 28). Claimant did not go deer hunting every year. When he did go deer hunting, claimant would average about 2 or 3 shots, however, sometimes he would not fire a single round. (Tr. 26, 27). Claimant did not wear ear protection while hunting. Claimant would also hunt elk and would only fire his rifle if he actually saw an elk. He testified that the last four years he had not seen any elk. (Tr. 27).

The ALJ found that claimant's hearing loss was caused by his work. In doing so, the ALJ relied on the opinion of Mr. McClellan, audiologist.

On review, the insurer contends that claimant's exposure to avocational activities (mortar fire and hunting) were the cause of his hearing loss. According to the insurer, Mr. McClellan's opinion is biased and based on an inaccurate history. Alternatively, the insurer asserts that the opinion of Dr. Maurer should be found dispositive because it is well reasoned and based on a complete history.

Dr. Maurer, clinical audiologist, performed an insurer-arranged examination. (Ex. 17). His test results revealed that claimant had binaural hearing loss in certain frequencies. In December 1994, Dr. Maurer reported that claimant's unprotected firing of 20 mortar rounds a year from 1954-1957 and his work for his employer from 1956-1960 were the major contributing causes of his hearing loss. (Ex. 17-4). Dr. Maurer also stated that noise-induced hearing loss reaches a peak 12-15 years after exposure. Further, Dr. Maurer opined that, since claimant has worn ear protection after 1960, his work did not contribute to his present hearing loss. Id.

In a January 1995 letter to the insurer, Dr. Maurer opined (after reviewing claimant's audiograms from 1971 to 1994) that claimant's work exposure prior to 1960 caused his hearing loss. Dr. Maurer also stated that claimant's measurable hearing loss, from 1971 to 1994 (as represented by the 1994 audiogram when compared to the 1971 test), was due to his exposure to mortar fire and 40 years of intermittent hunting activities. (Ex. 21-1, 2).

Dr. Hodgson, who reviewed medical records on behalf of the insurer, opined that claimant's unprotected exposure to the mortar fire was the major cause of his hearing loss. Dr. Hodgson also noted that claimant's left ear hearing loss has progressed "somewhat" more than his right ear. Dr. Hodgson believed that this difference was consistent with claimant's shooting activities. (Ex. 24).

In September 1994, Mr. McClellan found that claimant had significant high frequency, binaural hearing loss. (Ex. 9-1). Comparing claimant's June 1971 hearing results (baseline) with contemporaneous test results, Mr. McClellan noted significant differences in claimant's hearing. Based on these differences, Mr. McClellan opined that claimant's high frequency hearing loss was probably related to his employment, since claimant had no other significant avocational noise exposure. (Ex. 25).

In reviewing Dr. Maurer's report of December 1994, Mr. McClellan noted that Dr. Maurer did not have claimant's 1971 and 1992 audiograms when he examined claimant in December 1994. (Ex. 19). Mr. McClellan indicated that these audiograms were objective evidence that claimant's hearing loss was related to his work for his employer. Id.

Reviewing the report of Dr. Hodgson (which attributed claimant's hearing loss to mortar fire and hunting), Mr. McClellan opined that claimant's exposure to the mortar firing in 1954-57 would not have caused his hearing loss between 1971 and 1994. (Ex. 25-1). As such, Mr. McClellan opined that "some if not all of the change of [claimant's] hearing loss from 1970-1994" is related to his work. (Ex. 25).

Because claimant's hearing loss was a progressive consequence of years of noise exposure, we analyze the condition as an occupational disease. See Valtinson v. SAIF, 56 Or App 184 (1982). To prove compensability of an occupational disease, claimant must show that his work exposure was the major contributing cause of his binaural hearing loss. See ORS 656.802(2). Finally, in resolving a complex medical causation issue, such as that presented here, we rely on medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986).

Here, we are not persuaded by the opinions of Drs. Maurer and Hodgson. In December 1994, Dr. Maurer opined that claimant's work prior to 1960 and his shooting activities (mortar fire and hunting) caused his present hearing loss. He also stated that hearing loss reaches a peak 12-15 years after exposure. Then in January 1995, after reviewing claimant's serial audiograms, Dr. Maurer changes his opinion stating that claimant's work prior to 1960 was "largely responsible" for his pre-1971 hearing loss and that claimant's hearing loss after 1971 was caused by his exposure to mortar firing and hunting. (Ex. 21-1). We find Dr. Maurer's opinion inconsistent. For instance, according to Dr. Maurer, claimant's hearing loss due to mortar firing would be most significant 12-15 years after exposure or (using the

outside limits) up until 1972. However, Dr. Maurer fails to adequately explain why he changed his opinion to believe that claimant's greater/worsened hearing loss from 1971-1994 was caused by his mortar firing exposure from 1971-1994. Because Dr. Maurer's opinion is inconsistent without adequate explanation for the inconsistencies we accord it little persuasive weight. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Somers v. SAIF, supra.

Further, we decline to give Dr. Hodgson's opinion (that the major cause of claimant's hearing loss was mortar fire and hunting) dispositive weight given that both Dr. Maurer (initial opinion) and Mr. McClellan believed that claimant's mortar fire could not have caused his hearing loss years after the exposure. Additionally, although Dr. Hodgson's advances an explanation for why claimant's hearing loss is worse in the left ear as opposed to his right ear (i.e. hunting) Dr. Hodgson fails to adequately explain how claimant's gun fire as opposed to his work activities was the cause of his hearing loss.

Conversely, we find the opinion of Mr. McClellan persuasive. Mr. McClellan opined that claimant's significant hearing loss from 1971 to 1994 was probably related to his employment.[1] (Ex. 25). See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986 ); Gormley v. SAIF, 52 Or App 1055 (1981). In reaching this conclusion, Mr. McClellan relied on the audiogram from 1971 to 1994 which evidenced significant hearing loss during this time, as well as considering claimant's history of vocational and avocational noise exposures (as evidenced by his reading and commenting on Dr. Maurer's report.) See Somers v. SAIF, supra.

Further, Mr. McClellan adequately addressed Dr. Hodgson's opinion (that mortar fire and hunting caused claimant's hearing loss) believing that claimant's exposure to the mortar fire in 1954-57 could not have caused claimant's significant hearing loss.[2] Therefore, we find Mr. McClellan's opinion persuasive. Accordingly, claimant has shown that the major contributing cause of his hearing loss was his work activities. Consequently, claimant has a compensable occupational disease claim.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 May 30, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

---

[1] The insurer contends that Mr. McClellan's opinion was biased. However, the record fails to support such a contention. Further, although Mr. McClellan may have benefited (by actually selling the hearing aids to claimant) from claimant receiving hearing aids, such "bias" does not rise to the level of questioning Mr. McCellan's opinion especially in light of Dr. Maurer's opinion that hearing aids may benefit claimant.

[2] We note that Mr. McClellan's opinion is in accord with Dr. Maurer's opinion that noise induced hearing loss peaks 12-15 years after the exposure. Since claimant's mortar firing took place in 1954-57, its damaging effects would have been greatest up until 1972. Based on this reasoning, the mortar firing cannot adequately explain claimant's significant hearing loss between 1971 and 1994.

In the Matter of the Compensation of
**DOUGLAS D. LaGRAVE, Claimant**
WCB Case Nos. 95-03737, 94-13964 & 94-13963
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Charles L. Lisle, Defense Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Medite Corporation (Medite), a self-insured employer, requests review of those portions of Administrative Law Judge (ALJ) McCullough's order that: (1) found that claimant had timely requested a hearing on Medite's denial of compensability and responsibility for claimant's aggravation claim for a right shoulder condition; and (2) set aside the denial. Argonaut Insurance Company, on behalf of Rescue Industries (Argonaut), cross-requests review of that portion of the order that set aside its denial of compensability and responsibility for claimant's bilateral carpal tunnel condition. On review, the issues are timeliness, compensability and responsibility. We reverse in part, vacate in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Timeliness of Hearing Request

Claimant has two accepted claims with Medite, a January 1989 claim for bilateral carpal tunnel syndrome (CTS) and an August 1989 claim for a right shoulder strain. While working for Argonaut's insured, claimant sought medical attention for bilateral CTS and bilateral shoulder pain. On September 23, 1994, claimant filed a claim against Argonaut's insured for both conditions (claim no. 12X037381). Argonaut issued a responsibility denial of both conditions on October 5, 1994, which it amended on October 10, 1994. Argonaut issued a compensability denial for both conditions on November 1, 1994.

On October 5, 1994, claimant filed a claim with Medite for his carpal tunnel condition. (Ex. 27). Medite issued two denials on November 4, 1994: one denied compensability and responsibility for the CTS (claim no. 88116102) and the other denied compensability and responsibility for the right shoulder condition (claim no. 89115048). Claimant received both of Medite's denials on November 9, 1994.

On November 15, 1994, claimant requested a hearing, specifying denials dated October 5, 1994, October 10, 1994, November 1, 1994 and November 4, 1994; claim numbers 12X37381 and 88116102; and dates of injury as January 9, 1989 and September 9, 1994.

The ALJ concluded that claimant's November 15, 1994 request for hearing was a timely appeal of Medite's November 4, 1994 denial regarding claimant's right shoulder claim. Medite contends that claimant's November 15, 1994 request for hearing addressed only the November 4, 1994 denial of the carpal tunnel syndrome. We agree.

It is well understood that a claimant has an obligation to request a hearing in response to each denied claim. Naught v. Gamble, Inc., 87 Or App 145 (1987); Victoria L. Springer, 46 Van Natta 2419 (1994); Richard S. Olson, 43 Van Natta 657 (1991). A request for hearing must be referable to a particular denial. Guerra v. SAIF, 111 Or App 579, 584 (1992). To determine whether a hearing request is referable to a particular denial, we consider the request itself, read as a whole and in the context in which it was submitted. See Kevin C. O'Brien, 44 Van Natta 2587, 2588 (1992).

On this record, we conclude that claimant's hearing request did not constitute an adequate request for hearing from Medite's November 4, 1994 denial of claimant's right shoulder condition. Claimant initially filed a claim with Medite requesting reopening of his CTS claim. Medite responded with a denial of the CTS claim and a denial of the right shoulder claim. Claimant filed a claim for CTS and bilateral shoulder pain with Argonaut. Argonaut denied both conditions as part of the same claim.

Claimant's November 15, 1994 request for hearing provides complete information for each denial (i.e., date of injury and claim number) except for the November 4, 1994 right shoulder denial. Although the request stated a November 4, 1994 denial date, there was another denial by Medite which issued the same date. That denial concerned claim number 88116102, claimant's CTS claim, and was the claim number claimant specified on his request for hearing. In addition, claimant's retainer agreement regarding the Medite claim also refers only to claim number 88116102.

In addition, at the beginning of the hearing, claimant admitted that the request for hearing does not reference the denial that pertains to the right shoulder claim and formally raised the right shoulder denial at that time. (Tr. 6). Claimant also admitted that it was possible that he may have failed to bring in Medite's second denial or may have been confused about what to do with it. (Tr. 60). Consequently, when we read the request as a whole and in the context in which it was submitted, we conclude that it was not a request for hearing on Medite's November 4, 1994 right shoulder claim denial.

Because claimant did not timely request a hearing on Medite's right shoulder claim denial, we reverse the ALJ's opinion on the timeliness issue and vacate that portion of the ALJ's opinion that finds claimant's current right shoulder condition compensable and that responsibility lies with Medite.

Compensability/Responsibility - CTS

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

Compensability/Responsibility - Bilateral Shoulder Condition

Argonaut denied claimant's bilateral shoulder condition. Dr. Weintraub addressed only claimant's right shoulder, diagnosing the condition as impingement syndrome.

We adopt and affirm that portion of the ALJ's opinion that concluded that claimant failed to establish the compensability of his right shoulder condition claim with Argonaut's insured, and supplement as follows.

Dr. Radecki was the only physician to offer an opinion on claimant's bilateral shoulder condition. He concluded that, because claimant's complaints were symmetrical, his bilateral shoulder condition is not related to work at Argonaut's insured because his work there does not require repetitive flexion and extension. Although Dr. Weintraub disagreed with Dr. Radecki's opinion, Weintraub addressed only the impingement syndrome in the right shoulder. The medical evidence regarding claimant's bilateral shoulder condition does not establish the compensability of claimant's bilateral shoulder claim.

Claimant's attorney is entitled to an assessed fee for services on review regarding the bilateral CTS issue raised by Argonaut's cross-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 bilateral CTS issue is $1,000, payable by Argonaut. 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 March 20, 1995, as amended March 30, 1995, is affirmed in part, reversed in part, and vacated in part. That portion of the order that found that claimant had timely requested a hearing on Medite's denial of the right shoulder condition is reversed. That portion of the order setting aside Medite's denial of the right shoulder condition is vacated. The attorney fee awarded against Medite is vacated. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $1,000, to be paid by Argonaut.

In the Matter of the Compensation of
**BETH D. MOORE, Claimant**
WCB Case No. 94-06568
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board en banc.

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

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

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.802, the occupational disease statute, which applies retroactively to this case. Or Laws 1995, ch 332, §§ 56, 66; Volk v. America West Airlines, 135 Or App 545 (1995). Amended ORS 656.802(2)(a) continues to provide that the worker must prove that employment conditions were the major contributing cause of an occupational disease. However, amended ORS 656.802(2)(c) adds the requirement that occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7). Amended ORS 656.005(7)(a)(B)[1] 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."

Moreover, ORS 656.005(24), which was added to the workers' compensation law by Oregon Law 1995, ch 335, § 1, defines "preexisting condition" as "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."[2]

Here, claimant has three noncompensable conditions that preexisted her CTS: obesity, diabetes mellitus, and high blood pressure. Claimant is currently being treated for diabetes and high blood pressure. Dr. Button hypothesizes that obesity is a predisposition to the development of CTS. Based on this opinion, we conclude that each of claimant's noncompensable conditions qualifies as a "preexisting condition" under ORS 656.005(24). Consequently, our first inquiry is whether any of these conditions combined with claimant's CTS to cause or prolong disability or a need for treatment and our second inquiry is whether claimant's work conditions are the major contributing cause of her right CTS. After our de novo review of the record, we conclude that none of the specified conditions combined with claimant's CTS to cause or prolong her disability or need for treatment and that her work activities are the major contributing cause of her condition.

Dr. Button hypothesized that obesity may cause or contribute to cardiovascular compromise through increased body mass, which can occur in the carpal tunnel region, based on his findings that obesity and CTS are associated generally with the sedentary occupation of bus driver. He also eliminated claimant's work activities as a bus driver as a cause of her CTS on the basis of his personal experience driving some buses around the bus parking yard, concluding that the steering and vibration from driving a bus was insufficient to cause CTS.

We find his opinion unpersuasive on two grounds: First, his opinion regarding obesity and cardiovascular compromise associated with CTS in bus drivers generally is not specific to the causation of claimant's condition, nor does it prove that her obesity combined with her CTS to prolong her disability or need for treatment. Second, his analysis of claimant's on-the-road driving conditions based

---

[1] ORS 656.005(7) applies retroactively to this case. Or Laws 1995, ch 332, § 66; Volk, supra.

[2] ORS 656.005(24) also applies retroactively to this case. Or Laws 1995, ch 332, § 66; Volk, supra.

on his personal experience of merely driving an empty bus in a protected yard is insufficient to establish the extent of the work activities that claimant herself performed during her workdays as a driver of a fully loaded bus on city streets. Somers v. SAIF, 77 Or App 259 (1986).

Dr. Sedgewick, in contrast, opined that claimant's work activities were the major contributing cause of her right CTS condition.[3] He questioned claimant about her non-work activities and eliminated repetitive activities that might also be causal. He also eliminated claimant's diabetes as a cause or predisposition to the development of her CTS, reasoning that she had no subjective complaints nor was there documentation of peripheral neuropathy that would lead him to such an attribution.[4] (Ex. 26-19, 20, 21). He also ruled out any factor except employment that was specifically causative of claimant's CTS. (Ex. 26-21 and ff.).

We conclude that Dr. Sedgewick's opinions, when read together, establish that claimant's preexisting conditions did not combine with claimant's right CTS condition to cause or prolong her disability or need for treatment. See amended ORS 656.802(2)(c) and 656.005(7)(a)(B). Moreover, his opinions establish that claimant's work activities were the major contributing cause of her right CTS condition. See amended ORS 656.802(2)(a). Consequently, we conclude that claimant's right CTS 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 $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

## ORDER

The ALJ's order dated March 29, 1995 is affirmed. Claimant's attorney is awarded $1,200 for services on review, to be paid by the self-insured employer.

---

[3] The employer argues that Dr. Sedgewick's categorization of claimant's right CTS as "atypical" is tantamount to saying that it was not caused by work. This argument is not well taken. The fact that the appearance of claimant's subjective symptoms was unrepresentative of the average case does nothing to detract from Dr. Sedgewick's opinion on the cause of the condition, particularly where the condition itself has been established by objective nerve conduction studies.

Moreover, we are not persuaded by the employer's argument that Dr. Sedgewick's opinion should be rejected because he changed his opinion on medical causation three times. Dr. Sedgewick initially opined that claimant's work activities were the major contributing cause of her right CTS. Then, Dr. Sedgewick reasonably admitted that, if the gripping and vibration from driving a bus were no more rigorous than driving a car, it would be difficult to attribute claimant's CTS to her work activities. However, this employer-provided hypothesis was not congruent with the facts. When apprised of claimant's actual bus driving duties, Dr. Sedgewick returned to his original opinion that work activities were the major contributing cause of claimant's right CTS.

[4] We do not find Dr. King's contrary, but unexplained, opinion regarding a lack of association with peripheral neuropathy persuasive. Uris v. Compensation Department, 247 Or 420, 424 (1967); Somers, supra.

In the Matter of the Compensation of
**MARK C. ONKALO, Claimant**
WCB Case No. 94-13352
ORDER ON REVIEW
Welch, Brunn, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Gunn and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that set aside its denial of claimant's right foot injury claim. On review, the issue is compensability.

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

Claimant sustained a right foot injury at work. A heavy metal tube had been attached to a large magnet suspended above claimant's foot. For unknown reasons, the tube detached from the magnet and fell to the ground, injuring claimant's right foot. At the time, claimant was intoxicated. The ALJ concluded that, in the absence of any, much less clear and convincing, evidence that claimant's injuries were due to his intoxication, the employer had not proved that claimant's claim was not compensable under former ORS 656.005(7)(b)(C).

To defeat a finding of compensability under former ORS 656.005(7)(b)(C), the insurer had to prove, by clear and convincing evidence, that claimant's consumption of alcoholic beverages was the major contributing cause of his injuries. The Legislature recently amended ORS 656.005(7)(b)(C). The statute now allows a carrier to prove an alcohol defense by a preponderance of the evidence. Or Laws 1995, ch 332, § 1 (SB 369, § 1);[1] Our first inquiry is whether that statute applies here. It does.

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). Amended ORS 656.005(7)(b)(C) is not among the exceptions to that general rule. See SB 369, § 66 (enumerating exceptions to general retroactivity provision). Consequently, because this matter has not been finally resolved on appeal, amended ORS 656.005(7)(b)(C) applies here. Therefore, we review this matter under the "preponderance of the evidence" standard.

Our next inquiry is whether the insurer has established, by a preponderance of the evidence, that the major contributing cause of claimant's injuries was his consumption of alcoholic beverages. The answer is "no."

Based on his conclusion that claimant was impaired[2] by alcohol when he was injured, Dr. Brady, forensic pathologist, concluded that claimant's alcohol consumption was the major contributing cause of his injuries. (Ex. 7). At hearing, claimant's counsel asked Dr. Brady what claimant had done to contribute to the accident. Brady responded:

> "Number one is, obviously, I don't know mechanically what happened to the magnet attachment and the beam.[3] I have no expertise on that, nor do I have an opinion. My opinion is that -- because of the alcohol level in [claimant's] system, that his normal sense of care and caution was impaired, as I've told the [ALJ], and I believe that his position in relationship to the beam supported by the magnet would be such so as to place himself in potential danger should something happen.

---

[1] Amended ORS 656.005(7)(b)(c) provides that a "'[c]ompensable injury' does not include: * * * (C) Injury the major contributing cause of which is demonstrated to be by a preponderance of the 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." SB 369, § 1 (emphasis added).

[2] The parties dispute whether claimant was impaired when he was injured. In view of our conclusion that the insurer has failed to establish that claimant's intoxication caused his injury, see discussion, infra, we do not address that issue.

[3] Dr. Brady refers to the tube as a "beam."

"* * * * *

> " * * * I've said already that I don't know how it disconnected, but for Pete's sake, don't put yourself beneath the magnet. And the normal sense of care and caution and, I believe, the normal work activity of a sober careful person would be not to place yourself in harm's way, so that if something does happen -- the problem here is not that the magnet fell. The problem is that [claimant] or his foot was underneath the magnet when it went." (Tr. 56-57).

Dr. Brady later reiterated that he did not know why the beam and the magnet had separated. (Tr. 58).

Dr. Brady's report and testimony is not sufficient to establish the insurer's defense under amended ORS 656.005(7)(b)(C). First, Brady repeatedly admits that he was not familiar with the mechanics of magnet operation. Second, there is no persuasive support for Dr. Brady's assertion that a sober person would not have acted as did claimant, viz., work beneath the magnet and the tube; indeed, the only evidence that is even tangentially related to this issue is claimant's testimony that he was never instructed about the danger of a tube detaching from the magnet. (Tr. 67).

Because Dr. Brady's opinion is predicated on an unsupported premise -- that claimant acted unsafely -- we discount it. There being no other persuasive evidence to support the insurer's position, we conclude that the record fails to establish, by a preponderance of the evidence, that claimant's consumption of alcoholic beverages was the major contributing cause of his injuries.

The insurer analogizes this case to Ronald Martin, 47 Van Natta 473 (1995). There, we found persuasive unrebutted medical expert testimony that the claimant's injuries were the result of drug-related impairment; we also relied on testimony that the claimant's error in judgment had caused his injuries. 47 Van Natta at 475. Here, in contrast, we have found persuasive reasons not to rely on the medical expert testimony, albeit unrebutted, regarding the cause of claimant's injuries. Moreover, there is no evidence that an error in judgment caused claimant's injuries; the precise mechanism of the magnet-beam separation is unknown. Accordingly, Martin is inapposite.

In sum, for the reasons stated in the ALJ's order, as supplemented here, we agree that the insurer has failed to establish that, under amended ORS 656.005(7)(b)(C), claimant's right foot injury claim is not 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 $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his attorney's statement of services), the complexity of the issue, and the value of the interest involved.

## ORDER

The ALJ's order dated February 24, 1994 is affirmed. For services on review, claimant's attorney is awarded $1,200, to be paid by the insurer.

In the Matter of the Compensation of
**FREDDY VASQUEZ, Claimant**
WCB Case No. 95-01693
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) upheld the SAIF Corporation's denial, on behalf of the Department of General Services/Inmate Injury Fund, of claimant's January 5, 1995 aggravation claim for a worsened left ankle condition; (2) dismissed claimant's request for hearing regarding an asserted April 1995 aggravation claim; and (3) did not award penalties for SAIF's allegedly unreasonable claim processing. On review, the issues are aggravation, penalties, and whether claimant's request for hearing regarding the April 1995 claim was premature.

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

Claimant argues on review that the ALJ erred in treating claimant's May 1994 and March 1995 aggravation claims as two separate claims, thereby declining to consider medical evidence generated after the denial of the first claim to answer the general question of whether claimant's compensable condition worsened since the last arrangement of compensation. Essentially, claimant asks that the record be viewed as relating to one aggravation claim, instead of two.[1]

However, we find that the record does not support a conclusion that claimant alleges only one worsening over a time period from claim closure until hearing. Instead, we find that the May 1994 claim was distinct from later developments, whether or not those later developments constitute a claim.

It is undisputed that claimant's May 1994 aggravation claim was formally denied in January 1995. The ALJ upheld that denial, based on the treating doctor's opinion that claimant's left ankle condition had not worsened between the last arrangement of compensation[2] and the January 5, 1995 denial. We agree with the ALJ's reasoning and conclusion in this regard, except that we find that claimant has not established that his compensable condition worsened between the last arrangement of compensation and his March 1995 worsened symptoms. See Ronald L. McMahill, 39 Van Natta 399, on recon, 39 Van Natta 474 (1987).

---

[1] If the evidence supported this approach, we would agree with claimant. See Rater v. Pacific Motor Trucking Co., 77 Or App 418 (1986) (Where evidence offered was relevant to a pending hearing on a denied claim, there was no "new" claim); Vandehey v. Pumilite Glass and Building Co., 35 Or App 187 (1987) (Where the claimant's request for hearing had already raised the issue, the appeal was "already under way" and subsequent evidence was not a new claim). In Rater, supra, the court held that a doctor's report (relating to an examination subsequent to an aggravation claim) was not a new claim because the report contained information relevant to issues raised by claimant's existing hearing request. Similarly, in Vandehay, supra, the court determined that a doctor's letter (following an aggravation claim) was relevant to issues raised by the claimant's request for hearing regarding an existing aggravation claim. In both cases, the court declined to treat subsequent evidence as new and separate aggravation claims because doing so would "create situations in which multiple hearings concerning a single claimant could proceed simultaneously, each concerned with essentially the same issue." 77 Or App 418, 423.

Here, claimant requested a hearing from SAIF's January 5, 1995 denial of his May 1994 aggravation claim. Thereafter, in March 1995, claimant reported having significantly increased left ankle pain, following a specific stepping incident. (Ex. 2A-12) In our view, the evidence relating to claimant's March 1995 condition is not merely evidence relevant to the May 1994 claim. Instead, considering the extended time between the May 1994 claim and the March 1995 incident, claimant's testimony regarding the circumstances of the 1995 event, and the medical evidence memorializing that event, we find that the March 1995 evidence relates to an alleged worsening separate and distinct from that which was claimed in 1994 and at issue pursuant to claimant's hearing request from the January 5, 1995 denial. Accordingly, because claimant's 1995 evidence is not merely relevant to his existing request for hearing, we agree with the ALJ that this case is not properly analyzed as one aggravation claim.

[2] The last arrangement of compensation was either the February 4, 1994 "Order on Reconsideration of Final Determination" or the November 15, 1993 "Final Determination." (See O&O p.5n.8).

Claimant's testimony indicates that he suffered at least a symptomatic worsening thereafter, specifically, in March 1995. (Tr. 12, 18-24). We need not determine whether or when claimant perfected an aggravation claim reporting the worsening, because even if he did, we would agree with the ALJ's conclusion that a request for hearing from a denial of any such (March 1995) claim was premature.[3] Under these circumstances, we conclude, as did the ALJ, that claimant was not entitled to a hearing on a purported March 1995 worsening when this hearing convened on April 26, 1995.[4]

Finally, we note that the Department of Administrative Services has jurisdiction over inmate injury claims arising from injuries occurring on or after June 30, 1995. See OAR Ch. 125, Div. 160; see also Or Laws 1995, ch. 384, §§ 22, 29.

ORDER

The ALJ's order dated May 19, 1995 is affirmed.

---

[3] Accordingly, we render no ruling regarding claimant's condition as of or after the March 1995 worsened symptoms.

[4] The 1995 Legislature amended ORS Chapter 655, which pertains to Inmate Injury Fund claims. The amended statutes and the ensuing administrative rules provide that an inmate contesting action taken on his or her claim is entitled to administrative review and a contested case hearing with the Department. See Or Laws 1995, ch. 384, §§ 22, 29; OAR Ch. 125, Div. 160, especially OAR 125-160-900, subsections 2&3 (temp. rules, effective September 28, 1995). The aforementioned rules are applicable to injuries which occurred on and after June 30, 1995. OAR 125-160-000 (temp. rule, effective September 28, 1995). Because amended Chapter 655 has no retroactivity provision and the injury in the present case occurred before June 30, 1995, the Hearings Division and the Board retain jurisdiction over this matter under former Chapter 655.525.

---



In the Matter of the Compensation of
**BARBARA J. WATSON, Claimant**
WCB Case No. 94-14285
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Karl L. Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the SAIF Corporation's denial of her injury/occupational disease claim for a cervical strain. On review, the issue is compensability. We reverse.[1]

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the second, third and last sentences of the fifth paragraph on page 3.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had failed to prove the compensability of her occupational disease claim for a cervical strain. Specifically, the ALJ concluded that the medical opinion of Physician's Assistant (PA) Pylkki, as concurred in by Dr. Naugle, her supervising physician, was insufficient to carry claimant's burden of proof. We disagree.

---

[1] Because of his prior association with the employer in this case, Member Gunn has recused himself from reviewing this matter.

Credibility

The ALJ concluded that claimant's description of her job was not credible and that the work history reported to PA Pylkki was inaccurate. When credibility findings have been based on claimant's demeanor, we generally defer to the credibility findings of the ALJ. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). However, when the ALJ's credibility finding is based on the substance of the witness' testimony, rather than the witness' demeanor, we are equally capable of assessing credibility. Id. at 285.

The record shows that claimant worked for the employer as a cook. Her duties included carrying bulk food items from the storage area one flight below the kitchen to storage areas in the kitchen, food preparation, line cooking, which included lifting pots of food, banquet preparation, and clean up. The weights of the items she carried, such as boxes of frozen french fries and frozen hamburger patties, weighed about 15 to 20 pounds, as did the oil container for the french fry cooker. (Tr. 67, 68, 69). Her workdays during the period in question ranged from a little less than 7 hours to 9 hours, with the exception of August 20 and 21, when her hours increased to 13 and 13.5 hours respectively; and August 29, 30 and 31, when her hours increased to 11.75, 14.5, and 15.25 hours respectively. (Ex. 11). On August 20, the employer catered a banquet for 80 persons and on August 31, a banquet for 150 persons. (Ex. 11). Claimant worked her regular hours on September 1 and 2. (Ex. 11).

On September 3, 1994, claimant sought treatment for neck pain, headache and ear fullness, which she had been experiencing for a week and a half and for which her self-medication with aspirin was ineffective. Claimant attributed her discomfort to long work days preparing for the banquets and carrying food items up to the kitchen from the downstairs storage area, as well as lifting cooking pots and cleaning the french fry cooker. (Exs. 5 and 6). She reported the same information concerning the onset of her neck symptoms and her job duties to PA Pylkki. (Ex. 9-14 through 9-19).

After our de novo review of the record, we find that claimant's reports and testimony accurately reflect her job duties and increased hours at the times of the banquets. Accordingly, we find that PA Pylkki's medical history is accurate and in accordance with claimant's credible testimony that she cooked, carried provisions up a flight of stairs, and worked extremely long shifts (from 4 to 7 hours longer than normal) during the period in question.

Compensability

The ALJ concluded that expert medical testimony is required where there is a question regarding the cause of an occupational disease. Although an occupational disease claim may involve complexities, where a case is not complex, expert medical evidence is not required. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993). Here, we need not decide whether the PA's opinion qualifies as an expert medical opinion because we find that the compensability issue is not medically complex.

In Barnett, the court enumerated relevant factors for determining whether expert testimony of causation is required: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker previously was free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

Here, the circumstances are straightforward and uncomplicated. Claimant performed physical work as a cook for the employer during a normal work day of seven to nine hours. Her duties are outlined above. Then, on two occasions less than a week apart, claimant worked 11 to 14 hour days for several days in a row performing banquet preparation and clean up in addition to her regular duties. She then returned to her normal schedule for two more days. (Ex. 11). She began experiencing headaches and severe neck pain while assisting with banquets which required extensive lifting. (Tr. 10-12).

Claimant promptly sought medical attention for her symptoms and promptly filed a claim with the employer. (Exs. 2 and 4). The record indicates that claimant has no preexisting condition, and there is no expert medical evidence that the alleged work events could not have been the cause of the injury. Because the circumstances of claimant's injury do not raise any of the factors requiring expert medical evidence as enumerated in Barnett, we conclude that expert medical evidence regarding the cause of claimant's neck strain is not required.

PA Pylkki, who provided continuous treatment and observation of claimant's neck strain, concluded that claimant's work activities were the major contributing cause of her condition. Dr. Naugle countersigned her chart notes and concurred in her opinion. PA Pylkki considered the possibility that claimant's neck pain could be due to a virus or allergy, but eliminated those possibilities for two reasons: (1) the ear fullness did not persist, though the neck pain did; and (2) the finding of muscle spasms supported a muscle injury diagnosis. (Ex. 9, pp. 24-26). Moreover, PA Pylkki's conclusion is consistent with the emergency room findings of Dr. Lloyd, who reported that claimant's ears were clear bilaterally, found tender neck muscles and eliminated "headache" as a diagnosis. (Ex. 4). Additionally, PA Pylkki also questioned claimant regarding her private life and found nothing that would be contributory to her muscle strain. (Ex. 9 at 20). Finally, there is no medical evidence which implicated any non-work-related factor as a cause of claimant's condition. Consequently, we conclude that claimant has proven that her work activities were the major contributing cause of her neck strain pursuant to ORS 656.802(2).[2]

Moreover, based on the uncontroverted finding of muscle spasms, (See Ex. 6-1), we find that the existence of the neck strain was established by medical evidence supported by objective findings.[3] Accordingly, claimant's occupational disease claim is compensable.

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 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 counsel may go uncompensated.

## ORDER

The ALJ's order dated March 9, 1995 is reversed. The SAIF Corporation's denial is set aside and the claim remanded to SAIF for processing according to law. Claimant's attorney is awarded an attorney fee of $3,500 for services at hearing and on review, to be paid by SAIF.

---

[2] Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.802, the occupational disease statute. Or Laws 1995, ch 332, § 56 (SB 369, § 56). We need not address the retroactive applicability of the statute because, under either version of the statute, claimant's burden of proof remains the same.

[3] Subsequent to the ALJ's order, the 1995 Legislature amended the definition of "objective findings" in ORS 656.005(19). SB 369, § 1. We need not address the retroactive applicability of this amendment because, under either version of the statute, our analysis and result in this case remains the same.

---



In the Matter of the Compensation of
**THOMAS A. YONEY, Claimant**
WCB Case No. 94-14759
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that: (1) denied its motion for postponement of the hearing; and (2) set aside the April 20, 1994 Determination Order and the December 1, 1994 Order on Reconsideration as premature. On review, the issues are postponement and premature closure. We affirm in part and reverse in part.

## FINDINGS OF FACT

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

We do not adopt the next to the last sentence in the 15th paragraph of the findings of fact. We also do not adopt the ultimate finding of fact.

Prior to hearing, the insurer requested that the hearing be postponed pending resolution of a medical services dispute involving the reasonableness and necessity of a proposed cervical surgery. The ALJ denied this motion. The insurer renewed its motion at hearing, and the ALJ again denied it.

## CONCLUSIONS OF LAW AND OPINION

### Postponement

The insurer argues that the premature closure decision turns on whether the proposed anterior cervical fusion surgery is appropriate treatment, a matter that is not within the Hearings Division's or the Board's jurisdiction. Therefore, the insurer contends, the ALJ erred in denying its motion to postpone the hearing until the medical services issue was decided by the appropriate forum. Based on this reasoning, the insurer requests that we vacate the ALJ's order and remand the matter for hearing following a final determination of the medical services issue by the appropriate forum.

OAR 438-06-081 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 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." Thus, the postponement rule requires that a postponement motion based on incomplete case preparation be denied, unless there is a showing of due diligence by the moving party.

In prehearing discussions about the postponement issue, the insurer argued that the failure of the managed care organization (MCO) to render a decision on the appropriateness of the proposed surgery during the period from October 11, 1994, the date of Dr. Melgard's surgery recommendation, through February 27, 1995, the date of hearing, was an extraordinary circumstance justifying postponement. (Opinion and Order, page 2). The ALJ disagreed, found no extraordinary circumstances beyond the control of the insurer, and declined to grant the motion. We agree.

On review, the insurer offers no argument and cites no evidence regarding any circumstances beyond its control that would justify postponement. In addition, the evidence in the record does not support the insurer's position. In this regard, a February 25, 1995 letter from the president of the MCO to the insurer states that the insurer "recently inquired" about the MCO's timelines regarding requests for treatment or appeals of the MCO's decisions. (Ex. 104). This "recent inquiry" does not support a finding that the insurer used "due diligence" in pursuing the MCO decision, a matter the insurer contends needed to be completed before the ALJ could reach a decision on the premature closure issue.

On this record, we find the ALJ did not err in declining to postpone the hearing. In addition, we decline to vacate the ALJ's order pending resolution of the medical services issue.

### Premature Closure

Finding that material improvement in claimant's condition was reasonably anticipated at the time of claim closure, the ALJ concluded that the claim was prematurely closed by the April 20, 1994 Determination Order and the December 1, 1994 Order on Reconsideration. We disagree and reverse.

The propriety of the closure turns on whether claimant was medically stationary at the time of the April 20, 1994 Determination Order, considering claimant's condition at the time of closure and not subsequent developments. See ORS 656.268(1);[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).

---

[1] We note that ORS 656.268(1) was amended by SB 369, § 30. However, none of the amended provisions are applicable to this case.

It is claimant's burden to prove that his claim was prematurely closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). 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).

Although several physicians render opinions as to the reasonableness and necessity of the proposed cervical surgery, there are few opinions in the record that focus on whether claimant was medically stationary at claim closure. We analyze those opinions that relate to the issue of whether claimant was medically stationary at claim closure.

Claimant has an accepted herniated disc at C5-6. (Ex. 91). Dr. Rosoff, claimant's initial attending physician, referred claimant to Dr. Rosenbaum, neurosurgeon, who performed surgery on claimant's neck on August 5, 1993. (Ex. 32). This surgery consisted of a bilateral microposterior cervical foraminotomy at C5-6. Dr. Rosenbaum acknowledged that claimant obtained no relief from his symptoms following this surgery. (Ex. 43). On August 26, 1993, claimant underwent a repeat MRI scan. (Exs. 37, 43). Dr. Rosenbaum interpreted the MRI as showing "no additional abnormalities." (Ex. 43). Although noting that claimant had not had any improvement in his pain, Dr. Rosenbaum stated that he was not certain there was anything further he had to offer claimant. Id.

On December 9, 1993, claimant sought treatment from Dr. Grewe, a neurosurgeon who had examined claimant in July 1993 and provided a second opinion regarding the need for the August 1993 surgery. Dr. Grewe found that claimant's December 1993 examination was very similar to his earlier July 1993 examination and noted that claimant had "fairly minimal" neurological deficit. (Ex. 54-2). In discussing possible treatment, Dr. Grewe stated:

> "I advised [claimant] that should all conservative measures fail and his symptoms remain problematic, than [sic] an anterior C5-6 procedure carries some hope for gaining improvement. This would assume that the spondylitic changes at C5-6 are in fact producing a radicular irritation. I advised him that without more significant neurological deficit, it is always conforming [sic] a 'pain generator' and therefore anterior cervical decompression and fusion at C5-C6 carries some risk for failure." (Ex. 54-2).

On December 23, 1993, claimant was examined by Dr. Parsons, neurologist, on behalf of a MCO. (Ex. 58). Dr. Parsons opined that the studies revealed no lesion that could benefit from further surgery. (Ex. 58-3). He recommended continuing conservative treatment. Id.

On March 15, 1994, Dr. Rosenbaum examined claimant and found him medically stationary. (Ex. 73). He noted that, since the August 1993 surgery, claimant "continued to complain of pain in the posterior cervical region radiating bilaterally into the upper extremities." (Ex. 73-1). He opined that claimant had reached "maximum improvement from his injury," and there was "no further recommended treatment." (Ex. 73-2). Dr. Rosoff concurred. (Ex. 80). Relying on the opinions of Drs. Rosenbaum and Rosoff, the Evaluation Division closed the claim by Determination Order on April 20, 1994. (Ex. 85).

Claimant requested reconsideration. On November, 11, 1994, Dr. Weller, neurologist, served as the medical arbiter and performed a record review. (Ex. 98). Dr. Weller agreed with Dr. Rosenbaum that claimant had "reached maximum improvement from his injury." (Ex. 98-1).

In the meantime, on May 3, 1994, claimant returned to Dr. Grewe and consented to additional cervical surgery. (Ex. 87-2). Dr. Grewe discussed the possibility of this further surgery as follows:

> "By [claimant's] description, his pain is incapacitating and 'ruining my life.' I advised him he does not have concerning neurological deficit and therefore disposition ultimately becomes one of pain management. I advised him that an anterior decompression at C5-C6 with interbody fusion carries some chance of gaining improvement. However, I advised him that without neurological deficit, there is increased risk for surgical failure. Certainly, his symptoms are classic for radicular pain and Spurling's maneuver readily reproduces these symptoms." (Ex. 87-1).

On October 6, 1994, claimant was examined by Dr. Melgard, neurologist, who subsequently became claimant's attending physician. (Exs. 97A, 97C). Dr. Melgard agreed with Dr. Grewe's suggestion for an anterior discectomy and fusion at C5-6. (Ex. 97A-3, 97B). Dr. Melgard also stated: "[Claimant] tells me that he continues to have distress and has been able to work in a lighter job. Since he has had distress since his [August 1993] surgery, and in fact worse since his surgery, I really do not believe that there is an intervall [sic] where he was stationary." (Ex. 97B).

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physicians, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810 (1983). Here, there are no persuasive reasons not to rely on the opinions of claimant's treating physicians, Drs. Rosenbaum and Rosoff.

Claimant argues that Dr. Rosenbaum is not persuasive because he did not consider the need for further surgery. We disagree. Dr. Rosenbaum ordered and reviewed a post-surgical MRI to determine whether a lesion had been missed during claimant's August 1993 surgery. He found that the MRI showed no additional abnormalities and later concluded that no further treatment was needed. In addition, claimant testified that he discussed the possibility of a second surgery with Dr. Rosenbaum. (Tr. 43). On this record, we conclude that Dr. Rosenbaum considered the possible need for further surgery in concluding that claimant was medically stationary.

Dr. Grewe did not give an opinion as to claimant's medically stationary status. On the other hand, no incantation of "magic words" or statutory language is required, provided that the opinion otherwise meets the appropriate legal standard. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Prior to claim closure, Dr. Grewe suggested the possibility of additional cervical surgery if conservative measures failed to relieve claimant's pain. (Ex. 54-2). The record demonstrates that claimant continued to experience pain. However, Dr. Grewe's opinion is too speculative to support a finding that this proposed treatment represented a reasonable expectation of further material improvement. Therefore, we do not find Dr. Grewe's opinion persuasive evidence that claimant's claim was prematurely closed.

Moreover, since Dr. Melgard merely agreed with Dr. Grewe's opinion without further explanation, we likewise find his opinion unpersuasive. In addition, although Dr. Melgard provides the only "post-closure" medical opinion regarding claimant's medical stationary status that relates back to claimant's condition at claim closure, he does not apply the proper legal standard. In this regard, Dr. Melgard opines that claimant has never been medically stationary because he has remained in "distress" since his August 1993 surgery. (Ex. 97B). However, the correct standard is whether there is a reasonable expectation of further material improvement from medical treatment or the passage of time. ORS 656.005(17). Furthermore, Dr. Melgard examined claimant only once, approximately six months after claim closure. For all of these reasons, we do not find Dr. Melgard's opinion persuasive evidence that claimant was not medically stationary at claim closure.

On this record, we find no persuasive reason not to rely on claimant's treating physicians' opinions that claimant was medically stationary at claim closure. Therefore, claimant has failed to meet his burden of proving that his claim was prematurely closed.

## ORDER

The ALJ's order dated May 3, 1995 is reversed in part and affirmed in part. That portion of the order that set aside the April 20, 1994 Determination Order and the December 1, 1994 Order on Reconsideration as premature is reversed, as is the related out-of-compensation attorney fee. The April 20, 1994 Determination Order and the December 1, 1994 Order on Reconsideration are reinstated and affirmed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
**KATHRYN P. ENGLISH, Claimant**
WCB Case No. 94-10848
ORDER ON RECONSIDERATION
Darris K. Rowell, Claimant Attorney
Kevin L. Mannix, Defense Attorney

On October 10, 1995, we reversed the Administrative Law Judge's (ALJ's) order which had set aside the insurer's denial of claimant's injury claim for a mid-back condition. In our order, we found that claimant was not credible in reporting her medical history. As such, we declined to rely on claimant's reporting her physical complaints to the examining physicians. Further, we found the lack of medical evidence affirmatively relating claimant's condition to a work incident dispositive.

In her request for reconsideration, claimant contends that this case does not present a complex medical matter requiring expert medical opinion of causation. We disagree. In addition to our prior reasoning, we offer the following supplementation.

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 the 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.

Here, we find claimant's situation complex because of her history of back problems and the fact that claimant's condition was initially diagnosed as thoracic strain, but then progressed to include pain throughout her body. (Exs. 1, 3). As such, we find that expert medical opinion was required in this case. Consequently, because the record contains no persuasive medical opinion, claimant has failed in her burden of proof. ORS 656.266.

Accordingly, we withdraw our October 10, 1995 order. On reconsideration, as supplemented herein, we adhere to and republish our October 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
**LUCILLE BOYER, Claimant**
WCB Case No. C5-02703
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Coons, et al., Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On September 26, 1995, we 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 October 24, 1995, we disapproved the parties'disposition. On November 1, 1995, the insurer requested reconsideration, submitting an addendum to amend the original CDA. The motion was timely filed and is in accordance with administrative rules. Accordingly, we reconsider the CDA. OAR 438-09-035(l).

The original CDA contained language that the proceeds "should not be offset under 42 USC § 424a." We found that such an agreement was outside "matters regarding a claim" which could be disposed by a CDA. Furthermore, finding that this portion of the disposition was a substantial part of the underlying bargain, we disapproved the entire CDA. In a footnote, we acknowledged that we routinely approve CDAs containing discussions of the effect of Social Security benefits on the valuation of the settlements, but found such agreements distinguishable because they did not direct the federal government not to offset proceeds.

In the addendum, the parties agree to delete the original provision to which we objected and replace it with the following:

> "Oregon law provides that the amount of any permanent total disability benefits payable to an injured worker shall be reduced by the amount of any disability benefits the worker receives from federal Social Security. ORS 656.209(l). Claimant's expected Social Security Disability compensation would be awarded to claimant for all times pertinent to this agreement. Therefore, the parties based their valuation of the settlement amount in this agreement on this assumption. The parties reduced their allocation of benefits for future disability payments by the monthly sums that it was anticipated claimant would receive in Social Security Disability, based on claimant's current earnings record."

Inasmuch as this provision merely explains the parties' assumptions concerning Social Security benefits and does not direct the federal government not to offset proceeds, we find the CDA, as amended, to be in accordance with the terms and conditions prescribed by the Board.

Accordingly, on reconsideration, the parties' CDA is approved as amended. An attorney fee of $4,500 also is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
**CONNIE M. JOHNSON, Claimant**
WCB Case No. 92-06467
ORDER ON REMAND
Skalak & Alvey, Claimant Attorneys
Craig Creel, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Wright Schuchart Harbor v. Johnson, 133 Or App 680 (1995). The court has reversed our prior order finding that claimant did not waive the issue of compensability of medical services and further concluding that claimant proved the compensability of such benefits. Connie M. Johnson, 44 Van Natta 495 (1994). Concluding that we must determine whether claimant implicitly waived the medical services issue, the court has remanded for reconsideration.

## FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact with the following supplementation.

When claimant filed her request for hearing form, she indicated that the issues were aggravation and medical services. At the beginning of the hearing, claimant's attorney and the insurer's attorney agreed with the ALJ's statement that the "sole issue in this proceeding is the compensability of an alleged aggravation." (Tr. 2). At no time during the hearing did either of the parties assert that claimant was entitled to medical services for her compensable knee claim.

## CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial of claimant's aggravation claim. On review, we initially affirmed and adopted the ALJ's order, adding:

> "By agreeing with the [ALJ's] conclusion that claimant has failed to proved a compensable aggravation claim, we do not mean to suggest that claimant cannot assert a valid medical services claim under ORS 656.245. [Cite omitted]."

On reconsideration, we first noted that claimant's request for hearing included medical services among the issues to be litigated. We further found that, even though claimant's attorney at hearing agreed that the sole issue was aggravation, claimant did not waive that question in the absence of an "express declaration * * * that claimant no longer wished to pursue the medical services issue[.]" Connie M. Johnson, supra. Thus, we found the issue "sufficiently raised and not waived[.]" Proceeding to the merits, we concluded that claimant proved entitlement to medical services.

On appeal, the court first discussed the effect of waiver, stating that if claimant waived the medical services claim before the ALJ, she was barred from asserting the issue before us on reconsideration, and we erred in determining the claim. 133 Or App at 685. The court further concluded that we erred in deviating from the general principle that waiver may be either explicit or implicit from a party's conduct. Id. at 686. The court explained that its holding was based on the "fundamental relationship between medical services and aggravation under the worker's compensation statutes"; that is, a claimant may attempt to obtain medical services benefits under ORS 656.245 or 656.273 as an aggravation. Id.[1]

As instructed by the court, we look to the "totality of the circumstances" to determine if claimant waived her right to assert a claim for medical services based on ORS 656.245. Id. at 688. The "totality of circumstances" in this case narrows to determining if claimant's counsel's agreement with the ALJ's statements at hearing constitutes an implied waiver of the medical services claim raised by the request

---

[1] On April 26, 1995, the Board granted the parties an opportunity to file supplemental briefs following issuance of the court's judgment and record. Although we received the appellate judgment on September 7, 1995, the parties did not submit supplemental briefs. The briefing schedule for submitting such briefs also has expired. Thus, we have proceeded with our reconsideration without benefit of further argument from the parties.

for hearing form. We decide that it does. In particular, because claimant's attorney agreed with the ALJ that the "sole issue" was aggravation, we find that counsel impliedly evinced an intent to seek medical services based only on a theory of aggravation under ORS 656.273 rather than 656.245. Thus, we conclude that claimant waived any claim for medical services under ORS 656.245.[2]

Accordingly, on reconsideration, the ALJ's order dated March 8, 1993 is affirmed.

IT IS SO ORDERED.

---

[2] In a "Motion for Reconsideration", the employer asserted that we should apply amended ORS 656.245. Or Laws 1995, ch 332, § 25 (SB 369, § 25). In light of our conclusion that claimant waived a medical services claim under ORS 656.245 and, thus, she is barred from asserting such claim before us, we need not determine the effect, if any, of the amended statute.

---



In the Matter of the Compensation of
**JASON O. OLSON, Claimant**
WCB Case No. 94-08484
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration that reduced claimant's unscheduled permanent disability for a lumbar and thoracic injury from 17 percent (54.4 degrees), as awarded by a Notice of Closure, to 7 percent (22.4 degrees). In addition, claimant argues that the ALJ erred in admitting a supplemental report from a medical arbiter (Exhibit 15) and declining to admit supplemental reports from claimant's treating physician and an examining physician (Exhibits 18 and 19). On review, the issues are evidence and extent of unscheduled permanent disability. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction, supplementation, and summary. Dr. Rosenbaum served as an examining physician, not a consulting physician.

Claimant's claim was closed by Notice of Closure on March 3, 1994. Claimant requested reconsideration of this Notice of Closure and raised several issues, including these issues regarding unscheduled permanent disability: impairment, age, education, and adaptability. (Ex. 16). In addition, claimant requested appointment of a panel of medical arbiters. On June 24, 1994, claimant was examined by a panel of medical arbiters consisting of Dr. Bobker, neurologist, Dr. Martens, orthopedist, and Dr. Wilson, orthopedic surgeon. (Ex. 14). Subsequently, the Department sought additional information from Dr. Martens regarding claimant's residual functioning capacity. By letter dated June 30, 1994, Dr. Martens responded that claimant "has no restrictions in regard to residual functional capacity." (Ex. 15).

By Order on Reconsideration dated July 1, 1994, the Department found claimant entitled to 7 percent unscheduled permanent disability, which consisted solely of the impairment value for claimant's loss of range of motion. The Department concluded that claimant was not entitled to an adaptability factor, finding him without restrictions regarding his residual functional capacity and capable of performing unrestricted, heavy work, his base functional capacity. (Ex. 17).

Claimant requested a hearing, arguing that he was entitled to an adaptability value and chronic condition awards for his thoracic and lumbar spine. In support of these arguments, claimant submitted letters from Dr. Rosenbaum, examining neurosurgeon, and Dr. Scott, treating physician. (Tr. 5-8, 15-6; Exs. 18, 19). Both letters were issued after the medical arbiter examination and the reconsideration order. The ALJ declined to admit these letters and affirmed the Order on Reconsideration.

The parties stipulated at hearing that claimant's highest employment strength demand in the preceding five years was that of material handler, with a heavy strength classification. (Tr. 12-13, Ex. 8).

## CONCLUSIONS OF LAW AND OPINION

### Evidence

At hearing, the ALJ relied on Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), in declining to admit Exhibits 18 and 19 (the "post-reconsideration order" reports from Drs. Rosenbaum and Scott). The ALJ reasoned that, because a medical arbiter had been appointed, medical evidence of claimant's impairment developed after the medical arbiter's report was not admissible. We agree.

On review, claimant does not contend that Exhibits 18 and 19 are admissible for purposes of establishing impairment findings. However, he contends that these exhibits are admissible for purposes of establishing his adaptability value. We disagree.

As a preliminary matter, we disagree with the insurer's contention that claimant did not offer Exhibits 18 and 19 at hearing for the purposes of establishing his adaptability value. To the contrary, although the insurer objected to these exhibits solely on the ground that they were "post-medical arbiter" evidence regarding impairment, claimant presented these exhibits both as evidence of impairment and adaptability. (Tr. 5-8, 15-16). Nevertheless, for the following reasons, we need not resolve the question of the admissibility of these exhibits for purposes of adaptability.

After the ALJ's order, the legislature enacted Senate Bill 369, which applies retroactively in most cases. Or Laws 1995, ch 332, § 66 (SB 369, § 66). ORS 656.283(7), as amended, provides, 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[.]" SB 369, § 34.

We need not decide whether the amendments in ORS 656.283(7) apply retroactively in this case because, as discussed in the extent section below, even if we considered Exhibits 18 and 19, the result would be the same.

Claimant also argues that the ALJ erred in admitting Exhibit 15, which is Dr. Martens' response to the Department's request for clarification regarding claimant's residual functioning capacity. Claimant argues that the Department should have asked for clarification from the full medical arbiter panel, not just one member of that panel. On that basis, claimant argues that Exhibit 15 is medical evidence generated subsequent to the medical arbiter's examination and, as such, is not admissible.

We note that claimant did not object to Exhibit 15 at hearing. (Tr. 5). However, we have found that, given the express statutory limitation on evidence provided by ORS 656.268(7),[1] we may consider the admissibility of evidence pursuant to ORS 656.268(7) even if a party does not object to the evidence at hearing. David J. Rowe, 47 Van Natta 1295 (1995). Therefore, we proceed to consider the admissibility of Exhibit 15.

We find that the ALJ properly admitted Exhibit 15. 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 former ORS 656.268(7). Daniel L. Bourgo, 46 Van Natta 2505 (1994); Ryan F. Johnson, 46 Van Natta 844 (1994); Anne M. Younger, 45 Van Natta 68 (1993). Here, the medical arbiter's "clarification" report fits within this exception because it was generated in response to a request for further information from the Department. Therefore, this "clarification" report is admissible. Id.

---

[1] ORS 656.268(7) was also amended by Senate Bill 369, and the amendments appear to retroactively apply to claimant's claim. SB 369, § 30(7). The relevant provision is found at amended ORS 656.268(7)(g), which provides that "[a]fter reconsideration, no subsequent medical evidence of the worker's impairment is admissible . . . [before any forum] . . . for purposes of making findings of impairment on the claim closure." Besides renumbering the provision, the changes to ORS 656.268(7)(g) essentially consist of adding the phrase "after reconsideration." Assuming without deciding that the amended version of the statute is applicable, this change does not affect the admissibility of Exhibit 15.

Furthermore, contrary to claimant's argument, the fact that the Department asked for clarification from only one member of the medical arbiter panel does not take the response out of the realm of being a medical arbiter's report, nor does it make the report inadmissible. Instead, claimant's argument is essentially directed at the persuasiveness of the "clarification" report, which is a factual question that will be addressed in the extent section.

Extent of Unscheduled Permanent Disability

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

Claimant first argues that the Department improperly reduced the extent of permanent disability awarded in the Notice of Closure because the insurer did not challenge the award in reconsideration. In this regard, claimant contends that a notice of closure is a concession or a stipulation from the carrier as to a baseline of permanent disability. In support of this contention, claimant notes that ORS 656.268(4)(e) provides for only the worker to request reconsideration of a notice of closure.

We disagree with claimant's argument. There is no evidence that the insurer has stipulated to a baseline of permanent disability. In addition, we have held that the Department can modify unscheduled permanent disability values on reconsideration, even where a claimant has not specified disagreement with those particular values. See Russell D. Sarbacher, 45 Van Natta 2230 (1993) (Department had authority to reduce an award made by a notice of closure, even though the claimant sought an increase and the carrier had not requested a reduction of the award); Darlene K. Bentley, 45 Van Natta 1719, 1722 (1993) (Department had authority to modify the education and adaptability values assigned by the carrier's notice of closure, and increase disability award, although the claimant made no challenge to the award on that basis).

Under these circumstances, we conclude that the Department did have authority to reduce claimant's award. We, therefore, proceed to the merits of the issue of extent of unscheduled permanent disability.

Claimant argues that he is entitled to an adaptability factor of 4 based on a comparison of his residual functional capacity in the medium/light range with the heavy range classification of his job as a material handler, his highest employment strength demand in the preceding five years. OAR 436-35-310(6). We disagree that claimant has established a residual functional capacity in the medium/light range.

Claimant was found medically stationary on February 24, 1994. At that time, Dr. Rosenbaum, examining neurosurgeon, stated that claimant was capable of working at an occupation that did "not involve heavy bending, lifting and twisting." (Ex. 7-3). On March 3, 1994, claimant's claim was closed. On April 1, 1994, Dr. Scott, claimant's treating osteopath, approved a modified job offer that involved occasional lifting of 30 to 35 pounds. (Ex. 11).

On June 24, 1994, the medical arbiter panel examined claimant. (Ex. 14). Their report did not discuss claimant's residual functional capacity; however, they found that claimant "is not unable to repetitively use any body part, and he has no chronic or permanent medical condition arising out of this injury." (Ex. 14-3). Subsequently, in response to the Department's inquiry, Dr. Martens stated that claimant "has no restrictions in regard to residual functional capacity." (Ex. 15).[2]

We find the medical arbiters' reports constitute persuasive evidence that, at the time of reconsideration, claimant had a residual functional capacity of heavy work. In this regard, the panel's comments regarding the lack of chronic and permanent medical conditions support Dr. Martens' subsequent opinion that claimant has no restrictions regarding his residual functional capacity.

---

[2] Dr. Martens' letter was expressly addressed to Ms. Greene, Workers' Compensation Division, Appellate Unit. Moreover, claimant acknowledges that "[t]he Director sought additional information regarding residual functional capacity, but sought that information, not from the panel of arbiters established to determine impairment, but from a single physician." (Claimant's appellant's brief, Page 7, Lines 1 - 5), (Emphasis added). In light of such circumstances, we find that Dr. Martens' supplemental report was in response to a Department request for further information. As such, the report is admissible. See Daniel L. Bourgo, supra.

Furthermore, our conclusion would remain the same even if Exhibits 18 and 19 were considered. Exhibit 18 is a September 21, 1994 letter from Dr. Rosenbaum, responding to claimant's attorney's questions and concurring with a lifting limit of 35 pounds. Exhibit 19 is a September 26, 1994 letter from Dr. Scott, responding to claimant's attorney's questions and stating that, based on the job analysis she approved on April 1, 1994, claimant was restricted to lifting no more than 35 pounds. Dr. Scott stated that she last saw claimant on March 30, 1994.

Evaluation of a worker's disability is made as of the date of the reconsideration. ORS 656.283(7). Here, Dr. Rosenbaum apparently last examined claimant on February 24, 1994, while Dr. Scott last examined claimant on March 30, 1994. The medical arbiters' June 24, 1994 examination is more contemporaneous with the July 1, 1994 reconsideration order. In addition, Dr. Scott's opinion regarding claimant's physical capacities is not persuasive because she had not seen claimant for almost six months at the time she rendered that opinion. We find the medical arbiters' opinion, including Dr. Martens' clarification report, more persuasive evidence as to claimant's physical abilities at the time of reconsideration. On that basis, we find that claimant has no restrictions to his residual functioning capacity; therefore, claimant is not entitled to an adaptability value. Consequently, we agree with the ALJ's conclusion that claimant is not entitled to unscheduled permanent disability beyond the Order on Reconsideration award of 7 percent.

## ORDER

The ALJ's order dated November 3, 1994 is affirmed.

**Board Members Hall and Gunn concurring in part and dissenting in part.**

We agree with the majority that Exhibits 18 and 19 are not admissible. However, we disagree that Exhibit 15 is admissible. Therefore, we respectfully dissent.

Exhibit 15 is admissible only if it qualifies as a "clarification" report from a medical arbiter that was generated in response to a request for further information from the Department. Daniel L. Bourgo, supra; Ryan F. Johnson, supra; Anne M. Younger, supra. Because Dr. Martens' subsequent report was addressed to the Department, an inference can be drawn that the report was in response to a Department inquiry. Since claimant apparently does not challenge that inference, we will not address the question. In any event, the pivotal issue is whether the report from one physician of a three-member panel constitutes a "clarification" report from a medical arbiter. We submit that, under the facts of this case, the subsequent physician's report does not qualify as a clarifying medical arbiter's report.

Here, claimant requested a panel of medical arbiters. Such a panel was appointed, examined claimant, and issued a report containing the opinion of the entire panel. (Ex. 14). Dr. Martens was only one member of that panel of three physicians. Under these circumstances, the "medical arbiter" consisted of the entire panel. In other words, as claimant argues, where a panel of arbiters is requested, it is those medical determinations upon which the entire panel can agree that represent the opinion of the medical arbiter. Any opinion from a single member of that panel does not satisfy that standard, especially when the single member does not have the authority or permission from the other panel members to respond on behalf of the entire panel. All panel members should author or at least approve of the clarifying response. Therefore, we would find that Dr. Martens' June 30, 1994 letter does not qualify as a clarifying medical arbiter opinion. Accordingly, we would find Exhibit 15 inadmissible.

In the Matter of the Compensation of
**IRAJ OSTOVAR, Claimant**
WCB Case No. 94-14163
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside the employer's denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

To establish compensability of a stress-related mental condition, claimant must prove that the employment conditions are the major contributing cause of the disease and must establish its existence with medical evidence supported by objective findings. ORS 656.802(2).[1] Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles. Furthermore, there must be a diagnosis of a mental disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. Amended ORS 656.802(3)(a)-(d).

The ALJ concluded that claimant had established compensability of his mental disorder as an occupational disease. The employer contends that claimant's mental disorder is noncompensable because it arose from conditions which were either generally inherent in any working situation or because it arose from the employer's reasonable discipline, corrective actions or job performance evaluations. Claimant contends that his mental disorder is due to the stress of having two supervisors who gave claimant conflicting instructions. Claimant further contends that this is a stressor which is not generally inherent in every working situation and that his mental stress claim is compensable.

Claimant was employed as a loss control manager at the employer's Medford, Oregon store. Claimant had worked for the employer for seventeen years, most of that time as a loss control manager. In February 1993, the employer made a change in the structure of its management with regard to loss control managers. Originally, claimant was supervised by the store manager. After the change, claimant was supervised by the district manager. Also at some point in recent years, the employer had changed its policy to require that loss control personnel become certified. There were two levels of certification. The associates were given a test by the personnel office. Claimant passed this test and was certified as an associate. The second level was to become certified as a loss control manager. Claimant had not completed this phase of the certification.

After the management change, the store manager, Mr. Adams, continued to treat claimant as if he was claimant's direct supervisor. This caused claimant stress since the directions of the two supervisors were not always consistent.

---

[1] The 1995 Legislature has amended ORS 656.802(2) and (3). Or Laws 1995, ch 332, § 56 (S.B. 369, § 56). According to § 66 of SB 369, the 1995 amendments apply retroactively unless a specific exception is stated in the Act. Because there is no specific exception, we conclude that the 1995 amendments apply to claimant's claim. See Volk v. America West Airlines, 135 Or App 565 (1995).

In February 1993, the loss prevention district manager evaluated the store where claimant worked. Several deficiencies were noted and compliance was expected within 60 days. (Ex. 7). In May 1993, claimant was evaluated by the loss prevention district manager. Claimant received a poor evaluation. (Ex. 8). Deficiencies were noted in several areas. Prior to his 1993 evaluation, claimant had always received satisfactory or better evaluations. Claimant was placed on a 45 day re-evaluation period. Claimant was expected to make a noticeable improvement in the deficient areas and was also expected to complete his training certification for loss control manager. Claimant's certification training consisted of studying 18 modules and taking and passing a test concerning the total operation of the store. Mr. Adams, the store manager, agreed to oversee claimant's training, even though the district manager, Mr. Coyle, was claimant's direct supervisor.

Claimant was given time at work to study, but was also expected to spend time on the floor and finish his reports. Claimant was also expected to file his reports in typewritten form. Claimant previously handwrote his reports and did not know how to type. He was not given any assistance in typing his reports. This caused claimant frustration as did the expectation that he would learn how to deal with computers.

Claimant's probation period was extended in July 1993 for an additional 60 days. Dr. Sasser took claimant off work on July 20, 1993. Claimant returned to work in October 1993. Claimant's probationary status was again continued in October 1993 for 60 more days. In December 1993, claimant's probationary status was continued again because Mr. Adams believed that claimant was beginning to make a sincere effort to correct the deficiencies noted in the May 1993 notice of corrective action and to complete his certification training. Claimant had completed 6 of the 18 modules.

In February 1994, Mr. Adams took claimant off probation, with apprehension, but indicated that claimant was still expected to complete his certification training. Claimant had not completed any more modules at the time he was taken off probation. Claimant was taken off work by Dr. Sasser the day after Mr. Adams took claimant off probation. Claimant subsequently took early retirement and never returned to work.

Two physicians address the nature and cause of claimant's condition. Dr. Sasser, psychiatrist, has treated claimant. He first examined claimant in May 1993 for increasing depression, frustration and perception of stress on the job secondary to interactions with his manager. Dr. Sasser diagnosed an adjustment disorder with anxiety and depression. At that time, claimant reported difficulties over the last four years since the current store manager, Mr. Adams, arrived.

Dr. Sasser opined that it was medically probable that the major cause of claimant's diagnosed mental condition was stress at work. (Exs. 6; 2-6). Dr. Sasser did not explicitly outline the various stressors that he believed contributed to claimant's mental disorder. However, his contemporaneous chart notes mentioned many work-related stressors. These included the change in supervisors, the corrective action (probations, training) and the fact that the employer did not pay claimant's health insurance premium while he was on medical leave. Claimant also expressed feelings of being undermined, disregarded and harrassed at work. In one chart note, Dr. Sasser stated that it was difficult to know whether claimant was being harrassed at the administrative level or whether claimant was unable to keep up with changing expectations and technology in his area. (Ex. 2-5). Dr. Sasser believed that claimant's situation at work might be more than just reasonable disciplinary action, though, because claimant's supervisor, Mr. Adams, had called Dr. Sasser and suggested that claimant had had a prior stress claim. This information was apparently untrue. In a February 1994 chart note, Dr. Sasser opined that part of claimant's stress appeared to be due to claimant's being in a role that had changed because of management changes or management style. Dr. Sasser indicated that there was a definite interpersonal conflict between claimant and the manager and that claimant felt that he had been placed in a position of great responsibility with no authority. Dr. Sasser thought that one of the major conflicts in claimant's job was the lack of authority that claimant once had as director of security. (Ex. 2-7).

Dr. Glass, psychiatrist, examined claimant for the employer. Dr. Glass did not diagnose claimant as suffering from a mental disorder. Rather, Dr. Glass found that claimant had an "occupational problem" relating to the loss of his job status. Dr. Glass concluded that claimant's work exposure was not the major contributing cause of claimant's current symptoms. Dr. Glass indicated that claimant was unable to keep up with the job or make the kinds of changes necessary. (Ex. 5).

In Karen M. Colerick, 46 Van Natta 930 (1994), we found that changes in procedures, turnover in personnel, understaffing and altered job descriptions/duties constituted conditions generally encountered in every working situation. Thus, we concluded that those conditions were excluded from consideration in determining whether or not employment conditions were the major contributing cause of the claimant's mental disorder. We have also previously held that operating within everchanging technological parameters can be a condition generally inherent in every work place. Barbara D. Pacheco, 46 Van Natta 1499 (1994). In Pacheco, we noted that it is the manner in which an employer handles technological changes that determines whether the situation is generally inherent in every work place. We concluded that if reasonable training is provided to implement technological changes, the situation can be a condition that is generally inherent in every work place.

Based on the record, much of claimant's work-related stress was due to changes in his job and the necessity to become certified as a loss control manager. Additional stress was caused by the changes in the management structure. We conclude that changes in claimant's job description and the need to become certified as a loss control manager are conditions generally inherent in any job. Karen M. Colerick, supra; Barbara D. Pacheco, supra. We further find nothing in the record that persuades us that the certification training provided to claimant was unreasonable. We recognize that claimant has trouble with reading and that the training program was difficult for him. Nevertheless, there is no evidence that the training program, although difficult for claimant personally, was unreasonable. In addition, we note that claimant was able to complete 6 of the 18 training modules. Accordingly, we conclude that the stress caused by the changes in claimant's job and the need for certification are conditions generally inherent in every working situation and are, therefore, excluded from consideration in determining the major contributing cause of claimant's mental condition. See Karen M. Colerick, supra.

A second source of stress for claimant was the employer's placement of claimant on probation until he could remedy the deficiencies noted in the May 1993 evaluation and become certified as a loss control manager. We conclude that the employer's actions in placing claimant on probation amounted to reasonable corrective actions. Claimant was a long time employee and the employer acted reasonably by granting him training and extending his probation period in order to allow him to obtain his certification. The record supports a finding that the employer's policy had changed to require that loss control managers be certified. The record also shows that claimant's job description and duties had changed. It was not unreasonable for the employer to place claimant on probation in an effort to get claimant to comply with the new standards for loss control managers. Accordingly, we conclude that stress caused by the employer's reasonable corrective actions may not be considered in determining the major contributing cause of claimant's mental disorder.

The ALJ found that claimant received, at times, conflicting directions from Mr. Adams and from the district manager. The ALJ concluded that having two people act as direct supervisors was not a condition which was generally inherent in every working situation. While we agree that having two supervisors who give an employee different and conflicting directions is not a condition which is generally inherent in every job, we note that Dr. Sasser does not indicate that this stressor is the major contributing cause of claimant's mental disorder. Rather, Dr. Sasser's reports and chart notes suggest that the change in claimant's job description, the certification requirement and the employer's reasonable corrective actions were significant stressors for claimant. Dr. Sasser's reports do not factor out these stressors in concluding that claimant's work stress was the major contributing cause of his mental disorder. Given the contrary medical opinion and Dr. Sasser's failure to specifically identify the work-related conditions or events that contributed to claimant's condition, we are unable to conclude that claimant has established compensability of his mental disorder.

## ORDER

The ALJ's order dated March 7, 1995 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

**Board Member Gunn dissenting.**

The majority's decision has broadened the definition of "generally inherent" to encompass almost every work-related stressor. In this case, the majority finds that the changes in claimant's job and the need for certification training are conditions generally inherent. However, the changes in claimant's job resulted in claimant having essentially two supervisors who gave conflicting instructions to claimant about his job duties and his training. Thus, I would conclude that the stressors claimant experienced at work were more than conditions which are "generally inherent" or reasonable discipline.

Prior to the implementation of the changes in the loss control area and in the employer's management structure, claimant had received satisfactory or better evaluations. Soon after the changes were implemented, claimant received his first poor evaluation. Although claimant was given some work time to study for his certification, he was still also expected to complete all of his other duties. In addition, although claimant could not type, he was required to type his reports, whereas he had previously handwritten the reports without the employer's objection. Claimant was given no help in typing his reports. I would find that the manner in which the employer handled the changes in the area of loss control was not reasonable. Claimant's training regimen (under the direction of essentially two supervisors) did not amount to "reasonable training."

Two incidents in particular show that the conditions in which claimant worked were more than generally inherent stressors. First, claimant's supervisor contacted claimant's physician and falsely reported that claimant had had a prior stress claim. Second, although the employer ostensibly placed claimant on probation because of his failure to become certified as a loss control manager, the employer ultimately removed claimant from probation even though he had never completed his certification training. The fact that claimant was taken off probation without receiving his certification makes it likely that probation was unnecessary in the first place and was merely harassment. These two incidents make it evident that the conditions claimant faced at work existed in a real and objective sense and were more than generally inherent conditions or reasonable discipline. They also lend credence to claimant's assertions that he was being harassed by his supervisors.

Like the ALJ, I would rely on Dr. Sasser's opinion to find that the work conditions claimant experienced were the major contributing cause of his mental disorder. Thus, I would find that claimant has a compensable stress claim. For these reasons, I respectfully dissent.

---

November 9, 1995 Cite as 47 Van Natta 2199 (1995)

In the Matter of the Compensation of
**JOSE SOLIS, Claimant**
WCB Case No. 92-15053
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Mills' order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal order. We affirm.

## FINDINGS OF FACT

Claimant initially requested a hearing on November 24, 1992 challenging a September 25, 1992 Director's vocational services order. At the time of his hearing request, claimant was represented by an attorney. The case was set for hearing in February 1993. The February 1993 hearing was not held and the hearing was later reset for October 28, 1993. By October 28, 1993, claimant was no longer represented by legal counsel, and the hearing was postponed in order to allow claimant to obtain an attorney.

In December 1993, claimant obtained a new attorney and his hearing was reset for March 29, 1994. By letter dated March 28, 1994, claimant's then-attorney withdrew his request for hearing. On April 6, 1994, ALJ McCullough issued an order dismissing claimant's hearing request. After receiving a letter from claimant objecting to the dismissal of his case, ALJ McCullough abated his dismissal order on May 3, 1994. By letter dated May 24, 1994, claimant's attorney withdrew from her representation of claimant. On June 10, 1994, ALJ McCullough vacated his April 6, 1994 dismissal order and ordered that the case be reset for a new hearing.

Claimant obtained a new attorney and his hearing was reset for March 3, 1995 before ALJ Mills. Claimant's attorney filed a supplemental hearing request raising the issue of aggravation. On the record

at the March 3, 1995 hearing, claimant's new attorney requested that claimant's hearing request on the vocational services and aggravation issues be dismissed. The parties specifically reserved for potential future settlement or litigation, an issue regarding the scope of acceptance. Claimant was present at the hearing and agreed, when asked by the ALJ, that he understood that his hearing request was being dismissed. (Tr. 3). In a March 10, 1995 order, ALJ Mills dismissed claimant's hearing request.

CONCLUSIONS OF LAW AND OPINION

The record indicates that claimant's hearing request was dismissed in response to claimant's then-attorney's withdrawal of that request. Claimant does not dispute his then-attorney's authority to act on his behalf, nor does he dispute the fact that the ALJ dismissed his request for hearing in response to his then-attorney's withdrawal of the hearing request. Under these circumstances, we find no reason to alter the ALJ's dismissal order. See David R. Robertson, 47 Van Natta 687 (1995); William A. Martin, 46 Van Natta 1704 (1994); Henry B. Scott, Jr., 45 Van Natta 2382 (1993); Verita A. Ware, 44 Van Natta 464 (1992).

ORDER

The ALJ's order dated March 10, 1995 is affirmed.

**Board Member Gunn dissenting.**

It is clear that claimant, who is Spanish speaking, objects to the dismissal of his case. When asked by the ALJ whether he understood that his case was going to be dismissed, claimant responded "Okay." This statement is insufficient, in my opinion, to establish that claimant understood that he was agreeing to dismiss his hearing request. The fact that claimant said "okay" in response to the ALJ's question does not, in my mind, overcome claimant's obvious objections to the dismissal of his case. Accordingly, I would remand this matter with instructions that claimant be asked, in Spanish, if he agrees to the dismissal of his case. If it is not claimant's intent to dismiss his hearing request, then the request should be reinstated. For these reasons, I respectfully dissent from the majority's opinion.

---

November 9, 1995 Cite as 47 Van Natta 2200 (1995)

In the Matter of the Compensation of
**ANDRES L. ZAVALA, Claimant**
WCB Case No. 94-14867
ORDER ON REVIEW
Dye & Malagon Associates, Claimant Attorneys
Les Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) McCullough's order which declined to award temporary total disability benefits from November 2, 1994 through March 2, 1995. In his brief, claimant contends that the case should be remanded to the ALJ to further develop the record in light of amendments to ORS Chapter 656. On review, the issue is temporary total disability. We deny the motion to remand, and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and the parties' stipulated facts as adopted by the ALJ.

CONCLUSIONS OF LAW AND OPINION

Claimant was injured on July 26, 1994. The SAIF Corporation accepted his claim on September 9, 1994.

On November 1, 1994, Dr. Ferguson, attending physician, signed a written release to return to modified work. (Stipulated fact; Ex. 5). On the same date, the employer gave the written work-release to claimant, and offered claimant, in writing, the modified employment. (Stipulated fact; Ex. 4). Claimant failed to return to work on November 2, 1994 as requested, and he declined the written job offer. (Stipulated fact; Ex. 4).

The ALJ, pursuant to former ORS 656.268(3)(c), concluded that the attending physician had given claimant a written release to return to modified work, and that SAIF was justified in terminating claimant's temporary disability compensation.

Subsequent to the ALJ's order, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. ORS 656.268(3) is among the amended provisions. Or Laws 1995, ch 332, § 30(3) (SB 369, § 30(3)). Amended ORS 656.268(3) states in part:

> "Temporary total disability benefits shall continue until whichever of the following events first occurs:
>
> "* * * * *
>
> "(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

Claimant contends that this case should be remanded to the ALJ, in light of the new legal standard set out in ORS 656.268(3)(c), because there is no evidence in the record to establish whether claimant was "advised" by Dr. Ferguson concerning the release to modified employment. We disagree.

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 his brief, claimant acknowledges that, at hearing, both parties stipulated to the facts as set out in the ALJ's order. Specifically, the parties stipulated that claimant's attending physician signed a written release to allow claimant to return to modified work. Furthermore, the record contains the letter signed by Dr. Ferguson that describes the modified job, and states that Dr. Ferguson agrees the position was appropriate for claimant. (Ex. 5). Finally, the parties also stipulated that the employer gave Dr. Ferguson's written release to claimant on November 1, 1994. Finally, claimant does not explain what additional evidence would be presented that would reasonably be likely to affect the outcome of this case.

In light of this evidence, we conclude that the record is sufficiently developed and that, pursuant to amended ORS 656.268(3)(c), claimant was advised by his attending physician of the modified work. Accordingly, we deny claimant's motion to remand, and affirm the ALJ's order.

## ORDER

The ALJ's order dated March 28, 1995 is affirmed.

In the Matter of the Compensation of
**KATHLEEN M. BUTLER, Claimant**
WCB Case No. 94-14739
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) denied its motion to dismiss claimant's hearing request regarding this dispute, which involves a managed care organization's (MCO's) disapproval of proposed medical treatment; and (2) directed SAIF to authorize and pay for the proposed treatment. 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, in view of the recent enactment of Senate Bill 369, Or Laws 1995, ch 332 (SB 369), we lack jurisdiction over this matter. We agree.

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." 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.

Claimant raises several constitutional arguments in opposition to the retroactive application of amended ORS 656.260(6) to this case. We are not inclined to address such arguments. 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). Nevertheless, we have considered and, for the following reasons, reject, those arguments.

Claimant first asserts that the retroactive application of amended ORS 656.260(6) to this case violates the Contracts Clause of Article I, section 21, of the Oregon Constitution.[1] Claimant relies on Eckles v. State of Oregon, 306 Or 380 (1988), which holds that retroactive application of section four of

[1] Claimant does not assert a federal Contracts Clause argument.

the Transfer Act, Or Laws 1982 (Special Session), ch 2, impaired employers' contracts with SAIF regarding monies in the Industrial Accident Fund. Claimant's arguments lack merit.[2]

Article I, section 21, provides, in part, that "[n]o * * * law impairing the obligation of contracts shall ever be passed." Determining whether a law violates that clause involves a two-step process: One, ascertaining whether a contract exists to which the person asserting an impairment is a party; and two, ascertaining whether the law has impaired an obligation of that contract. Hughes v. State of Oregon, 314 Or 1, 13-14 (1992).

Claimant's reliance on Eckles v. Oregon, supra, suggests that she believes that the retroactive application of amended ORS 656.260(6) will impair SAIF's contracts with its insureds. If that is the case, that argument fails the first prong of the Contract Clause test, because claimant is not a party to those contracts.

To extent that claimant believes the retroactive application of amended ORS 656.260(6) to this case will impair her employment contract with SAIF's insured, that argument also fails, because claimant has not apprised us of the existence or terms of any such contract, much less how it allegedly will be impaired by amended ORS 656.260(6). Accordingly, that argument fails under both prongs of the Contract Clause test.

Finally, to the extent that claimant asserts that the Workers' Compensation Act itself (or any provision thereof) constitutes a contract for purposes of Article I, section 21, we reject that argument outright. Statutes do not create contracts for purposes of Article I, section 21, in the absence of unambiguous legislative intent to create such a contract. E.g., Hughes v. State of Oregon, supra, 314 Or at 17. Here, claimant has identified no such legislative intent. In any event, even if the Act is characterized as a contract, amended ORS 656.260(6) effects no substantive change in the rights that flow from the Act; it merely directs the parties to a different forum for resolving MCO-medical services disputes. Therefore, it cannot be said to impair an obligation arising under the Act. For all these reasons, we reject claimant's Article I, section 21, arguments.

Claimant next asserts that the retroactive application of amended ORS 656.260(6) to this matter violates the Due Process Clause of the United States Constitution. US Const, Am XIV, § 1. We disagree.

Claimant asserts that, because she has a vested right in the benefits that the ALJ ordered SAIF to provide her, the Legislature cannot retroactively deprive her of those benefits without violating her due process rights.[3] We disagree.

---

[2] Claimant also refers us to Greist v. Phillips, 128 Or App 390, rev allowed 320 Or 270 (1994), in support of her due process argument. In that case, the issue was whether legislation that did not contain a retroactivity clause should be applied retroactively. Here, section 66 of SB 369 clearly expresses the legislative intent that the amendments generally apply retroactively. See Volk v. America West Airlines, 135 Or App 565, 572-73 (1995) (SB 369, § 66(5)(a) manifests legislative intent that amendments apply to matters for which the time to appeal the Board's decision had not expired or, if appealed, have not been finally resolved by the courts). Greist does not apply here.

Claimant also refers us to Ida M. Walker, 43 Van Natta 1405 (1991), for the proposition that we will not apply laws retroactively if to do so will produce an absurd or unjust result. Claimant evidently wishes us to hold that the retroactive application of amended ORS 656.260(6) to this case will produced an absurd and/or unjust result. We rejected a similar argument in Walter L. Keeney, 47 Van Natta 1387 (1995), and do so again here.

[3] Claimant also apparently asserts that the retroactive application of amended ORS 656.260(6) violates dues process because it is arbitrary and irrational or harsh and oppressive. See Kilpatrick v. Snow Mountain Pine Co., 105 Or App 240, 244, rev den 311 Or 426 (1991) (federal due process prohibits arbitrary and irrational or particularly harsh and oppressive legislation). Claimant has not adequately developed this argument for review. Therefore, we will not address it, see Ronald B. Olson, 44 Van Natta 100, 101 (1992) (Board declined to address constitutional argument not adequately developed for review), except to note the Court of Appeals' citation to SB 369's legislative history. Volk v. America West Airlines, supra n 2, 135 Or App at 569-72. That history reveals that the legislature wanted the Act to apply both retroactively and prospectively to assure uniform application of the law to pending and future cases. See id. at 570-71. In our view, that is a rational basis for the generally retroactive application of the Act.

First, because an order regarding claimant's benefits has yet to become final, claimant's entitlement to such benefits has not yet matured into a vested right. See, e.g., Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413 (1995) (in ongoing medical services dispute, court held that amendments to ORS 656.245, 656.327 and 656.704 did not deprive claimant of any rights that had vested by virtue of a final determination of the case) 137 Or App at 417; see also State ex rel v. Kiessenbeck, 167 Or 25, 30 (1941) (the first and essential quality of a judgment or decree that gives rise to a vested right is that it be a final determination of the rights of the parties); Roberts et al v. State Tax Com., 229 Or 609, 614 (1962) ("vested right" is an immediate right to present enjoyment, or a present fixed right to future enjoyment). On that ground alone, claimant's "vested right" argument fails.

Second, the amendments to ORS 656.260(6) have not deprived claimant of any benefit; they have simply clarified that the Director is the proper entity before which these matters are now to be litigated. Indeed, SB 369 makes it clear that the Director will have the same authority as the Board had to award benefits in MCO disputes. See Liberty Northwest Ins. Corp. v. Yon, supra, (amendments to ORS 656.245, 656.327 and 656.704 eliminated claimant's choice to have medical services dispute resolved by Board, but did not deny him opportunity to have claim reviewed) (slip op at 5); see generally amended ORS 656.260; see also SB 369, § 42d(1), (5) (authorizing Director to award attorney fees in disputes arising under amended ORS 656.260, and prohibiting the Board or the Hearings Division from awarding attorney fees or penalties for matters arising under the Director's jurisdiction).

Last, claimant makes an argument based on section 66(9) of SB 369, which declares an emergency to exist and provides that the Act is to take effect on its passage. Claimant asserts that, because there is no workers' compensation emergency in Oregon, the retroactive application of amended ORS 656.260(6) violates due process. In making this argument, claimant relies on a DCBS document entitled, "OREGON WORKERS' COMPENSATION: Monitoring The Key Components Of Legislative Reform." Claimant asks us to take administrative notice of this document.[4]

We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," such as a Department order or filing with the Board. See, e.g., Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). The DCBS document does not meet that standard. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985) (court held that Board lacked authority to take administrative notice of Dictionary of Occupational Titles); see also Rodney J. Thurman, 44 Van Natta 1572 (1992) (Board declined to take administrative notice of carrier's "1502" form). Accordingly, we will not take administrative notice of it. Because claimant's emergency-due process argument is premised on the DCBS document, we reject that argument.[5]

In sum, for these reasons, we conclude that we are without jurisdiction to address the merits of this MCO-medical services dispute. Accordingly, we vacate the ALJ's order and dismiss claimant's hearing request.

## ORDER

The ALJ's order dated April 7, 1995 is vacated. Claimant's hearing request is dismissed.

---

[4] Claimant did not supply us with a copy of this document.

[5] Even if we addressed the merits of claimant's emergency argument, we would likely reject that argument, based on SB 369's legislative history to the effect that the Legislature intended the Act to apply uniformly to all pending and future cases. Volk v. America West Airlines, supra n 2, 135 Or App at 570-71; see note 3, supra. Moreover, if the Legislature had not declared an emergency, SB 369 would have gone into effect on September 9, 1995, the effective date of non-emergency legislation enacted by the Regular Session of the 1995 Legislature. Once that date passes, the emergency issue will be moot.

**Board Member Gunn dissenting.**

The majority concludes that, under Ronald R. Streit, Sr., 47 Van Natta 1577 (1995), the Director has exclusive jurisdiction over this managed care organization (MCO) dispute and, therefore, vacates the Administrative Law Judge's order and dismisses claimant's hearing request. The majority then goes on to reject an Oregon Constitution Contracts Clause argument that, I believe, has merit and serves as a basis for our retaining jurisdiction over this matter. Consequently, I dissent.

Claimant asserts that the retroactive application of amended ORS 656.260(6) to this case violates the Contracts Clause of Article I, section 21, of the Oregon Constitution. Article I, section 21, provides, in part, that "[n]o * * * law impairing the obligation of contracts shall ever be passed." Determining whether a law violates that clause involves a two-step process: One, ascertaining whether a contract exists to which the person asserting an impairment is a party; and two, ascertaining whether the law has impaired an obligation of that contract. Hughes v. State of Oregon, 314 Or 1, 13-14 (1992). I believe that the answer to both of those inquiries is "yes."

I recognize that there is no evidence of a specific employment contract to which claimant is a party. However, in my view, the Workers' Compensation Act is a legislatively-created "social contract" that is sufficient to satisfy the first element of the Contracts Clause test.

A "social contract" results when a combination of persons agree, for their mutual protection, to surrender individual freedom of action to government. See Black's Law Dictionary 1246 (5th ed 1979). Here, the citizens of Oregon have agreed, for their mutual protection, to surrender certain individual freedoms in the workplace to the legislature. In response, the legislature has found that employment inevitably involves injury to some workers and that litigation regarding such injuries is often expensive and only minimally beneficial. ORS 656.012(1)(a), (b). In light of those findings, the legislature has expressed the policy underlying the Workers' Compensation Act: To provide, through a non-adversarial system, benefits to injured workers on a no-fault basis; to restore such workers to physical and economic self-sufficiency; and to encourage employers to maintain safe work places. ORS 656.012(2)(a)-(d). In exchange, the legislature has afforded employers the benefit of the Act's exclusive remedy provisions, amended ORS 656.012(1)(c), (2)(e), 656.018, and limited employer costs through the compensability and disability standards and by the managed care process.

As a whole, those findings and policies manifest citizen consent to legislative action that limits their ability to pursue causes of action against their employers for work-related injuries. In turn, the citizens expect to receive full and adequate care for those injuries. That process has created a "social contract" that can serve as a basis for an Article I, section 21, challenge. Hughes v. Oregon, supra, 314 at 13-14. Moreover, as an Oregon citizen and a worker, claimant is a "party" to that contract. Accordingly, she has satisfied the first element of the Contracts Clause test. Id.

Alternatively, other provisions of the Workers' Compensation Act create a contract sufficient to support a Contracts Clause challenge. ORS 656.260(6) gives claimants the right to contest matters involving MCOs. Moreover, ORS 656.245(5) establishes that, when a carrier contracts with an MCO, the workers for the insured "are subject to the contract" and "shall receive medical services in the manner prescribed by the contract." On the basis of those statutes, I would conclude that a worker governed by an MCO contract has proved the existence of a "statutory contract" to which he or she is a party for purpose of Article I, section 21. Because claimant is governed by an MCO contract, I would hold that, for that additional reason, she has established the first element of the Contracts Clause test. Hughes v. Oregon, supra, 314 Or at 13-14.

In sum, under either the "social" or "statutory" contract analyses, claimant has established a contract sufficient to support an Article I, section 21 Contracts Clause challenge. The next inquiry is whether amended ORS 656.260(6) impairs claimant's rights. It does.

Under former ORS 656.260, the parties had the right to litigate MCO disputes before the Board and its Hearings Division. Job G. Lopez, 47 Van Natta 193 (1995). That process included a full evidentiary hearing, wherein the parties were given an opportunity to present both documentary and testimony evidence.

Under amended ORS 656.260(6), the parties now must litigate MCO disputes before the Director. I believe that the parties will not be afforded the same opportunity to a plenary hearing if they go before the Director. Experience has taught me that "hearings" before the Director are conducted in a much more limited manner than they are before the Board or the Hearings Division. Many of these "hearings" are conducted without the benefit of testimonial evidence. For that reason, I believe that ORS 656.260, as amended, impairs claimant's contract rights that arose under former ORS 656.260(6). Hughes v. State of Oregon, supra, 314 Or at 13-14.

In sum, I believe that claimant has established that amended ORS 656.260(6) violates Article I, section 21's Contracts Clause. Therefore, I would hold that amended ORS 656.260 should be applied only to those cases that arose after June 7, 1995, the effective date of the Bill. See Eckles v. State of Oregon, 306 Or 380, 399 n 18 (1988) (Contracts Clause does not protect future contracts). Because this case arose before then, I would apply former ORS 656.260(6) and hold that we have jurisdiction over this case.

Finally, I wish to express my concern about the MCO process in general. That process enables MCOs and carriers to contract for the provision of medical services to injured workers. I have nothing against that idea in theory. Reality is, however, a different thing.

Since 1990, MCOs and carriers have been able to, and do, prevent workers from obtaining entire classes of diagnostic and curative services by virtue of the terms of the MCO-carrier contracts, which are hidden from the public's eye. See ORS 656.260(9). Now, the 1995 Legislature has determined that the Director, who oversees MCOs and carriers, has exclusive jurisdiction over MCO disputes. As I stated earlier, I predict that workers who receive care under MCO contracts now will have little opportunity to present their cases as fully to the Director as they did before the Board and the Hearings Division. I also predict that there will be nothing that either the Director or we, as members of the public, will be able to do about it. Because I find this process unfair and, in this case, in violation of Article I, section 21, of the Oregon Constitution, I dissent.

**Board Member Hall dissenting.**

I respectfully disagree with the majority's rejection of the constitutional arguments raised in this case. Nevertheless, the majority has spoken. These issues will, no doubt, now be decided by the courts. See, e.g., Employment Dept. v. Vitko, 134 Or App 641 (1995) (court declined to address constitutionality of law that had not been applied to case); see also Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413 (1995) (rejecting due process challenge to retroactive application of amended ORS 656.327(1) to pending medical services claim); Volk v. America West Airlines, 135 Or App 565 (1995) (holding that 1995 amendments to Workers' Compensation Act apply to matters for which time to appeal Board's decision has not expired or, if appealed, has not been finally resolved by courts).

---

November 13, 1995 Cite as 47 Van Natta 2206 (1995)

In the Matter of the Compensation of
**LEON M. HALEY, Claimant**
WCB Case No. 93-14807
ORDER ON RECONSIDERATION
Callahan & Stevens, Claimant Attorneys
Roberts, et al, Defense Attorneys

The self-insured employer requests reconsideration and abatement of our October 20, 1995 Order on Review which set aside its denial of claimant's neck and back injury claim. The employer contends that we erred in not finding the major contributing cause standard of ORS 656.005(7)(a)(B) applicable and invites us to provide guidance regarding the meaning of a "combined" condition. However, for the following reasons, we continue to find ORS 656.005(7)(a)(B) inapplicable.

The application of ORS 656.005(7)(a)(B) is contingent on the presence of a compensable injury which "combined" with a preexisting condition. In determining whether this statutory provision applies, we consider all potential contributors to claimant's current condition, not just the precipitating cause. See Dietz v. Ramuda, 130 Or App 397 (1994).

Here, the employer contends that the "natural inference" is that claimant's previous neck and shoulder problems "acted together" with the December 1993 work incident to cause disability or a need for medical treatment. Thus, the employer challenges our prior conclusion that there was no "combination" under former or amended ORS 656.005(7)(a)(B). The employer refers us to medical evidence suggestive of a combined condition, but does not cite us to any specific opinion that expressly supports such a conclusion. To the contrary, as discussed in our prior opinion, we continue to find that the record is silent on whether claimant's work injury "combined with" his preexisting shoulder and neck condition.

Therefore, upon further review of the medical record, we continue to adhere to our conclusion that the medical evidence is insufficient to establish that claimant's preexisting shoulder and neck condition and December 1993 injury "combined" to cause disability or a need for medical treatment. We, therefore, conclude that ORS 656.005(7)(a)(B) is not applicable.

Accordingly, we withdraw our October 20, 1995 order. On reconsideration, as supplemented and modified herein, we continue to adhere to the reasoning and conclusions reached in our original order. Consequently, we republish our October 20, 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
**TIMOTHY H. KRUSHWITZ, Claimant**
WCB Case No. 94-10445
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order which: (1) declined to award an "out-of-compensation" attorney fee beyond the 10 percent (not to exceed $1,050) awarded by the Department's Order on Reconsideration; and (2) declined to award an "out-of-compensation" attorney fee beyond that previously paid by the insurer pursuant to a prior Board order. On review, the issue is attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

An April 25, 1994 Order on Reconsideration found that claimant's claim was prematurely closed because an accepted psychological condition was not medically stationary at the time of closure. (Ex. 15). Therefore, pursuant to former ORS 656.268(6)(a)[1], the Order on Reconsideration set aside a Determination Order as premature, and ordered the insurer to pay claimant's attorney 10 percent of the increased temporary disability resulting from the claim being reopened. Id. Further, relying on OAR 436-30-050(14),[2] the Director inserted a maximum fee award not to exceed the Board's maximum award under OAR 438-15-045 ($1,050).

The ALJ concluded that the Director properly limited claimant's attorney fee. Claimant argues that former ORS 656.268(6)(a) (now ORS 656.268 (6)(c)) does not allow the Director discretion to impose a maximum fee award pursuant to Board rules. The insurer argues that former ORS 656.268(6)(a) must be read in conjunction with the statute as a whole, particularly in conjunction with ORS 656.388,[3] which

---

[1] Effective June 7, 1995, the legislature enacted SB 369, causing former ORS 656.268(6)(a) to be renumbered ORS 656.268(6)(c). Or Laws 1995, ch. 332, § 30. The substance of the statute did not change. In any event, the amendments to ORS 656.268(6) only apply to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. See SB 369, § 66(4). Because claimant became medically stationary prior to the effective date of the Act, we refer to the former statute, which contains the same language as the amended statute.

[2] OAR 436-30-050(14) provides, in pertinent part: "The reconsideration order shall order the insurer or self-insured employer to pay the attorney out of any additional compensation awarded but not more than the maximum attorney fee allowed in * * * OAR 438-15-045."

[3] ORS 656.388(1) was amended, in part, by SB 369, § 44. The amendments do not affect the results of this decision.

generally provides for ALJ and Board approval of attorney fees based on a schedule of fees established by the Board after consultation with the Oregon State Bar.

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. See Miller v. Employment Division, 290 Or 285 (1980); Charles M. Anderson, 43 Van Natta 463 (1991). But, where there is a conflict between an administrative rule and a substantive provision of ORS Chapter 656, the statute, rather than the rule, controls. In such circumstances, we apply the statute and give no effect to the rule. Forney v. Western States Plywood, 66 Or App 155 (1983); Walden J. Beebe, 43 Van Natta 2430 (1991). Here, we find that there is a conflict between OAR 436-30-050(14) and the substantive provisions of ORS 656.268(6)(a).

To begin, we are not persuaded by the insurer's argument that ORS 656.388 applies in this case. ORS 656.388(1) states, in part, that an ALJ or the Board must approve an attorney fee for services rendered before an ALJ or the Board. Here, the proceeding for which an attorney fee was awarded was a reconsideration proceeding before the Director. The parties had not yet even requested a hearing before an ALJ.

Rather, the applicable statute, former ORS 656.268(6)(a), clearly states that, in any reconsideration proceeding, the department "shall order the insurer or self-insured employer to pay the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker." Thus, the statute provides for an unlimited attorney fee, and imposes no maximum award. OAR 436-30-050(14) imposes a maximum fee award not to exceed the Board's maximum award under the Board's rule. Finding no authority that requires or authorizes the Director to adopt the Board's rules concerning attorney fees, we conclude that there is a conflict between the Director's rule and ORS 656.268(6)(a). Therefore, we apply the statute and give no effect to the rule. See Forney v. Western States Plywood, supra.

Accordingly, we reverse that portion of the ALJ's order which affirmed the Reconsideration Order's maximum attorney fee award. Instead, in accordance with ORS 656.268(6)(a), claimant's attorney is entitled to an "out-of-compensation" fee equal to 10 percent of the temporary disability resulting from the Order on Reconsideration. In the event that this substantively increased temporary disability award has already been paid to claimant pursuant to the April 25, 1994 Order on Reconsideration, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994) aff'd Volk v. America West Airlines, 135 Or App 565 (1995).

We adopt and affirm that portion of the ALJ's order which pertains to the insurer's payment of an "out-of-compensation" fee pursuant to the previous Board order.

## ORDER

The ALJ's order dated February 22, 1995 is reversed in part and affirmed in part. That portion of the order that affirmed the Order on Reconsideration's maximum attorney fee limitation is reversed. Claimant's attorney is awarded an "out-of-compensation" fee equal to 10 percent of the temporary disability compensation resulting from the Order on Reconsideration. In the event the temporary 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. The remainder of the order is affirmed.

In the Matter of the Compensation of
**LYLE H. BRENSDAL, Claimant**
WCB Case Nos. 94-10824 & 94-10270
CORRECTED ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation (on behalf of Ross Electric) requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) set aside its denial of claimant's low back and neck conditions; and (2) upheld Epic Insurance Services' (on behalf of Amelco Electric) denial of claimant's "new injury" claim for the same conditions. Epic cross-requests review of those portions of the ALJ's order that: (1) set aside its denial of claimant's "new injury" claim for his left arm condition; and (2) upheld SAIF's denial of the same condition. In addition, Epic seeks remand for consideration of evidence regarding claimant's "post-hearing" left arm surgery. Claimant cross-requests review of those portions of the ALJ's order that awarded his attorney $2,500 to be paid by SAIF and $1,000 to be paid by Epic. On review, the issues are remand, compensability, responsibility and attorney fees. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with one exception. We do not adopt the ALJ's finding in the fifth paragraph that claimant noted left arm pain for the first time following the March 1994 incident.

## CONCLUSIONS OF LAW AND OPINION

### Scope of acceptance

Claimant, an electrician, was injured in October 1966, while employed by SAIF's insured, Ross Electric. The ALJ found that SAIF had accepted claimant's 1966 claim, but there was no written record of the acceptance. Claimant argues that he has an accepted, disabling injury involving his neck and low back that was accepted by SAIF after the 1966 accident. Claimant asserts that he is seeking benefits for the same conditions and he contends that SAIF may not deny what it accepted in 1966.

On July 21, 1994, SAIF issued a partial denial of claimant's claim on the ground that there was insufficient evidence that claimant's current condition was the result of the 1966 industrial injury. (Ex. 29). The ALJ concluded that SAIF's July 21, 1994 denial was a current condition denial, rather than a retroactive denial.

Once a claim is accepted, the carrier may revoke acceptance within two years only under certain circumstances. Amended ORS 656.262(6)(a). The scope of acceptance is a factual determination. SAIF v. Tull, 113 Or App 449 (1992).

SAIF does not dispute that it accepted claimant's claim for the 1966 incident. Claimant testified that his medical bills after the 1966 accident were paid, but he did not receive any disability awards. (Tr. 47, 88). Claimant did not remember what body parts he mentioned in his 1966 claim. (Tr. 87). There is no written acceptance of the claim and there are no contemporaneous medical records available to allow us to determine what condition was accepted. See Georgia Pacific v. Piwowar, 305 Or 494, 496 n.2 (1988) (although it was difficult to ascertain the nature of the employer's acceptance, the employer admitted that it had accepted the claim as submitted); Timothy Hasty, 46 Van Natta 1209 (1994) (when the acceptance does not identify the specific condition, we look to contemporaneous medical records to determine what condition was accepted).

Based on this record, we are unable to determine what conditions SAIF accepted as a result of claimant's 1966 injury. Under these circumstances, we are not persuaded by claimant's argument that SAIF is attempting to deny conditions that it accepted in 1966.

Compensability

Claimant has several current conditions. Dr. Belza, claimant's treating physician, diagnosed claimant with degenerative changes at the three lower lumbar levels, mild degenerative changes of the thoracic spine and osteophytic change and degenerative changes at C5-6 that corresponded to his neck and left arm symptomatology. (Exs. 16, 26). Dr. Belza recommended an anterior cervical discectomy to treat the bony spurs on claimant's cervical spine as well as the disk protrusion at C5-6. (Exs. 26, 58-10). Dr. Belza also diagnosed chronic neck pain and chronic low back pain. (Ex. 58-7). In addition, Drs. Fuller and Snodgrass mentioned that claimant had a "[p]robable old minor compression fracture L1." (Ex. 48-5, 49).

In October 1966, while working for Ross Electric, claimant fell more than two stories and landed flat-footed on the ground. Claimant testified that he "was hurting all over" and he sought medical treatment on the day of his injury. (Tr. 46). Claimant's back was x-rayed and he was off work several weeks. (Tr. 46, 47). Claimant testified that when he went back to work, his back and neck were painful. (Tr. 48).

Claimant testified that, between 1966 and 1973, he had back and neck pain but did not feel like he needed any medical treatment. (Tr. 48, 49). In December 1973, claimant was in a motor vehicle accident on the same day he was scheduled to have knee surgery. (Tr. 49). Dr. Van Olst, the knee surgeon, examined claimant and reported that he had mild to moderate aching between the shoulder blades and some feeling of tingling in his right hand, but that had cleared. (Ex. B). Dr. Van Olst commented that claimant's cervical injury was not significant enough to prohibit going forward with the knee surgery. (Id.) Claimant testified that he was off work after the knee surgery, but not because of any problem with his neck. (Tr. 50).

Claimant continued to have pain in his neck and lower back. Claimant sought chiropractic treatment in 1983 because his back "locked up" while bowling and he could not straighten up. (Tr. 51). Since the 1980's, claimant has been receiving chiropractic care on a regular basis to help him continue to work. (Tr. 77, 83).

In March 1994, claimant was digging a trench while employed by Epic's insured, Amelco Electric, and experienced increased pain in his neck and low back. Claimant sought chiropractic treatment and was taken off work for a week. (Tr. 60). Claimant had not been off work for neck or low back symptoms since 1966. (Tr. 60-61). Claimant was subsequently treated by Dr. Belza.

Reasoning that the material contributing cause standard applied to claimant's claim, the ALJ concluded that claimant's current conditions flowed directly from his 1966 work incident. SAIF argues that the ALJ erred in concluding that claimant could prove compensability under a material causation standard.

We need not resolve that question, because we conclude that, even under the higher standard, claimant prevails. Claimant asserts that, under the last injurious exposure rule, he has established a compensable occupational disease claim. SAIF agrees that claimant's current conditions are compensable on the basis of his entire work exposure.

In order to establish the compensability of his occupational disease claim for his neck and low back conditions, claimant must prove that employment conditions were the major contributing cause of his conditions. Amended ORS 656.802(2)(a); Or Laws 1995, ch 332 § 56(2)(a) (SB 369, § 56(2)(a)). Under the "rule of proof" prong of the last injurious exposure rule, claimant need not prove that employment with any one employer was the major contributing cause of the conditions; it is sufficient to show that the conditions were in major part caused by employment-related exposure. See Runft v. SAIF, 303 Or 493, 500 (1987); Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994).

Given the long passage of time since claimant's 1966 injury and the multiple potential causes of claimant's back and neck conditions, we find that the causation issue is a complex medical question, which must be resolved on the basis of expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

There is no indication in the record that any of claimant's low back and neck conditions preexisted his 1966 industrial incident. Dr. Belza testified that the combination of claimant's work over the years, including the 1966 accident, was the major contributing cause of claimant's neck and low back conditions. (Ex. 58-55 & 58-56). Drs. Fuller and Snodgrass reported that claimant's present condition received a "major contribution" from the pick swinging incident of March 1994. (Ex. 48). In a follow-up report, Dr. Fuller opined that the pick-swinging incident in 1994 provided the major contribution for claimant's current neck and arm pain. (Ex. 49). Drs. Dinneen and Watson reported that claimant's work as an electrician and the injury of March 1994 were the major contributing cause of claimant's need for treatment. (Ex. 53).

Based on these medical reports, we conclude that claimant's combined employment conditions over the years were the major contributing cause of his neck and low back conditions. See amended ORS 656.802(2)(a). Accordingly, claimant has established the compensability of his conditions.

Responsibility

The ALJ applied ORS 656.308(1) and determined that SAIF was responsible for claimant's claim. The ALJ found that claimant's March 1994 injury at Epic's insured was not the major contributing cause of claimant's conditions, and, therefore, responsibility did not shift to Epic.

In determining which carrier is responsible for claimant's condition, we must first decide whether this case is governed by ORS 656.308 or the last injurious exposure rule. ORS 656.308(1) applies when the medical treatment or disability for which benefits are sought involves a condition that previously has been processed as a part of a compensable claim. Smurfit Newsprint v. DeRosset, 118 Or App 368, 371 (1993).

Although there is a prior accepted claim in this case, the record is insufficient to allow us to determine what conditions were accepted as a result of claimant's 1966 work incident. Furthermore, there is no evidence that claimant's current conditions were accepted or processed with the 1966 claim. Dr. Belza testified that the probable diagnosis of claimant's condition in 1966 would have been cervical strain, lumbar strain, spinal trauma and a traumatic compression of the L1 vertebrae. (Ex. 58-18; 58-55). Dr. Fuller speculated that claimant's minor compression fracture at L1 resulted from the 1966 injury. (Ex. 49). Claimant's current conditions, which are diagnosed as degenerative changes at the three lower lumbar levels, mild degenerative changes of the thoracic spine and osteophytic change and degenerative changes at C5-6, are different conditions than the 1966 conditions referred to by Dr. Belza and Dr. Fuller.

Based on the probable 1966 diagnosis from Drs. Belza and Fuller, we conclude that claimant's current back and neck conditions are not the "same conditions" as the accepted 1966 injury. Therefore, ORS 656.308(1) is not applicable. When ORS 656.308(1) is not applicable, the last injurious exposure rule applies to assign responsibility. SAIF v. Yokum, 132 Or App 18 (1994); Mary A. Kelley, 47 Van Natta 822 (1995).

The "last injurious exposure rule" provides that where, as here, 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, 241 (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 began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994). 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).

In October 1966, while working for Ross Electric, claimant fell more than two stories and landed flat-footed on the ground. Claimant testified that he "was hurting all over" and he sought medical treatment on the day of his injury. (Tr. 46). Claimant said that his back was x-rayed and the doctor told him to stay home and stay in bed for awhile and to go back to work when he felt better. (Id.) Claimant did not receive any other medical treatment after that doctor's visit. (Id.) Claimant testified that he was off work several weeks and when he went back to work, his back and neck were painful. (Tr. 47, 48).

Dr. Belza testified that claimant's 1966 injury was the direct and material cause of claimant's current need for medical treatment for his neck and low back conditions. (Ex. 58-54). Dr. Belza also believed that claimant's fall in 1966 started the pain syndrome in his neck and low back. (Ex. 58-56). Drs. Watson and Dinneen reported that claimant had a "[h]istory of cervical and lumbar strain phenomenon, associated with degenerative spondylosis at both levels, onset 1966." (Ex. 53). Drs. Watson and Dinneen opined that claimant's symptoms originated from 1966. (Id.)

Although Drs. Fuller and Snodgrass believed that claimant's automobile accident and the March 1994 work incident were the major contributors to claimant's current conditions, they suspected claimant may have had a slight compression fracture of L1 resulting from the fall of 1966. (Exs. 48, 49). In a subsequent report, however, Dr. Fuller reviewed the records in connection with claimant's 1973 motor vehicle accident and found that the new information suggested that claimant had no serious injury to his neck or back in 1966. (Ex. 52).

We are not persuaded by Dr. Fuller's conclusion that claimant's 1973 treatment suggests that claimant had no serious neck or back injury in 1966. The 1973 medical records indicate that Dr. Van Olst, the knee surgeon, was focused on treatment for claimant's knee problem and was concerned whether it was still appropriate to perform surgery in light of claimant's motor vehicle accident. (Ex. B). Dr. Van Olst determined that claimant had not suffered any injuries that were significant enough to prohibit going forward with the knee surgery. (Id.) We are not persuaded that the 1973 medical records establish that claimant did not have any residual low back or cervical conditions following the 1966 injury.

We are persuaded by the opinions of Dr. Belza and Drs. Watson and Dinneen that claimant's medical treatment in 1966 was related to his current compensable conditions. Although the record does not establish a diagnosis for claimant in 1966, the preponderance of medical evidence establishes that claimant first began to receive medical treatment for symptoms related to his compensable conditions in 1966. See Timm v. Maley, supra; SAIF v. Kelly, supra. In 1966, claimant was employed by SAIF's insured, Ross Electric. Therefore, we assign initial responsibility for claimant's compensable conditions to SAIF.

SAIF argues that, regardless of which date is the appropriate triggering date for the initial assignment of responsibility, responsibility should shift to Epic because it was the last employer with employment conditions that actually contributed to a worsening of claimant's current conditions. Claimant also contends that he sustained a new injury to his neck while working for Epic's insured.

In order to shift responsibility to a later carrier, the later employment conditions must "contribute to the cause of, aggravate, or exacerbate the underlying disease." Bracke v. Baza'r, supra, 293 Or at 250; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (later employment conditions must have actually contributed to a worsening of the condition). A claimant must suffer more than a mere increase in symptoms. Timm v. Maley, 134 Or App 245, 249 (1995); see Bracke 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").

Claimant has had occasional complaints of left arm and hand numbness and tingling since 1966. (Tr. 51-52, 79, 86, 90-92, 94). In March 1994, claimant's work at Epic's insured, Amelco, involved a lot of underground work and digging and shoveling. (Tr. 58). Claimant noticed pain in his lower back when he started working there and the pain got worse. (Tr. 59). Claimant had difficulty walking because of the low back pain. (Id.) One day claimant picked up a pick and felt a sharp stabbing pain in his left arm. (Tr. 60). In describing the March 1994 work incident, claimant testified:

> "Well, I wouldn't say it is the same pain. It is pain that I've had before, but this was a lot more intense. I've had sharp pains in my arm before when I get a pinched nerve in my back, but this was a lot more intense at that time. But I didn't think of but it was still just another pinched nerve." (Tr. 108).

Claimant sought chiropractic treatment and was taken off work for a week. (Tr. 60). Claimant was subsequently treated by Dr. Belza.

Drs. Fuller and Snodgrass reported that the March 1994 work incident appeared to be the first time claimant had "major" left arm pain and the left arm pain appeared to be a "firm entity." (Ex. 48-6 & 48-7).[1] Drs. Fuller and Snodgrass concluded that the 1994 pick-swinging incident aggravated claimant's neck condition and possibly pathologically worsened his neck. (Id.) In a subsequent report, Dr. Fuller concluded that 1994 work incident provided the major contribution for claimant's cervical and arm pain. (Ex. 49). Drs. Watson and Dinneen opined that claimant's work and the March 1994 injury was the major contributing cause of claimant's need for treatment.[2] (Ex. 53). Although Dr. Belza believed that claimant's 1966 injury contributed approximately 45 percent to claimant's current condition, he testified that the March 1994 injury caused an aggravation of claimant's neck and low back conditions. (Ex. 58-55, 58-61).

We conclude that the medical evidence establishes that claimant's subsequent employment at Epic's insured, Amelco, actually contributed to a worsening of claimant's conditions. See Bracke v. Baza'r, supra; Oregon Boiler Works v. Lott, supra. Therefore, responsibility for claimant's neck and low back conditions shifts to Epic.[3]

Remand

Epic requests that the Board remand the case to the ALJ if we conclude that the record is insufficient to establish the origin of claimant's left arm pain and its relationship to the neck condition. Epic argues that the left arm pain claimant experienced in March 1994 is not a separate condition, as the ALJ found, but a radicular symptom of claimant's cervical symptoms. Claimant agrees that his arm symptoms are a radicular component of his compensable neck condition, but he contends that Epic is responsible.

Drs. Fuller and Snodgrass found that claimant's left arm pain did not seem to be a "firm entity" until 1994 and the first time that claimant had major left arm pain was after the pick-swinging incident. (Ex. 48-6, 48-7). Drs. Fuller and Snodgrass reported that it was possible that the 1994 incident pathologically worsened claimant's neck since he appeared now to have radicular problems in the left arm. (Ex. 48-7). Dr. Belza testified that claimant's left arm problems were consistent with the existence of bony osteophytes at the C5 and C6 vertebrae. (Ex. 58-44).

We agree with Epic that the medical record establishes that claimant's left arm pain is related to his neck condition and is not a separate condition. Consequently, we decline to address Epic's request for remand.

---

[1] Although Drs. Fuller and Snodgrass focused on the 1994 pick-swinging incident based in part on the "absence of pre-existing left arm pain," (Ex. 48-8), it is clear from their report that they had reviewed at least some of claimant's chiropractic reports and concluded that claimant's left arm did not appear to be a "firm entity" until 1994. (Ex. 48-5 & 48-6). The chiropractic reports document occasional left arm and shoulder complaints. (Exs. 1-7). In Dr. Fuller's November 14, 1994 report, he referred to a 1983 report from Dr. Fox and said: "It is evident that [claimant] did not have radicular pain in the left arm as of that date, but did have interscapular pain -- typical of disc degeneration." (Ex. 49-3). Dr. Fuller opined that the left arm pain was new as of 1994 and was related to the pick-swinging incident. (Id.)

[2] Drs. Watson and Dinneen had reviewed claimant's previous records and noted that occasional references were made to left shoulder and arm discomfort and left arm numbness. (Ex. 53-2). They reported that claimant told them that "no substantial symptoms involving left arm complaints were noted" until March 30, 1994. (Id.)

[3] Alternatively, if we assume that claimant first sought treatment for his neck and back conditions while Epic was on the risk, Epic would still be responsible for claimant's conditions. Epic could shift responsibility to a prior carrier by showing that claimant's work activity while the prior carrier was on the risk was the sole cause of claimant's neck and low back conditions, or that it was impossible for conditions while Epic was on the risk to have caused those conditions. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985). As we discussed earlier, the medical evidence indicates that claimant's work activities at Epic actually contributed to his neck and low back conditions. Therefore, Epic has not established that claimant's work activity while a prior carrier was on the risk was the sole cause of claimant's conditions or that it was impossible for conditions while Epic was on the risk to have caused those conditions. Accordingly, Epic would remain responsible for claimant's neck and low back conditions.

Attorney Fee

Claimant cross-appeals, arguing that the ALJ should have awarded the fee of $5,100 requested in the fee petition, since there were no objections. The ALJ awarded an attorney fee of $2,500, to be paid by SAIF and $1,000, to be paid by EPIC. 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 $3,500, payable by Epic. In reaching this conclusion, we have particularly considered the time devoted to the denial issues (as represented by the hearing record), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant is also entitled to a fee on Board review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the denial issues is $1,500, to be paid by Epic. 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 award for services devoted to his unsuccessful cross-request regarding the attorney fee issue.

ORDER

The ALJ's order dated March 20, 1995 is reversed in part and affirmed in part. The SAIF Corporation's denial of responsibility is reinstated and upheld. Epic's denial of responsibility is set aside and the claim is remanded to Epic for processing according to law. The ALJ's $3,500 total attorney fee award shall be paid by Epic. Claimant's attorney is awarded $1,500 for services on review, payable by Epic. The remainder of the ALJ's order is affirmed.

---

November 14, 1995 Cite as 47 Van Natta 2214 (1995)

In the Matter of the Compensation of
**MEREJILDO MEJIA, Claimant**
WCB Case No. 94-00119
ORDER ON REVIEW
Dye & Malagon Associates, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) found that it prematurely closed claimant's injury claim; and (2) set aside its partial denial of claimant's current low back condition. On review, the issues are premature closure and compensability. We affirm.

FINDINGS OF FACT

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

Claimant retained an attorney on December 30, 1992, prior to the January 1993 examinations by Dr. Hazel, not after the Notice of Closure.

Immediately after claimant's September 4, 1992 work injury, x-rays revealed a normal bony and articular structure in claimant's spine from the low back to the neck. (Exs. 2-1, 7-1 and 7-3). Repeat x-rays revealed bilateral spondylolysis at L5 with Grade 1 spondylolisthesis at L5-S1. (Ex. 8). Claimant was referred to Dr. Hazel for evaluation and treatment. Dr. Hazel reviewed the x-rays and did not find any abnormalities. He diagnosed lumbosacral, cervical and thoracic strains. (Ex. 11-2).

In a March 11, 1993 letter, the employer sent the following to claimant:

"The last medical report we received indicates you have not been seen regarding your injury since 1/21/93.

> "If you feel that further medical care is required, please arrange to see your doctor immediately.
>
> "Please check one of the blocks at the bottom of this letter indicating either that you have arranged to return to your doctor or that you have made a complete recovery. * * *
>
> "If we do not hear from you or your doctor within two weeks, we will consider you fully recovered and close your claim subject to the limitations of the law."

The employer did not send a copy to claimant's attorney.

On the same date, the employer sent a Form 828 to Dr. Hazel to indicate, among other things, whether claimant was medically stationary. (Ex. 20). The employer did not send a copy to claimant's attorney.

In December 1993, Dr. Geibel, medical arbiter, found x-ray evidence of bilateral L5 pars defect (spondylolysis) with Grade I L5-S1 spondylolisthesis. (Ex. 21A-2). He also diagnosed chronic neck pain, but found no abnormalities in the cervical or thoracic spine. (Ex. 21A-2).

The presence of a Grade I spondylolisthesis with bilateral spondylolysis at L5-S1 was also confirmed by Dr. Lee, orthopedist. (Ex. 24).

Claimant raised the issue of premature closure in his request for reconsideration and again at hearing.

## CONCLUSIONS OF LAW AND OPINION

We briefly recite the relevant facts. In September 1993, claimant fell at work, injuring his head, neck, low back and buttocks. Dr. Hazel, claimant's attending physician, found no spinal abnormalities. The employer accepted disabling cervical, thoracic and lumbosacral strains. Claimant was reexamined by Dr. Hazel on December 8, 1992 and again on January 21, 1993. Dr. Hazel released claimant to regular work, limited to a 2-4 hour day. Claimant was unable to perform his regular work. After the employer told claimant that there was no other work available, claimant relocated to Texas.

On February 19, 1993, Dr. Hazel reported that claimant's condition was not medically stationary. On March 11, 1993, the employer sent claimant a letter to his Oregon address, stating that, "[i]f we do not hear from you or your doctor within two weeks, we will consider you fully recovered and close your claim subject to the limitations of the law." A copy of this letter was not provided to claimant's attorney.

The employer administratively closed claimant's injury claim by Notice of Closure on April 19, 1993, declaring claimant medically stationary as of April 4, 1993. Claimant requested reconsideration of the Notice of Closure, raising the issue of premature closure and requesting a medical arbiter examination. On December 7, 1993, Dr. Geibel performed an arbiter examination. The Order on Reconsideration affirmed the administrative closure.

On May 2, 1994, subsequent to a definitive diagnosis of bilateral spondylolysis and Grade I spondylolisthesis, the employer issued a partial denial of those conditions, on the basis that they preexisted claimant's injury and were now the major contributing cause of claimant's current low back condition. (Ex. 26).

### Premature Closure

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

The employer closed claimant's claim administratively by Notice of Closure pursuant to OAR 436-30-035. Former OAR 436-30-035(7) (WCD Admin. Order 5-1992) provided that the worker will be presumed to be medically stationary when the worker no longer requires medical treatment, when the worker has not sought medical treatment in excess of 28 days, unless so instructed by the attending physician, and the insurer has notified the worker by letter that claim closure may be requested for failure to seek medical treatment. In his order, the ALJ declined to decide whether the employer appropriately applied the rule. Instead, the ALJ reviewed the medical record and concluded that claimant was not medically stationary at the time of claim closure.

On review, the employer contends that the closure was appropriate both administratively and substantively on three grounds: First, the administrative closure was appropriate; second, claimant failed to prove by a preponderance of the evidence that his accepted conditions were not medically stationary as of April 4, 1993; and third, citing amended ORS 656.268(1)(a), the employer contends it has the authority to close a claim when the accepted injury is no longer the major contributing cause of the worker's combined condition.

The employer closed claimant's claim administratively under the authority of OAR 436-30-035. Accordingly, we address the appropriateness of that closure before turning to the employer's remaining arguments.

In Paniagua v. Liberty Northwest Insurance Corporation, 122 Or App 288, 289 (1993), the court stated that the initial issue to be addressed in administrative closure cases is whether the notice given claimant by an insurer was adequate for claim closure under OAR 436-30-035. Because the Board reviewed the medical reports and determined that the claimant was medically stationary at the time of claim closure, before deciding whether the insurer's notice was sufficient, the court remanded. Id.

On remand, we concluded that, in order to be entitled to claim closure based on a presumption that the claimant is medically stationary, the notice given by the insurer must be in strict compliance with OAR 436-30-035. Bertha Paniagua, 46 Van Natta 55 (1994). In reaching this conclusion, we reasoned that the purpose of this rule is not to penalize the worker for failing to see his or her doctor. Rather, we explained, the rule appropriately allows the claim to be closed based on a presumption that, if the worker needed medical treatment, she would have sought medical treatment. However, "the notice given must clearly and plainly state that the claim will be closed if claimant fails to return to the doctor for treatment." Id.

The notice in Paniagua stated only that the claim would be closed if the claimant or her doctor did not contact the insurer within two weeks. We found that the notice did not comply with the rule and was, therefore, inadequate to allow claim closure based on a presumption that claimant was medically stationary. Id.

Here, the notice is similarly flawed. It advised claimant "[i]f we do not hear from you or your doctor within two weeks, we will consider you fully recovered and close your claim subject to the limitations of the law." It did not clearly and plainly state that the claim would be closed if claimant failed to return to his doctor for treatment within two weeks. Thus, we find the employer's notice inadequate to trigger application of the presumption. See Tammy M. Tallmon, 46 Van Natta 742 (1994); Bertha Paniagua, supra. Consequently, the employer's administrative closure was not proper.[1]

Moreover, even if the employer's closure had been proper, we find that the medical evidence does not support a conclusion that claimant was medically stationary at claim closure. "Medically stationary" means that no further material improvement would reasonably be expected from either medical treatment or the passage of time. ORS 656.005(17). Claimant's condition and the reasonable expectation of improvement are evaluated as of the date of closure. ORS 656.005(17); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The question of claimant's medically stationary status is primarily a medical question requiring competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

Prior to closure, two medical opinions were provided by Dr. Hazel, claimant's attending physician. These medical reports, taken together, are somewhat equivocal as to claimant's medically stationary status. Specifically, on February 19, 1993, Dr. Hazel reported that he had examined claimant on January 21, 1993 and that claimant was not medically stationary at that time. (Ex. 19). On January 21, 1993, Dr. Hazel also released claimant to modified work with a 30 pound lifting restriction for 30 days and authorized physical therapy for 30 days. On March 11, 1993, Dr. Hazel checked a box indicating that he did not know whether claimant was medically stationary, as he had not seen him since January 21, 1993. (Ex. 20).

---

[1] We also note that the employer is forbidden to contact a worker who is represented by counsel, as here, without giving prior or simultaneous written notice to the worker's attorney if the contact affects the termination of the worker's benefits. ORS 656.331(1)(b). ORS 656.331(1)(b) was not amended by SB 369. The employer did not provide a copy of the letter to claimant's attorney. Compliance with the statute may well have negated the need for further litigation on this matter.

In addition, Dr. Geibel, who performed an arbiter's examination in December 1993, found continuing symptoms in the low back and neck and opined that claimant had not reached maximal medical improvement due to his misdiagnosis to date. (Ex 21A-3). In light of these medical opinions, we conclude that claimant was not medically stationary at the time of closure.

Finally, the employer argues that closure was appropriate pursuant to amended ORS 656.268(1)(a) because the accepted injury is no longer the major contributing cause of claimant's combined condition. We disagree.

Assuming without deciding that amended ORS 656.268(1)(a)[2] applies in this case to permit the employer to administratively close claimant's claim, the employer's argument fails. The employer accepted cervical, thoracic and lumbosacral strains. As noted above, the medical evidence indicates that, as of the April 19, 1993 date of closure, claimant was continuing to suffer from the accepted cervical, thoracic and lumbar strains. Moreover, at the time the employer closed the claim, there was no medical evidence that claimant's accepted injury had combined with the preexisting spondylolisthetic condition. Instead, at the time of closure, Dr. Hazel maintained that claimant's spine was normal. Thus, at the time it closed the claim, the employer had no medical evidence to support its contention that it closed the claim because the accepted injury was no longer the major contributing cause of claimant's combined condition.

Because the employer's notice closing the claim administratively was infirm, and because claimant has established that he was not medically stationary at the time of closure, we affirm the ALJ's opinion setting the Order on Reconsideration and Notice of Closure aside as premature.

Compensability

On May 2, 1994, the employer issued a partial denial of claimant's bilateral spondylolysis and Grade I spondylolisthesis on the basis that these conditions preexisted and are unrelated to the accepted strain injury and that these conditions are considered to be the major contributing cause of claimant's current low back condition.

Assuming that the denial was a denial of medical services for claimant's current condition, the ALJ concluded that the major contributing cause test of ORS 656.005(7)(a)(B) is inapplicable to establish the compensability of claimant's spondolytic conditions. Instead, citing Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), and Edward M. Ellison, 47 Van Natta 232 (1995), the ALJ applied a material contributing cause test to find that claimant's current low back condition is compensable.

Subsequent to the ALJ's order, the legislature extensively revised the workers' compensation law. Or Laws 1995, ch 332 (SB 369). The employer contends that amended ORS 656.005(7)(a)(B) controls here. We need not resolve whether amended ORS 656.005(7)(a)(B) applies in this case, because claimant has satisfied the major contributing cause standard.

Under either version of the statute, there must be evidence that: (1) claimant's compensable injury combined with his preexisting spondolytic conditions to cause or prolong disability and a need for treatment; and (2) that the compensable injury is the major contributing cause of the disability or need for treatment of the combined condition. Where, as here, claimant's low back was asymptomatic prior to his work injury, we analyze the relative contribution of each cause, including the precipitating cause. Deitz v. Ramuda, 130 Or App 397 (1994).

Given the length of time before claimant's preexisting condition was definitively diagnosed, we find the causation issue is a complex medical question which must be resolved on the basis of expert medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Bennett v. SAIF, 122 Or App 381 (1993). We generally afford greater weight to the opinions of the claimant's attending physician, absent persuasive reasons not to do so. Weiland v.SAIF, 64 Or App 810 (1983). Here, claimant was originally treated by Dr. Hazel. However, we find persuasive reasons not to defer to his opinion. Dr. Hazel initially opined that claimant did not have the spondylolisthetic condition that was diagnosed by

---

[2] Amended ORS 656.268(1)(a) provides that claims shall not be closed if the worker's condition has not become medically stationary unless the accepted injury is no longer the major contributing cause of the worker's combined condition.

several other doctors and maintained this position throughout his deposition. (Ex. 31A). Moreover, once he acknowledged the presence of spondylolisthesis, he merely categorized it as congenital without further discussion. (Ex. 32).

Other opinions regarding the effect of claimant's injury on his preexisting congenital condition were offered by Drs. Geibel, Lee, Todd and Poulson. In contrast to the opinion of Dr. Hazel, each doctor opined that claimant's fall combined with his spondylolisthetic condition to cause or prolong disability and a need for treatment. (Exs. 24-3, 29, 31, 33, 35-1, 36-2 and 37). Because claimant's injury combined with his preexisting condition, it is claimant's burden to prove that the injury is the major contributing cause of the disability or need for treatment of the combined condition.

We find Dr. Poulson's opinion the most persuasive. Somers v. SAIF, 77 Or App 259 (1986). Dr. Poulson diagnosed claimant's current condition as a chronic unstable spine due to the combination of the September 1992 accident and claimant's spondylolysthesis. He explained the mechanism of the September 1992 fall on claimant's preexisting condition as follows. Spondylolisthesis is a condition in which the ligaments and joints are not stable as in a normal back because there is only soft tissue, rather than a bony bridge, to hold the vertebrae at L5 and S1 together. Thus, this site of instability made claimant more vulnerable to injury. As a result, although the spondylolisthesis is not visibly worse by x-ray, the spine was more severely injured in the fall than a normal spine would be. Dr. Poulson opined that the September 1992 accident was the major contributing cause of claimant's need for treatment. (Ex. 35).

This opinion is supported by that of Dr. Geibel, who also opined that claimant's current symptoms were due to his Grade 1 spondylolisthesis with instability, and that the injury (the fall) was the major precipitating event for his current lumbar symptoms. (Ex. 29). (Dr. Geibel's opinion that claimant's soft tissue injury, i.e., the lumbar strain, probably resolved within six to eight weeks, is not germane to the analysis of the effect of the fall on the spondylolisthetic condition).

Dr. Lee's conclusory opinion that claimant's congenital abnormality is greater than fifty-one percent of his problem is not persuasive, as he does not address the effect of the fall on claimant's spondylolysthetic condition or explain his conclusion. Somers v. SAIF, supra.

We conclude that claimant has met his burden to prove that the September 1992 injury is the major contributing cause of the disability of the combined condition and the major contributing cause of the need for treatment of the combined condition.[3]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

## ORDER

The ALJ's order dated May 3, 1995 is affirmed.[4] For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the employer.

---

[3] We note that the employer also contends that, pursuant to Section 3 of SB 369, in an accepted injury claim, disability solely caused by or medical services solely directed to a worker's preexisting condition, are not compensable unless work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition. Here, disability and medical services are required by a combined condition, as established above. Assuming without deciding whether Section 3 applies in these circumstances, the medical evidence also indicates that claimant's preexisting condition has pathologically worsened. Moreover, because claimant has proven the compensability of his claim under the major contributing cause standard, we decline to address the employer's argument regarding the applicability of Jocelyn, supra, Ellison, supra, or Beck v. James River Corp., 124 Or App 484 (1993), rev den 318 Or 478 (1994), to this matter.

[4] Because the claim remains in open status, and the carrier is processing the open claim according to law, we vacate that portion of the ALJ's order correcting the periods of substantive temporary disability awarded in the Order on Reconsideration.

In the Matter of the Compensation of
**EILEEN F. ROBERTS, Claimant**
WCB Case No. 95-02942
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's low back injury claim. On review, the issue is whether claimant's injury was in the course and scope of her employment.

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

Based on her analysis of the parties' testimony, including an assessment of credibility, the ALJ concluded that claimant's injury occurred in the course and scope of her employment. The ALJ also concluded that claimant had established medical causation based on Dr. Willey's undisputed medical report.

On review, SAIF contends that Dr. Willey's medical report is insufficient to establish medical causation. Claimant argues that SAIF is precluded from raising the issue of medical causation on review. We agree with claimant.

SAIF denied claimant's low back injury claim on the sole ground that the injury did not occur in the course and scope of her employment. The denial did not include language stating that SAIF was not waiving any further questions regarding compensability. (Ex. 5). Moreover, at hearing, the parties agreed that the issue before the ALJ was course and scope. (Tr. 5). The entire hearing focused on the time, place and circumstances of the injury, including claimant's credibility and the nature of her work duties, and not on her medical condition.

Consequently, despite the ALJ's findings regarding medical causation, we conclude that the issue of medical causation had not been raised at hearing. We conclude that it would be fundamentally unfair to decide the case on a different basis than that argued while the record was open. Donald A. Hacker, 37 Van Natta 706 (1985) (Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue; such an opportunity does not exist if there is no notice that the issue is in controversy); compare Judith M. Morley, 46 Van Natta 882 (1994) (Where parties try an issue by implicit agreement, the issue is properly before the ALJ). Accordingly, we decline to address SAIF's arguments on that issue for the first time on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

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 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 July 7, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
**DAN D. CONE, Claimant**
WCB Case Nos. 94-01799 & 94-01423
ORDER ON RECONSIDERATION
Terry & Wren, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

The self-insured employer requested reconsideration of that portion of our May 26, 1995 Order on Review that set aside its denial of claimant's occupational disease claim for his current low back condition. Specifically, the employer requests that we reconsider our decision under the new statutory standards established by Senate Bill 369, which took effect on June 7, 1995. Or Laws 1995, ch 332 (SB 369). In order to allow claimant an opportunity to respond, we abated our order on June 26, 1995. We have received claimant's response and now proceed with our reconsideration.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact with the following exceptions: (1) Dr. Henbest (neurologist) was providing conservative treatment for claimant's low back condition during October 1993; (2) there is no medical evidence that a horse plowing exhibition in October 1993 independently contributed to claimant's low back condition; and (3) we do not adopt the second Ultimate Finding of Fact.

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the facts. Claimant has been working for the employer since 1980. Until 1986, claimant performed heavy labor moving 100 pound bags of sugar ("throwing sugar"). After 1986, claimant's work duties became seasonal. He worked as a welder from February to September and the remainder of the year was spent performing light work.

Claimant suffered a compensable low back strain in June 1985, which the employer accepted as a nondisabling injury. Since then, he has had persistent low back pain with occasional numbness and tingling in his legs. (Ex. 37-1; tr. 70, 90). Claimant treated conservatively with chiropractor Dr. Williams. (Ex. 4).

In September 1992, due to increasing pain in the low back and legs, claimant was referred to neurosurgeon Dr. Henbest. (Ex. 14). Dr. Henbest released claimant from work and ordered MRI scans, which revealed lateral disc protrusions/herniations at L4-5 and L5-S1, on the left. (Exs. 14, 16). Dr. Henbest released claimant for modified work and prescribed conservative treatment. (Ex. 16). In March 1993, myelogram CT scans showed a worsening of the low back condition, with large disc herniations at L4-5 and L5-S1, on the left. (Exs. 21, 22). After conservative treatment proved unsuccessful in relieving low back symptoms, Dr. Henbest performed surgery to remove the ruptured L4-5 disc on January 4, 1994. (Exs. 40-43). He did not operate on the L5-S1 disc herniation because it was asymptomatic. (Ex. 40). Following surgery, claimant's radicular symptoms were relieved. (Ex. 44).

Claimant filed alternative claims for the low back condition against the employer; one claim was for a new occupational disease, and the other claim alleged his condition was compensably related to the accepted 1985 injury. The employer denied both claims.

In our prior order, we reasoned that, although claimant has worked for the same employer, we still apply the same "responsibility" principles of ORS 656.308(1) in determining under which claim--the 1985 claim or the new occupational disease claim--claimant's low back condition will be processed. See David L. Large, 46 Van Natta 96 (1994); Peggy Holmes, 45 Van Natta 278 (1993). Applying those principles, we found that claimant's 1985 work accident caused a lumbar disc injury which worsened (resulting in a disc herniation) due, in major part, to claimant's subsequent work activities with the employer. We therefore concluded that claimant had carried his burden of proving the compensability of his low back condition as a new occupational disease claim.

Occupational Disease Claim

Subsequent to issuance of our prior order, the occupational disease statute, ORS 656.802, was amended by the 1995 Legislature. SB 369, § 56. Those amendments apply retroactively to this case. See SB 369, § 66(1); Volk v. America West Airlines, 135 Or App 565 (1995). Amended ORS 656.802(2)(b) provides:

"If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease."

"Preexisting disease" is defined as:

"[A]ny 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...." Amended ORS 656.005(24) (SB 369, §1).

Here, claimant's occupational disease claim rests on the theory that work conditions worsened his 1985 low back injury, resulting in the herniated disc condition and resultant need for surgery. Under that theory, claimant is asserting that the 1985 injury contributed to his need for surgery. He is also asserting that the repetitive microtrauma of his work conditions subsequent to the 1985 injury caused a worsening of that injury. Inasmuch as the "onset" of claimant's occupational disease claim is the worsening of his low back condition caused by work conditions after the 1985 injury, we find that the 1985 injury constitutes a "preexisting disease" within the meaning of amended ORS 656.005(24).

Claimant argues that the onset of his occupational disease claim was the 1985 accident itself. We disagree. The 1985 low back injury was already accepted by the employer as a nondisabling claim. Hence, in order for claimant to prove a new occupational disease claim involving the same low back injury/condition, as opposed to an aggravation of the 1985 injury, he must show that a "series of traumatic events or occurrences" subsequent to the 1985 injury[1] caused a worsening of the 1985 injury/condition. We believe this analysis is the most reasonable application of the "responsibility" principles of ORS 656.308(1) to the same-employer context.[2] See Peggy Holmes, supra.

Because claimant's occupational disease claim is based on a worsening of a preexisting disease, he must prove that "employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." Amended ORS 656.802(2)(b). Hence, it is no longer sufficient for claimant to prove that work conditions were the major contributing cause of the worsening of the preexisting disease; he must also prove that work conditions were the major contributing cause of the "combined condition" itself. The "combined condition" in this case is the herniated disc condition, which resulted from the combination of the 1985 injury and the repetitive microtrauma of his subsequent work conditions. Therefore, claimant must prove that "post-1985" work conditions were the major contributing cause of the herniated disc condition.

Because the application of the "major contributing cause" standard is complicated and involves multiple potential causes, we find that the issue is a complex medical question which must be resolved on the basis of expert medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 281 (1993). The medical evidence in this case was generated by Drs. Williams, Henbest, Bills and Burton.

None of the doctors opined that "post-1985" work conditions were the major contributing cause of the herniated disc condition requiring surgery. Dr. Williams, the treating chiropractor, opined that the 1985 injury and subsequent work trauma were the reasons for the herniated disc condition. (Ex. 56). However, Dr. Williams did not indicate that the "subsequent work trauma" itself was the major contributing cause of the herniated disc condition.

---

[1] Ordinarily, we would look to work conditions subsequent to closure of the initial injury claim to determine whether a new occupational disease claim had been established. See Chella M. Morton, 43 Van Natta 321 (1991). In this case, however, the 1985 injury claim was accepted as nondisabling, and the employer was therefore not required to close the claim under the law then in effect.

[2] We are mindful that ORS 656.308(1) was also amended by the 1995 Legislature. SB 369, § 37. However, those amendments do not affect our analysis or result in this case.

Dr. Henbest, the treating neurosurgeon, opined that the 1985 injury was the major contributing cause of the disc condition and that the subsequent insults at work and in recreation were a material contributing cause. (Ex. 53). Dr. Bills, the examining orthopedic surgeon, could not attribute the development of the herniated disc condition, in major part, to claimant's work activity. (Ex. 50-4). Dr. Burton, examining neurologist, did not render an opinion relating the herniated disc condition, in major part, to work conditions. (Exs. 51, 54).

Based on the medical record in this case, we find no expert medical evidence which attributes claimant's herniated disc condition, in major part, to claimant's work conditions after the 1985 injury. Absent such evidence, we conclude that claimant has not carried his burden of proving an occupational disease claim under amended ORS 656.802(2)(b).

Medical Services

We now turn to claimant's claim that his herniated disc condition is compensably related to the accepted 1985 injury. The employer contends that, under amended ORS 656.245(1)(a), claimant must prove that the 1985 injury was the major contributing cause of the herniated disc condition. See SB 369, § 25. Claimant responds that Section 25 of SB 369 does not apply retroactively to this case, and alternatively, that the "material contributing cause" standard is applicable to his claim. We need not resolve this particular statutory dispute because we find that, even if the "major contributing cause" standard was applied, claimant has carried his burden of proof.[3]

As we noted above, Dr. Henbest, the treating neurosurgeon, opined that the 1985 injury was the major contributing cause of the herniated disc condition. (Ex. 53). He explained that claimant sustained a disc bulge as a result of the 1985 injury and that subsequent trauma to the back (at work and in recreation) resulted in further disc deterioration and, ultimately, disc herniation. (Ex. 53). In other words, Dr. Henbest implicated the 1985 injury as the primary factor leading to the disc herniation.

Drs. Bills and Burton, on the other hand, saw no relationship between the 1985 injury and the disc herniation. However, neither doctor persuasively rebutted Dr. Henbest's opinion that the 1985 disc bulge predisposed claimant for the disc herniation. Dr. Bills could not relate the 1985 bulging disk and injury as the major contributing cause of claimant's January 1994 herniated disc/surgery. In fact, Dr. Bills identified no primary factor contributing to the disc herniation. Moreover, although Dr. Bills implicated degenerative disc disease as a contributing factor, he did not discuss the role of the 1985 disc bulge in the progression of the degenerative disc disease over the seven years preceding the disc herniation. Finally, Dr. Burton did not support a relationship between claimant's 1985 injury and his present problem. Yet, Dr. Burton further stated that a disc bulge may or may not make the disc more susceptible to herniation, (Ex. 54-5); however, he did not explain why he did not believe that was the case here.

After reviewing the aforementioned opinions, we find that, as claimant's treating surgeon, Dr. Henbest's opinion is better-reasoned, complete and, therefore, most persuasive. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988); Somers v. SAIF, 77 Or App 259, 263 (1986). Accordingly, we find that the 1985 injury was the major contributing cause of the disc herniation requiring surgery. The employer's January 24, 1994 partial denial of claimant's medical services claim is therefore set aside.

Attorney Fees

The ALJ awarded claimant's attorney an assessed fee of $2,400 under ORS 656.386(1) for efforts at hearing in setting aside the employer's partial denial of claimant's medical services claim. Claimant cross-requested review, asking that we increase the ALJ's assessed fee award if we found his occupational disease claim compensable. Inasmuch as we have affirmed the ALJ's determination that claimant has not proven his occupational disease claim, we need not address claimant's contention.

---

[3] We also need not decide whether, as claimant alleges, the application of the "major contributing cause" standard to claims involving preexisting conditions is in violation of the Americans With Disabilities Act, or whether retroactive application of Section 25 of SB 369 would violate claimant's due process rights under the U.S. Constitution.

However, claimant's attorney is entitled to an assessed fee for defending against the employer'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 assessed attorney fee for claimant's counsel's services on review and on reconsideration is $1,700. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief, his response to the employer's petition for reconsideration, and claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved. We have not considered claimant's attorney's services on cross-appeal regarding the occupational disease claim and services regarding the attorney fee issue. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986) (attorney fees are not "compensation" for purposes of awarding attorney fees).

Accordingly, in lieu of our May 26, 1995 order, the ALJ's order dated June 30, 1994 is affirmed. For services on Board review and on reconsideration, claimant's attorney is awarded an assessed fee of $1,700, payable by the self-insured employer.

---

November 15, 1995 Cite as 47 Van Natta 2223 (1995)

In the Matter of the Compensation of
**MARK E. COOPER, Claimant**
WCB Case No. 94-05070
ORDER ON RECONSIDERATION (REMANDING)
Daniel Snyder, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our June 14, 1995 Order on Review that found the claim prematurely closed. On July 7, 1995, we abated our order to allow claimant an opportunity to respond. Claimant's response has been received, and we proceed with our reconsideration.

In our June 14, 1995 order, we concluded that the employer improperly administratively closed claimant's claim pursuant to former OAR 436-30-035(7).[1] (WCD Admin. Order 5-1992). In reaching this conclusion, we found that the employer's notice to claimant failed to strictly comply with former OAR 436-30-035(7). Therefore, we found that the notice was inadequate to trigger the presumption of medically stationary status. Alternatively, we also determined that claimant's compensable low back condition was not medically stationary at claim closure.

On reconsideration, the employer argues that the recently enacted amendments to ORS 656.268(1) made by Senate Bill 369 apply to this case and result in a finding that the claim closure was proper. In addition, it argues that our alternative analysis regarding claimant's medically stationary status at claim closure has been "retroactively overruled" by these amendments.

The 1995 Legislature recently amended ORS 656.268(1). Or Laws 1995, ch 332, §30 (SB 369, §30). Amended ORS 656.268(1) provides, in relevant part:

> "(1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed if the worker's condition has not become medically stationary unless:
>
> "* * * *

---

[1] Former OAR 436-30-035(7) provides that the worker will be presumed to be medically stationary when the worker has not sought medical treatment in excess of 28 days, unless so instructed by the attending physician, provided that the carrier has notified the worker that claim closure would occur due to the worker's failure to seek medical treatment. Pursuant to Paniagua v. Liberty Northwest Insurance Corporation, 122 Or App 288 (1993), and Bertha Paniagua, 46 Van Natta 55 (1994), the notice given by the carrier must be in strict compliance with former OAR 436-30-035 in order for the medically stationary presumption to apply.

"(b) Without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control."

Under former ORS 656.268(1), a claim could not be closed if the worker's condition was not medically stationary. However, under amended ORS 656.268(1)(b), a claim can be closed without the worker's condition being medically stationary where the worker fails to seek medical treatment for 30 days without the attending physician's approval, and the worker fails to affirmatively establish that such failure was beyond his or her control.

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). Because amended ORS 656.268(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.[2]

Claimant argues that it is "unreasonable" to retroactively apply amended ORS 656.268(1)(b) to his claim, contending that he should not be retroactively required to have considered whether his cessation of medical treatment was with the "approval" of his attending physician when the law at the time did not require consideration of that question. We disagree with claimant's argument.

In Ida M. Walker, 43 Van Natta 1402 (1991), we examined the issue of the retroactive application of 1990 amendments to the Workers' Compensation Law. We determined that the 1990 Act generally applied retroactively to existing claims, with the exception of those "saved" by the litigation savings clause or specific exceptions provided in other sections. However, we concluded that the legislature did not intend the new law to be applied retroactively 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.

Claimant's contention that it is "unreasonable" to retroactively apply amended ORS 656.268(1)(b) to his claim is similar to the standard developed in Walker. However, applying the Walker standard, we find that retroactive application of amended ORS 656.268(1)(b) does not produce an absurd or unjust result inconsistent with the purposes and policies of the Workers' Compensation Law. In this regard, prior to the 1995 amendments, claimant's claim could be closed by rule based on a presumption of medically stationary status when claimant had not sought treatment for a period of more than 28 days "unless so instructed by the attending physician." Former OAR 436-30-035(7); Paniagua v. Liberty Northwest Insurance Corporation, supra; Bertha Paniagua, supra.[3] Thus, prior to the enactment of amended ORS 656.268(1)(b), claimant was on notice that his claim could be closed if he failed to seek medical treatment without his attending physician's approval. Accordingly, retroactive application of amended ORS 656.268(1)(b), which permits claim closure under essentially the same circumstances as

---

[2] 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 ORS 656.268(1) does not alter a procedural time limitation, section 66(6) does not apply to this case.

[3] We disagree with Member Hall's interpretation of the Paniagua holding. We concur that the court did not overrule the fundamental premise that the merits of a premature closure issue remained irrespective of the procedural closure issue. Yet, the precise holding of Paniagua is that the procedural closure issue must be first addressed, before review of the merits of the premature closure issue can proceed.

Here, consistent with the Paniagua rationale, we are first conducting an analysis of the procedural closure issue. Because we consider that issue to be insufficiently developed and since we have found compelling reasons to justify such an action, we have remanded for further evidence taking. When remand is completed, it is entirely possible that both claim closure issues (procedural and merits) will eventually be examined. Nevertheless, to address the merits of the premature closure issue prior to review of the procedural issue would be in direct conflict with the Paniagua holding.

the prior rule, does not create an unjust or absurd result.[4] Therefore, we conclude that amended ORS 656.268(1)(b) applies to claimant's claim.

However, contrary to the employer's argument, application of amended ORS 656.268(1)(b) does not necessarily result in a finding that the claim closure was proper. For the reasons discussed below, we find the record insufficiently developed to determine whether claim closure was proper.

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., Helen M. Callendar, 47 Van Natta 1626 (1995) (case remanded to ALJ because record devoid of evidence regarding change in "actual worsening" legal standard regarding aggravation claims enacted by SB 369); 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 656.268(1)(b) went into effect. Although amended ORS 656.268(1)(b) allows for claim closure where the worker is not medically stationary when the worker fails to seek medical treatment for 30 days without the attending physician's approval, it does not allow for such closure where the worker affirmatively establishes that such failure was beyond his or her control. The record is devoid of either documentary or testimonial evidence regarding whether claimant's failure to seek medical treatment was attributable to reasons beyond his control.

Under the circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant's failure to seek medical treatment was for reasons beyond his control. Moreover, because amended ORS 656.268(1)(b) 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's failure to seek medical treatment was for reasons beyond his control.

---

[4] Dissenting Member Hall contends that retroactive application of the amended statute would produce an absurd and unjust result. This conclusion is based on the proposition that claimant "cannot be expected to comply with a requirement that was not enacted for almost two years after the fact." We disagree with such reasoning.

As discussed below, unlike in Rick A. Webb, supra, claimant is not being required to complete a form that did not exist at the time in question. Rather, we are merely examining the reasons for his conduct (i.e.; his failure to seek medical treatment for a specified period).

Had we proceeded to a retroactive application of the amended statute without first remanding the case for further development and then found that claimant had failed to satisfy the requisite criteria contained in the statute, we would concur that such a conclusion would be unjust. Without prior notice that such a statutory standard was required and no opportunity to subsequently present relevant evidence, claimant would have been unfairly precluded from explaining his conduct prior to claim closure.

In contrast to the aforementioned scenario, our reasoning achieves a fair and reasonable outcome. In remanding the case for further development, claimant is not prevented from only presenting documentary or testimonial evidence which was already in existence during the period that he neglected to seek medical treatment. To the contrary, he, as well as the employer, will have the opportunity to submit whatever admissible evidence they can garner to assist the ALJ in determining whether claimant's failure to seek medical treatment was "attributable to reasons beyond [his] control." Although some of this evidence may already have been generated during the relevant period, it is likely that most of such evidence will be developed at the remand hearing (particularly since the pivotal question pertains to claimant's reasons for failing to seek treatment). In any event, since neither parties' opportunity to develop the record on this pivotal question is being curtailed, we cannot agree with the dissent's assessment that our decision produces an absurd and unjust result.

In reaching this conclusion, we note that claimant urges us to infer that he had the "tacit" or "implied" approval of the attending physician to fail to seek treatment based on the fact that he did not seek treatment for a period of several months. We decline to infer that failure to seek treatment, without more, necessarily means that the attending physician approved of such failure. However, because we are remanding the matter for further development regarding whether claimant's failure to seek treatment was for reasons beyond his control, we consider it appropriate to allow the parties an opportunity on remand to present additional evidence and argument regarding any approval, or lack thereof, from the attending physician for claimant's failure to seek medical treatment.

Finally, in his response to the employer's request for reconsideration, claimant requests that we reconsider our decision that his L3-4 disc herniation is not compensable. After conducting our reconsideration and reviewing claimant's motion and arguments, we have nothing further to add to our prior order regarding the compensability issue. Consequently, we adhere to and republish that portion of our June 14, 1995 order which dealt with the compensability of the L3-4 disc herniation condition.

In summary, we vacate those portions of both ALJ Schultz' October 18, 1994 order and our June 14, 1995 order that dealt with the premature closure issue and remand this case to ALJ Schultz for further proceedings consistent with this order regarding the premature closure issue. 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 on the premature closure issue.

In addition, we affirm that portion of ALJ Schultz' October 18, 1994 order, as supplemented in our June 14, 1995 order, that dealt with the compensability of the L3-4 disc herniation condition, and we adhere to and republish that portion of our June 14, 1995 order which dealt with that compensability issue.

IT IS SO ORDERED.

**Board Member Hall concurring in part and dissenting in part.**

I agree with the majority that amended ORS 656.268(1)(b) and former OAR 436-30-035(7) are similar in effect in that both allow claim closure based on a "presumption" of medically stationary status where the worker has not sought medical treatment for a certain number of days without the "approval" or "instruction" of the attending physician. I also agree with the majority that application of amended ORS 656.268(1)(b) does not necessarily result in a finding that the claim closure was proper. However, I disagree with the majority's interpretation of the consequences of these holdings. Therefore, I must respectfully dissent.

Amended ORS 656.268(1)(b) adds a new condition that was not required under former OAR 436-30-035(7). This new condition is the requirement that the worker must "affirmatively establish" that his or her failure to seek medical treatment for a period of 30 days "is attributable to reasons beyond the worker's control." Amended ORS 656.268(1)(b). The majority recognizes that this is a new requirement created by amended ORS 656.268(1)(b) and remands the matter to the ALJ for the submission of evidence regarding whether claimant's failure to seek medical treatment was for reasons beyond his control. At first glance, that may seem like a reasonable method to cure the otherwise absurd and unjust result which flows from the retroactive application of amended ORS 656.268(1)(b). However, on closer examination, I submit that remanding this case provides no cure because there is no escaping the fact that retroactive application of this statute produces an absurd and unjust result.

In this regard, claimant's failure to seek treatment for a 30 day period occurred in 1993, almost two years before the new requirement created by amended ORS 656.268(1)(b) was enacted. In 1993, there was no duty to prove that failure to seek treatment was for reasons beyond the worker's control. See former OAR 436-30-035(7). I submit that claimant cannot be expected to comply with a requirement that was not enacted for almost two years after the fact.

In Rick A. Webb, 47 Van Natta 1550 (1995), the Board applied the reasoning in Ida M. Walker, supra, and concluded that retroactive application of amended ORS 656.273(3) would produce an absurd and unjust result and, therefore, declined to apply that amendment retroactively. There, the relevant portion of amended ORS 656.273(3) created a new requirement that a worker provide written notice of

an aggravation claim in a form and format prescribed by the Director. Given the fact that, at the time the claimant made his aggravation claim, there was no such notification requirement and the insurer had not previously challenged the aggravation claim on the basis of lack of notification, we concluded that it would be absurd and unjust to require the claimant to use a Director's form that was not even in existence at the time he made his aggravation claim.

The same reasoning applies here. It is simply absurd and unjust to require claimant to comply with a requirement that was not in existence at the time he failed to seek medical treatment. As the Board has previously recognized, 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, 47 Van Natta 1328 (1995) (citing Satterfield v. Satterfield, 292 Or 780 (1982), and Ida M. Walker, supra). Such would be the result here if amended ORS 656.268(1)(b) were applied.

For these reasons, I disagree with the majority's decision to remand this case for application of amended ORS 656.268(1)(b). Instead, under these circumstances, I find a reasonable basis for departing from a literal reading of Section 66 of Senate Bill 369. Therefore, I would decline to retroactively apply amended ORS 656.268(1)(b). In the alternative, I would find that claimant's inability to anticipate a new rule of law nearly two years in advance of its enactment affirmatively establishes a reason "beyond the worker's control" for his failure to get the attending physician's approval to not seek treatment for a period of 30 days.

In any event, a more important point is that an administrative closure, even if properly implemented, does not preclude a worker from proving on the merits that his or her claim was prematurely closed. After all, an administrative closure is based on a presumption that a worker not seeking medical treatment for a certain period of time, without the attending physician's approval, must not need such treatment and, therefore, can be presumed to be medically stationary. However, this presumption may be rebutted by evidence that the worker was not medically stationary at claim closure. In other words, whether by rule or statute, an administrative closure is a claims processing mechanism; such a closure does not affirmatively establish that a worker's condition is medically stationary.

I reach this conclusion based on the following reasoning. To ascertain what the legislature intended when it enacted ORS 656.268(1)(b), I 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 legislatures' intent, I 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, I 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)).

Amended ORS 656.268(1)(b) provides, in pertinent part:

> "(1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed if the worker's condition has not become medically stationary unless:
>
> "* * * *
>
> "(b) Without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control."

Under former ORS 656.268(1), a claim could not be closed if the worker's condition was not medically stationary. However, under amended ORS 656.268(1)(b), a claim can be closed without the worker's condition being medically stationary if certain specified conditions are met. On the other hand, amended ORS 656.268(1)(b) refers to the permissibility of closing claims under certain specified

conditions when "a worker's condition has not become medically stationary." (Emphasis added). The statute does not state that a worker is considered medically stationary when those specified conditions are met. To the contrary, ORS 656.005(17) provides the only definition of "medically stationary," and that definition was not changed in Senate Bill 369. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

In light of these clear statements by the legislature, I interpret amended ORS 656.268(1)(b) as providing a procedural method for closing a claim where the worker's condition is not medically stationary. This statute does not establish a new definition for "medically stationary," nor does it affirmatively establish that a worker is medically stationary when his or her claim is closed pursuant to amended ORS 656.268(1)(b). ORS 656.005(17) remains the statute that defines "medically stationary" status. Thus, the language of amended ORS 656.268(1)(b) does not support the employer's argument that we should essentially expand this processing statute to be conclusive on the medically stationary issue and to foreclose addressing the merits of the claim.

Finally, I find that the court's decision in Paniagua v. Liberty Northwest Insurance Corp., 122 Or App 288 (1993), supports my general analysis regarding the effects of the procedural closure allowed by amended ORS 656.268(1)(b). In Bertha Paniagua, 44 Van Natta 2289 (1992), claimant contended that her claim was prematurely closed and that notice, pursuant to former OAR 436-30-035(7), was inadequate. The Board first addressed the merits of the premature closure issue, found that the claim was not prematurely closed, and concluded that the notice issue was rendered moot.

In Paniagua v. Liberty Northwest Insurance Corp., supra, the court reversed and remanded the case to the Board for reconsideration based on the parties' concession that the Board should have addressed the alleged irregularity of the notice before reaching the merits of the claimant's contention regarding premature closure. On remand, the Board held that the notice given by the insurer must be in strict compliance with former OAR 436-30-035 in order for the medically stationary presumption to apply. Bertha Paniagua, 46 Van Natta 55 (1994). Because the notice was not in strict compliance with the rule, the Board found that the notice was inadequate to allow claim closure based on a presumption that the claimant was medically stationary. In addition, the Board found that the record was inadequate to justify claim closure on the merits. Id.

Although the court's decision in Paniagua dealt with an administrative closure pursuant to former OAR 436-30-035(7), I find that it supports my general analysis regarding the procedural closure allowed by amended ORS 656.268(1)(b). In this regard, the court did not find that the premature closure issue ended with an analysis of the adequacy of the notice. Instead, it agreed with the parties that that analysis must occur before addressing the merits of the premature closure issue. Thus, Paniagua supports the proposition that a procedural closure does not foreclose reaching the merits of a premature closure issue.[1]

Based on the above reasoning, I would hold that, even if it is eventually determined that claimant's claim was permissibly closed pursuant to amended ORS 656.268(1)(b), claimant may prove on the merits that he was not medically stationary at claim closure. In this regard, the majority and I are in agreement. (See footnote 3 in the majority's opinion). Furthermore, as we found in our initial order, claimant has met his burden of proof on the merits. Therefore, with the preceding supplementation, I would adhere to and republish our June 14, 1995 order, without remanding the case to the ALJ.

---

[1] I respectfully submit the majority misunderstands my reference to Paniagua, supra. I do not take exception with the requirement of determining the "procedural/notice" basis for claim closure before addressing the merits. Rather, I cite Paniagua in response to the employer's argument that the Board's analysis concerning claimant's medically stationary status (i.e., our substantive analysis of the medical merits) has been retroactively overruled by Senate Bill 369. Further, the Paniagua discussion herein is premised on my position that amended ORS 656.268(1)(b) should not be applied retroactively and, thus, our original analysis (both procedurally and substantively) based on the prior law applies. In that analysis, we addressed the procedural issue of the adequacy of the notice before addressing the substantive issue of the medical merits of the closure.

In the Matter of the Compensation of
**DEANNA L. KLOCK, Claimant**
WCB Case No. 94-08902
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that: (1) found that claimant was not entitled to additional temporary partial disability (TPD) benefits; and (2) declined to assess a penalty for the insurer's allegedly unreasonable claims processing. On review, the issues are temporary disability and penalties. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the second paragraph and with the following supplementation.

Claimant's regular job required occasional lifting of 30 to 50 pounds. (Ex. 1; Tr. 13, 14, 32).

Following claimant's August 18, 1993 injury, Dr. Scoltock, her attending physician, took her off work. In September 1993, he released her to modified work with a lifting restriction of 10 pounds and other physical restrictions. (Ex. 1A-1). Over the next several months, Scoltock gradually increased the number of hours and decreased the physical restrictions until, on December 14, 1993, he released claimant to work eight hours a day but continued the lifting restriction of 20 pounds. (Exs. 8, 11, 11A, 13).

At the time of injury, the insurer calculated claimant's temporary total disability (TTD) benefits on the basis of a 32.17 hour, five-day work week. (Ex. 14). As of December 15, 1993, claimant was working a reduced hourly schedule. (Exs. 19-2 through 19-5; Tr. 38, 42).

## CONCLUSIONS OF LAW AND OPINION

### Unilateral Termination of Temporary Partial Disability

The ALJ concluded that claimant had been released to regular work and that, therefore, the insurer appropriately terminated claimant's TPD payments as of December 15, 1993. We disagree.

Claimant was compensably injured on August 18, 1993. She was initially seen by Dr. Nelson, her family practitioner, who released her to modified work on August 20, 1993. (Ex. 7). Her condition worsened and she changed physicians to Dr. Scoltock, who subsequently took her off work. (Ex. 1A-1). Dr. Scoltock released her to modified work on September 10, 1993. (Ex. 1A-1). On December 14, 1993, he released her to work eight hours a day but continued the lifting restriction of 20 pounds. (Exs. 8, 11, 11A, 13). The insurer terminated temporary disability payments as of December 15, 1993, on the basis that claimant was no longer losing time from work. The issue here is claimant's entitlement to TPD subsequent to December 14, 1993.[1]

Claimant's claim is in open status; therefore, the issue is claimant's procedural entitlement to temporary disability. A worker is entitled to procedural temporary disability for all periods in which a claim remains open and the attending physician has authorized benefits for temporary disability. OAR 436-30-036(1); Mary A. Lockwood-Pascoe, 45 Van Natta 355 (1993). We conclude that claimant was entitled to TPD benefits from December 15, 1993 until termination is authorized by law.

---

[1] The insurer argues for the first time on review that it had no obligation to resume TTD payments after claimant quit her job on January 11, 1994. Because this issue was not raised at hearing, we decline to address it on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

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 temporary disability benefits. Trevor E. Shaw, 46 Van Natta 1821, on recon 46 Van Natta 2168 (1994). Those requirements were not met here.

Although Dr. Scoltock released claimant to work eight hours a day subsequent to December 14, 1993, he continued to restrict claimant's lifting to 20 pounds. Claimant's regular employment required occasional lifting of 30 to 50 pounds. Furthermore, the fact that claimant was able to perform her job only with the assistance of others to accomplish the 30 to 50 pound lifting requirement is not evidence of a release to regular work. See former ORS 656.268(3)(b). In addition, on January 4, 1994, when Dr. Scoltock increased claimant's lifting restriction to 20 pounds repetitively and 30 pounds occasionally, he noted that he did not intend to give claimant a "full release" until her next appointment at the soonest. (Ex. 13). Accordingly, we conclude that Dr. Scoltock did not release claimant to regular work within the meaning of former ORS 656.268(3)(b). Gary D. Smith, 45 Van Natta 298 (1993) (A restriction on a worker's ability to perform his or her regular work is not a release to return to regular work); see also Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986) (Employer must strictly comply with administrative rule setting forth procedural requirements for terminating TTD). Accordingly, the insurer was not entitled to unilaterally terminate TPD under former ORS 656.268(3)(b). Eulalio M. Garcia, 47 Van Natta 96, 97 (1995); Trevor E. Shaw, supra.[2]

Alternatively, the insurer contends that claimant is not entitled to TPD after December 14, 1994, because she did not lose wages as a result of her injury. Specifically, the insurer contends that she did not lose wages because her hours were reduced for reasons unrelated to her injury. We interpret the insurer's contention to mean that, because the employer reduced claimant's work hours, her wage loss should be calculated based on the lesser amount of hours worked than the amount of hours she worked at the time of injury. We disagree.

Generally, a claimant is entitled to temporary disability compensation if he or she has sustained wage loss as a result of the compensable injury. See RSG Forest Products v. Jensen, 127 Or App 247, 250-51 (1994) (A worker is entitled to interim compensation if he has suffered loss of earnings as a result of a work injury). TTD benefits are based on the wage paid at the time of injury. ORS 656.210; Coombe v. SAIF, 111 Or App 71, 75 (1992). Once the TTD rate is established, it remains constant for the life of the claim, subject only to annual increases. Id. Here, claimant was released to modified work at the time the employer reduced her hours. Because her disability was partial, she was entitled to temporary partial disability benefits. ORS 656.212.

Subsequent to the ALJ's decision in this matter, the Legislature enacted Senate Bill 369, which amended ORS 656.212. SB 369 § 16. Amended ORS 656.212(2), which is applicable to this case,[3] now provides that TPD is to be calculated based on the loss reflected in a comparison of claimant's wages at modified employment with her at-injury wages. Thus, where a claimant's wages at modified employment are the same as the at-injury wages, the calculation of claimant's TPD rate may result in zero. Claimant's at-injury wage was based on a 32.17 hour work week. (Ex. 14). There is no evidence that claimant received her at-injury wage for modified work, which would, theoretically, permit the insurer to calculate claimant's benefits for TPD at a rate of zero. In contrast, the preponderance of evidence indicates that claimant's hours subsequent to December 15, 1993, were reduced by the employer below those that she worked at the time of injury. (Ex. 14; Tr. 30, 36, 37, 38, 42). Such a reduction would indicate that claimant was entitled to a proportionately greater rate of TPD. ORS 656.212(2).

---

[2] Subsequent to the parties' briefing in this matter, ORS 656.268(3)(b) was amended by Senate Bill 369. See Or Laws 1995, ch 332, §§ 80, 66(1) (SB 369, §§ 30, 66 (1)). It now provides that temporary total disability benefits shall continue until "the attending physician advises the worker and documents in writing that the worker is released to return to regular employment." As noted above, the record shows that Dr. Scoltock did not advise claimant and document in writing that she was released to return to regular employment. We need not address the retroactivity of the amended statute here, because we conclude that, under either the former or amended version of the statute, the result would be the same.

[3] See Volk v. America West Airlines, 135 Or App 565 (1995) (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. Cf. Motel 6 v. McMasters, 135 Or App 583 (1995) (Retroactivity exception for procedural time limits applies to responsibility/denial requirements of amended ORS 656.308(2); therefore, apply former law).

We accordingly conclude that the insurer did not have the authority to unilaterally terminate claimant's temporary disability payments by calculating the rate at zero. Consequently, because the insurer improperly terminated claimant's TPD payments after December 15, 1993, claimant is entitled to have her TPD payments reinstated. Accordingly, we reverse the ALJ's decision regarding TPD and remand the claim to the insurer for further processing according to law.

Penalties

Claimant requests penalties and attorney fees for the insurer's unreasonable resistance to the payment of compensation.

Claimant is entitled to a penalty of up to 25 percent of the amounts due if the carrier unreasonable refuses to pay compensation. Amended ORS 656.262(11) (formerly ORS 656.262(10)).[4] Because there is no evidence that the strict administrative requirements for unilateral termination of temporary disability benefits prior to claim closure have been met, and because there is no evidence that claimant's TPD should have been calculated at zero, we conclude that SAIF's termination of temporary disability payments was unreasonable. Claimant is entitled to a 25 percent penalty based on the temporary disability due as of the October 25, 1994 hearing as a result of this order. Claimant's attorney shall receive one-half of this penalty in lieu of an attorney fee. Amended ORS 656.262(11)(a).

ORDER

The ALJ's order dated January 3, 1995 is reversed. The insurer is directed to pay temporary disability benefits beginning from the effective date of its termination of such benefits until termination is authorized by law. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's attorney. A penalty is assessed equal to 25 percent of the temporary disability benefits due and owing as of the October 25, 1994 hearing as a result of this order, to be equally divided between claimant and her attorney.

---

[4] SB 369, §§ 28, 66 (June 7, 1995).

---



In the Matter of the Compensation of
**ARLENE J. KOITZSCH, Claimant**
WCB Case No. 90-13984
ORDER ON REMAND
Craine & Love, Claimant Attorneys
Pamela A. Schultz, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Ins. Co. v. Koitzsch, 135 Or App 524 (1995). The court reversed our order in Arlene J. Koitzsch, 46 Van Natta 2265 on recon 46 Van Natta 2347 (1994), which had awarded a carrier-paid attorney fee under ORS 656.388(1) when claimant obtained an increased permanent disability award following 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 concluded that, under ORS 656.388(1), attorney fees could be paid only from a claimant's compensation award. Consequently, the court has remanded for reconsideration.

Consistent with the court's mandate, we withdraw that portion of our order which granted a $4,000 carrier-paid attorney fee under ORS 656.388(1).

Although the sole issue before the court was the propriety of the carrier-paid attorney fee, claimant raises an issue on remand that pertains to the insurer's actions in processing the claim, i.e., the rate at which the permanent partial disability award is to be paid. Specifically, claimant contends that in light of the passage of Senate Bill 369 (SB 369, § 17), her award of permanent partial disability should be paid at the higher rate of $347.51 per degree (see amended ORS 656.214(2)), rather than the $145 per degree rate that claimant asserts the insurer has paid.

Throughout the extensive litigation in this case, the essential issue has been the extent of claimant's scheduled permanent disability. As previously noted, however, the most recent appeal to the court pertained to the insurer's objection to the carrier-paid attorney fee under ORS 656.388(1). Under these circumstances, it does not appear that the rate of payment for claimant's scheduled permanent disability award was an issue. Consequently, we find that, as this juncture, any ruling regarding the applicable rate for claimant's permanent disability benefits would be premature and advisory in nature. See, e.g., David J. Aronson, 47 Van Natta 1948 (October 6, 1995); see also James J. Sheets, 44 Van Natta 400 (1992). Should claimant disagree with the insurer's actions in paying the permanent disability awarded in this case, she may seek a hearing concerning that matter. See ORS 656.283(1). The issue would be ripe at that time.

IT IS SO ORDERED.

---

November 15, 1995 Cite as 47 Van Natta 2232 (1995)

In the Matter of the Compensation of
**DONALD McNURLIN, Claimant**
WCB Case No. 95-01310
ORDER ON REVIEW
Max Rae, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) set aside its denial of claimant's injury claim for a low back condition; and (2) awarded claimant's attorney an assessed fee of $3,000 for prevailing over the denial. Claimant requests the Board to consider an untimely filed respondent's brief. On review, the issues are timeliness of brief, compensability and attorney fees. We affirm.

## FINDINGS OF FACT

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

In lieu of the ALJ's finding that claimant slipped and fell onto his back on concrete, we find that claimant slipped and fell backward, striking his low back against a wooden step and landing flat on the ground.

## CONCLUSIONS OF LAW AND OPINION

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

### Timeliness of Brief

Claimant's respondent's brief was due on August 21, 1995, 21 days from the date of mailing of the insurer's appellant's brief. OAR 438-11-020(2). Since claimant's respondent's brief was not filed with the Board until August 22, 1995, the brief was rejected as untimely. Claimant moves for reconsideration of this rejection, explaining that the brief was untimely filed because of a calendaring error. He argues that the one-day delay in filing was not prejudicial to the Board review process and should not result in the rejection of his brief.

Ordinarily, the Board will not consider a brief that is untimely filed unless a request for an extension is granted. Extensions of time for filing of briefs are allowed only on written request filed no later than the date the brief is due. OAR 438-11-020(3). Briefing extensions will not be allowed unless the Board finds that extraordinary circumstances beyond the control of the party requesting the extension justify the extension. Id.

Here, claimant did not file a request for briefing extension within the requisite time period. In addition, we do not find claimant's attorney's calendaring error to constitute an extraordinary circumstance beyond the control of the requesting party. Lester E. Sanders, 46 Van Natta 1153, 1154 (1994). Accordingly, we adhere to our prior decision and reject claimant's respondent's brief as untimely.

Compensability

The ALJ found that claimant's October 30, 1994 work injury, when he slipped and fell onto his back while kicking a door closed, combined with his previous low back injury which he suffered in Washington in 1992, resulting in disability and the need for back treatment. Reasoning that ORS 656.005(7)(a)(B) applied to this claim, the ALJ concluded that claimant carried the burden of proving that the 1994 injury was the major contributing cause of his subsequent disability and need for treatment.

On review, the insurer contends that the ALJ erred in concluding that claimant carried his burden of proving compensability. Citing Dietz v. Ramuda, 130 Or App 397 (1994), the insurer argues that the ALJ misapplied the "major contributing cause" standard under ORS 656.005(7)(a)(B). After reviewing the record, we conclude that ORS 656.005(7)(a)(B) does not apply to the facts of this case.[1]

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 these 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, we do not find that the October 30, 1994 injury combined with a preexisting condition to cause or prolong disability or the need for treatment. The medical record shows that claimant's injuries in 1992 and 1994 were to different areas of the low back. The 1992 low back injury was to the L4-5 disc, eventually requiring surgery to fuse the L4-5 disc. (See Exs. 3, 4-1). The 1994 injury, on the other hand, was caused by a direct blow to the upper portion of the low back. Dr. Nelson's examination findings following the 1994 injury revealed a hematoma across the right paraspinal region and approximately L2. (Ex. 4-3). He diagnosed low back bruising, possibly bony contusion and possibly other bony injury, as well as a musculoskeletal strain. (Ex. 4-3). He later reported a diagnosis of "post direct low back trauma with the exacerbation of previous back injury and new bony contusion." (Ex. 6-1).

The ALJ relied on Dr. Nelson's latter report ("exacerbation of previous back injury") as evidence that the 1994 injury combined with the 1992 injury. We read the report differently. The diagnosis merely reflects that claimant continued to have residual symptoms resulting from the 1992 injury. Indeed, claimant testified that, prior to the October 30, 1994 incident, he was continuing to treat conservatively (with hot tub soaks, pain medication and muscle relaxants) for symptoms from the 1992 injury. However, the mere fact that claimant was having symptoms due to the 1992 injury does not prove that the 1994 injury "combined" with the 1992 injury. This is particularly true where, as here, the medical record shows that the 1992 and 1994 injuries were to different areas of the low back.

The ALJ also relied on claimant's 827 form, in which claimant checked a box indicating that the same body part was injured before. (Ex. 11). Again, however, the "same body part" may merely refer to the low back; it does not prove that the 1994 injury "combined" with the previous injury. In this regard, based on the complicated nature of the "combination " issue, we find that this issue is a complex medical question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993). The record is devoid of any persuasive medical opinion stating that there was a "combination" of the 1992 and 1994 injuries. Hence, we conclude the record does not preponderate in favor of such a finding. Absent a finding that the 1994 injury combined with a preexisting condition, claimant need only prove that the 1994 injury was a material contributing cause of his subsequent disability and need for treatment. ORS 656.005(7)(a); Linda K. Trueblood, 46 Van Natta 902, 904 (1994); Gary Stevens, 44 Van Natta 1178 (1992); Mark N. Wiedle, 43 Van Natta 855 (1991).

---

[1] Subsequent to the ALJ's order, ORS 656.005(7)(a)(B) was amended by the 1995 Legislature, effective June 7, 1995. Or Laws 1995, ch 332, § 1. Inasmuch as we conclude that ORS 656.005(7)(a)(B) does not apply to these facts, our analysis and result in this case would be the same under either the former or amended version of the statute.

Dr. Nelson's opinion amply supports a finding that the 1994 injury was a material contributing cause of the subsequent disability and need for treatment. There is no persuasive evidence to the contrary. Accordingly, with the modification that we apply the material, rather than the major, contributing cause standard to the 1994 injury claim, we affirm the ALJ's conclusions and opinion.

Attorney Fees

The insurer also contends that the ALJ's assessed fee award of $3,000 was excessive. However, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $3,000 is a reasonable fee for claimant's attorney's services at hearing. 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 counsel may go uncompensated.

Ordinarily, claimant's attorney would be entitled to an assessed fee for services on review under ORS 656.382(2). However, inasmuch as claimant's respondent's brief was rejected as untimely filed, we conclude that no assessed fee may be awarded under ORS 656.382(2). See Shirley M. Brown, 40 Van Natta 879, 882 (1988).

ORDER

The ALJ's order dated May 19, 1995 is affirmed.

---



In the Matter of the Compensation of
**MICHAEL L. MOORE, Claimant**
WCB Case Nos. 95-00915 & 94-15519
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that upheld the denial of claimant's cervical condition made by the SAIF Corporation on behalf of its insured, Murakami Produce Company. On review, the issue is compensability.

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

On review, the parties agree that ORS 656.005(7)(a)(B)[1] applies in this case. Hence, the dispositive issue is whether the November 4, 1994 work incident was the major contributing cause of claimant's current cervical condition and need for medical treatment. Applying the above statute, the ALJ concluded that it was not. We agree.

Claimant argues that his preexisting cervical condition would not have become symptomatic if not for the November 4, 1994 work incident. Therefore, relying on U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), claimant argues that his current cervical condition is compensable.

Burtis did not set forth a rule of law 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. Indeed, the Court of Appeals has subsequently explained, in Dietz v. Ramuda, 130 Or App 397 (1994) (a decision relied on by the ALJ), that an event which

---

[1] Subsequent to the ALJ's order, Senate Bill 369 (SB 369) was enacted. Or Laws 1995, ch 332 (SB 369). The bill amends ORS 656.005(7)(a)(B). (SB 369, § 1). Here, we need not resolve the applicability of this amendment because, under either version of the statutes, the result would be the same.

precipitates symptoms of a preexisting condition is not necessarily the major contributing cause of those symptoms. There, a claimant experienced a heart attack after an extended period of smoke inhalation. The claimant had been diagnosed with preexisting, although asymptomatic, coronary artery disease. The court agreed with our application of ORS 656.005(7)(a)(B) in determining whether the work incident 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.

In both Burtis and Dietz, the court held that the proper analysis under ORS 656.005(7)(a)(B) turns on whether the medical evidence establishes that the work injury is the major contributing cause of a claimant's current disability and need for treatment. Hence, the application of ORS 656.005(7)(a)(B) is largely dependent on an evaluation of the medical evidence in each case. See Alec E. Snyder, 47 Van Natta 838 (1995); Lance A. Banaszek, 47 Van Natta 361 (1995).

After our review of the record, we agree with the ALJ's conclusion that claimant failed to carry his burden of proving, by a preponderance of the evidence, that the November 4, 1995 work incident is the major contributing cause of his current cervical condition and need for treatment.

ORDER

The ALJ's order dated April 7, 1995 is affirmed.

---

November 15, 1995 Cite as 47 Van Natta 2235 (1995)

In the Matter of the Compensation of
**IRENE E. WELDON, Claimant**
WCB Case No. 95-00576
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral hand and wrist conditions. On review, claimant asserts that the ALJ abused his discretion by declining to continue the hearing to enable claimant to take depositions. On review, the issues are the propriety of denial of continuance and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Propriety of Denial of Continuance

Relying on OAR 438-07-005(3), claimant asserts that the ALJ abused his discretion by declining to continue[1] the hearing to enable claimant to depose Drs. Guido and Rosenbaum. We disagree.

---

[1] Claimant also asserts that the ALJ erred in declining to postpone the hearing. Lacking any evidence of extraordinary circumstances justifying a postponement, OAR 436-06-081, we reject that argument.

An ALJ may continue a hearing on a showing of due diligence in attempting to obtain and present final rebuttal evidence. OAR 438-06-091(3). In Billie L. Thomas, 45 Van Natta 2432 (1993), the claimant received a carrier-requested medical report months before hearing, but did not arrange to cross-examine the author until after the carrier submitted the report to the ALJ as an exhibit. Consequently, the deposition was scheduled for a date after the hearing date. In view of the claimant's receipt of the report well before hearing, we held that due diligence had not been established and that the ALJ did not err by declining to hold open the record for the deposition.

Thomas is directly on point. Here, claimant received the reports of Drs. Rosenbaum and Guido at least three months before hearing. Claimant did not, however, arrange to cross-examine Rosenbaum or Guido until after SAIF submitted their reports to the ALJ as exhibits a month before hearing. As a result, the depositions were scheduled for dates after the hearing date. Because claimant had several months within which to determine whether she wanted to cross-examine the doctors, we conclude, as we did in Thomas, that claimant has failed to establish due diligence in attempting to obtain rebuttal evidence. The ALJ did not abuse his discretion by declining to continue the hearing.

Claimant's reliance on OAR 438-07-005(3) is misplaced. That rule provides that medical reports offered by an insurer will be accepted as prima facie evidence, provided the insurer agrees to produce the expert for cross-examination on the claimant's request.[2] Claimant asserts that, because that language does not specify when a claimant must request to cross-examine the author of a report offered by an insurer, we should hold that she was not required to make such a request until after she had received SAIF's exhibits submission. We disagree.

OAR 438-07-005(3) concerns the effect to be given medical reports offered by an insurer. It does not address the ALJ's discretion to continue a hearing to enable a claimant to cross-examine the author of a medical report offered by an insurer. OAR 438-06-091(3) does. As stated above, because claimant has failed to establish due diligence in attempting to obtain rebuttal evidence, the ALJ did not abuse his discretion under OAR 438-06-091(3) by declining to continue the hearing.

Compensability

Claimant asserts that, based on the existing record, she has established the compensability of her hand and wrist conditions as an occupational disease. We disagree.

Claimant relies on the reports of Drs. Guido, Button and Rosenbaum. Dr. Guido, treating physician, originally diagnosed "[h]and pain, secondary to excessive keyboard work with poor work posture." (Ex. 1a-1). Dr. Button, consulting physician, initially recorded claimant's history of work activities and attributed her condition to her work generally. (See Exs. 2a, 3-2). In a later report, however, Button stated that he was "struck by the lack of any objective physical findings and excessive subjective symptomology." (Ex. 7-1). Further, Button viewed claimant's ongoing symptoms as the result of stress and her "predisposition for heightened awareness for subjective symptomology." (Id. at 2). Dr. Rosenbaum, examining physician, concluded that, in light of claimant's continued symptoms after she left her employment, her current symptom complex was related to her preexisting fibromyalgia, not work. (Ex. 6-4).

On this record, we find that these opinions fail to establish that claimant's work activities were the major contributing cause of her bilateral hand and wrist conditions. ORS 656.802(2). Drs. Guido and Button generally attribute claimant's symptoms to her work; however, they fail to state whether her work is the precipitating or the major contributing cause of her conditions. An event that precipitates symptoms of a condition is not necessarily the major contributing cause of that condition. Dietz v. Ramuda, 130 Or App 397, 401 (1994). Because Guido's and Button's reports could be read to identify only the precipitating cause of claimant's hand and wrist conditions, they do not establish the compensability of those conditions. Moreover, Dr. Button's final report suggests that the conditions for

[2] The rule also authorizes the exclusion of the reports of any medical expert who has refused to make herself or himself available for cross-examination. Here, there is no evidence that any expert refused to make herself or himself available for cross-examination.

which claimant seeks compensation may not even exist. Last, Dr. Rosenbaum's opines that claimant's fibromyalgia, and not her work, is the major contributing cause of her conditions. Those opinions, both separately and as a whole, fail to meet claimant's burden of proof. Accordingly, we affirm the ALJ's decision upholding SAIF's denial of claimant's bilateral hand and wrist conditions.

ORDER

The ALJ's order dated May 5, 1995 is affirmed.

---

November 16, 1995 Cite as 47 Van Natta 2237 (1995)

In the Matter of the Compensation of
**DARAL T. MORROW, Claimant**
WCB Case Nos. 94-10771 & 94-08852
ORDER OF ABATEMENT
Bischoff & Strooband, Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney
Scott Terrall & Associates, Defense Attorneys

Sedgwick James, as claims administrator for the self-insured employer, requests abatement and reconsideration of our October 18, 1995 Order on Review that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. Sedgwick James contends that our opinion is not a correct statement of the applicable law. Specifically, Sedgwick James contends that we failed to address the law of either Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), or ORS 656.308(1).

In order to allow sufficient time to consider the motion, we withdraw our October 18, 1995 order. The SAIF Corporation and claimant are granted an opportunity to respond to Sedgwick James' motion. To be considered, those responses must be submitted 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
**MARTIN L. MOYNAHAN, Claimant**
Own Motion No. 95-0472M
OWN MOTION ORDER ON RECONSIDERATION

Claimant, pro se, requests reconsideration of our September 29, 1995 Own Motion Order in which we declined to reopen his 1988 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery.

On October 10, 1995, we abated our September 29, 1995 order, and allowed the insurer 14 days in which to file a response to the motion. We have received the insurer's response, and proceed with our consideration.

ISSUES

(1) Whether claimant perfected an aggravation claim prior to the expiration of his aggravation rights.

(2) Whether claimant is entitled to temporary disability compensation, under the Board's own motion jurisdiction.

FINDINGS OF FACT

On March 3, 1988, claimant sustained a compensable injury to his left knee. On April 3, 1989, claimant underwent a revision of his left knee arthroplasty. A September 25, 1989 Physical Capacities Evaluation (PCE) recommended that claimant be released to return to work in a sedentary capacity. Claimant was found to be medically stationary on October 11, 1989.

Claimant returned to modified work on October 17, 1989. On October 17, 1989, the employer offered claimant a job consistent with his sedentary work limitations. The employer acknowledged that "this limitation is permanent."

Claimant voluntarily retired from the work force in 1990.

Claimant's claim was first closed by Determination Order on February 20, 1990. A September 17, 1990 Stipulation and Order affirmed that claimant's left knee condition was medically stationary on October 11, 1989, and that the Determination Order of February 20, 1990 "shall otherwise remain affirmed..."

In a September 24, 1994 medical report, Dr. Brooks, consulting physician, opined that claimant did not require physical therapy or consideration of operative treatment.

Claimant's aggravation rights expired on February 20, 1995.

In a June 7, 1995 evaluation, Dr. Chamberlain, claimant's treating physician, recommended a revision to claimant's tri-compartmental knee replacement.

On June 16, 1995, claimant advised the insurer by letter of Dr. Chamberlain's surgery recommendation.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Board's "own motion" authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Aggravation rights expire five years after the first claim closure unless the injury was in a nondisabling status for one or more years after the date of injury, in which case the aggravation rights expire five years after the date of injury. ORS 656.273(4)(a) and (b).

Claimant's claim was first closed by Determination Order on February 20, 1990. That closure was affirmed by a September 17, 1990 Stipulation and Order. Therefore, claimant's aggravation rights expired five years from the February 20, 1990 closure, or on February 20, 1995.

Claimant, by his October 2, 1995 statement, appears to contend that, since the insurer paid for a September 27, 1994 appointment with a physician regarding his left knee condition, the appointment constituted a claim for "aggravation" prior to February 20, 1995, when his aggravation rights on this claim expired. However, in order to perfect an aggravation claim, a report must put the insurer on notice that the requested medical services are for a "worsened condition," and it must be supported by objective findings. See ORS 656.273(1).

In the September 27, 1994 report, Dr. Brooks, consulting physician, opined that:

> "It appears that presently the [claimant] is functioning at a reasonably high level despite his previous knee abnormality and multiple operative treatments. There is no suggestion of loosening of the intercompartmental components.
>
> "The [claimant], at this point, appears not to require formal physical therapy or consideration of operative treatment.
>
> "[Claimant] was given samples of oral anti-inflammatory medications, including Relafen, Lodine and Daypro to use as necessary. The [claimant] was encouraged to return back if there were additional problems which I would not necessarily expect."

We conclude that Dr. Brooks' report is not sufficient to put the insurer on notice that claimant's condition had worsened prior to the expiration of his aggravation rights. See Krajacic v. Blazing Orchards, 84 Or App 127 (1987). The fact the insurer paid for the examination does not obligate it to determine that the examination constituted a claim for aggravation if the results do not indicate a worsening. Accordingly, we find that the case is properly processed under our own motion authority pursuant to ORS 656.278.

Temporary Disability Compensation

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

On June 7, 1995, Dr. Chamberlain, claimant's then-treating physician, opined that "[m]y feeling is that ultimately [claimant] needs a revision to tri-compartmental knee replacement." Thus, we conclude that claimant's compensable condition has now worsened requiring surgery.

Notwithstanding the above, 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 was not in the work force at the time of the current disability on the grounds that: (1) claimant was offered, accepted, and subsequently quit, a position with the employer-at-injury which was modified to take into consideration the restrictions outlined in the Physical Capacities Evaluation report of September 29, 1989; (2) there are no medical records generated which contraindicate that the position offered was not suitable; and (3) claimant chose to retire at age 62, even though permanent, modified and suitable work was made available to him.

Claimant contends that, although he retired in 1990, he did so because he could no longer work as a mechanic and he wasn't "cut out" for office work. Claimant contends that he is currently willing to work, and would be seeking work for which he is trained except that the compensable injury makes a work search futile. Claimant has the burden of proof on this issue and must provide persuasive evidence that he is willing to work and that a work search would be futile because of his compensable condition for the period in question.

In his October 2, 1995 letter, claimant advised that he withdrew himself from the work force in 1990. Claimant stated that the reason he retired at that time "was my inability to do the job that I was hired to do, that of bus mechanic." He stated that even simple tasks, like changing running lights were difficult, required climbing ladders, and he couldn't bend his knee sufficiently to perform "brake jobs." In addition, claimant stated that:

> "I wasn't cut out for office work, nor was I needed there. Since I was 62 at the time, I decided it would be best for all concerned if I took early Social Security retirement, and I did so, even though my plan had been to work full time, at least until I was 65."

In contrast to claimant's contentions, claimant was offered a suitable, modified position in 1989, which he accepted, but voluntarily quit, because he was unable to do the job he was originally hired to do, prior to his injury. In this case, claimant's PCE indicated that "[i]t does not appear feasible for [claimant] to function as a "heavy equipment mechanic." (See PCE of September 29, 1989). There are no subsequent medical reports which would indicate that claimant will ever function again as a mechanic, and, indeed, the PCE indicates that "return to work at the job of injury is not realistic at this time since the worker does not have the functional capacities to perform at the level required on that job."

Claimant's contention that the proposed surgery will enable him to perform work other than sedentary or light category work is contradicted by the evaluators' opinions that claimant's "[p]rognosis for eventual return to medium or heavy range work is poor." There is nothing in the record to indicate that claimant has been able to perform work other than light or sedentary work since 1989.

In addition, the evaluators recommended that claimant be returned to work within the limitations described in the evaluation. The employer complied with the recommendations, and offered claimant a position which was suitable and permanent. There are no medical reports in the record subsequent to the physical capacities evaluation which indicate that the job offered to claimant was unsuitable.

Finally, although claimant has stated in a letter that he is willing to work, it appears that he is only willing to work as a mechanic, a job in which the medical record indicates he cannot realistically function. Although claimant was offered suitable modified work in the past, he quit the position voluntarily. Claimant's unsworn statement that he is willing to work is not persuasive when viewed in the light of his past actions and unrealistic goals.

In addition, claimant stated in his October 2, 1995 letter that:

> "I am sure that Dr. Michael Rodi, who is doing the surgery this month would state that, "a work search would be futile because of claimant's compensable condition for the period in question," if that is necessary."

No opinion from Dr. Rodi or any other current physician regarding whether it is futile for claimant to seek work or regarding claimant's inability to work in general is in the record.

On the record, we do not find that claimant has carried his burden of proving he remained in the work force at the time of disability. Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 29, 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
**ANDRES L. ZAVALA, Claimant**
WCB Case No. 94-14867
CORRECTED ORDER ON REVIEW
Dye & Malagon Associates, Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

It has come to our attention that the Board's November 9, 1995 Order on Review contained a clerical error. Specifically, two lines of a paragraph at the bottom of page 2 were repeated at the top of page 3.

To correct this oversight, we withdraw our November 9, 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 Administrative Law Judge (ALJ) McCullough's order which declined to award temporary total disability benefits from November 2, 1994 through March 2, 1995. In his brief, claimant contends that the case should be remanded to the ALJ to further develop the record in light of amendments to ORS Chapter 656. On review, the issue is temporary total disability. We deny the motion to remand, and affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact and the parties' stipulated facts as adopted by the ALJ.

## CONCLUSIONS OF LAW AND OPINION

Claimant was injured on July 26, 1994. The SAIF Corporation accepted his claim on September 9, 1994.

On November 1, 1994, Dr. Ferguson, attending physician, signed a written release to return to modified work. (Stipulated fact; Ex. 5). On the same date, the employer gave the written work-release to claimant, and offered claimant, in writing, the modified employment. (Stipulated fact; Ex. 4). Claimant failed to return to work on November 2, 1994 as requested, and he declined the written job offer. (Stipulated fact; Ex. 4).

The ALJ, pursuant to former ORS 656.268(3)(c), concluded that the attending physician had given claimant a written release to return to modified work, and that SAIF was justified in terminating claimant's temporary disability compensation.

Subsequent to the ALJ's order, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. ORS 656.268(3) is among the amended provisions. Or Laws 1995, ch 332, § 30(3) (SB 369, § 30(3)). Amended ORS 656.268(3) states in part:

> "Temporary total disability benefits shall continue until whichever of the following events first occurs:
>
> "* * * * *
>
> "(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

Claimant contends that this case should be remanded to the ALJ, in light of the new legal standard set out in ORS 656.268(3)(c), because there is no evidence in the record to establish whether claimant was "advised" by Dr. Ferguson concerning the release to modified employment. We disagree.

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 his brief, claimant acknowledges that, at hearing, both parties stipulated to the facts as set out in the ALJ's order. Specifically, the parties stipulated that claimant's attending physician signed a written release to allow claimant to return to modified work. Furthermore, the record contains the letter signed by Dr. Ferguson that describes the modified job, and states that Dr. Ferguson agrees the position was appropriate for claimant. (Ex. 5). Finally, the parties also stipulated that the employer gave Dr. Ferguson's written release to claimant on November 1, 1994. Finally, claimant does not explain what additional evidence would be presented that would reasonably be likely to affect the outcome of this case.

In light of this evidence, we conclude that the record is sufficiently developed and that, pursuant to amended ORS 656.268(3)(c), claimant was advised by his attending physician of the modified work. Accordingly, we deny claimant's motion to remand, and affirm the ALJ's order.

ORDER

The ALJ's order dated March 28, 1995 is affirmed.

---

November 20, 1995 Cite as 47 Van Natta 2242 (1995)

In the Matter of the Compensation of
**RICHARD G. SHIELDS, Claimant**
WCB Case No. 94-09444
ORDER OF ABATEMENT
Black, Chapman, et al, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

On October 27, 1995, we affirmed that portion of an Administrative Law Judge's (ALJ's) order which set aside the SAIF Corporation's denial of claimant's left leg condition, but reversed that portion of the ALJ's order which assessed a penalty for an allegedly unreasonable denial. Announcing that they have agreed to resolve their dispute, the parties seek abatement of our order to await consideration of their forthcoming proposed settlement.

Based on the parties' representations, we withdraw our October 27, 1995 order. On receipt of the proposed settlement, we shall proceed with our consideration of the agreement. In the meantime, the parties are requested to keep us fully apprised of any future developments regarding this case.

IT IS SO ORDERED.

---

In the Matter of the Compensation of
**JOHNNY C. TINKER, Claimant**
WCB Case Nos. 92-10036 & 92-03014
SECOND ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests 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 fully consider the matter, we abated our order on reconsideration and allowed Maryland Casualty an opportunity to respond. Having received Maryland Casualty's response, we proceed with our reconsideration.

Claimant asserts that Maryland Casualty's denial of his "current condition" did not include an L3-4 or L5-S1 condition. We disagree.

In January 1992, Dr. Kaesche, who began treating claimant in 1982, reported that claimant's multiple level laminotomies and discectomies were the most probable cause of his current back difficulties. (Ex. 30). In addition, Medical Consultants Northwest, in a June 19, 1992 report, diagnosed claimant's current condition as including "post-operative three level lumbar laminectomy and discectomy, L3-S1 as well as "post-operative laminectomy and discectomy at L4-5." (Ex. 36). Finally, on July 9, 1992, Dr. Kaesche, in a letter to Maryland Casualty, noted it was difficult to determine which event or operation was causing claimant's current condition as claimant had undergone surgery on three different levels in his back. (Ex.38). Thereafter, on July 21, 1992, Maryland Casualty denied claimant's current condition. (Ex. 39).

Based on the above, we conclude that claimant's current condition, as denied by Maryland Casualty, included L3-4 and L5-S1 conditions. Consequently, we continue to adhere to our prior decision to uphold Maryland Casualty's denial to the extent that it denied claimant's L3-4 and L5-S1 conditions. Moreover, given the medical evidence which indicated that claimant's current condition was a combination of surgeries and injuries from L3 to S1, it is our obligation as a fact finder to determine what conditions claimant was seeking compensation for in order to determine the appropriate legal standard. See Daniel S. Field, 47 Van Natta 1457, 1458 (1995). Finally, we note that claimant did not challenge Maryland Casualty's prior request for reconsideration on this basis. Rather, claimant indicated that the sole issue was whether, under the facts of this case, "claimant's current condition is compensable, and has been compensable since the 1982 event, regardless of the scope of any prior acceptance." (See Claimant's Response to the Employer's Motion to Reconsider, p. 3).

Accordingly, as supplemented herein, we adhere to and republish our August 31, 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
**DONAT E. FLORES, Claimant**
WCB Case No. 94-14169
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that found that the insurer's partial denial of left carpal tunnel and de Quervain's syndrome conditions was not precluded by its acceptance. In addition, claimant requests review of the ALJ's interim order denying claimant's motion for a "judge-designated, insurer-paid" medical examination under OAR 438-07-005(5). On review, the issues are scope of acceptance (preclusion) and entitlement to an insurer-paid medical examination.

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

We do not adopt the portion of the ALJ's order entitled "Left-Wrist Medical Services." (O&O pp.6-7).

Claimant contends that the insurer's partial denial of claimant's claims for left carpal tunnel and de Quervain's syndrome conditions is precluded by its acceptance. We disagree.

We agree with the ALJ that, with regard to the claims for the left wrist, the insurer did not accept carpal tunnel syndrome or de Quervain's syndrome. (See Exs. 1, 76; O&O p. 5, third full paragraph). Accordingly, we also agree with the ALJ's implicit conclusion that the insurer's partial denial of those conditions is not precluded by its concession that it had accepted a left wrist ganglion condition. (See Ex. 76).

Finally, we find that the ALJ's interim ruling denying claimant's motion for a "judge-designated, insurer-paid" medical examination under OAR 438-07-005(5) was proper. See John M. Ames, 44 Van Natta 684, on recon, 44 Van Natta 916 (1992) (An ALJ should not exercise his or her discretion to provide a basic element of proof).

ORDER

The ALJ's order dated April 17, 1995 and his interim order dated December 27, 1994 are affirmed.

In the Matter of the Compensation of
WCB Case Nos. 94-05322 & 94-03973
**JIM M. GREENE, Claimant**
ORDER ON REVIEW
Max Rae, Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the SAIF Corporation's denial on behalf of Oregon State Hospital of claimant's cervical conditions; and (2) upheld SAIF's denial on behalf of St. Vincent DePaul of claimant's "new injury" claim for the same conditions. On review, the issues are compensability and, alternatively, responsibility.

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

Claimant contends that certain sections of SB 369 violate Article I, section 10, of the Oregon Constitution and the Americans With Disabilities Act (ADA), 42 USCA § 12101 et seq. Particularly, claimant asserts that the "major contributing cause" standard set forth in amended ORS 656.005(7) and 656.802(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 denial of a worker's claim under the 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 cervical claim is compensable. We do not address those arguments for the following reasons.

First, the parties tried the current injury claim theory under former ORS 656.005(7)(a)(B). That statute, which was in effect when the ALJ heard this case, contained the "major contributing cause" and preexisting disease or condition language that claimant objects to now. Consequently, claimant could have raised his constitutional and ADA arguments regarding that language at hearing. Because claimant did not raise those arguments until now, we are not inclined to consider them. Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991). Nevertheless, we have considered and, for the following reasons, reject claimant's arguments.

Claimant asserts that, subsequent to the hearing in this case, the Legislature amended ORS 656.018 to prohibit claimants from bringing civil actions for industrial injuries, Or Laws 1995 ch 332, § 5 (SB 369, § 5), whereas under Errand v. Cascade Steel Rolling Mills Inc., 320 Or 509 (1995), he had the option of bringing an action in civil court if his claim was held not compensable. Therefore, he asserts that, in view of amended ORS 656.018, application of the "major contributing cause" test to his claim will deprive him of a remedy in violation of Article I, section 10, of the Oregon Constitution.

To test that theory, claimant must first demonstrate that he has been injured by operation of amended ORS 656.018. See McKinney v. Watson, 74 Or 220, 223 (1915) (taxpayer required to pay increased taxes had right to challenge constitutionality of legislation effecting tax increase). To do that, claimant must obtain a legal ruling that, under amended ORS 656.018, he is prohibited from bringing a civil action regarding those conditions. Because claimant has not done that, we conclude that claimant's Article I, section 10 challenge fails.

Claimant next asserts that, subsequent to the hearing in this case, the Legislature enacted ORS 656.005(24), which defines "preexisting condition" more restrictively than did the court in Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991), rev den 313 Or 210 (1992). Particularly, claimant asserts that, under Spurgeon, predispositions were not preexisting conditions, while under ORS 656.005(24) they are. See SB 369, § 1.

---

[1] The ALJ analyzed the current condition claim under former ORS 656.005(7)(a)(B). The Legislature recently amended that statute. Or Laws 1995, ch 332, § 1 (SB 369, § 1). The current condition claim fails under both the former and amended versions of the statute for lack of sufficient evidence that claimant's January 1994 work injury was the major contributing cause of his disability and need for treatment.

This case does not involve an alleged predisposition; it concerns a preexisting degenerative spinal condition. Because the distinction that claimant makes between Spurgeon and ORS 656.005(24) does not apply to this matter, we reject claimant's ORS 656.005(24)/Spurgeon argument.

Last, we find claimant's ADA arguments insufficiently developed for our review. Particularly, claimant refers us to 42 USCA § 12102(2), which defines "disability" as "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; * * * (C) being regarded as having such an impairment." Claimant then asserts that his cervical conditions constitute a disability that affects his work, which, according to claimant, "is considered to be a major life activity" for purposes of subsection 12102(2)(A). He also asserts that, under amended ORS 656.005(24), which defines "preexisting condition," he should be regarded as having an impairment under subsection 12102(2)(C). (Claimant's Supplemental Brief at 6). Claimant offers no persuasive authoritative support for those assertions. Consequently, we reject his ADA arguments.

ORDER

The ALJ's order dated March 14, 1995 is affirmed.

---



In the Matter of the Compensation of
**JENICE L. PALMER, Claimant**
WCB Case No. 94-06433
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

On August 24, 1995, we abated our July 26, 1995 order in which we affirmed the Administrative Law Judge's (ALJ's) order finding claimant's medical treatment, for her current right knee degenerative joint disease, compensable under ORS 656.005(7)(a)(B). We took this action to consider the insurer's motion for reconsideration. Having received claimant's response to the insurer's motion, we now proceed with our reconsideration.

The insurer contends that the medical evidence from claimant's attending physician, Dr. Gargaro, establishes that claimant's compensable August 14, 1992 right knee injury was the major contributing cause of her need for treatment only from the date of injury to the date claimant became medically stationary on November 18, 1993. (Exs. 28-18, 20, 25, 26). Therefore, the insurer argues that claimant's right knee condition is not compensable after November 18, 1993.

We agree with the insurer's interpretation of Dr. Gargaro's medical opinion based on the cited portions of his deposition testimony and his August 25, 1994 medical report. The issue then becomes whether the insurer can limit its responsibility for claimant's right knee condition under ORS 656.005(7)(a)(B) in the manner in which it suggests. For the following reasons, we find that it can.

In Pedro C. Rodriguez, 47 Van Natta 710 (1995), on recon 47 Van Natta 871 (1995), the ALJ partially upheld a carrier's denial of the claimant's back/neck condition under ORS 656.005(7)(a)(B) as it pertained to the claimant's current condition. We affirmed the ALJ's decision and rejected the claimant's contention that the ALJ should only have decided whether the initial injury had occurred, not whether his current condition was compensable. We reasoned that it was our task to determine which provisions of the Workers' Compensation Law were applicable. See Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994)); Daniel S. Field, 47 Van Natta 1457 (1995).

In our view, the statement of issues at the hearing in Rodriquez encompassed not only the issue of whether an injury had occurred as the claimant had alleged, but also the compensability of the claimant's neck/back condition. We agreed that the medical evidence established that the claimant's preexisting spinal disease had combined with his compensable injury to prolong his disability and need for treatment. Because the medical evidence also established that the compensable injury was not the major contributing cause of the claimant's need for treatment after November 3, 1993, we found that the claimant's back/neck condition was not compensable after that date.

In this case, we have already determined in our original order that ORS 656.005(7)(a)(B) is applicable. Claimant's counsel described the issue at hearing as "de facto denial of arthritis of the right knee." Counsel further explained that the "theory" was that the preexisting arthritis had been aggravated by the consequences of the accepted industrial injury. (Tr. 1). The insurer's counsel did not disagree with claimant's attorney's description of the issue.

Inasmuch as there was no limitation of the compensability issue under ORS 656.005(7)(a)(B) to a particular time frame, we conclude, as we did in Rodriquez, that the statement of the issues encompassed the compensability of claimant's current condition under ORS 656.005(7)(a)(B). See also Danny B. Conner, 47 Van Natta 705 (1995) ("combined" condition found compensable until the date that compensable injury was no longer the major contributing cause). Compare Laverne J. Butler, 43 Van Natta 2454 (1991) (where denial and the issues presented at hearing were limited to whether the initial injury was compensable, the ALJ did not err in deciding only that issue). Moreover, because we agree that Dr. Gargaro's medical opinion establishes that claimant's compensable injury was no longer the major contributing cause of claimant's need for treatment after November 18, 1993, we conclude that claimant's right knee condition was not compensable after that date. Accordingly, we modify our original order and uphold the insurer's denial for claimant's right knee condition after November 18, 1993.

Therefore, on reconsideration, as modified herein, we republish our July 26, 1995 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

**Board Member Haynes specially concurring.**

I would not have affirmed the ALJ's order finding this claim compensable under ORS 656.005(7)(a)(B). However, I accept the majority's opinion that claimant sustained a compensable right knee injury. Moreover, I agree for the reasons cited in the Order on Reconsideration that the insurer is not responsible for claimant's right knee condition after she became medically stationary on November 18, 1993.

---

November 22, 1995 Cite as 47 Van Natta 2247 (1995)

In the Matter of the Compensation of
**THOMAS E. ANDREWS, Claimant**
WCB Case No. 94-11050
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
John M. Pitcher, Defense Attorney
Emmons, et al, Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) declined to admit medical reports by Dr. Lax because he was unavailable for cross-examination; and (2) upheld the self-insured employer's partial denial of claimant's claim for his current low back condition. On review, the issues are evidence and compensability.

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

The ALJ declined to admit Dr. Lax's medical reports, (Exhibits 35A, 35aa, 37A and 45), reasoning that, because Dr. Lax left the state and had refused to make himself available for cross-examination by the employer, admission of his reports would be contrary to substantial justice. On review, claimant contends that the ALJ erred in excluding Dr. Lax's reports, arguing that the doctor's unavailability for cross-examination was due to the employer's lack of due diligence and to events beyond claimant's control. We disagree.

ALJ's are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the ALJ's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

ORS 656.310(2) provides that the contents of medical reports presented by a claimant for compensation shall constitute prima facie evidence as to matters contained therein, provided that the doctor rendering the reports consents to submit to cross-examination. In addition, OAR 438-07-005(3) provides that "[t]he reports of any medical or vocational expert who has refused to make herself or himself available for cross-examination shall be excluded from the record unless good cause is shown why such evidence should be received." Hence, the doctor's consent to cross-examination is a condition precedent to the admissibility of the doctor's medical reports as prima facie evidence of matters contained therein.

Here, we find that Dr. Lax refused to consent to cross-examination. The employer first received a copy of Dr. Lax's medical report, which attributed the current low back condition to the accepted 1991 injury, in July 1994. In response, the employer sent medical records to Dr. Lax in preparation for telephone conferences. However, Dr. Lax instructed the employer's attorney to call him after August 29, 1994. When the employer's attorney complied with the request, Dr. Lax declined to schedule a telephone conference because his practice had closed.

The employer denied the low back claim on September 9, 1994, and claimant filed a hearing request on September 14, 1994. On September 22, 1994, the Board notified the parties that a hearing in this matter was scheduled for December 6, 1994. After further unsuccessful attempts to arrange a deposition with Dr. Lax, the employer sent claimant's attorney a letter on October 24, 1994, which demanded cross-examination of Dr. Lax and requested claimant's attorney's assistance in arranging a deposition with the doctor. Meanwhile, Dr. Lax had left the state in early October 1994 to start a practice in Ohio. Subsequently, both claimant's attorney and the employer's attorney made repeated attempts to schedule a deposition with Dr. Lax, but the doctor refused to cooperate.[1]

The facts of this case do not show a lack of due diligence on the employer's part. The employer's attorney acted diligently in attempting to arrange a deposition with Dr. Lax after receipt of his reports in July 1994. It was Dr. Lax who requested a delay until after August 29, 1994. When the employer's attorney complied with the request, Dr. Lax refused to cooperate. Thereafter, Dr. Lax moved to Ohio and has not responded to numerous requests by both the employer's attorney and claimant's attorney for a deposition. Although Dr. Lax's refusal to cooperate was a circumstance beyond claimant's control, that factor is outweighed by the prejudicial effect of admitting his reports without a reasonable opportunity for the employer to cross-examine the doctor regarding his opinion.

Therefore, in accordance with OAR 438-07-005(3), Dr. Lax's reports must be excluded from the record, unless there is a showing of good cause why the reports should be received. We find no showing of good cause why Dr. Lax's reports should be received in evidence. Accordingly, we conclude the ALJ did not abuse his discretion in excluding Exhibits 35A, 35aa, 37A and 45.

Furthermore, even were we to consider Dr. Lax's reports, we would still conclude that claimant has not carried his burden of proving the compensability of his current low back condition. Like the ALJ, we find that the opinion of the Western Medical Consultants' panel was based on the most complete history regarding claimant's low back problems, particularly those which preexisted the accepted 1991 injury. They attributed claimant's current condition to the natural progression of degenerative changes in the low back.

Drs. Lax and Moen, on the other hand, opined that the 1991 injury was the major cause of claimant's current low back condition. However, they did not have a complete history of claimant's pre-1991 low back problems. Although Dr. Moen adhered to his opinion even after learning of claimant's pre-1991 low back problems, we find his opinion unpersuasive for the following reasons. His opinion is based on claimant's history of persistent low back pain from the 1991 injury through 1994, a history which is inconsistent with the absence of contemporaneous medical reports of such problems. Dr.

[1] Our factual findings regarding the evidentiary issue are based on the parties' uncontested representations in pre-hearing memoranda and supporting documents which were submitted to the ALJ.

Moen's opinion is also inconsistent with the opinion of Dr. Novak, claimant's treating physician following the 1991 injury, who opined that the 1991 injury was a low back strain which resolved quickly. Dr. Novak also recalled there was no evidence of radiculopathy or other signs of disc injury in 1991. Finally, although Drs. Lax and Moen were claimant's attending physicians, because they did not begin to see claimant until 1994, three years after the 1991 injury, their causation opinions are not entitled to greater weight. Accordingly, we affirm the ALJ's decision to uphold the employer's partial denial.

ORDER

The ALJ's order dated June 28, 1995 is affirmed.

---



In the Matter of the Compensation of
**JULIE BALDIE, Claimant**
WCB Case Nos. 94-12616 & 94-09048
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Janice Pilkenton, Defense Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Jeld-Wen/Windmill Inns requests review of Administative Law Judge (ALJ) Stephen Brown's order which: (1) set aside its denial of claimant's "new injury" claim for a left shoulder condition; and (2) upheld SAFECO/Inn at Otter Crest's denial of claimant's aggravation claim for the same condition. In its brief, SAFECO argues that Windmill Inns' responsibility disclaimer was untimely. On review, the issues are timeliness of disclaimer, compensability and responsibility. We reverse in part and modify in part.

FINDINGS OF FACT

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

On April 19, 1994, claimant saw Dr. Nitzberg, keeping an appointment she had scheduled prior to her April 17, 1994 fall at Windmill Inns.

Claimant's accepted left shoulder condition at SAFECO's insured had not resolved prior to her April 17, 1994 left shoulder injury. The April 17, 1994 injury at Windmill Inns was not the major contributing cause of claimant's need for treatment.

CONCLUSIONS OF LAW AND OPINION

On August 30, 1993, claimant injured her left shoulder while working for SAFECO's insured. SAFECO accepted a left shoulder muscle strain. (Ex. 7). Following the injury, claimant treated with Drs. Forsyth and Konowalchuk for left shoulder problems with chronic pain.

On March 4, 1994, claimant began working for the self-insured employer, Windmill Inns. On April 17, 1994, claimant fell at work, and exacerbated her left shoulder injury. Windmill Inns denied compensability of claimant's current left shoulder injury, and disclaimed responsibility for the condition.

The ALJ, relying on the opinion of Dr. Morrison, orthopedist, concluded that claimant had proved that her April 17, 1994 left shoulder injury, when combined with her preexisting left shoulder strain and calcific deposits, was the major contributing cause of her disability and need for treatment. See former ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590 (1993). We disagree.

Dr. Forsyth was claimant's treating physician following her August 1993 injury with SAFECO. He last treated claimant on February 2, 1994, because claimant was moving away from the area. Nevertheless, because claimant was not medically stationary[1] when she moved, Dr. Forsyth recommended that claimant see a physician in the town to which she was moving. (Tr. 19; Exs. 30, 40-5, 6). Even though claimant's left shoulder continued to bother her after she moved and began her new job with Windmill Inns, claimant stated that she was not able to obtain treatment from a new attending physician until she found a physician who was accepted by an MCO specified by SAFECO. (Ex. 40-5, 6).

Claimant's first scheduled appointment with the new physician, Dr. Nitzberg, was on April 19, 1994, two days after her fall while working for Windmill Inns. (Ex. 18-1). On referral from Dr. Nitzberg, claimant first saw Dr. Morrison on May 2, 1994. Dr. Morrison obtained a history of claimant's August 1993 injury, and reported that claimant felt "that by the 1st of March of this year she had about 95% of her range of motion and was doing reasonably well." (Ex. 18-2). In light of his understanding of claimant's shoulder condition at the time of her first visit, Dr. Morrison opined that claimant's need for treatment resulted from her fall while working for Windmill Inns in April 1994. (Ex. 27). Dr. Morrison subsequently signed a form from SAFECO's attorney agreeing that the major contributing cause of claimant's disability and need for treatment was claimant's April 1994 injury. (Ex. 34).

On July 27, 1994, Dr. Forsyth stated that he could not give a definitive answer as to whether claimant had sustained a new injury, or whether her current condition was related to her prior injury. (Ex. 30). Dr. Forsyth stated that if claimant was able to begin her new employment with Windmill Inns, and not have need for ongoing care until the reinjury, she had reached a point of being medically stationary. (Id). Subsequently, Dr. Forsyth signed a form from SAFECO's attorney agreeing that claimant was medically stationary from her accepted left shoulder injury at the time of her April 1994 injury. (Ex. 35).

On December 15, 1994, Dr. Dickerman examined claimant and thoroughly reviewed claimant's medical records. (Ex. 38). He obtained a history of chronic left shoulder symptoms since August 1993. (Ex. 38-6). Dr. Dickerman specifically asked claimant about Dr. Morrison's statement that claimant's shoulder was 95 percent improved since the August 1993 injury. Claimant did not recall telling Dr. Morrison that her shoulder was so improved since the original injury. (Ex. 38-12). Rather, claimant informed Dr. Dickerman that by the time she saw Dr. Morrison, two weeks after her April 1994 fall, her current shoulder symptoms had returned to their chronic baseline levels before the April 1994 fall. (Ex. 38-5).

Dr. Dickerman diagnosed left shoulder calcific tendonitis which preexisted claimant's August 1993 injury, and left shoulder hyperextension with chronic pain suggestive of chronic calcific tendonitis. (Ex. 38-20). He opined that claimant's current condition is first, in major part, related to the preexisting calcific tendonitis, and second to the August 1993 injury. He stated that the April 1994 work incident only transiently increased claimant's pain syndrome without changing the underlying pathology responsible for the symptoms. (Ex. 38-22).

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). Additionally, we rely on medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986).

Here, Dr. Forsyth, claimant's treating physician for the August 1993 injury, initially stated that he could not give a definitive answer as to whether claimant's condition after the April 1994 injury related to her August 1993 injury because he had not seen claimant since February 1994. Not knowing whether claimant had sought treatment after moving away, Dr. Forsyth opined that if claimant did not have the need for ongoing treatment after she began her employment with Windmill Inns, he would have concluded that claimant was medically stationary. Subsequently, after a conversation with SAFECO's attorney, Dr. Forsyth signed a statement agreeing claimant was medically stationary at the time of her April 1994 fall because she had not sought medical treatment after she left Dr. Forsyth's care. We conclude that Dr. Forsyth's opinion was based on erroneous and/or incomplete information.

[1] On March 15, 1994, Dr. Forsyth estimated that claimant would be medically stationary in May 1994. (Ex. 17).

The preponderance of the evidence indicates that claimant did have continuing left shoulder symptoms since her August 1993 injury. Furthermore, claimant attempted to seek treatment for the shoulder, but she initially could not make an appointment until she located a physician who belonged to the specified MCO. In light of this evidence, we are not persuaded by Dr. Forsyth's conclusory opinion that claimant was medically stationary at the time of her April 1994 work incident. Weiland v. SAIF, supra; Somers v. SAIF, supra.

We find Dr. Dickerman's opinion more persuasive than Dr. Morrison's. Assuming that the statement in Dr. Morrison's initial report concerning claimant's condition by the first of March 1994 was accurately recorded, in light of the preponderance of other medical evidence, we are not convinced that it is correct. Furthermore, Dr. Morrison subsequently reviewed claimant's statement (Ex. 40) that she had not been out of pain since her August 1993 injury. Dr. Morrison agreed that, if claimant testified at hearing consistently with the recorded statement,[2] the major contributing cause of her current need for treatment would remain her August 1993 injury. (Ex. 39). Accordingly, we are not persuaded by Dr. Morrison's conclusory opinion that the major contributing cause of claimant's current disability and need for treatment is her April 1994 work incident.

After our de novo review of the evidence, we conclude that claimant's April 17, 1994 fall at work was not the major contributing cause of her disability or need for treatment. See ORS 656.005(7)(a)(B)[3].

In order for a carrier to shift responsibility to a subsequent carrier under ORS 656.308(1), it must show that the worker sustained a new compensable injury or occupational disease. Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314, 317 (1993). Proof of a new compensable occupational disease requires that the carrier establish that work conditions at the subsequent employment were the major contributing cause of the injury or occupational disease. Id.

Here, based on the foregoing reasoning, we conclude that SAFECO, the insurer with the previously accepted left shoulder injury, has failed to prove that claimant sustained a compensable left shoulder injury in her April 1994 fall while working for Windmill Inns. Accordingly, SAFECO remains responsible for claimant's left shoulder condition. See Smurfit Newsprint v. DeRosset, 118 Or App 368, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).[4]

We now turn to the issue of attorney fees. SAFECO's denial stated, in part: "[Y]our current need for care is related to the March, 1994 slip-and-fall injury while working at the Windmill Inn * * *. Therefore, * * * responsibility for your current condition and need for treatment is denied with regard to responsibility only." (Ex. 29). Because SAFECO did not deny compensability, claimant is not entitled to an attorney fee for services at hearing under former ORS 656.386(1) as against SAFECO. See James D. Lollar, 47 Van Natta 740 (1995) (claimant's attorney entitled to an attorney fee under ORS 656.386(1) if denial raised compensability issue, and claimant's attorney was instrumental in obtaining rescission of compensability portion of denial).

Windmill Inns, however, denied both compensability and responsibility, and stated that it was not requesting the appointment of a paying agent pursuant to ORS 656.307 because compensability of the claim had not been determined. (Ex. 36). The ALJ awarded an attorney fee, payable by Windmill Inns, the then-responsible carrier.

On review, we have now concluded that SAFECO, not Windmill Inns, is responsible. However, we conclude that the nonresponsible party, Windmill Inns, is nevertheless responsible for an attorney fee under ORS 656.386(1). We do so for the following reasons.

---

[2] Claimant testified that she had never been free of left shoulder problems after the August 1993 injury. (Tr. 8)

[3] Inasmuch as our decision would be the same under either version of the statute, we need not address the question of which statute is applicable.

[4] Because SAFECO has failed to prove that claimant sustained a compensable injury while working for the second employer, we need not address the issue of an untimely disclaimer of responsibility. In doing so, we are mindful that the statute concerning disclaimers of responsibility has been amended. See Or Laws 1995, ch 332, § 37 (SB 369, § 37); Motel 6 v. McMasters, 135 Or App 583 (1995).

Safeway Stores, Inc. v. Hayes, 119 Or App 319, 323-24 (1993), holds that, when the non-responsible carrier creates the need for the claimant to establish the compensability of a claim, that carrier is responsible for payment of an attorney fee at hearing pursuant to former ORS 656.386(1). See Raymond E. Merideth, Jr., 46 Van Natta 431, 434 (1994). Furthermore, it has been the Board's long-standing policy to hold a carrier ultimately determined not responsible for a claimant's condition responsible for an attorney fee under former ORS 656.386(1) if the carrier denies the compensability of the claim and the responsible carrier only denies that it is responsible for the claim. Raymond H. Timmel, 47 Van Natta 31, 33 (1995); Dorothy J. Hayes, 44 Van Natta 792, 793 (1992) (quoted with approval in Hayes, supra, 119 Or App at 323); 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).

As previously noted, Windmill Inns denied compensability prior to the hearing. Because of this compensability denial, claimant's compensation was at risk. Claimant has now established that her left shoulder conditon is compensable. Thus, she has prevailed against Windmill Inns' compensability denial. Although we have determined that Windmill Inns is not reponsible for claimant's left shoulder condition, we nonetheless conclude that it is responsible for an attorney fee pursuant to ORS 656.386(1).[5] Raymond H. Timmel, supra.

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 concerning the compensability issue is $1,800. In reaching this decision, 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.

Amended ORS 656.308 is also applicable in this case.[6] ORS 656.308(2)(d) states:

> "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."

Accordingly, notwithstanding ORS 656.386(1) (that entitles claimant to an attorney fee for prevailing over a compensability denial), and ORS 656.382(2) (that provides for an attorney fee for successfully defending against a carrier's request for hearing/review), amended ORS 656.308(2)(d) limits claimant to a maximum $1,000 attorney fee for "finally prevailing against a responsibility denial," absent a showing of extraordinary circumstances.

This case involved a standard responsibility issue involving claims for aggravation/new injury. The hearing lasted for one hour and a half. There was one witness besides claimant. The hearing transcript numbered 43 pages. Further, the record consisted of 40 exhibits, none of which were apparently procured by claimant's counsel. Finally, there were no depositions. We, therefore, conclude that there were no "extraordinary circumstances" to justify a greater fee than the statutory maximum. Accordingly, for services at hearing concerning the responsibility issue, in lieu of the ALJ's $2,800 attorney fee award, we conclude that claimant is entitled to a $1,000 attorney fee, payable by SAFECO. ORS 656.308(2)(d).

Finally, on review, claimant did not file a brief. In light of such circumstances, assuming for the sake of argument that we were authorized to award an attorney fee in excess of $1,000, or that we are authorized to award an attorney fee under ORS 656.382(2) regarding the compensability issue which was potentially at risk by virtue of our de novo review of the ALJ's order (see Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992), mod 119 Or App 447 (1993)), we would decline to do so. See Shirley M. Brown, 40 Van Natta 879 (1988).

---

[5] Senate Bill 369 has amended ORS 656.386(1) to require that a claimant finally prevail against a "denied claim," i.e., a claim the 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. Inasmuch as Windmill Inns' October 21, 1994 denial expressly stated that claimant's left shoulder condition was not compensable, and because we have determined that this condition is compensable, claimant's attorney is entitled to an attorney fee under either version of ORS 656.386(1).

[6] Subsequent to the ALJ's order, the legislature amended ORS 656.308. Or Laws 1995, ch 332, § 37 (SB 369, § 37).

ORDER

The ALJ's order dated February 15, 1995 is reversed in part and modified in part. Jeld-Wen's (Windmill Inns) denials are set aside to the extent that they deny compensability, but are reinstated and upheld to the extent that they deny responsibility. SAFECO's denial of responsibility is set aside, and the claim is remanded to SAFECO for processing according to law. In lieu of the ALJ's $2,800 attorney fee award to be paid by Windmill Inns, claimant's attorney is awarded an attorney fee of $1,000, payable by SAFECO, and a $1,800 attorney fee, payable by Windmill Inns.

---

November 22, 1995 Cite as 47 Van Natta 2253 (1995)

In the Matter of the Compensation of
**BALDOMERO C. CONTRERAS, Claimant**
WCB Case No. 94-14262
ORDER ON RECONSIDERATION (REMANDING)
Willner & Associates, Claimant Attorneys
Roberts, et al, Defense Attorneys

The insurer requests reconsideration of our October 30, 1995 order which remanded this matter to the Administrative Law Judge (ALJ) for further evidence taking concerning the good cause issue. Specifically, the insurer objects to our determination that the ALJ erred in declining to allow claimant's testimony regarding his conversation with an employee of the insurer.

The insurer contends that we erred in reversing the ALJ's evidentiary ruling, because the standard for reviewing an ALJ's evidentiary ruling is "abuse of discretion." The insurer's argument assumes that we did not find abuse of discretion in not allowing the testimony. This is not the correct conclusion to be drawn from our order.

Claimant attempted to testify regarding a telephone conversation he had with an employee of the insurer. The conversation gave claimant the impression that the insurer's denial would be rescinded. "Good cause" for failing to file a timely request for hearing on a denial can be established through evidence that a claimant relied on the misleading statement of a carrier's representative. See Voorhies v. Wood, Tatum, Mosser, 81 Or App 336, rev den 302 or 342 (1986). By failing to allow claimant's testimony regarding the conversation with the insurer's employee, the ALJ prevented the admission of evidence which was necessary to determine whether good cause had been established. This was error. Thus, under these particular circumstances, it was an abuse of discretion to exclude the testimony regarding good cause.

The insurer next argues that the record was not developed on the good cause issue because of claimant's failure to make an offer of proof. As we indicated in our prior order, existing Board precedent did not require an offer of proof. We indicated that, as a result of our decision, we might look unfavorably upon the failure to make an offer of proof in the future.[1] This remains our decision.

In reaching our conclusions in this case, we emphasize that this forum is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. ORS 656.283(7). Rather, substantial justice governs the conduct of hearings. Here, for the reasons expressed in our prior order, as supplemented in this order, we did not find that the interests of substantial justice were served by excluding claimant's testimony concerning good cause.

Accordingly, our October 30, 1995 order is withdrawn. On reconsideration as supplemented herein, we republish our October 30, 1995 order in its entirety.

IT IS SO ORDERED.

---

[1] The insurer asserts that our pronouncement "is of no value to the bar." We disagree with such a contention. Our statement represents a notice to future litigants that the failure to seek permission to present offers of proof may preclude that litigant from obtaining remand for subsequent presentation of that proof. Such guidance is extended to practitioners in the interests of providing some assistance when litigating future cases.

In the Matter of the Compensation of
**EDWARD D. GIOVANNETTI, Claimant**
WCB Case No. 94-12631
ORDER ON REVIEW
Thomas L. LaFollett, Claimant Attorney
Moscato, Byerly, et al, Defense Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The alleged noncomplying employer requests review of Administrative Law Judge (ALJ) Schultz's order which set aside the SAIF Corporation's denial, on its behalf, of claimant's head injury claim. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

On July 30, 1994, claimant was employed as a professional wrestler. After an earlier wrestling match, claimant and another male wrestler, "P," and two female wrestlers, began to set up the "angle," which was a preview of the next match. The "angle" and the wrestling matches were scripted and choreographed by the wrestlers. The "angle" did not include a scenario in which the match's promoter would enter the ring. In fact, in accordance with administrative rules of the State Boxing and Wrestling Commission, no one is allowed in the ring or the "safety zone" surrounding the ring during a match except the referee and match participants. See OAR 230-130-100(6).

During the "angle," "P" and the two women wrestlers were in the ring when claimant began to enter the ring. (Exs. 15, 16). "P" had "kicked" one of the females, and lifted her over his head, in preparation for a body slam. At the same time that claimant entered the ring to participate in the "angle," the wrestling match promoter began to enter the ring from the opposite side. Id. Generally, promoters do not enter the ring until the match is completely over. Nevertheless, the promoter hurried into the ring, yelling at the wrestlers as he entered. Id.

"P" was standing, holding the female wrestler above his head. Id. Claimant quickly approached the promoter. Throwing his body into the promoter (Tr. 116), claimant bumped and pushed the promoter backwards toward the ropes, knocking off the promoter's glasses and causing papers to fall from the pocket of the promoter's shirt. Approximately three seconds after being bumped and pushed, as claimant turned away from him, the promoter hit claimant on the left side of his head, causing an injury. (Exs. 15, 16).

Meanwhile, "P" had completed his body slam of the female wrestler, and was proceeding with the "angle." He walked toward the promoter and pushed him, indicating that the promoter leave. Then, as the promoter bent down to pick up the papers he had dropped, "P" hit him on the head. Id. The promoter stepped toward "P," and claimant pushed him away. Claimant then pushed the promoter out of the ring. Id. The entire sequence of events took place in 25 seconds.

No member of the audience approached the ring or attempted to enter the ring while the promoter was in the ring. Security personnel were stationed outside the ring. Id.

## CONCLUSIONS OF LAW AND OPINION

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. Under that statute, four elements must be satisfied: (1) the claimant must be an active participant; (2) in assaults or combats; (3) that are not connected with the job assignment; and (4) that amount to a deviation from customary duties. See Hope C. Panages, 47 Van Natta 626 (1995).

The employer contends that claimant was an active participant in an assault or combat and, therefore, his injuries are not compensable. See ORS 656.005(7)(b)(A). Claimant responds that he appropriately used reasonable force when he "bumped" the promoter or, alternately, he had withdrawn from the assault or combat when he was attacked by the promoter.

The ALJ found that the promoter's entry into the ring was inappropriate and created a tense situation which threatened the safety and security of the wrestlers, and possibly the crowd. Consequently, the ALJ concluded that claimant was not an active participant in an assault or combat. We disagree.

Claimant argues that, because he was a licensed wrestler, he occupied a unique position at a wrestling event and, therefore, he was entitled to use reasonable force to defend himself or others. After viewing the videotapes of the incident, we find no reason to conclude that claimant or the wrestlers were physically threatened by the promoter. Although the promoter came yelling into the ring, we are not persuaded that he was preparing to physically intercede in the "angle."

Review of the videotape suggests that the audience interpreted the episode as part of the "angle." In fact, one videotape shows a security person standing close to the side of the ring, calmly watching the match. (Ex. 15). Furthermore, the promoter had only taken a couple of steps into the ring when claimant ran across the ring toward him, and knocked him into the ropes. Accordingly, we conclude that bumping and pushing the promoter was not connected with claimant's job assignment, and was a deviation from his customary duties.

Claimant next argues that he was not an "active participant" because he had withdrawn from the confrontation when he was hit by the promoter. A claimant may be an "active participant" if he assumes an active or aggressive role in the 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).

Here, after reviewing the sequence of events as depicted on the videotape, we are not persuaded that claimant's conduct constituted a withdrawal from the confrontation. To begin, claimant initiated the physical nature of the encounter by forcefully bumping and pushing the promoter, causing the promoter to be thrown against the ropes, dislodging the promoter's glasses and other personal possessions. Thereafter, claimant turned away from the promoter, but within three seconds of doing so, the promoter struck claimant. This exchange prompted further action from claimant, resulting in claimant throwing the promoter from the ring.

The events detailed above all occurred within 25 seconds of the promoter's entrance into the ring. In light of this rapid sequence of events, we are not persuaded that claimant had withdrawn from the altercation. Irvington Transfer v. Jasenosky, supra; see Hope C. Panages, supra (claim not compensable when the claimant had, but did not avail herself of, the opportunity to withdraw from the altercation); Ronald A. Smith, 47 Van Natta 807 (1995) (the claimant's actions intended to assault and injure and went beyond self-defense). Accordingly, we conclude that claimant was an active participant in an assault or combat and that his injury is not compensable. See ORS 656.005(7)(b)(A). Therefore, we reverse the ALJ's order and reinstate SAIF's denial in its entirety.

## ORDER

The ALJ's order dated April 3, 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
**DELORES LOVING, Claimant**
WCB Case No. 94-10671
ORDER ON RECONSIDERATION
Goldberg & Mechanic, Claimant Attorneys
Roberts, et al, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our October 26, 1995 Order on Review that assessed a penalty under amended ORS 656.262(11)(a) for unreasonable claims processing. The employer challenges our determination that once it received Dr. Kennedy's July 20, 1994 report, the continuation of its "back-up" denial was not supported by a legitimate doubt regarding its liability for the claim. Specifically, the employer argues that its subsequent receipt of Dr. Marble's report defeated any basis for assessing a penalty "notwithstanding whether it would have procedurally supported the issuance of a second back-up denial."

Having considered the employer's motion and argument, we withdraw our October 26, 1995 order and proceed with our reconsideration.[1]

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." Amended ORS 656.262(11)(a). As we explained in our order, although an employer may reasonably deny a claim, it may later obtain information that makes continuation of the denial unreasonable. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). The employer is under a continuing obligation to process the claim, and 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.

In this case, on July 21, 1994, the employer issued its "back-up" denial after it received Dr. Kennedy's March 8, 1994 chart note indicating that claimant's plantar fasciitis may not be work-related. Just days after it issued the denial, the employer received Dr. Kennedy's July 20, 1994 report, which stated that claimant's condition was caused in major part by her work activities and explained why his opinion had changed from his original assessment. We found that this later report destroyed any legitimate doubt the employer may have had about its liability for claimant's condition when it issued the "back-up" denial. We further found that Dr. Marble's report, which the employer solicited a few months later, did not reestablish a reasonable foundation for the "back-up" denial because it did not constitute "later obtain[ed] evidence" under amended ORS 656.262(6). We explained that Dr. Marble's report was essentially a reevaluation of claimant's unchanged "post-acceptance" condition, which does not constitute "later obtain[ed] evidence." See CNA Ins. Co. v. Magnuson, 119 Or App 282 (1993); John J. Rice, 46 Van Natta 984 (1994).

The employer asserts that, for purposes of our penalty analysis, we presumed that its "back-up" denial was properly issued.[2] The employer then reasons that assuming the "back-up" denial was properly issued, it would have no obligation to rely exclusively on "later obtained evidence" in order to show that it had a legitimate doubt regarding the compensability of the claim. We disagree.

The only foundation for the issuance of the "back-up" denial in this case was Dr. Kennedy's initial chart note of March 8, 1994. Once that foundation was destroyed (by virtue of Dr. Kennedy's subsequent reports), the employer's continuation of the "back-up" denial was unreasonable. The

---

[1] As the employer acknowledges, our de novo review encompasses all issues raised or raisable on the entire record before us regardless of whether those issues were raised by the parties on review. Destael v. Nicolai Co., 80 Or App 596, 600-01 (1986). Here, a penalty for the employer's alleged "unreasonable denial" was at issue at hearing and on review. Although the particular theory on which we relied to affirm the penalty (legitimate doubt destroyed) was not addressed by the parties, it is naturally encompassed within the unreasonable denial issue. Therefore, it is within our purview on de novo review.

[2] What we actually stated was that we need not decide whether Dr. Kennedy's March 8, 1994 report constituted "later obtained evidence" because even if it did, the employer could not prove the noncompensability of claimant's condition. (Order on Review at 3). In analyzing the penalty issue, we again explained that we need not decide the issue because Dr. Kennedy's subsequent report would have destroyed any legitimate doubt the employer may have had in any event. (Order on Review at 5).

employer may not, as in this case, seek to rebuild the foundation for its "back-up" denial with evidence that would not otherwise constitute "later obtain[ed] evidence" justifying such a denial under ORS 656.262(6). We therefore reject the employer's contention that Dr. Marble's report was sufficient to create and sustain a reasonable doubt and eliminate the basis for penalties under amended ORS 656.262(11)(a).

Accordingly, we withdraw our October 26, 1995 order. On reconsideration, as supplemented herein, we republish our October 26, 1995 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---



In the Matter of the Compensation of
**FRANK MILES, Claimant**
WCB Case No. 94-13851
ORDER ON REVIEW
Max Rae, Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that: (1) upheld the self-insured employer's denial of claimant's bilateral shoulder injury claim; (2) upheld the employer's denial of claimant's occupational disease claim for a bilateral shoulder condition; and (3) declined to assess penalties for an allegedly unreasonable denial of the shoulder injury claim. In addition, on review, claimant requests a penalty for the employer's allegedly unreasonable denial of the occupational disease claim. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. On August 22, 1994, claimant filed an 801 form for a left shoulder and neck injury allegedly related to a fall at work in August 1992. (Ex. 2). On November 7, 1994, Dr. Shaw, treating physician, opined that it was "possible" that claimant's diagnosed subacromial impingement syndrome was related to the fall at work two years earlier. (Ex. 2A). On November 8, 1994, the employer issued a denial of the injury claim. (Ex. 3). On February 7, 1995, the employer issued a denial of claimant's subsequent claim for an occupational disease for a bilateral shoulder condition. (Ex. 6).

## CONCLUSIONS OF LAW AND OPINION

### Compensability of the Bilateral Shoulder Injury Claim

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

### Compensability of the Bilateral Shoulder Occupational Disease Claim

The ALJ found that claimant has a bilateral overuse syndrome in his shoulders caused in major part by his work activities. We adopt the ALJ's reasoning and conclusions regarding this finding. (Exs. 4, 7). The employer agrees that the medical evidence can be fairly read to support this conclusion. (Employer's Response Brief, page 3). However, the ALJ also found, and the employer argues, that claimant failed to establish a compensable occupational disease claim because claimant failed to show that the overuse syndrome resulted in disability or required medical treatment. We disagree.

The compensability of both injuries and occupational diseases is tied to a requirement that the condition requires medical services or results in disability or death. ORS 656.005(7)(a); 656.802(1)(c). Here, claimant was not physically disabled from his shoulder condition. He has continued performing his regular job without any limitations. The question is whether the occupational disease required medical services.

The statutes do not define "medical services." The court in Finch v. Stayton Canning Co., 93 Or App 168 (1988), while pointing out that there is no definition for the term "medical services" as found in ORS 656.005(7)(a), held that the claimant who had symptoms, and sought the assistance of a physician for treatment even though no actual treatment was recommended, had received the required "medical services" and suffered a compensable occupational disease. The court said, "That no treatment is available for an injury or disease does not mean that a claimant is not injured or sick." Id. at 173; David M. Crymes, 45 Van Natta 267 (1993); Kelly Barfuss, 44 Van Natta 239 (1992).

Here, claimant sought treatment for severe pain in his neck and shoulders from Dr. Shaw, orthopedist, who performed a physical examination and prescribed medication and shoulder stretching exercises. (Ex. 1B). Furthermore, Dr. Shaw agreed with Dr. Burr, examining orthopedist, that claimant's shoulder condition was caused by his work activities. (Ex. 4-5, 7-12). We find that the treatment claimant received from Dr. Shaw constituted medical services within the meaning of ORS 656.802(1)(c). Finch v. Stayton Canning Co., supra; David M. Crymes, supra.

The employer argues that claimant has not established that any medical treatment was required. In support of this argument, the employer contends that Dr. Shaw agreed with Dr. Burr's statement that claimant "does not need treatment." (Ex. 7-19). However, Dr. Burr's statement was made in the context of claimant's need for treatment at the time Burr examined claimant on January 18, 1995. (Ex. 4-5, 4-6). In addition, Dr. Burr stated that claimant does not require "further treatment or evaluation." Id. (Emphasis added). That is the statement with which Dr. Shaw concurred. (Ex. 7-19). The fact that claimant needed no further treatment at the time he was examined by Dr. Burr does not mean that he did not require the medical services provided earlier by Dr. Shaw.

On this record, we find that claimant has established that the occupational disease required medical services. Accordingly, claimant has proved a compensable occupational disease claim.

Penalties

The ALJ found that, at the time it issued its denial, the employer had a legitimate doubt as to its liability for the injury claim. Therefore, the ALJ concluded that the injury denial was not unreasonable and declined to assess a penalty. We adopt the ALJ's reasoning and conclusions regarding this issue.

On review, claimant argues that he sought penalties based on the unreasonableness of both denials. Moreover, he argues, the employer's occupational disease denial was unreasonable and he is entitled to a penalty on that basis. We disagree that claimant raised at hearing the issue of penalties regarding the occupational disease denial.

Claimant agreed with the ALJ's statement of issues, which explicitly included a penalty issue regarding only the injury denial. (Tr. 2-3). In addition, contrary to claimant's argument, he did not raise the issue of penalties regarding the occupational disease denial in his opening statement. (Tr. 3-5). Instead, during his opening statement, claimant addressed only the penalty issue regarding the injury denial. Id. On this record, we find that claimant did not raise at hearing a penalty issue regarding the occupational disease denial. Because that issue was not raised at hearing, we decline to reach it on review. EBI Insurance Company v. Chandler, 112 Or App 275 (1992); Anderson v. West Union Village Square, 44 Or App 685 (1980); Donald A. Rasberry, 43 Van Natta 1847 (1991).

Attorney Fees

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 of the occupational disease is $2,500, payable by the employer. 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 April 28, 1995 is reversed in part and affirmed in part. That portion of the order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral shoulder overuse syndrome is reversed. The employer's denial of claimant's occupational disease claim for a bilateral shoulder overuse syndrome is set aside and the claim is remanded to the employer for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant is awarded an attorney fee of $2,500, to be paid by the employer.

---



In the Matter of the Compensation of
**SALLY A. NIEBUHR, Claimant**
WCB Case No. 94-03590
CORRECTED ORDER ON REVIEW
Lavis, Alvey, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Podnar's order which set aside its denial of claimant's current low back condition. On review, the issue is compensability.

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

The ALJ set aside the insurer's denial of claimant's current low back condition pursuant to former ORS 656.005(7)(a)(B). The ALJ found that claimant's low back injury of May 18, 1993 had combined with a preexisting degenerative disc disease at L3 through S1, and that the medical evidence established that claimant's compensable injury is the major contributing cause of claimant's need for treatment and disability.

On review, claimant contends that the ALJ erred in applying ORS 656.005(7)(a)(B). Claimant asserts that the only issue was the compensability of claimant's degenerative condition, not the compensability of her medical treatment. 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). It is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995).

Here, the medical evidence indicates that claimant's work incident combined with her preexisting degenerative disc disease to cause disability or a need for medical treatment.[1] (See Exs. 19, 24) (lumbar spine strain rendered preexisting degenerative condition symptomatic). Accordingly, claimant has the burden of proving that her 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. Amended ORS 656.005(7)(a)(B).

We agree with the ALJ's reasoning and conclusion that the medical evidence establishes that

---

[1] 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), Or Laws 1995, Ch 332, §§ 1, 66, 69 (SB 369, §§ 1, 66, 69). Both the former and amended versions of that statute contain the "major contributing cause" test of compensability. Because the evidence meets that test, we conclude that claimant's current low back condition is compensable under either version of ORS 656.005(7)(a)(B). In light of such circumstances, we need not address claimant's arguments that retroactive application of the statute is inappropriate or that remand is warranted.

claimant's compensable injury is the major contributing cause of the disability and need for treatment of the combined condition. Thus, we affirm the ALJ's decision.[2]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 May 8, 1994 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

---

[2] The insurer asserts that claimant's compensable injury must have "pathologically worsened" her preexisting degenerative disc disease for it to be compensable under ORS 656.005(7)(a)(B). We disagree. Medical treatment or disability for a preexisting condition which combines with an otherwise compensable injury is compensable if the compensable injury is the major contributing cause of the medical treatment or disability of the combined condition. There is no requirement in ORS 656.005(7)(a)(B) that the compensable injury worsen pathologically the preexisting condition, only that the injury "combine with" a preexisting condition. Although Section 3(1) of Senate Bill 369 and amended ORS 656.802(2)(b) contain "pathological worsening" requirements, neither provision is applicable here. ORS 656.802 is not relevant because this is not an occupational disease claim. Given our finding that claimant's current low back condition is a "combined condition," Section 3 is not germane because claimant's disability is not solely caused by and her medical treatment is not solely directed to the preexisting condition.

**Board Member Haynes specially concurring.**

I concur with the ALJ and the majority that claimant's compensable injury is the major contributing cause of her disability and need for medical treatment. Thus, I agree that claimant has sustained her burden of proving that her current low back condition is compensable under either version of ORS 656.005(7)(a)(B). However, I may have reached a different conclusion had the March 3, 1994 report from the examining physicians, Drs. Burr and Wilson, been more persuasive. I concur with the ALJ's opinion that the examining physicians provided little or no analysis in their report. Given its deficiencies, this report is insufficient to overcome the weight given to Dr. Cockroft's March 22, 1994 medical report.

I also note that the ALJ cited U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), rev den 318 Or 24 (1993), as authority for his finding that claimant's low back condition is compensable under ORS 656.005(7)(a)(B). However, I question the continued validity of Burtis in light of Dietz v. Ramuda, 130 Or App 397 (1994) (an event which precipitates symptoms of a preexisting condition is not necessarily the major contributing cause of those symptoms). See also Alec E. Snyder, 47 Van Natta 838 (1995). I also question its viability in light of the amendments to ORS 656.005(7)(a)(B) contained in Senate Bill 369.

In conclusion, I am bound by the record developed at hearing, which supports the ALJ's decision to set aside the insurer's denial. However, given my concerns regarding the ALJ's reliance on Burtis, and the fact that the insurer may have prevailed with more persuasive medical evidence from the examining physicians, I must specially concur.

---



In the Matter of the Compensation of
**JOHN F. O'NEALL, JR., Claimant**
WCB Case Nos. 94-10204 & 94-06831
ORDER OF ABATEMENT
Max Rae, Claimant Attorney
Kevin L. Mannix, Defense Attorney

On October 30, 1995, we affirmed an Administrative Law Judge's order that: (1) set aside the insurer's denials of claimant's new low back injury claim; (2) determined that claimant's Grade 1 spondylolisthesis was a compensable component of the low back injury claim; (3) upheld the insurer's

denial of claimant's aggravation claim for a mid-back condition; and (4) declined to award a penalty for the insurer's allegedly unreasonable denial of claimant's low back injury claim. Announcing that they have resolved their disputes, the parties seek abatement of our order to await consideration of their proposed settlement.

Based on the parties' representations, we withdraw our October 30, 1995 order. On receipt of the proposed settlement, we shall proceed with our consideration of the agreement. In the meantime, the parties are requested to keep us fully apprised of any future developments regarding this case.

IT IS SO ORDERED.

---



In the Matter of the Compensation of
**PAUL E. PERSCHMANN, Claimant**
WCB Case No. 94-11880
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Schultz's order which set aside its denial, on behalf of the alleged noncomplying employer, of claimant's injury claim for left wrist and left shoulder conditions. Claimant cross-requests review of that portion of the ALJ's order that upheld SAIF's denials of his injury claim for low back and neck strains and right thigh paresthetica, and claimant's occupational disease claim for a mental disorder. On review, the issues are compensability. We reverse in part and affirm in part.

## FINDINGS OF FACT

On July 30, 1994, claimant was employed as a professional wrestler. After an earlier wrestling match, claimant and another male wrestler, "G," and two female wrestlers, began to set up the "angle," which was a preview of the next match. The "angle" and the wrestling matches were scripted and choreographed by the wrestlers. The "angle" did not include a scenario in which the match's promoter would enter the ring. In fact, in accordance with administrative rules of the State Boxing and Wrestling Commission, no one is allowed in the ring or the "safety zone" surrounding the ring during a match except the referee and match participants. See OAR 230-130-100(6).

During the "angle," claimant and the two women wrestlers were in the ring when "G" began to enter the ring. Claimant had "kicked" one of the females, and lifted her over his head, in preparation for a body slam. At the same time that "G" entered the ring to participate in the "angle," the wrestling match promoter began to enter the ring from the opposite side. Generally, promoters do not enter the ring until the match is completely over. Nevertheless, the promoter hurried into the ring, yelling at the wrestlers as he approached.

As the promoter entered the ring, claimant was standing, holding the female wrestler above his head. "G" saw the promoter in the ring and quickly approached him. Throwing his body into the promoter (Tr. 116), "G" bumped and pushed the promoter backwards toward the ropes, knocking off the promoter's glasses and causing papers to fall from the pocket of the promoter's shirt.

Meanwhile, claimant had completed his body slam of the female wrestler, and was proceeding with the "angle." He walked toward the female wrestler's feet, near where the promoter was now standing after his encounter with "G." Claimant then pushed the promoter, telling him to get out of the ring. As the promoter bent down to pick up the papers he had dropped, claimant hit him in the head with his open left hand.

No member of the audience approached the ring or attempted to enter the ring while the promoter was in the ring. Security personnel were stationed outside the ring. Id. The entire incident lasted 25 seconds. (Ex. 15).

## CONCLUSIONS OF LAW AND OPINION

SAIF argues that claimant was an active participant in an assault or combat and, therefore, his injuries are not compensable. See ORS 656.005(7)(b)(A). The ALJ reasoned that the promoter's entry into the ring was inappropriate and created a tense situation which threatened the safety and security of the wrestlers, and possibly the crowd. Consequently, the ALJ concluded that claimant was not an active participant in an assault or combat. We disagree.

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. Under that statute, four elements must be satisfied: (1) the claimant must be an active participant; (2) in assaults or combats; (3) that are not connected with the job assignment; and (4) that amount to a deviation from customary duties. See Kessen v. Boise Cascade Corp., 71 Or App 545 (1984); Hope C. Panages, 47 Van Natta 626 (1995).

Claimant first contends that we should rely on the ALJ's findings of fact because the ALJ found claimant's testimony credible based on demeanor. 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 519, 528 (1991) ("Although the Board should seriously consider the testimony the ALJ believes to be reliable, the 'substantial evidence' standard does not require the Board to adopt the [ALJ's] findings or to 'explain away' disparities between the Board's and the [ALJ's] determinations"); see also Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Here, the record contains two videotapes of the entire "angle," filmed from two different directions. (Exs. 15, 16). Because the videotapes conflict with claimant's testimony, particularly with regard to the imminence of potential danger to the wrestlers, we decline to rely on that testimony.

Claimant next contends that his job duties exceeded those of a wrestler, and that he did not deviate from his job duties when he pushed and hit the promoter. Specifically, claimant argues that he had additional responsibilities to ensure the safety of other wrestlers, and maintain control in the ring. In that context, claimant contends that, because he believed the situation was "out of control" when the promoter entered the ring, he had to make sure the fans did not overreact and enter the safety zone or attack the wrestlers as they left the ring. Therefore, claimant argues that he was not an active participant in an assault or combat. We do not agree.

In viewing the videotape, we do not find that the situation in the ring or the audience was out of control. The female wrestlers appeared to continue to perform the script, as did claimant and "G," except when "G" bumped the promoter and claimant pushed and hit the promoter. Claimant never turned his attention to the audience in apprehension of someone entering the ring, and there is no evidence that any persons from the audience attempted to approach the ring or enter the ring. Review of the videotape reveals nothing to suggest that the audience interpreted the episode as anything other than part of the "angle." In fact, one videotape shows a security person standing close to the side of the ring, calmly watching the match. (Ex. 15).

Finally, it was not legal for the promoter to enter the ring. Moreover, he was, in fact, subsequently fined for entering the ring. Notwithstanding such conduct, we remain persuaded that claimant actively participated in an assault or combat. We base this conclusion on the following reasoning.

A claimant may be an "active participant" if he assumes an active or aggressive role in the 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). Here, it is clear that claimant participated in the assault when, as he walked toward the feet of the woman wrestler who was lying on the mat, he turned aside to push the promoter. Further, when it appeared that claimant might return to the "angle" and possibly withdraw from the fight, claimant again turned his attention to the promoter. Rather than calling for assistance from security personnel or escorting the promoter from the ring, claimant struck the promoter in the face as the promoter bent over to pick up the papers that had been knocked out of his pocket.

Accordingly, in light of this evidence, we conclude that claimant's alleged injuries occurred when he was an active participant in an assault or combat. ORS 656.005(7)(b)(A). Therefore, we reverse the ALJ's order and reinstate SAIF's denial in its entirety.

## ORDER

The ALJ's order dated April 3, 1995 is reversed in part. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

**Board Member Gunn dissenting.**

In a business dedicated to the presentation of organized mayhem, this case provides an odd set of facts. Given the nature of claimant's work, I am not surprised at his response to the promoter's presence in the ring, particularly given the regulations of organized wrestling. In light of claimant's testimony that his job involved ensuring the safety of the participants in the ring, and keeping everyone else out of the ring, I do not find that he was an active participant in an "assault" or "combat." Therefore, I respectfully dissent.

---



In the Matter of the Compensation of
WCB Case No. 93-13637
**JAMES L. RASMUSSEN, Claimant**
ORDER ON REVIEW
Harrell & Nester, Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Gunn and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its partial denial of claimant's diabetes and related treatment. In his respondent's brief, claimant renews his request for penalties and attorney fees for SAIF's unreasonable denial. On review, the issues are compensability, 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

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

Claimant has had non-work related diabetes since 1979. Finding that "claimant's work activities were a material contributing cause of the preexisting condition to flare up with an increase in symptoms," a prior order found claimant's diabetic foot ulcerations and need for treatment compensable. The compensability of claimant's underlying diabetes was not litigated. Claimant has since been hospitalized on numerous occasions for foot infections and surgery, including partial amputations of both feet. Further amputations are proposed.

On September 29, 1993, SAIF denied "the compensability of [claimant's] diabetic condition and/or any treatment being rendered as a result of [his] preexisting diabetic condition[.]" (Emphasis supplied). Finding that SAIF was attempting to deny a portion of the claim found compensable in a prior proceeding, the ALJ set aside SAIF's partial denial.

On review, SAIF contends it did not intend to deny claimant's diabetic foot condition but, rather, only to deny claimant's underlying diabetes and treatment therefor. Carriers are bound by the express language of their denials. Tattoo v. Barrett Business Services, 118 Or App 348, 351-52 (1993). The testimony of SAIF's claims adjuster notwithstanding, we find the language of the denial ("SAIF Corporation is denying ... any treatment being rendered as a result of your preexisting diabetic condition") encompassed the diabetic foot condition previously found compensable Therefore, given the posture of this case, to the extent SAIF's denial purported to deny treatment related to claimant's diabetic foot condition, the denial is set aside.[1] The ALJ's order is modified accordingly.

Claimant seeks a penalty for SAIF's unreasonable denial. The ALJ found SAIF's partial denial unreasonable. We agree with and adopt his conclusion. However, finding that there were no "amounts due" upon which a penalty could be based, the ALJ did not award a penalty. Our review of the record reveals unpaid medical billings. (See Ex. 108; Tr. 12 and 18).

Consequently, we assess SAIF a penalty for its unreasonable denial of compensation equal to 25 percent of the outstanding medical bills due through November 21, 1994, the date of hearing. ORS 656.262(11)(a). See Conagra, Inc. v. Jeffries, 118 Or App 373 (1993). Of that amount, one-half shall be paid to claimant and one-half shall be paid to claimant's counsel, in lieu of an attorney fee. ORS 656.262(11)(a).

Finally, claimant's attorney is entitled to an assessed fee on review for prevailing over SAIF's request for 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 counsel's services on review regarding the compensability issue is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to a separate attorney fee award for his efforts to obtain a penalty.

## ORDER

The ALJ's order dated December 19, 1994 is modified in part and reversed in part. The SAIF Corporation's denial, insofar as it denied treatment related to claimant's diabetic foot condition, is set aside. SAIF's denial, insofar as it denied the compensability of claimant's preexisting diabetes and related treatment (excluding the diabetic foot condition), is reinstated and upheld. SAIF is assessed a penalty equal to 25 percent of the outstanding medical bills due through November 21, 1994, (the date of hearing) to be divided equally between claimant and his attorney. For services on review concerning the compensability issue, claimant's counsel is awarded a $1,000 attorney fee, to be paid by SAIF.

---

[1] We find no merit to SAIF's contention that the ALJ erred in relying on SAIF v. Roam, 109 Or App 169 (1991), to find that it is necessary to treat claimant's diabetes in order to treat the compensable diabetic foot condition. The preponderance of the medical evidence establishes that the treatment claimant requires for diabetes is inseparable from the treatment required for the compensable diabetic foot condition.

In the Matter of the Compensation of
**GREGORY D. SCHULTZ, Claimant**
WCB Case No. 94-07903
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that increased claimant's unscheduled permanent disability award for a low back condition from 20 percent (64 degrees), as awarded by Order on Reconsideration, to 32 percent (102.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact but not her finding of ultimate fact, with the following exception.

In lieu of the ALJ's finding that the November 1, 1993 Physical Capacities Evaluation (PCE) placed claimant in the light category, we find that claimant's residual functional capacity (RFC) was in the light/medium category.

## CONCLUSIONS OF LAW AND OPINION

Impairment Factor

The ALJ rated claimant's impairment value as 17 percent, based on lost ranges of lumbar motion (9 percent), lumbar disc compression fracture (5 percent) and chronic condition impairment (5 percent). In concluding that claimant was entitled to the 5 percent chronic condition award, the ALJ declined to apply the Director's rule, OAR 436-35-320(5)(a), which provides:

> "Unscheduled chronic condition impairment is considered after all other unscheduled impairment within the body area, if any, has been rated and combined under these rules. Where the total unscheduled impairment within a body area is equal to or in excess of 5%, the worker is not entitled to any unscheduled chronic condition impairment."[1]

The ALJ reasoned that, although claimant had more than 5 percent impairment in the low back, he was entitled to the additional 5 percent chronic condition award under the statutory criteria for rating unscheduled permanent disability. The ALJ noted that the scheduled chronic condition rule (OAR 436-35-010(6)) does not contain a similar limitation. Finding the limitation on unscheduled chronic conditions to be arbitrary, the ALJ concluded that the Director exceeded his statutory authority in promulgating OAR 436-35-320(5)(a).

On review, SAIF argues that the ALJ was bound by statute to apply the standards adopted by the Director. Alternatively, SAIF argues that the Director's promulgation of OAR 436-35-320(5)(a) did not exceed the authority delegated to him by the legislature.

The Director is charged with the duty to "[p]rovide standards for the evaluation of disabilities." ORS 656.726(3)(f). The Board and ALJ's, on the other hand, are charged with the duty to apply the standards. ORS 656.283(7) provides, in pertinent part, that "[t]he Administrative Law Judge shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726." (Emphasis supplied.) Similarly, ORS 656.295(5) provides that "[t]he board shall apply to the review of the claim such standards for the evaluation of disability as may be adopted by the director pursuant to ORS 656.726." (Emphasis supplied.)

---

[1] A worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. OAR 436-35-320(5). "Body area" means the cervical/upper thoracic spine (T1-T6)/shoulders area and the lower thoracic spine (T7-T12)/low back/hips area. Id.

There is no statutory provision which allows the Board or ALJ's to adopt standards, or to ignore standards adopted by the Director.[2] Hence, we reject claimant's contention that we have the authority to invalidate any portion of the standards. The case cited by claimant to support his contention, Welliver Welding Works v. Farmen, 133 Or App 203 (1995), is inapposite for the following reason. In Farmen, the court affirmed our holding that a Director's vocational assistance rule conflicted with the vocational assistance statute, and was therefore invalid. At the time we decided Farmen, however, ORS 656.283(2) expressly provided that the Board could modify a Director's decision regarding vocational assistance if the decision violated a statute or exceeded the Director's statutory authority.[3] There is no similar provision in the statutes which permits the Board to invalidate a Director's rule regarding the evaluation of permanent disabilities. Absent such a provision, we conclude that we (and the ALJ) lack authority to invalidate the Director's standards. Accordingly, the ALJ erred in refusing to apply OAR 436-35-320(5)(a).

Furthermore, even if we assumed we had authority to invalidate a Director's standard, we would find that OAR 436-35-320(5)(a) did not exceed the Director's statutory authority. ORS 656.214(5) provides that the criteria for rating unscheduled permanent 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)." Subparagraph (A) of ORS 656.726(3)(f) provides that the criteria for evaluation of unscheduled permanent disabilities "shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job."

The above-quoted criteria for the evaluation of unscheduled disability is an inexact statutory term, because the legislature has expressed itself completely, but the meaning of its enactment is subject to agency interpretation. Springfield Education Assn. v. School Dist., 290 Or 217, 224-28 (1980). Therefore, our task is to determine whether the Director has erroneously interpreted the law.[4] England v. Thunderbird, 315 Or 633, 638 (1993).

We begin with an examination of why the Director has treated unscheduled chronic condition impairment differently from scheduled chronic condition impairment. Scheduled disabilities are those involving the loss of use or function of any of a series of organs or body parts specifically enumerated in ORS 656.214(2) through (4). The calculation of scheduled disabilities is based exclusively on the evaluation of loss of use or function, i.e., physical impairment, due to the compensable condition.

Unscheduled disabilities, on the other hand, are based on loss of earning capacity, as determined by four factors: (1) impairment due to the injury; (2) age; (3) education; and (4) adaptability to perform a given job. Of these factors, both the impairment and adaptability factors are rated on the basis of an evaluation of the injured worker's residual disability.[5] Because the worker's residual disability may impact both the impairment and adaptability factors, there is the potential for the worker

---

[2] Indeed, if an ALJ or the Board determines that the Director's standards do not address a particular worker's disability, the claim must be remanded to the Director for the promulgation of a temporary rule amending the standards to accommodate the worker's disability. E.g., Thrasher v. Reynolds Metals, 133 Or App 13 (1995).

[3] ORS 656.283 was amended extensively by the 1995 Legislature. Or Laws 1995, ch 332, § 34 (SB 369, § 34). As amended, ORS 656.283 no longer provides for Board review of the Director's vocational assistance decisions. Rather, the Director is now empowered to review his own decisions, subject to judicial review.

[4] The dissent misinterprets this reference. See N. 7. In embarking on this analysis, we are proceeding with an examination of the validity of the standard only under the assumption that we are statutorily authorized to invalidate a Director's disability standard. For the reasons previously discussed, we have already concluded that we are without statutory authority to take such an action. As earlier explained, our task is to apply the Director's disability standards.

[5] "Adaptability to perform a given job" is determined by comparing the strength demands of the worker's job at injury with the worker's maximum residual functional capacity. OAR 436-35-310. "Residual functional capacity" is the worker's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. OAR 436-35-270(3)(d). Hence, the lesser the worker's residual ability to perform activities due to the compensable condition, the higher is the rating for the adaptability factor.

to receive double compensation for the same disability.[6] It is this potential for double compensation which distinguishes unscheduled disabilities from scheduled disabilities and supports the Director's different treatment of each in rating chronic condition impairment.

Claimant argues that ORS 656.726(3)(f)(A) expressly requires that all of his injury-related impairment, including chronic conditions, must be rated before the rating may be "modified" by the factors of age, education and adaptability. We disagree. The phrase "permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability" must be viewed as a whole, as the criteria for calculating "loss of earning capacity." After all, it is the loss of earning capacity for which the worker is being compensated by the unscheduled disability award. In excluding unscheduled chronic condition impairment in those cases where the worker's impairment has already been rated at 5 percent or more, we conclude that the Director did not exceed his statutory authority in calculating "loss of earning capacity" pursuant to ORS 656.726(3)(f).

Accordingly, we disagree with the ALJ's conclusion that the 5 percent limitation in OAR 436-35-320(5) is arbitrary and exceeded the Director's statutory rulemaking authority under ORS 656.726(3)(f)(A). After excluding the unscheduled chronic condition award pursuant to OAR 436-35-320(5)(a), we modify the ALJ's impairment rating to 14 percent.

Social/Vocational Factors

SAIF next contends that the ALJ erred in calculating the sum of the age and education factors as 2, but then using the sum of 3 in her final disability calculation. Claimant does not rebut SAIF's contention. We find that the sum of the age and education factors should be 2, and we modify the ALJ's conclusions and reasoning accordingly.

Finally, SAIF contends that the ALJ erred in rating claimant's adaptability factor as 5. The ALJ's rating was based on the findings that claimant's base functional capacity (BFC) was heavy work, whereas his residual functional capacity (RFC) is light work. SAIF argues that claimant's RFC is medium/light work, rather than light work. We agree.

The adaptability factor is measured by comparing the worker's BFC to the worker's maximum RFC at the time of becoming medically stationary. OAR 436-35-310(2). RFC refers to "an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition." OAR 436-35-310(3)(b).

Here, claimant became medically stationary on December 1, 1993. On November 1, 1993, claimant underwent a work tolerance screening, which revealed that he can lift 32.5 pounds occasionally and 16 pounds frequently. (Ex. 12-14). Claimant's attending physician, Dr. Macha, concurred with the screening results. (Ex. 1-4). Although the work tolerance evaluator rated claimant's level of work as light, the actual results of the screening indicate that claimant is capable of medium/light work. "Light" means the ability to occasionally lift 20 pounds and frequently lift or carry up to 10 pounds. OAR 436-35-310(3)(f). "Medium" means the ability to occasionally lift 50 pounds and frequently lift or carry up to 25 pounds. OAR 436-35-310(3)(h). "Medium/light" means the ability to do more than light activities, but less than the full range of medium activities. OAR 436-35-310(3)(g). We conclude, based on the work tolerance screening results, that claimant's RFC is light/medium work. Accordingly, his adaptability factor is rated as 4. See OAR 436-35-310(6).

Disability Calculation

We now proceed to calculate claimant's unscheduled permanent disability award. After multiplying the sum of the age and education factors (2) by the adaptability factor (4), the product is 8. When that product is added to the impairment factor (14), the total unscheduled permanent disability award is 22 percent. See OAR 436-35-280. We reduce the ALJ's award accordingly.

---

[6] This potential for double compensation was considered by the Department in response to public testimony in 1991 calling for changes in the rating of chronic condition impairments. In an apparent reference to the limitation on unscheduled chronic condition impairment in OAR 436-35-320(5), the Department stated: "Unscheduled disability already considers restrictions on activity in the determination of the adaptability factor. However, the permanent rules allow a value for impairment for chronic condition in an unscheduled body part for those workers who have no other ratable impairment." Exhibit C for WCD Admin. Order 2-1991, Summary of Testimony and Agency Responses, page 5.

ORDER

The ALJ's order dated December 21, 1994 is modified. In lieu of the ALJ's award, and in addition to the 20 percent (64 degrees) unscheduled permanent disability granted by the Order on Reconsideration, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, for a total unscheduled permanent disability award to date of 22 percent (80 degrees). The ALJ's attorney fee award is modified accordingly.

**Board Member Gunn concurring in part and dissenting in part.**

I agree with the majority that the Board is without authority to invalidate a portion of the Director's authority. However, because I believe the statutory scheme provides a mechanism by which claimant could receive an award for his chronic condition, I dissent.

ORS 656.726(3)(f)(C) grants the Director the authority to promulgate a temporary rule when it is found that a worker's disability is not addressed by the "standards." The court has interpreted this provision to allow the Board to remand a case to the Director in those instances where the Director has failed to adopt a temporary rule or "stay" proceedings pursuant to ORS 657.726(3)(f)(C). Gallino v. Courtesy Pontiac-Buick-GMC, 134 Or App 538 (1993).

Here, there is no dispute that claimant suffers from a chronic condition. While the Director's rules indicate that a worker will not receive an award for an unscheduled chronic condition if the impairment is in excess of 5 percent, I do not believe this equates to a rule that addresses claimant's impairment. Rather, I conclude that claimant's impairment is not addressed by the "standards." Consequently, I would remand this case to the Director for consideration of a temporary rule which expressly addresses claimant's disability.

For these reasons, I respectfully dissent.

**Board Member Hall dissenting.**

The majority concludes that it is within the Director's authority to promulgate a rule which does not allow for an unscheduled chronic condition award where a worker has other impairment which exceeds 5 percent. Because I agree with the ALJ that allowing such an award in the case of an injury to a scheduled body part but now allowing a similar award where the injury is to an unscheduled body part is arbitrary and exceeds the Director's statutory authority, I dissent.

ORS 656.283(7) provides, in pertinent part, that "[t]he Administrative Law Judge shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726." Similarly, ORS 656.295(5) provides that "[t]he board shall apply to the review of the claim such standards for the evaluation of disability as may be adopted by the director pursuant to ORS 656.726." Thus, we are bound by statute to apply the standards "as may be adopted by the director pursuant to ORS 656.726." That does not mean, however, that we are without authority to determine the validity of the standards. Rather, we are not bound to apply "standards" which exceed the Director's statutory authority. See Welliver Welding Works v. Farmen, 133 Or App 203 (1995) (affirmed Board's holding that the Director's vocational assistance rule conflicted with the statute and was invalid).[1]

ORS 656.726(3)(f) authorizes the Director to "[p]rovide standards for the evaluation of disabilities." Subparagraph (A) of that statute further provides that the criteria for evaluation of unscheduled permanent disabilities "shall be permanent impairment due to the industrial injury as modified by the factors of age, education, and adaptability to perform a given job." ORS 656.726(3)(f)(A). Although the Director is authorized to promulgate standards for the evaluation of disabilities, he must exercise that authority in accordance with legislative intent. An administrative agency may not, by its rules, amend, alter, enlarge, or limit the terms of the statute. Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988).

---

[1] While the majority seems to indicate that the Board does not have the authority to invalidate the Director's "standards," it goes on to acknowledge the Board's authority ("our task") to determine whether the Director has erroneously interpreted the law. (Majority Op. at p. 4). Thus, it would appear that the majority agrees that the Board has the authority to review a Director's rule in order to determine whether it is consistent with the statutory grant of power. See England v. Thunderbird, supra.

There are three classes of statutory terms, each of which conveys a different responsibility for the agency promulgating the rules under the statute and for the administrative/judicial body reviewing the agency's rule making: (1) terms of precise meaning, whether of common or technical parlance, requiring only factfinding by the agency and administrative/judicial review for substantial evidence; (2) inexact terms which require agency interpretation and administrative/judicial rule for consistency with legislative policy; and (3) terms of delegation which require legislative policy determination by the agency and administrative/judicial review of whether that policy is within the delegation. Springfield Education Assn. v. School Dist., 290 Or 217, 223 (1980).

I conclude that the terms "permanent impairment due to the industrial injury" in ORS 656.726(3)(f)(A) are inexact terms, i.e., the legislature has expressed its meaning completely, but that meaning remains to be spelled out in the agency's rule or order. An inexact term gives the agency interpretive but not legislative responsibility. See Springfield Education Assn. v. School Dist., supra, 290 Or at 233. In determining whether the agency's interpretation is consistent with legislative policy, we must discern and apply the legislature's intent. The best indication of legislative intent is the words of the statute themselves. State ex rel Juv. Dept. v. Ashley, 312 Or 169, 174 (1991).

The term "permanent impairment" is not defined by statute; however, "impairment" is defined by the Director as "a decrease in the function of a body part or system as measured by a physician according to the measurement methods described in the American Medical Association Guides to the Evaluation of Permanent Impairment." OAR 436-35-005(5). Hence, by the Director's own definition, "impairment" is a loss of function of a body part or system, which, interestingly enough, is the same criterion used for measuring permanent disability in scheduled body parts. See ORS 656.214(2).

The remainder of the "standards" use the term "impairment" in referencing both scheduled and unscheduled permanent disability. See OAR 436-35-007; 436-35-010(6); 436-35-270(2); 436-35-280(1); 436-35-320. Other than the limitation on unscheduled chronic conditions, the rules do not make a distinction between impairment to a scheduled body part and impairment to an unscheduled body part. The same is true of the statutes. Scheduled permanent disability is based on loss of use or function, i.e., "impairment" according to the Director's rules. ORS 656.214(2). Similarly, unscheduled permanent disability is also based on impairment. ORS 656.726(3)(f)(A). While impairment in an unscheduled permanent disability situation is also modified by societal factors, the fact remains that the base requirement is impairment, just as with scheduled permanent disability.

Yet, as the ALJ observed, scheduled chronic condition awards are not subject to the same 5 percent limitation imposed on unscheduled chronic conditions awards. See OAR 436-35-010(6). Moreover, there is no apparent reason for the different treatment of chronic conditions. As the ALJ explained:

> "Unscheduled PPD [permanent partial disability] is determined on the basis of both impairment and societal factors. A chronic condition constitutes impairment, as opposed to a modifying social factor such as age and education. It must be established by a preponderance of the medical evidence based on objective findings. ORS 656.726(3)(f)(B). If such proof is presented, there is no readily apparent reason why the impairment should be considered as scheduled PPD, but not unscheduled PPD. ORS 656.726(3)(f)(A) provides that unscheduled PPD shall be evaluated on the basis of impairment as modified by the societal factors. If the chronic condition is proven, it exists and should be rated, regardless of the application of societal factors to the final calculation.
>
> "The total disregard of acknowledged impairment in some circumstances pertaining to unscheduled PPD, unlike full recognition of scheduled impairment, is arbitrary and inconsistent with the statutory directives regarding the standards." (Opinion and Order pp. 4-5).

Inasmuch as the Director recognizes chronic condition impairment, and I find no statutory or administrative basis for distinguishing unscheduled chronic conditions from scheduled chronic conditions, I agree with the ALJ that the 5 percent limitation in OAR 436-35-320(5) is arbitrary and exceeds the Director's statutory rulemaking authority under ORS 656.726(3)(f)(A).

The majority asserts that if a worker were granted a chronic condition award in an unscheduled permanent disability case, there is a potential for "double compensation" based on its assumption (and apparently the Director's) that residual disability may impact both impairment and adaptability factors. This assumption, however, has no statutory basis. ORS 656.726(3)(f)(A) expressly provides that the criteria for unscheduled permanent disability is permanent impairment "as modified by the factors of age, education and adaptability to perform a given job." Thus, the statute provides, without limitation, that all injury-related impairment must be rated. Only after impairment is rated may the rating be "modified" by social and vocational factors. There is no statutory basis for prohibiting a chronic condition award which is established by medical evidence supported by objective findings.

In addition, the criterion for rating the adaptability factor is significantly different from the criterion for chronic condition. A chronic condition is defined as the inability to repetitively use a body part. See OAR 436-35-320(5). The adaptability factor is based on a worker's residual functional capacity (RFC) to perform tasks of a "very heavy" to "sedentary" nature on an "occasional" or "frequent" basis. See OAR 436-35-310; OAR 436-35-270(3)(e)-(g). While a worker may be able to perform tasks occasionally or frequently, that does not mean he or she can perform those tasks repetitively. That is, while a worker may satisfy the RFC definition for performing medium work, i.e., have the capability to perform medium work as such is defined, the worker may nevertheless have an unscheduled body part which cannot be used repetitively. Afterall, as the majority states, residual functional capacity is based on "an individual's remaining ability to perform work related activities despite medically determinable impairment resulting from the accepted condition." (Majority Op. at p. 4, fn. 4) (Emphasis added). A worker may be able to perform medium work, despite the impairment of a chronic condition. Simply stated, RFC and adaptability do not encompass "impairment" and thus do not encompass a chronic condition limiting repetitive use of a body part. Therefore, there is no "double compensation."

Finally, it should not be overlooked that the Director does recognize an unscheduled chronic condition as impairment since the "standards" do allow for a 5 percent award if there is no other ratable impairment. OAR 436-35-320(5). This fact underscores the inconsistency in the Director's rules regarding chronic conditions. Such inconsistencies are contrary to the legislative directive that a worker be compensated for impairment suffered as a result of an on-the-job injury.

Under these circumstances, I would decline to apply the limitation in OAR 436-35-320(5) and would adopt the ALJ's overall impairment rating of 17 percent.

For these reasons, I respectfully dissent.

---



In the Matter of the Compensation of
**MELVIN F. TAYLOR, Claimant**
WCB Case No. 94-05577
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Christian, Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that upheld the insurer's denial of claimant's occupational disease claim for right shoulder conditions. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Degenerative Right Shoulder Condition

We adopt the ALJ's analysis regarding this issue.

Right Shoulder Subacromial Bursitis

Claimant's theory is that his preexisting degenerative right shoulder condition and his repetitive work activities resulted in an occupational disease, viz., right shoulder subacromial bursitis.[1] There is insufficient evidence to support that theory. Dr. Karmy, treating surgeon, stated that he did not believe that the degenerative condition could cause the bursitis. (Ex. 18-23). Therefore, claimant's bursitis is compensable as an occupational disease only if he can establish that his work activities were the major contributing cause of that condition. ORS 656.802(2).[2] He has not met that burden.

Dr. Karmy opined that claimant's work activities were the major contributing cause of claimant's need for treatment. (Ex. 16). In deposition, Karmy concluded that claimant's work activities were not the major contributing cause of his right shoulder condition. (Ex. 18-22). Although Karmy determined that claimant's repetitive shoulder use "created" the bursitis (see id. at 13), Karmy never identified the major contributing cause of that condition. In view of Karmy's statement that claimant's "right shoulder condition" was not caused, in major part, by his work activities, we find Karmy's failure to identify the major cause of claimant's right shoulder subacromial bursitis fatal to his claim for that condition.

In reaching this decision, we have considered claimant's arguments under ORS 656.005(7)(a)(B). We need not address those arguments because, even if ORS 656.005(7)(a)(B) applied, claimant's right shoulder subacromial bursitis claim would fail for lack of evidence regarding the major contributing cause of that condition.

For these reasons, we agree with the ALJ's decision to uphold the insurer's denial of claimant's right shoulder occupational disease claim.

ORDER

The ALJ's order dated February 24, 1995 is affirmed.

---

[1] The record refers to that condition as bursitis and tendinitis.

[2] Subsequent to hearing, the Legislature amended ORS 656.802. Or Laws 1995, ch 332, § 56. Those amendments are not at issue here.

**Board Member Gunn dissenting.**

I agree with the majority that claimant has failed to establish that his work is the major contributing cause of his right shoulder conditions. Because, however, I disagree with the application of the "major contributing cause" standard to this case, I dissent.

Claimant, who was 58 years old at hearing, had preexisting degenerative changes of the right shoulder due to the normal aging process. That process combined with his work activities to cause bursitis. The majority concludes that, under both ORS 656.802(2) and 656.005(7)(a)(B), claimant's bursitis claim fails for lack of evidence the his work activities were the major contributing cause of that condition.

The "major contributing cause" standard was enacted by the 1990 Legislature. Or Laws 1990 (Special Session), ch 2. The legislative history reveals that that standard was not intended to address "whether injured workers should and will get care, but rather where the responsibility for that care lies, and who should pay for it." Interim Special Committee on Workers' Compensation, May 7, 1990, Tape 3, Side A (Senate President Kitzhaber). The legislature recognized that, with the adoption of the Oregon Health Plan and other health care-related legislation in 1989, Or Laws 1989, chs 381, 836, the "major contributing cause" standard would merely redistribute responsibility for work-related injuries and diseases among carriers. (See id.) The predicate for the enactment of the "major contributing cause" standard was, then, a statewide "policy of universal access to health care." (Id.)

Today, that predicate is missing. Since 1990, the legislature has narrowed coverage under the Oregon Health Plan. See ORS Chapter 414. More important, Oregonians presently do not have universal health coverage. Because the basis for the 1990 Legislature's enactment of the "major contributing cause" standard does not exist, I posit that neither should the standard. For that reason alone, I would analyze this case under the "material contributing cause" standard.

I have another reason for questioning the wisdom of applying the "major contributing cause" standard to this claimant, who was 58 years old at hearing: Age discrimination.

This case is but one example of how the Workers' Compensation Act discriminates against older workers. As we age, degenerative processes begin to manifest themselves. Those processes thereby become "preexisting conditions" as to future injuries and diseases and, under present law, mandate the application of the "major contributing" cause standard to workers visited with the inevitable effects of longevity. See ORS 656.005(7)(a)(B); 656.802(2). It goes without saying that, because older people generally experience degenerative conditions more frequently than do younger people, the former much more likely will be burdened with the "major contributing cause" standard. In my view, that likelihood manifests an impermissive legislative hostility towards older persons that may violate the remedies clause of Article I, section 10, of the Oregon Constitution. Accordingly, for that additional reason, I would analyze this under the material, not major, contributing cause standard. The majority has determined to do otherwise. Consequently, I dissent.

---

November 22, 1995 Cite as 47 Van Natta 2272 (1995)

In the Matter of the Compensation of
**CATHERINE E. WOOD, Claimant**
WCB Case Nos. 94-08214 & 94-06498
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Balasubramani's order which: (1) upheld the SAIF Corporation's denials of her injury/occupational disease claims for right knee conditions; and (2) declined to award penalties and attorney fees for SAIF's allegedly unreasonable claim processing. In its brief, SAIF asserts that claimant did not timely request Board review. On review, the issues are compensability, penalties, attorney fees and jurisdiction. We affirm.

## FINDINGS OF FACT

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

Claimant, then a vehicle inspector for the Department of Environmental Quality, tripped and fell while performing her employment duties on January 15, 1987. Claimant's attending physician, Dr. Benz, diagnosed a patellofemoral contusion, which SAIF accepted on February 27, 1987 as a disabling right knee contusion. On May 4, 1987, Dr. Benz noted that claimant had developed prepatellar bursitis. (Ex. 4-2).

On November 17, 1987, an examining physician, Dr. Hardiman, reported that x-rays showed early degenerative osteoarthritic change involving both the patellofemoral and femoral-tibial articulations. (Ex. 7-2). Although Dr. Hardiman also diagnosed a right knee contusion, he reported that claimant's fall "aggravated" some preexisting degenerative changes.

On July 25, 1988, claimant's knee conditon was evaluated by a panel of examining physicians, Drs. Dinneen and Stoltzberg, who opined that claimant suffered bilateral knee contusions superimposed on preexisting degenerative changes. (Ex. 11). Dr. Benz concurred with the panel's report. (Ex. 12). The claim was then closed on August 19, 1988 by a Determination Order, which awarded 1 percent scheduled permanent disability.

Claimant sought no medical treatment for her right knee condition from June 1988 to February 1994, when she consulted Dr. Leverette for an exacerbation of right knee pain after she stood up after sitting for three hours in a meeting. (Ex. 17). Dr. Leverette diagnosed right patellar degenerative joint disease with recent exacerbation. Dr. Leverette referred claimant for a consultation with Dr. Tennant, who diagnosed mild osteoarthritis in the tibiofemoral joint, with lateral patellofemoral arthritic changes. (Ex. 19).

Claimant's right knee condition was subsequently evaluated by an examining physician, Dr. Duff, in March 1994. Dr. Duff diagnosed osteoarthritis in claimant's right knee and opined that this condition was the major contributing factor in claimant's disability and need for treatment. (Ex. 22-4).

On April 24, 1994, SAIF issued a denial of claimant's right knee degenerative joint disease (osteoarthritis) claim because the disease was the major contributing cause of claimant's disability and need for treatment. (Ex. 23). The denial, which referred to the claim number coinciding with claimant's 1987 accepted right knee contusion claim, stated:

> "In the event that you have a compensable claim, SAIF Corporation hereby issues a partial denial of all disability and need for treatment. It is our position that while all of your disability and need for treatment is the result of a combination of your injury and your preexisting condition, your injury is not the major contributing cause of your combined disability or need for treatment."

Dr. Benz reexamined claimant on August 14, 1994. Dr. Benz wrote in a September 14, 1994 letter to claimant's counsel that claimant's pathology in 1987 was patellofemoral arthralgia and probable patellofemoral chondromalacia. (Ex. 27). Noting that the diagnosis had changed from patellofemoral contusion to patellofemoral arthralgia and chondromalacia shortly after claimant's first visit in 1987, Dr. Benz opined that the 1987 injury was the major contributing cause of claimant's right knee condition.

## CONCLUSIONS OF LAW AND OPINION

Claimant testified that she had continuing problems with her right knee after she discontinued treatment in June 1988. (Trs. 20, 22). In addition, claimant contended that SAIF had, in 1987, denied "de facto" an aggravation of her preexisting degenerative knee conditions. Claimant further alleged that her current right knee chondromalacia, arthralgia and patellar problems diagnosed by Dr. Benz in 1994 had also been denied "de facto." Claimant also asserted that SAIF "de facto" denied medical services. Finally, claimant contended that SAIF's claim processing was unreasonable, entitling her to penalties and attorney fees.

The ALJ upheld the April 21, 1994 denial and denied all other relief claimant requested. Reasoning that SAIF had denied claimant's preexisting degenerative condition "de facto" in 1987, the ALJ upheld the "denial," finding that claimant had failed to prove that her compensable right knee contusion had worsened the degenerative condition. The ALJ also upheld the 1994 "de facto" denial of claimant's patellofemoral conditions, reasoning that there was insufficient medical evidence that the 1987 injury caused these conditions or that the 1994 "injury" was the major contributing cause of a symptomatic worsening. See U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). The ALJ upheld the April 21, 1994 denial of claimant's osteoarthritis, concluding that claimant's work activities were not the major contributing cause of this condition. Finally, the ALJ concluded that claimant was not entitled to medical services under ORS 656.245, finding insufficient evidence relating claimant's current condition to claimant's compensable right knee contusion.

Claimant requested reconsideration of the ALJ's order. In his reconsideration order, the ALJ determined that Dr. Benz' 1987 chart note diagnosing patellar bursitis was a claim which SAIF had denied "de facto." The ALJ set aside the denial, finding that this condition was caused by claimant's 1987 injury. The ALJ also withdrew that portion of his order finding that claimant's medical treatment was not related to her accepted condition, concluding that the issue of medical services was not raised by either party.

The ALJ issued his Order of Abatement and Reconsideration on May 19, 1995. That same day, claimant signed a certificate of mailing, certifying that she mailed a copy of her request for review of the ALJ's April 24, 1994 order to the parties. With the request for review, claimant attached a copy of the ALJ's April 24, 1994 order.

On review, claimant argues that the ALJ retained jurisdiction to issue a reconsideration order, even though she filed her request for review on the same day that the ALJ issued an abatement and reconsideration order. Claimant attaches an affidavit from a legal assistant, who avers that it was his "habit and routine" to deliver certified mail to the Post Office between 5 and 6 p.m. Since the Board's offices close at 5 p.m., claimant contends that her request for review must have occurred after issuance of the ALJ's abatement order and should be considered to have appealed both the original April 24, 1994 order and the May 19, 1994 reconsideration order. Finally, should we find that she perfected a valid appeal of the May 1994 Order of Abatement and Reconsideration, claimant seeks to "withdraw" her request for review with respect to the issues resolved in the reconsideration order.

On the merits, claimant contends that she has proved that her chondromalacia and degenerative joint disease were worsened by the 1987 injury. Claimant also alleges that SAIF's April 21, 1994 denial was an invalid prospective denial of future benefits and that she is entitled to an award of penalties and attorney fees based on SAIF's failure to timely accept her prepatellar bursitis condition and for SAIF's invalid prospective denial of future benefits.

SAIF responds that claimant's request for review of the ALJ's initial order was premature because it had been replaced by the reconsideration order when claimant's appeal had been filed. SAIF specifically argues that claimant's request for review only pertained to the April 24, 1995 order and that, because claimant did not request review of the ALJ's May 19, 1995 reconsideration order, there is no valid request for review of a final, appealable order. Thus, SAIF asserts that we do not have jurisdiction over claimant's request for review. Alternatively, SAIF contends that the ALJ properly determined that claimant's osteoarthritis is not compensable.

Jurisdiction

As a general rule, where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. See Ronald L. Ziemer, 43 Van Natta 1650); James D. Whitney, 37 Van Natta 1463 (1985). Here, on May, 19, 1995, the ALJ abated his April 24, 1994 order. That same day, claimant requested Board review of the ALJ's April 24, 1995 order. Inasmuch as the ALJ abated his order the same day as claimant requested Board review, we would generally give effect to the Order of Abatement. See Boyd C. Thornton, 44 Van Natta 1788 (1992).

However, in this case, claimant has submitted an unrebutted affidavit from a legal assistant establishing that claimant's request for review was mailed after 5 p.m., the latest time that the ALJ's reconsideration order could have mailed. Inasmuch as claimant's request for review was mailed within 30 days of the issuance of the ALJ's May 19, 1995 Order on Reconsideration, and because that reconsideration order supplemented and republished the ALJ's April 24, 1995 order, we conclude claimant's request encompassed both orders. See Rudolph A. Beeman, 43 Van Natta 55 (1991). Thus, we find that claimant's request for review was timely. We, therefore, proceed to the merits.[1]

Compensability

Claimant contends that her diagnosed chondromalacia and degenerative joint disease are compensable based on the medical opinions of Dr. Benz and Dr. Hardiman. Specifically, claimant asserts that her 1987 injury caused a worsening of those conditions. We disagree.

Claimant does not specify the precise legal standard to be applied in determining the compensability of her osteoarthritis and chondromalacia condition. SAIF, on the other hand, contends that the major contributing cause standard is applicable.

---

[1] Claimant seeks to "withdraw" appeal of the issues resolved in the ALJ's May 19, 1995 reconsideration order. However, a request for review pertains to the ALJ's order, not specific issues or WCB case numbers. We may address any issue considered by the ALJ, even in the absence of a cross-request for review on that issue. Destael v. Nicolai Company, 80 Or App 596, 600-01 (1986); Omer L. Oyster, 44 Van Natta 2213 (1992); William E. Wood, 40 Van Natta 999, 1001 (1988). As long as claimant maintains her request for review, SAIF can raise any issue even without a formal cross-request for review. Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983).

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)). Based on the medical opinions of Drs. Benz, Hardiman, Dinneen and Stolzberg, we find that the medical evidence establishes that claimant's osteorthritis preexisted claimant's compensable 1987 right knee contusion and, further, that this condition combined with the compensable injury to cause disability or a need for medical treatment. (Exs. 7, 11, 12). Accordingly, we conclude that ORS 656.005(7)(a)(B) is applicable with regard to the osteoarthritis condition.[2] Therefore, claimant must prove that her compensable injury is the major contributing cause of her need for medical treatment.

With respect to claimant's chondromalacia, Dr. Benz stated in a 1994 letter to claimant's counsel that he diagnosed this condition in 1987. (Ex. 27). However, Dr. Benz' chart notes do not reflect this diagnosis. We need not definitively determine whether a material or major causation standard applies to this condition, however, because we do not find this condition compensable under either standard.

Considering claimant's osteoarthritis condition first, Dr. Benz' September 14, 1994 medical report does not address the cause of this condition. (Ex. 27). While Dr. Hardiman stated in January 1987 that claimant's injury "aggravated" some preexisting degenerative changes, there is no explanation of Dr. Hardiman's conclusory statement. Thus, we do not find Dr. Hardiman's opinion to be persuasive evidence that claimant's 1987 injury is the major contributing cause of claimant's need for treatment of the combined/resultant condition. See Somers v. SAIF, 77 Or App 259 (1986) (greatest weight given to well-reasoned medical opinions). Based on this record, we agree with the ALJ that claimant has failed to sustain her burden of proving that her osteoarthritis condition is compensable.

We also reach a similar conclusion with respect to the chondromalacia condition that Dr. Benz mentioned in his September 14, 1994 medical report to claimant's attorney. As previously noted, Dr. Benz' contemporaneous medical records in 1987 and 1988 do not mention a chondromalacia condition. Although Dr. Benz now insists that the 1987 injury is the major contributing cause of this condition, we do not find this opinion persuasive because it is conclusory and lacks an explanation of how claimant's accident caused this condition. Somers v SAIF, supra. Moreover, Dr. Benz does not explain why the diagnosis of chondromalacia never appeared in his contemporaneous chart notes, nor does Dr. Benz acknowledge the substantial period of time from June 1988 to February 1994 in which claimant did not seek medical treatment. We thus agree with the ALJ that claimant has failed to sustain her burden of proof with respect to this condition.[3]

Penalties and Attorney Fees

Claimant contends that she is entitled to penalties and attorney fees for SAIF's failure to timely accept her prepatellar bursitis and for an allegedly prospective denial. SAIF does not dispute the ALJ's finding that a claim was made in 1987 for claimant's bursitis condition. Inasmuch as SAIF offers no justification for its failure to timely accept or deny this condition, we agree with claimant that SAIF's claim processing was unreasonable. However, claimant has not treated for this condition since 1988. There is no evidence in the record that any compensation for this condition was unpaid at the time of the hearing. Thus, there is no basis for a penalty under ORS 656.262(11). Moreover, under these circumstances, there was no unreasonable resistance to the payment of compensation that would allow

---

[2] 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 not established that the January 15, 1987 work injury was the major contributing cause of her need for treatment for the combined condition. Consequently, we do not address which version of the statute should apply to this case.

[3] As previously noted, Dr. Duff opined that claimant's osteoarthritis was the major contributing cause of claimant's need for treatment. Both Dr. Leverette and Dr. Tennant concurred with this assessment. (Exs. 24-2, 25-1).

for the assessment of an attorney fee under ORS 656.382(1). See SAIF v. Condon, 119 Or App 194 (1993); Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991). Thus, we deny claimant's request for penalties and attorney fees.

Finally, claimant contends that SAIF's April 1994 denial is a prohibited prospective denial. We disagree.

It is well settled that prospective denials are impermissible. An insurer may not deny its future responsibility for payment of medical services for a previously accepted claim. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). We look to the language of the denial notice itself. If it denies benefits for a current need for treatment, but does not preclude future benefits, it is not impermissibly prospective. Green Thumb v. Basl, 106 Or App 98 (1991).

In the present case, SAIF issued a partial denial of "all disability and need for treatment" for claimant's right knee degenerative joint disease (osteoarthritis). However, it did not deny SAIF's ongoing responsibility for claimant's accepted right knee contusion. Rather the denial specifically denied disability or medical treatment for the "combination" of the preexisting condition and the compensable injury. In light of such circumstances, we interpret the basis for SAIF's denial to be ORS 656.005(7)(a)(B). Thus, we find that the language of SAIF's partial denial purports only to deny a current need for treatment under that statute and cannot be presumed to deny all future benefits related to the compensable 1987 injury. Therefore, it is not an invalid prospective denial. Green Thumb v. Basl, supra.

## ORDER

The ALJ's order dated April 24, 1995, as supplemented on May 19, 1995, is affirmed.

In the Matter of the Compensation of
**TARA L. PRESSLEY, Claimant**
WCB Case No. 94-11817
ORDER ON REVIEW
Welch, Brunn, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) admitted exhibits 1 through 61; and (2) upheld the insurer's denial of her current right wrist condition and aggravation claim. On review, the issues are evidence and compensability.

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

Claimant argues that the ALJ erred in admitting Exhibits 1 through 61 because these documents are not relevant and material. The insurer argues that these exhibits were relevant and material to claimant's credibility, and therefore properly admitted.

Even without giving any weight to the evidence in exhibits 1 through 61,[1] we find, based on other inconsistencies in the record, that claimant is not credible and has not sustained her burden of proof. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987) (when the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility). For example, claimant did not offer any explanation for or rebuttal to Dr. Button's October, 1993 assessment that she was "basically faking" her responses to his testing. Dr. Button diagnosed a "functional, psychologic hand presentation" that had no direct relationship to her minor industrial injury of March 1993.[2] Moreover, at hearing, claimant denied any injury to her hand or wrist as a result of the altercation with the police officer, yet medical records contemporaneous with and subsequent to the incident indicate that this incident did cause some additional injury. Claimant reported to Dr. Browning on October 27, 1993 that the officer grabbed her right wrist despite her protestations and placed it behind her back. In other reports, claimant stated that she was thrown against her car or onto the ground by the police officer.

We further find that Dr. Van Allen's report is insufficient to establish material causation, as it is not based on a complete and accurate history. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Miller v. Granite Construction Co., 28 Or App 473, 478 (1977) (doctors' opinions based on an inaccurate history entitled to little or no weight).

ORDER

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

---

[1] We do not consider the evidence in the challenged exhibits because such evidence is not relevant to claimant's current wrist condition, nor was claimant impeached with this evidence at hearing.

[2] Claimant's then-treating physician, Dr. Browning, concurred with this diagnosis.

In the Matter of the Compensation of
**TERRY L. COX, Claimant**
WCB Case No. 94-04171
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.[1]

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that declined to assess an attorney fee for his counsel's services in obtaining a Director's vocational assistance order directing the insurer to assist claimant in the development of a training plan. On review, the issues are jurisdiction 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

Claimant sustained a compensable bilateral carpal tunnel condition beginning January 13, 1992. Claimant became medically stationary on February 8, 1993, and his claim was closed with an award of scheduled permanent disability by Notice of Closure issued on March 17, 1993.

After the claim was closed, claimant's treating physician advised the insurer that claimant would be unable to return to his regular job due to the compensable condition. The insurer thereafter declared claimant eligible for vocational services. Claimant sought retraining through an authorized training program (ATP); the insurer instead offered claimant a direct employment program (DEP). Claimant objected, and, through counsel, appealed to the Director.

The Director ordered the insurer to develop an ATP. The Director did not award claimant's counsel an attorney fee. Claimant requested a hearing, seeking an assessed attorney fee for his counsel's services in obtaining the Director's order. Finding that the insurer did not unreasonably resist the payment of compensation by offering claimant a DEP rather than an ATP, the ALJ declined to assess an attorney fee. 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 have previously 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 the claimant's hearing request for lack of jurisdiction.

Further, we addressed the question of jurisdiction over penalty and attorney fee matters related to vocational assistance disputes in Ronald E. Norton, 47 Van Natta 1580 (1995). Relying on Enyart, supra, we held that we are without authority to award penalties or attorney fees for matters arising under the Director's jurisdiction. See SB 369, § 42d(5). Therefore, in that case, we also vacated the ALJ's order and dismissed the claimant's hearing request for lack of jurisdiction.

---

[1] Although signatory to this order, Member Gunn refers the parties to his specially concurring opinion in Ross M. Enyart, 47 Van Natta 1540, 1542-43 (1995).

Inasmuch as this attorney fee case is before us on a request for hearing from a Director's vocational assistance order, and since we have held that the Director now has exclusive jurisdiction to resolve vocational assistance disputes, including related penalty and attorney fee matters, we conclude, based on our decisions in Enyart, supra, and Norton, supra, that we lack jurisdiction to consider this attorney fee matter. Accordingly, we vacate the ALJ's order and dismiss claimant's hearing request from the Director's order.

ORDER

The ALJ's order dated August 25, 1994 is vacated. Claimant's hearing request from the Director's order is dismissed for lack of jurisdiction.

---

November 28, 1995 Cite as 47 Van Natta 2279 (1995)

In the Matter of the Compensation of
**EDWARD F. EBERT, Claimant**
WCB Case No. 94-15103
ORDER OF ABATEMENT
Pozzi, Wilson, et al, Claimant Attorneys
Jeffrey R. Gerner (Saif), Defense Attorney

Claimant requests abatement and reconsideration of our November 8, 1995 Order on Review that affirmed an Order on Reconsideration's award of 21 percent (67.2 degrees) unscheduled permanent disability. Claimant contends that our order appears to be contrary to our decision in Deborah A. Johnston, 47 Van Natta 1949 (1995).

In order to allow sufficient time to consider this motion, we withdraw our November 8, 1995 order. The SAIF Corporation is granted an opportunity to respond to claimant's motion. To be considered, SAIF's response must be submitted within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

---

November 28, 1995 Cite as 47 Van Natta 2279 (1995)

In the Matter of the Compensation of
**JO W. ORMAN, Claimant**
Own Motion No. 91-0707M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Darris K. Rowell, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

Claimant requests reconsideration of our August 11, 1995 Own Motion Order, as reconsidered on October 30, 1995, in which we concluded that claimant's current enforcement action is barred by claim preclusion. With her request for reconsideration, claimant argues that we erred in finding claim preclusion bars her enforcement action. In addition, on the merits, claimant argues that she is entitled to the penalties initially awarded by our August 11, 1995 Own Motion Order, as well as procedural temporary disability benefits from July 10, 1990 through March 9, 1993. After considering claimant's arguments, we continue to find that her current enforcement action is barred by claim preclusion.

In Drews v. EBI Companies, 310 Or 134, 140 (1990), the Supreme Court quoted Rennie v. Freeway Transport, 294 Or 319 (1982), in summarizing the elements of claim preclusion:

> "'[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [i.e., precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action.'" Rennie v. Freeway Transport, 294 Or 319, 323 (1982).

In addition, the Court in Drews explained:

> "[c]laim preclusion does not require actual litigation of an issue of fact or law, as does issue preclusion. Nor does it require that the determination of the issue be essential to the final or end result reached in the action, claim, or proceeding. However, claim preclusion requires that specified characteristics be present in the former action or proceeding before the determination is conclusive on the parties in the future. The opportunity to litigate is required, whether or not it is used. Finality is also required. * * * Where there is an opportunity to litigate the question along the road to the final determination of the action or proceeding, neither party may later litigate the subject or question." Drews v. EBI Companies, supra. (Citations omitted).

In our October 30, 1995 Own Motion Order on Reconsideration, we determined that claimant was precluded from bringing her current enforcement action because she could have brought that action in 1993 when she requested review of the SAIF Corporation's claim closure. Claimant argues that the elements of claim preclusion are not met in her claim because the two actions are not based on the same "factual transaction." Specifically, claimant identifies the 1993 action as arising out of the claim closure itself and the current enforcement action as arising out of SAIF's conduct prior to claim closure. We disagree with claimant's argument.

Here, both the 1993 action and the current enforcement action are based on complaints about SAIF's processing of the claim that was authorized to be reopened by the October 16, 1992 Own Motion Order, as reconsidered November 25, 1992. In the 1993 action, claimant contended that SAIF had prematurely closed the claim reopened by the November 1992 order. By Own Motion Order Reviewing Carrier Closure dated August 10, 1993, as reconsidered September 9, 1993 and November 29, 1993, the Board affirmed SAIF's March 9, 1993 Notice of Closure. On June 5, 1995, claimant brought the current enforcement action before the Board in its own motion authority. In this enforcement action, claimant contended that SAIF had not properly processed the claim reopened by the November 1992 order prior to claim closure. Under these circumstances, we consider that both actions involved the same factual transaction.

Claimant contends that Donna Anderson, 46 Van Natta 1160 (1994), and John L. Desmond, 45 Van Natta 1454 (1993), support her contention that her current enforcement action is not barred by claim preclusion. We disagree.

In Donna Anderson, supra, the claimant brought an action in own motion requesting, among other things, procedural temporary disability benefits through the date of claim closure and penalties for the carrier's allegedly unreasonable failure to pay those benefits. The claimant did not argue that her medically stationary date was incorrect or that she was not medically stationary at claim closure. Applying Lebanon Plywood v. Seiber, 113 Or App 651 (1992), we determined that we were without authority to impose a procedural overpayment by awarding temporary disability benefits beyond the date that the claimant was substantively entitled to such benefits, i.e., the medically stationary date. 46 Van Natta 1162. However, we assessed a penalty for the carrier's unreasonable failure to pay temporary disability benefits on an open, accepted claim through the date of closure, where there was no basis for the carrier to unilaterally terminate the payment of such benefits prior to closure. 46 Van Natta 1163.

Claimant contends that, because there is no indication that the claimant in Anderson was required to appeal the Notice of Closure in order to raise the issue of penalties relating to the carrier's pre-closure conduct, that case "implicitly acknowledges that a claim for penalties based on an insurer's pre-closure conduct and claims raised on appeal from a Notice of Closure arise out of separate and distinct operative facts." (Claimant's Motion for Reconsideration, page 4). We disagree.

There was no claim preclusion issue involved in Anderson. Unlike the present case, Anderson did not involve a second action. Anderson involved an initial action for procedural temporary disability and penalties based on failure to pay those benefits. In claimant's case, she did not raise these issues until her second action, although she could have raised these issues in the action contesting the Notice of Closure. Therefore, we do not find that Anderson supports claimant's position.

Claimant quotes portions of John L. Desmond, supra, noting that the Board stated that its "order in this case addressed only claimant's procedural entitlement to temporary disability benefits and does not preclude claimant from establishing a greater substantive entitlement to those benefits by directly appealing from the Notice of Closure." 45 Van Natta 1456 n 1. Claimant contends that this quoted language means that a decision denying procedural entitlement does not bar a subsequent claim based on substantive entitlement. Thus, claimant contends, Desmond supports her position that she is not barred from seeking the current enforcement action. We disagree with this contention.

Claimant overlooks the procedural posture of Desmond, which was a "show cause" hearing conducted pursuant to OAR 438-06-075. Due to this procedural posture, the substantive entitlement issue was not before the Hearings Division or the Board and could be raised later by directly appealing the Notice of Closure. Therefore, Desmond does not support claimant's position.

In addition, claimant argues that the current enforcement action does not seek a remedy that is additional or alternative to the one sought in the 1993 action. We disagree. In the 1993 action contesting SAIF's Notice of Closure, claimant sought to have the Notice of Closure set aside as premature. In the current enforcement action, claimant seeks procedural temporary disability benefits and penalties. These are additional remedies to those sought in the 1993 action.

Finally, claimant argues that, although the issues raised in her current enforcement action could have been joined with those in the 1993 action, such joinder is permissive. However, the whole point to claim preclusion is that issues that can be joined must be joined or the party will not be able to litigate those issues in the future. Drews v. EBI Companies, 310 Or at 140.

Accordingly, we withdraw our August 11, 1995 order, as reconsidered on October 30, 1995. On reconsideration, as supplemented herein, we adhere to and republish those prior orders effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---

November 29, 1995 Cite as 47 Van Natta 2281 (1995)

In the Matter of the Compensation of
**KIM E. DANBOISE, Claimant**
WCB Case No. 94-14711
ORDER ON RECONSIDERATION
Bottini, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our November 7, 1995 order that affirmed an Administrative Law Judge's order that awarded claimant 21 percent (67.2 degrees) unscheduled permanent disability for a back injury, whereas an Order on Reconsideration had granted no permanent disability. Contending that claimant has failed to prove that his cervical impairment is due to his compensable cervical strain, SAIF asks that we find that claimant not entitled to a permanent disability award for that strain.

We withdraw our November 7, 1995 order for reconsideration. After considering SAIF's request and reviewing the record, we continue to find that claimant has established that his cervical impairment is due to his compensable injury.

SAIF refers us to Kathleen P. Farley, 46 Van Natta 971 (1994), in which we declined to award permanent disability because the medical experts had failed to address whether the claimant's disability was due to the compensable injury, and Julie A. Widby, 46 Van Natta 1065 (1994), in which we noted that there is no requirement that a medical arbiter report only impairment findings that are due to a compensable injury. Under those cases, SAIF asserts, claimant must prove that his cervical impairment was due to his compensable injury.

We agree that claimant has the burden of establishing that his cervical impairment is due to his compensable injury. ORS 656.214(5);[1] OAR 436-35-007(1). Claimant may, however, meet that burden by presenting a treating physician's or medical arbiter's report that: (1) contains impairment findings that are consistent with her compensable injury; and (2) does not attribute those findings to causes other than the compensable injury. Edith N. Carter, 46 Van Natta 2400 (1994); David J. Schafer, 46 Van Natta 2298 (1994). For the reasons stated in our prior order, we continue to conclude that claimant has met her burden under that standard.

In Shafer, we distinguished Julie A. Widby, supra, on the ground that, in the latter case, the medical arbiter had also commented on other noncompensable causes for the claimant's impairment. In Shafer, as here, there was no discussion of any noncompensable causes for the claimants' impairments. Consequently, Widby is inapposite.

Kathleen P. Farley, supra, does not dictate a contrary result. That case issued before Shafer and Carter, when we recognized that the "due to" requirement could be established by impairment findings consistent with a compensable injury and the lack of attribution of those findings to causes other than that injury. Because we continue to find Shafer and Carter well-reasoned, we reject SAIF's argument under Farley.[2]

Accordingly, our November 7, 1995 order is withdrawn. On reconsideration, as supplemented here, we republish our November 7, 1995 order in its entirety. The parties' appeal rights shall run from the date of this order.

IT IS SO ORDERED.

---

[1] Our prior order cited ORS 656.214(2) for the proposition that a worker's disability must be due to the compensable injury. Because this case involves unscheduled permanent disability, ORS 656.214(5) is the correct citation. We modify our prior order accordingly.

[2] SAIF also refers us to Christine M. Hasvold, 47 Van Natta 979 (1994), and Dave Perlman, 47 Van Natta 708 (1995). In Hasvold, there were noncompensable factors that may have contributed to the claimant's impairment. Here, no such factors have been identified. Perlman involved the validity of impairment findings. That is not an issue here. For these reasons, we do not rely on Hasvold or Perlman.

---

November 29, 1995 Cite as 47 Van Natta 2282 (1995)

In the Matter of the Compensation of
**LONNIE L. DYSINGER, Claimant**
WCB Case No. 95-02869
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members en banc.

Claimant requests review of Administrative Law Judge (ALJ) Daughtry's order that declined to award claimant additional temporary partial disability (TPD). On review, the issue is temporary partial disability. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Relying on Stone v. Whittier Wood Products, 124 Or App 117 (1993), the ALJ concluded that the insurer correctly calculated claimant's TPD rate based on his at-injury wage. Claimant asserts that, under Stone and former ORS 656.212, calculation of his "loss of earning power" requires that his TPD rate be based on his post-injury, higher wage. We disagree.

Former ORS 656.212 provides that TPD is to be based on "loss of earning power at any kind of work." Relying on the statute, the Stone court held that TPD must be measured by loss of earning power "at any kind of work," not just the job held at injury. 124 Or App at 122.

The Legislature recently amended ORS 656.212. Or Laws 1995, ch 332, § 16 (SB 369, § 16). Amended ORS 656.212 provides, in part:

> "When the disability is or becomes partial only and is temporary in character:
>
> "* * * * *
>
> "(2) The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive for an aggregate period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of wages bears to the wage used to calculate temporary disability pursuant to ORS 656.210." (Emphasis added).

ORS 656.210(2)(b)(A) provides that "[t]he benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury."[1] Consequently, under amended ORS 656.212, a worker's TPD rate is calculated based on a comparison of a claimant's wage at modified employment with his at-injury wage. To the extent that Stone holds otherwise, it is no longer good law.

Amended ORS 656.212 applies here, because it is not among the exceptions to retroactivity enumerated in section 66 of SB 369, and because appeal of this case was pending on June 7, 1995, the effective date of the legislation. See Volk v. America West Airlines, 135 Or App 565 (1995). Accordingly, we affirm the ALJ's decision to uphold the insurer's calculation of claimant's TPD rate based on a comparison of claimant's wage at modified employment with his at-injury wage.

ORDER

The ALJ's order dated May 1, 1995 is affirmed.

---

[1] SB 369 did not amend that subsection.

---

November 29, 1995 Cite as 47 Van Natta 2283 (1995)

In the Matter of the Compensation of
**JAMES EDMONDS, Claimant**
WCB Case No. 93-11930
ORDER ON REMAND (REMANDING)
Coons, Cole & Cary, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. The court has remanded our order, James Edmonds, 47 Van Natta 230 (1995), which affirmed an Administrative Law Judge's (ALJ's) order that awarded temporary disability. In accordance with the court's August 21, 1995 order, we review this case "pursuant to Senate Bill 369."

We begin with a brief summary of the relevant facts. At the time claimant was hired by the employer, claimant signed a drug policy which prohibited him from being under the influence of drugs while at work. Thereafter, claimant compensably injured his left hand and received medical treatment. At the time of his injury, claimant underwent a drug screen for which he tested positive for marijuana.

While claimant was recovering from his injury, the employer paid temporary total disability benefits (TTD). On September 1, 1993, claimant's attending physician released claimant to modified work. Also, on September 1, 1993, the employer issued two letters to claimant. One letter stated that claimant was fired for breaching the employer's policy. The other letter stated that a modified job was available, but that he would not be able to perform the "job" because of his termination. The employer then terminated claimant's TTD because claimant failed to begin employment for reasons unrelated to his compensable injury. Former ORS 656.268(3)(c).

The ALJ determined that the employer did not comply with former ORS 656.268(3) and its termination of claimant's temporary total disability was improper.

On review, we affirmed the ALJ's order, finding that claimant did not "fail" to begin employment because having been fired, he had no choice as to whether he would actually perform the modified work. James Edmonds, supra. We reasoned that the determinative fact was that modified work was never actually offered. Therefore, we concluded that the employer was not justified in unilaterally terminating payment of temporary disability. The employer petitioned for judicial review.

On remand from the court, the employer requests that, pursuant to the amendments to ORS 656.325(5)(b), we remand this case to the ALJ to reopen the record for admission of additional evidence. Claimant does not contest the employer's request. After further consideration of the matter, we grant the employer's request.

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.325(5)(b) to read: "If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers." Or Laws 1995, ch 332, § 40 (SB 369, § 40) (Emphasis added).

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 656.325(5)(b) 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 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, the record contains no evidence of whether "the employer ha[d] a written policy of offering modified work to injured workers." See ORS 656.325(5)(b). As such, we consider the record to be incompletely and insufficiently developed to determine whether the employer could have commenced payments of temporary partial disability after claimant was terminated for breaching its employment policy. Therefore, we find that there is a compelling reason to remand this matter for the submission of additional evidence regarding whether the employer had a written policy of offering modified work to injured workers.

Accordingly, we vacate the ALJ's order and remand this case to ALJ Spangler 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.

---

[1] Under § 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 656.325(5)(b) does not alter a procedural time limitation, § 66(6) does not apply to this case.

In the Matter of the Compensation of
**ILENE M. HERGET, Claimant**
WCB Case Nos. 94-13664 & 93-14722
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Balasubramani's order that: (1) awarded interim compensation; and (2) assessed a penalty for allegedly unreasonable claim processing. On review, the issues are interim compensation and penalties.

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

Since the ALJ's order, the legislature amended ORS 656.273(3), which defines the requirements for perfecting an aggravation claim. The statute 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." Or Laws 1995, ch 332, § 31 (SB 369, § 31).

This amended statute has been retroactively applied to an aggravation claim in litigation. See Sullivan v. Sears, Roebuck & Co., 136 Or App 302 (1995). Because this is such a case, the amended statute is likewise applicable here.

Claimant's entitlement to interim compensation in the form of temporary disability benefits depends on whether the employer received notice or knowledge of a medically verified inability to work in a medical report which satisfies the requirements of the above-quoted statute (and thus constitutes prima facie evidence in the form of objective findings that claimant's compensable condition has worsened). See ORS 656.273(6).[1] See Filogonia Reyes-Cruz, 46 Van Natta 1294, 1296 (1994).

Claimant contends that Dr. Harvey's June 15, 1994 letter to claimant's counsel (which the employer received on June 23, 1994) perfected her aggravation claim and triggered the employer's duty to pay interim compensation. In that letter, Dr. Harvey, attending physician, opined that claimant suffered an aggravation of her April 30, 1992 work injury in April 1994 while carrying stacks of paper at a new job. Noting claimant's increased pain and reduced range of motion since her April 1993 claim closure, Dr. Harvey reported that he had taken claimant off work for three weeks and recommended physical therapy in response to her April 1994 worsening. (Ex. 47).

The employer argues that claimant is not entitled to interim compensation on two bases. First, the employer contends that it was not required to respond to the claim because notice of the claim was not accompanied by the Department's aggravation form, as required by amended ORS 656.273(3). We disagree.

We have declined to impose the amended statute's "Department form" requirement retroactively, because retroactive application would produce an absurd and unjust result by requiring a claimant to comply with notice procedures not in existence when the claim was filed. Rick A. Webb, 47

---

[1] ORS 656.273(6) provides:

> "A claim submitted in accordance with this section shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, except that the first installment of compensation due under ORS 656.262 shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from a compensable worsening under subsection (1) of this section."

Van Natta 1550 (1995). Here, for the reasons explained in Webb, supra, claimant was not required to comply with procedural requirements not yet in existence.[2]

Moreover, we find that the above-described letter from claimant's attending physician establishes by written medical evidence supported by objective findings that claimant has suffered a worsened condition attributable to her compensable injury.[3] Consequently, we conclude that notice of this claim was legally sufficient and the employer was statutorily obligated to respond to it by timely paying interim compensation or issuing a denial. See ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991), remanded on other grounds, Stanley Smith Security v. Pace, 118 Or App 602 (1993) (Delineating the requirements for an aggravation claim under former ORS 656.273).

Alternatively, the employer contends that an order directing it to pay temporary disability benefits (in the form of interim compensation) for periods after claimant's August 11, 1994 medically stationary date amounts to imposition of an impermissible procedural overpayment on appeal, particularly because the claim has been found not compensable. See Lebanon Plywood v. Seiber, 113 Or App 651 (1992). We disagree.

The statutory obligation to pay interim compensation does not depend on whether the claim is ultimately determined to be compensable. See Patricia J. Sampson, 45 Van Natta 771 1993; A.G. McCullough, 39 Van Natta 65, 68 (1987).[4] Moreover, if the employer had denied the claim within 14 days, it would have had no duty to pay interim compensation. See Jones v. Emanuel Hospital, 280 Or 147, 151 (1977) ("ORS 656.262 gives the employer two choices: deny the claim or make interim payments."); Stanley Smith Security v. Pace, supra at 608. Under these circumstances, we agree with the ALJ that claimant is entitled to interim compensation commencing 14 days after receipt of notice of this aggravation claim and continuing until the date of hearing (when the claim was found not compensable). See ORS 656.273(6). See Stacie Pierce, 46 Van Natta 2395 (1994); Filogonia Reyes-Cruz, supra.

---

[2] Although we do not impose the "Department form" requirement retroactively (because that would produce an absure and unjust result), we do require compliance with the second sentence of amended ORS 656.273(3), which provides that the aggravation claim "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." Or Laws 1995, Ch 332, § 31 (SB 369, § 31). Because the latter requirement is not new, it is not applied "retroactivley" here. See former ORS 656.273; Doris A. Pace, 43 Van Natta 2526 (1991), remanded on other grounds, Stanley Smith Security v. Pace, 118 Or App 602 (1993).

[3] In reaching this conclusion, we note that Dr. Harvey's June 15, 1994 letter explicitly related claimant's worsened condition to her compensable work injury; reported objective findings of a worsening, including reduced range of motion; and advised the employer that he had taken claimant off work and prescribed physical therapy as a result of the worsening. In the letter, Dr. Harvey also acknowledged that he could not say that claimant had "a material worsening of her condition per se," because he had not yet ordered a repeat CT or MRI scan. (Ex. 47). However, in our view, Dr. Harvey's uncertainty in this regard, in light of his contemporaneous observations, does not mean that the letter was anything less than a claim for an aggravation under ORS 656.273(3). Because Dr. Harvey's letter constituted medical verification of claimant's inability to work and satisfied ORS 656.273(3), it triggered the employer's processing duties under ORS 656.273(6). In other words, because Dr. Harvey's June 15, 1995 medical verification of claimant's inability to work put the employer on notice of a worsening attributable to the compensable injury, the employer had a duty to respond to the claim.

[4] Here, as in McCullough, supra:

> "The noncompensability of the claim has become final by operation of law. However, this determination does not extinguish the issue of whether the employer properly exercised its processing obligations. . . . Were we to grant the employer's motion [to dismiss this matter], our decision could be interpreted as a concurrence with the proposition that it is not always necessary for an insurer/employer to fulfill its statutory obligations. In addition, such a decision could encourage future insurers/employers to forsake their processing obligations, if they understood that their conduct would not be subject to review once the underlying claim was found noncompensable." Id.; see Jones v. Emanuel Hospital, 280 Or 147 (1977).

Claimant's attorney is entitled to an assessed fee for services on review regarding the interim compensation 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 interim compensation issue is $750, 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. Finally, we note that claimant is not entitled to an attorney fee for services on review devoted to the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated May 1, 1995 is affirmed. For services on review, claimant's counsel is awarded a $750 attorney fee, payable by the self-insured employer.

---

November 29, 1995 Cite as 47 Van Natta 2287 (1995)

In the Matter of the Compensation of
**CRAIG L. HIATT, Claimant**
WCB Case No. 92-14383
ORDER ON REMAND
Donald E. Beer, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Hiatt v. Halton Co., 132 Or App 620 (1995). In our prior order, we upheld the self-insured employer's denial of claimant's left hearing loss condition. Craig L. Hiatt, 46 Van Natta 192 (1994). Concluding that the employer's failure to appeal a Determination Order (DO) award for left hearing loss barred it from arguing that the left hearing loss condition was not part of the accepted left otitis media claim, the court has reversed our prior order and remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured in February 1990 when a piece of hot metal entered his left ear. Claimant's injury claim was accepted for left otitis media. The claim was closed by a DO, which awarded 6 percent scheduled permanent disability for loss of hearing in the left ear.

Subsequent medical evidence revealed that claimant had a left-sided high frequency hearing loss which preexisted the compensable injury. The preexisting hearing loss resulted from noise exposure rather than from a physical injury. In response to this new medical evidence, the employer denied "left hearing loss."

Claimant requested a hearing from the employer's denial. Concluding that the employer was barred from denying the compensability of a disability that had been finally determined to be related to the compensable injury by a DO, the ALJ set aside the employer's denial of claimant's left hearing loss.

On Board review, we reversed the ALJ's order. Craig L. Hiatt, supra. We reasoned that claimant's accepted otitis media claim and his claim for left hearing loss did not arise out of the same aggregate of operative facts. On this basis, we reasoned that the preexisting hearing loss and the February 1990 injury did not constitute the same "claim" for purposes of claim preclusion. Accordingly, we concluded that the employer was not barred by claim preclusion from denying the preexisting left sided hearing loss. Addressing the merits, we concluded that claimant had not proven that his left high frequency sensorineural noise induced-hearing loss was causally related to his industrial injury or compensable otitis media condition.

The court reversed our order and remanded for reconsideration. Hiatt v. Halton Co., supra. The court acknowledged that there was no medical evidence indicating that claimant had any hearing loss that was not noise-related. Nevertheless, the court reasoned that the carrier could have sought a hearing on the DO and challenged the award if it believed that it was being made in part for a noncompensable condition. The court concluded that the carrier's failure to challenge the DO hearing loss award barred it from arguing that the left hearing loss was not part of the compensable claim. In reaching its decision, the court relied on Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 120 Or 507 (1995).

In conducting our reconsideration, we are mindful of the court's instructions. However, subsequent to the date of the court's decision, the legislature enacted SB 369, which amended ORS 656.262(10) (formerly ORS 656.262(9)). Or Laws 1995, ch 332, § 28 (SB 369, §28). According to § 66(5)(b) of SB 369, ORS 656.262(10) applies retroactively to all claims "without regard to any previous order or closure." Under § 66(5)(a) of SB 369, the amendments to ORS chapter 656 apply only to those matters for which an order or decision has not become final on or before the effective date of the Act. Inasmuch as there has been no final order or decision in this case and because the statute does not alter procedural time limitations, amended ORS 656.262(10) applies retroactively. See Volk v. America West Airlines, 135 Or App 565 (1995); Motel 6 v. McMasters, 135 Or App 583 (1995). Amended ORS 656.262(10) provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. 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." (Emphasis added).

Here, the insurer accepted only left otitis media and did not formally accept left hearing loss. Based on the clear language of amended ORS 656.262(10) payment of a DO award, "shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein * * *" According to § 66, the statute applies retroactively regardless of any previous order or closure. Thus, notwithstanding the court's prior decision in this case, the amended statute permits the carrier to deny the left hearing loss condition.[1]

Claimant contends that the DO award was for "hearing loss" rather than "noise-induced hearing loss." However, regardless of what type of hearing loss claimant had, there has never been an acceptance of hearing loss. Therefore, the carrier is not precluded from denying that condition.

Claimant next argues that amended ORS 656.262(10) does not apply because the carrier had not paid the disability award at the time the denial of hearing loss issued. We disagree and find that the statute governs this dispute. Regardless of when the carrier paid the benefits, claimant ultimately

---

[1] To the extent that amended ORS 656.262(10) can be considered ambiguous, the legislative history supports our reading of the statute. Testifying before the Senate Labor Committee, Representative Mannix, a sponsor of Senate Bill 369 stated:

> "ORS 656.262, sub (10) states that an award of permanent disability benefits for a condition does not preclude later denial of compensability of the condition. This is meant to overrule a recent decision which stated that once an award of permanent disability has been made, this will constitute a tacit irrevocable acceptance of the condition. What's the problem? If that court case stays in place, insurers and employers will be tempted to fight many awards of permanent disability that they might otherwise have eaten. Why will they fight it? Because they suddenly feel that they are now permanently obligated to provide benefits for life for a condition that was never really litigated. This says no, go ahead and pay out the disability benefits, you don't have to litigate it. Later on, if you develop evidence that this was a preexisting condition that's resolved, or subsequently developed condition that is not attributable to the injury, you can rescind that denial, you can litigate it, but go ahead and pay out the permanent disability award, you don't have to litigate it at that time. Otherwise, there is going to be an encouragement for insurers and employers to fight many permanent disability awards that they are just as willing right now to eat, that is, they pay the benefits." (Minutes of the Senate Labor and Government Operations Committee, Tape 15B, January 30, 1995).

Jerry Keene, a workers' compensation attorney, also testified before the Senate Labor Committee on behalf of the sponsors of Senate Bill 369. Keene indicated that SB 369, § 28(10) (amended ORS 656.262(10)) overruled Messmer v. Deluxe Cabinet Works, supra. (Minutes of the Senate Labor and Government Operations Committee, Tape 19A, February 1, 1995).

received them. Thus, since the carrier subsequently contested the compensability of the hearing loss condition at the hearing following payment of claimant's permanent disability award, amended ORS 656.262(10) would be applicable.

In fact, claimant contends that the carrier's failure to challenge the DO award bars it from denying the left hearing loss. We are unable to discern a distinction between a carrier's failure to challenge a DO award and its payment of an award. If a carrier does not challenge a DO award, it must, by law, pay that award. The issue, in either situation, then, is whether the carrier's ultimate payment of the hearing loss award, (i.e., the carrier's failure to challenge the DO award), precludes a denial of the left hearing loss condition. As we have concluded, amended ORS 656.262(10) permits the employer to contest the compensability of the condition rated by the closure order, where, as here, the condition has not been formally accepted.

Accordingly, in light of amended ORS 656.262(10) and as supplemented herein, we adhere to the reasoning expressed in our February 3, 1994 order which found that claimant's left hearing loss condition was not compensable.

IT IS SO ORDERED.

**Board Members Hall and Gunn dissenting.**

This case involves the effect of amended ORS 656.262(10). At first glance, it appears that the amendment to ORS 656.262(10) was intended to overturn Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994). The majority certainly concludes so and cites legislative history as support. This may be a case where the intentions of the sponsers and proponents (as reflected in the quoted testimony) did not end up embodied in the statutory language chosen to carry out the intentions. We offer this dissent because we do not believe that the statute, as amended, overrules the court's holding in Messmer.

In Messmer, the employer failed to appeal a Determination Order which had awarded permanent disability based in part on the effects of surgery for a noncompensable degenerative disc disease. The Messmer court held:

> "Although employer's payment of the compensation, by itself, does not constitute acceptance of a claim for the degenerative condition, ORS 656.262(9), employer's failure to challenge the award on the basis that it included an award for a noncompensable condition precludes employer from contending later that that condition is not part of the compensable claim. The result is not that the degenerative condition has been accepted; it is that employer is barred by claim preclusion from denying that it is part of the compensable claim." Id at 258. (Emphasis added).

On its face, amended ORS 656.262(10) simply expands on former ORS 656.262(9), which provided that mere payment of compensation shall not be considered acceptance of a claim or an admission of liability. Amended ORS 656.262(10) provides that 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). The nature of the provision has not been changed by the 1995 amendments. The statute still focuses on payment of an award. Just as payment was not previously considered acceptance or an admission, now payment does not preclude contesting compensability.

By contrast, Messmer did not focus on whether an employer's payment of an award bars it from subsequently denying a condition. Rather, Messmer focused on the preclusive effect of the failure to appeal an order making an award for a noncompensable condition. In other words, Messmer deals with claim preclusion (the effect of the failure to challenge or appeal the order making the award), rather than the effect of the payment of the award. Because the statute (even as amended) provides only that payment of the award shall not bar the employer from subsequently denying that condition, and does not address the preclusive effect of a party's failure to challenge the order, the amended statute does not address the legal basis underlying the Messmer holding.[1] Thus, because we believe that the statute, as it is written, has not modified or nullified the holding in Messmer, we respectfully dissent.

[1] Under the law in effect when Messmer was decided, and under current (amended) law, the employer/carrier could stay the payment of compensation. ORS 656.313.

In the Matter of the Compensation of
**DONALD L. MELTON, Claimant**
WCB Case Nos. 94-11197, 94-11198, 94-11206, 94-11199, 94-11200, 94-11201, 94-11203, 94-11202, 94-11205 & 94-11204
ORDER DENYING MOTION TO DISMISS
Bradley P. Avakian, Claimant Attorney
David Lillig (Saif), Defense Attorney
Zimmerman, Rice, et al, Defense Attorneys
Roberts, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys
Wallace & Klor, Defense Attorneys
John E. Snarskis, Defense Attorney
Lundeen, et al, Defense Attorneys
VavRosky, et al, Defense Attorneys

Claimant has requested review of Administrative Law Judge (ALJ) Lipton's September 21, 1995 order which: (1) upheld responsibility denials for claimant's hearing loss claim issued by the SAIF Corporation, Industrial Indemnity, and Liberty Northwest; (2) dismissed claimant's hearing requests concerning EBI Companies, Travelers Insurance, Argonaut Insurance, Continental Loss Adjusters, and Fireman's Fund Insurance; and (3) declined to award an attorney fee to claimant for prevailing over the compensability portion of denials issued by Liberty Northwest and Industrial Indemnity. Noting that they were dismissed as parties from the hearing, Continental Loss Adjusting, Travelers Insurance, Argonaut Insurance and EBI Companies have moved that they be dismissed from this proceeding. The motions are denied.

## FINDINGS OF FACT

Claimant filed hearing requests against the SAIF Corporation, Fireman's Fund Insurance Company, Industrial Indemnity, Continental Loss Adjusting, Argonaut Insurance, Industrial Indemnity, Travelers Insurance, Liberty Northwest, and EBI Companies, contesting the carriers' denials of his hearing loss claim. The hearing requests were consolidated.

At the hearing, without objection from any of the parties, claimant withdrew his hearing requests regarding EBI Companies, Continental Loss Adjusting, Travelers Insurance, Argonaut Insurance, and Firemans' Fund Insurance. Those hearing requests were dismissed in the ALJ's September 21, 1995 order which upheld the responsibility denials issued by the remaining carriers.

Claimant timely requested Board review of the ALJ's order. The Board mailed letters to all parties to the proceeding acknowledging claimant's request for review. Thereafter, Continental Loss Adjusting, Travelers Insurance, Argonaut Insurance and EBI Companies have moved for their dismissal from this proceeding.

## CONCLUSIONS OF LAW

Although the ALJ's conclusions and opinions in consolidated cases may be separately stated, if the ALJ's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. Riley E. Lott, Jr., 42 Van Natta 239 (1990); William E. Wood, 40 Van Natta 999 (1988).[1] On the other hand, if a party has been dismissed from a proceeding and its dismissal as a party is not contained in the appealed ALJ's order, it is not considered a party for purposes of Board review. See Jerry R. Miller, 44 Van Natta 1444 (1992).

---

[1] In Shawn C. Mann, 47 Van Natta 855 (1995), we noted that it was entirely appropriate for an ALJ to dismiss parties from a previously consolidated hearing by means of a dismissal order which was separate from the ALJ's Opinion and Order which would address the merits of the claimant's claims against the remaining carriers. Since the "dismissed" carriers would not be "parties" to the separate Opinion and Order, we reasoned that they likewise would not be "parties" on Board review of the appealed Opinion and Order. Here, in contrast to Mann and Miller, the dismissal of claimant's hearing requests was contained in the same order that addressed the merits of claimant's claims with the remaining carriers. Under such circumstances, all parties to the ALJ's order remain parties on Board review of that single, appealed order.

Here, the ALJ's dismissals, compensability, and responsibility determinations were contained in one final consolidated order. Inasmuch as that consolidated order has been appealed, we retain jurisdiction over that entire decision, and Continental Loss Adjusting, Travelers Insurance, Argonaut, and EBI Companies remain parties to this proceeding. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47 (1985); Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992); Riley E. Lott, supra; Rual E. Tigner, 40 Van Natta 1789 (1988). However, considering the parties' lack of objection to claimant's withdrawal of his hearing requests regarding the aforementioned carriers, as well as the lack of objection to the motions for dismissal, as a practical matter, the participation in this case by the "dismissed" carriers will likely be nominal. Lott, supra.

Accordingly, the motions to dismiss are denied. A hearing transcript has been ordered. On its receipt, copies will be provided to the parties' counsels and a briefing schedule will be implemented. On completion of that schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

---

November 29, 1995 Cite as 47 Van Natta 2291 (1995)

In the Matter of the Compensation of
**CLIVE G. OSBOURNE, Claimant**
WCB Case No. 93-00990
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members en banc.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its "back-up" denial of claimant's low back injury claim; and (2) set aside its denials of claimant's aggravation claim for his current low back condition. In his respondent's brief, claimant seeks a penalty for the employer's allegedly unreasonable claims processing. On review, the issues are "back-up" denial, compensability, aggravation and penalties. We affirm in part, reverse in part, and modify in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, and briefly summarize the pertinent facts as follows:

Claimant is a bus driver. On March 31, 1992, claimant reported to his supervisor that he felt a pull in his back when he was making a turn while driving. Claimant did not seek medical treatment or miss any time from work as a result of this incident until May 4, 1992.

Prior to the March 1992 work incident, claimant had been involved in a series of motor vehicle accidents. Claimant treated with Dr. Flowers, a chiropractor, for these prior accidents. Following accidents in April and May of 1990, claimant saw Dr. Flowers for neck and low back pain, the primary problem being in his neck. Claimant was declared medically stationary from these two accidents in September 1990. Claimant then reinjured his back and neck in an October 28, 1991 accident. He treated with Dr. Flowers through at least January 8, 1992.

Claimant filed a claim on May 6, 1992 arising out of the March 31, 1992 work incident. On the 801 form, claimant indicated that he had previously injured his lower back in car accidents in 1989 and 1990.

Claimant sought treatment May 4, 1992 for low back pain with Dr. Stahl. Dr. Stahl's notes reflect claimant reported "no major prior back injury." Dr. Stahl diagnosed a low back strain and recommended physical therapy. Claimant's physical therapy chart notes report that he had a prior motor vehicle accident. Claimant was declared medically stationary from the March 1992 work incident on June 13, 1992, with no objective evidence of impairment. On June 30, 1992, the employer accepted a disabling right lumbar strain, which claim was closed July 1, 1992 with minimal time loss and no permanent disability.

Claimant continued to experience low back pain throughout 1992. In November 1992, an aggravation claim was submitted which the employer denied on the basis of lack of objective findings on December 18, 1992. On April 15, 1993, Dr. Hamby reported that claimant's condition had worsened since his claim was closed in July of 1992.

In mid-1993, while litigating the denial of claimant's aggravation claim, the employer investigated claimant's prior back injuries. In August 1993, the employer requested and obtained records from Dr. Flowers of treatments following claimant's 1990 and 1991 automobile accidents. In September 1993, the employer received from another insurer a report of Dr. Flowers dated March 3, 1992, in which Dr. Flowers indicated that claimant had ongoing problems with muscle spasm in his back as a result of the October 1991 accident. Dr. Flowers stated that claimant's then-current prognosis was fair, and that he would be able to work, but with discomfort. The receipt of this report prompted the "back-up" denial just before the hearing on the aggravation denial, on the grounds of claimant's alleged misrepresentation. (See Ex. 72, Tr. at 18).

## CONCLUSIONS OF LAW AND OPINION

### "Back-Up" Denial

Finding that claimant did not intentionally misrepresent the nature or extent of his prior back problems, and reasoning that the employer's alleged erroneous acceptance resulted from its failure to adequately investigate the claim, the ALJ determined that the employer's "back-up" denial could not be upheld under the rule of Bauman v. SAIF, 295 Or 788 (1983).

On review, the employer contends the ALJ erred in finding that claimant did not make material misrepresentations which led to or induced its acceptance of the claim. The employer cites to claimant's misreporting of the dates of his prior motor vehicle accidents on the 801 form; his indication on the 827 form that his low back had not been injured before; and his report to Dr. Stahl that he had no "major prior back problems" and argues that these misrepresentations were sufficiently material to reasonably affect the claims processor's original decision regarding the compensability of his low back claim. We disagree, primarily for the reasons cited by the ALJ.

Claimant's misreporting of the dates of his accidents and the history he provided to Dr. Stahl must be considered in light of the other information claimant provided to the employer and claims processor. Claimant did disclose the fact he had previously injured his back on the 801. He apparently mentioned some prior back problems to Dr. Stahl, although he did not disclose any "major" previous back injuries. Claimant also reported to his physical therapist that he had received many chiropractic treatments for back pain due to a motor vehicle accident in 1989. Given that claimant did disclose the fact of a prior back injury to the employer, we are not persuaded that his failure to characterize his preexisting problem as "major" to Dr. Stahl or to accurately report the dates of his accidents is sufficiently material to reasonably affect the claims processor's decision to accept the claim.

We reached a similar conclusion in Charles A. Tureaud, 47 Van Natta 306 (1995). There, we declined to uphold the insurer's "back-up" denial of the claimant's low back injury claim where the claimant disclosed the fact that he had sustained a prior low back injury to the employer and his physician, but omitted to mention prior leg pain associated with that injury. We held that the claimant's failure to report that he had experienced leg pain with his prior injury was not sufficiently material to reasonably affect the insurer's decision to accept the claim. We also held that in light of the insurer's knowledge about the claimant's prior injury to the same body part, its failure to further investigate the claim prior to acceptance was not sufficient to support a "back-up" denial based on fraud, misrepresentation or other illegal activity.

Accordingly, we agree with the ALJ's conclusion that the employer has not established by a preponderance of the evidence that its acceptance was induced by fraud, misrepresentation or other illegal activity.

Alternatively, the employer contends that its "back-up" denial may be upheld under former ORS 656.262(6)[1] because it was issued within two years of the initial acceptance as a result of later obtained

[1] ORS 656.262(6) has been amended by Senate Bill 369. Or Laws 1995, ch 332 § 28 (SB 369, § 28). The amended version changed the burden of proof in non-fraud related "back-up" denial cases from "clear and convincing" to a "preponderance of the evidence."

evidence indicating the claim is not compensable. We decline to address this argument because it is an issue being raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not presented at hearing).

At hearing, the employer consistently defended its "back-up" denial under the Bauman rule, contending that claimant made "misrepresentations" which were discovered when it obtained the additional records.[2] (Tr. at 18). The employer did not argue that it could revoke its acceptance under ORS 656.262(6) or that Dr. Flowers' March 3, 1992 report, which it received in September 1993, constituted "later obtain[ed] evidence" as that phrase is used in the statute.[3]

We acknowledge that the employer's position on review could be characterized as merely a different theory in support of its "back-up" denial, rather than a separate issue. Nevertheless, because the employer did not make this "later obtain[ed] evidence" argument before or during the hearing, we conclude that claimant would be prejudiced if we considered this late-raised theory on review. Gunther H. Jacobi, 41 Van Natta 1031 (1989). In other words, we believe it would be fundamentally unfair to decide the case on a different basis than that argued while the record was open.

Aggravation/Current Condition Denials

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement or award of compensation. ORS 656.273(1).[4] Relying on the report of Dr. Hamby, the ALJ found that claimant's condition had worsened since the original work injury and set aside the employer's aggravation and current condition denials. Unlike the ALJ, we do not find the report and testimony of Dr. Hamby sufficient to establish that claimant's current condition is causally related to his accepted condition.

Dr. Hamby reported that claimant's need for treatment and work restrictions were caused by a worsening of symptoms of his prior accepted injury. In his deposition, however, Dr. Hamby confirmed that this opinion was based, in part, on the history provided to Dr. Stahl, i.e., that claimant had not had any previous major back injuries. Since the record establishes claimant had sustained a series of prior back injuries in motor vehicle accidents prior to the work incident in March 1992, we find that Dr. Hamby's opinion is not based on complete or accurate information. We therefore do not give his opinion any persuasive force. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Moreover, when provided with an accurate history of claimant's preexisting back injuries, Dr. Stahl opined that claimant's recurrence of pain in July and November of 1992 was more likely than not related to his preexisting condition rather than his work injury. Accordingly, we conclude that claimant has not met his burden of proof in establishing the compensability of his aggravation claim for his current low back condition.

---

[2] The "back-up" denial letter states that the claims processor "received additional information" which caused it to review the compensability of the original injury claim of March 30, 1992, and that "a material misrepresentation was made previously causing [the claims processor] to accept the claim." (Ex. 72).

[3] Although the employer argued in opening statements that Dr. Flowers' report caused it to "look at the claim again," we do not find this assertion sufficient to trigger the non-fraud, "later obtain[ed] evidence" section of the statute, particularly when the employer unequivocally focuses on claimant's "misrepresentations". (Tr. 17-18). Further, even if it were determined that the employer raised the statutory argument in closing argument, we will not consider on review an issue raised for the first time during closing argument. See Larry L. Schutte, 45 Van Natta (1993); Leslie Thomas, 44 Van Natta 200 (1992).

[4] The aggravation statute was also amended by SB 369, § 31. Among other things, a claimant must now establish "an actual worsening of the compensable condition supported by objective findings." Amended ORS 656.273(1). In this case, however, the result would be the same under either version of the statute.

Relying on Rosie B. Leal, 46 Van Natta 475 (1994),[5] the ALJ also held that the employer's current condition denial constituted nothing more than another "back-up" denial of the prior accepted condition, which denial he had already found impermissible. We disagree with the ALJ's analysis.

Unlike the ALJ, we are not persuaded that claimant's current low back pain is the same as his accepted condition which, according to the persuasive medical evidence, had fully resolved as of June 1992. As noted above, we do not consider Dr. Hamby's report as persuasive evidence that claimant's March 1992 back strain is the cause of his current disability or need for treatment. Further, we do not find that the current condition denial is the same as a "back-up" denial. The current condition denial does not deny the compensability of the original strain. Rather, the denial states the employer's position that claimant's current "need for treatment is not related to [his] March 30, 1992 injury, nor [his] employment." The employer had issued a separate "back-up" denial of the compensability of the original injury prior to issuing this current condition denial. Therefore, Rosie B. Leal is not applicable.

Penalties

Claimant argues on review that we should assess additional penalties against the employer for allegedly unreasonable claims processing in connection with the "back-up" denial. We decline to do so, for the same reasons articulated by the ALJ. The fact is the employer did not receive Dr. Flowers' March 3, 1992 report to the insurer handling claimant's off-work automobile accident until September 22, 1993, the day before the hearing set on the aggravation denial. That report created a legitimate doubt as to the compensability of claimant's claim, causing the employer to immediately issue a "back-up" denial. Although we also find the "back-up" denial must be set aside, we cannot conclude under these circumstances that the employer's conduct in this regard was unreasonable.

Attorney Fees

The ALJ awarded an assessed fee of $4,000 because claimant prevailed against the three denials at hearing. In light of our decision to reinstate two of those denials, we modify this attorney fee award.

Claimant's attorney is entitled to an assessed fee for services at hearing for prevailing against the employer's September 23, 1993 "back-up" denial. 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 is $2,500, 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.

In addition, claimant's attorney is entitled to an assessed fee for services on review regarding the "back-up" 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 is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 14, 1995 is affirmed in part, reversed in part and modified in part. The self-insured employer's denial of claimant's aggravation claim and its current condition denial are reinstated and upheld. In lieu of the ALJ's $4,000 attorney fee award, claimant's attorney is awarded $2,500, to be paid by the employer. The remainder of the order is affirmed. For services on review concerning the "back-up" denial issue, claimant's attorney is awarded $1,000, payable by the employer.

---

[5] In Rosie B. Leal, the insurer had previously accepted the claimant's 1983 back and neck injury as well as a resultant psychological component. When the claimant returned for psychiatric treatment and was diagnosed as having anxiety problems related to her personality makeup rather than as a residual of her injury, the insurer denied the claimant's current condition as not being related to her accepted injury. We found that the claimant's current psychological problems were the same as her prior accepted condition and that the insurer's denial of that condition constituted a "back-up" denial of compensability. Further, because the denial came more than two years after initial acceptance of the claim, and there was no evidence of fraud, misrepresentation or other illegal activity, we held the denial was invalid.

**Board Members Gunn and Hall specially concurring.**

We concur with the majority's decision to set aside the employer's "back-up" denial of claimant's low back claim because the employer has not established by a preponderance of the evidence that its initial acceptance of the claim was induced by fraud, misrepresentation or other illegal activity. See Bauman v. SAIF, 295 Or 788 (1983); Ebbtide Enterprises v. Tucker, 303 Or 459 (1987). We write separately, however, because unlike the majority, we would also consider the employer's alternate argument and conclude the employer has similarly failed to justify it's "back-up" denial under the "later obtain[ed] evidence" provision of ORS 656.262(6).

The majority concludes that the employer did not specifically raise the "later obtain[ed] evidence" argument at hearing, and therefore it is precluded from raising the issue on review. The majority also finds that it would be "fundamentally unfair" to claimant to consider this argument on review. We disagree, because we do not consider the employer's argument under ORS 656.262(6) be a "new issue" but instead an alternate legal theory in support of a central issue in this case: the propriety of its "back-up" denial.[1] We also find no prejudice to claimant by considering this argument on review, particularly because we are persuaded by the record that the employer's "later obtain[ed] evidence" argument also must fail. See Michelle C. Mendoza, 37 Van Natta 641 (1985); Anita A. Bade, 36 Van Natta 1093 (1984), aff mem, 73 Or App 344 (1985) (distinguishing between a "new issue" and alternative legal theory advanced for the first time on review, and considering the new theory where there was no prejudice to the adverse party).

Under amended ORS 656.262(6), if an employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and "later obtains evidence that the claim is not compensable" the employer may revoke the claim acceptance and issue a formal denial of the claim, as long as the denial is issued within two years of the date of the initial acceptance. In this case, the pivotal question is whether Dr. Flowers' March 3, 1992 report, which the employer received in September 1993, constitutes "later obtain[ed] evidence" that the claim was not compensable. If so, the employer's "back-up" denial may be upheld.

To constitute "later obtain[ed] evidence," the statute requires that there be something other than evidence the insurer or employer had at the time of initial acceptance. A reevaluation of known evidence does not constitute later obtained evidence. See CNA Ins. Co. v. Magnuson, 119 Or App 282 (1993) (the legislature intended that evidence warranting the retroactive denial "come about" after the insurer's original acceptance); see also Ralph E. Murphy, 45 Van Natta 725 (1993) ("back-up" denial set aside where the employer knew at the time of acceptance that the claimant was not an Oregon subject worker).

The employer contends that Dr. Flowers' report constitutes "later obtain[ed] evidence" because even though it was aware that claimant had injured his back in previous motor vehicle accidents, it did not know at the time of claim acceptance that claimant was still experiencing discomfort from an October 1991 accident as of March 1992.

Claimant, on the other hand, argues that because the employer was aware of his prior accidents, it could and should have investigated those accidents and obtained related medical records prior to the time it accepted the claim. In support of this contention, claimant cites Darwin G. Widmar, 46 Van Natta 1018 (1994), aff mem Alexsis Risk Management v. Liberty Northwest Insurance Corporation, 134 Or App 414 (1995) where, in dicta, we indicated that a doctor's report received after the claim was accepted was not "later obtain[ed] evidence" because the carrier was aware that this doctor had been treating the claimant and could have obtained his records before accepting the claim.

---

[1] As set forth in footnote 2 of the majority opinion, the "back-up" denial letter states that the claims processor "received additional information" causing it to review the compensability of claimant's original injury claim. (Ex. 72). We would find this language sufficient to preserve the "later obtain[ed] evidence" argument under ORS 656.262(6) even though the employer did not specifically make this argument at hearing.

In Tom C. Reeves, 38 Van Natta 31 (1986), we held that an employer or insurer has a duty to fully investigate the claim in order the determine claimant's right to compensation as well as its own responsibilities. In Charles A. Tureaud, 47 Van Natta 306 (1995) we concluded that the claimant had made sufficient disclosures about his prior injury so as to put the insurer on notice to further investigate the claim. We would find that the same is true in this case.

Claimant disclosed the fact of his prior back injuries in connection with motor vehicle accidents prior to the employer's acceptance of the claim. Although the claims processor noted "old injuries" and "obtain stmt & meds" in claimant's claim file, the processor apparently did not investigate further.[2] Had the processor done so, the employer would have likely received evidence indicating the nature and extent of claimant's back problems prior to the time the claim was accepted. Since claimant had worked for the employer for the preceding seven and a half years, it had the information available as to whether claimant had missed time from work as a result of these disclosed injuries. Moreover, although the employer contests claimant's failure to disclose the fact of his October 28, 1991 accident, it is not as if the employer had no indication of such an incident. On the contrary, in November 1991, claimant submitted a short term disability claim statement to the employer indicating that he had been involved in an auto accident, with a report from Dr. Flowers as his treating chiropractor. (Ex. 15). Claimant also obtained from the employer's payroll department statements of his time loss in connection with this injury. These records, which were generated by the employer prior to acceptance of claimant's claim, indicated that claimant was out of work because of the accident until January 2, 1992.

It was not until the parties were involved in litigation over claimant's aggravation claim that the employer began, in mid-1993, to fully investigate claimant's prior accidents and injuries. The employer requested chiropractic treatment records from Dr. Flowers in August 1993, and did not receive a copy of Dr. Flowers' March 3, 1992 report until September 22, 1993, after it subpoenaed records from the insurance carrier handling claimant's October 1991 auto accident.

Under these circumstances, we would not consider Dr. Flowers' report to be "later obtain[ed] evidence" for purposes of ORS 656.262(6). Rather, we would find that at the time of processing of claimant's claim in mid-1992, the employer had knowledge that claimant had been injured in an auto accident in late 1991 and that he had been treated by Dr. Flowers.[3] We would also find that Dr. Flowers' March 3, 1992 report is evidence that could have been discovered prior to the time the claim was accepted had the employer/claims processor been reasonably diligent in its investigation.[4] See Darwin G. Widmar, supra.

In conclusion, while we agree with the majority's decision to set aside the employer's "back-up" denial (and the decision to reinstate and uphold the aggravation and current condition denials), we would also address the employer's alternate argument under amended ORS 656.262(6) and further find that the "back-up" denial may not be upheld on the basis of "later obtain[ed] evidence."

---

[2] At the time the claim was accepted, the claims processor had Dr. Stahl's chart note, the physical therapy chart notes, the 801 form and the 827 form. The processor also had a verification of earnings provided by the employer based on only a 20 week wage average rather than the usual 26 week average.

[3] Under these circumstances, the employer's knowledge would be attributable to the claims processor. See SAIF v. Abbott, 103 Or App 49 (1990); Ralph E. Murphy, supra.

[4] We acknowledge that in Frederick D. Carter, 47 Van Natta 780 (1995), the Board essentially excused an employer's lack of diligence in initially investigating a claim on a showing of intentional fraud by the claimant. However, based on the reasoning expressed in Member Hall's dissenting opinion in Carter, we believe that a carrier's "back-up" denial (whether grounded on "fraud" or "later obtained" evidence) must satisfy a "due diligence" requirement in order to be upheld. Here, because a diligent "pre-acceptance" investigation by the employer reasonably could have uncovered the information on which it bases its "back-up" denial, we submit that the denial is invalid.

In the Matter of the Compensation of
**GREGORY D. SCHULTZ, Claimant**
WCB Case No. 94-07903
CORRECTED ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

It has come to our attention that the Board's November 22, 1995 Order on Review contains a clerical error. Specifically, the "Order" portion indicates that claimant's total unscheduled permanent disability award of 22 percent is equal to "80 degrees" when in fact it should read that 22 percent is equal to "70.4 degrees." Therefore, we withdraw our prior order and, as corrected herein, we adhere to and republish it. 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
**WENDY YOURAVISH, Claimant**
Own Motion No. 94-0619M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Jon C. Correll, Claimant Attorney
Liberty Northwest, Insurance Carrier

Claimant requests reconsideration of our October 12, 1995 Own Motion Order Reviewing Carrier Closure, in which we affirmed the insurer's June 3, 1995 Notice of Closure of her claim.

Claimant contends that "[u]nder ORS 656.278(3) and [sic] order by the Board during the time which a claimant has a right to request a hearing on the subject of aggravation is not an "Own Motion Order."" Citing ORS 656.273 and ORS 656.319, claimant contends that she has perfected an aggravation claim in this case, and that the matter should properly be addressed at a hearing before the Hearings Division, rather than before the Board.

Claimant's aggravation rights expired on July 10, 1994. In our prior order, we found that there was no medical report submitted to the insurer prior to July 10, 1994 which would have been sufficient to put the insurer on notice that the requested medical services were for a "worsened condition" under ORS 656.273(1). See Krajacic v. Blazing Orchards, 84 Or App 127 (1987). In addition, we concluded that claimant provided no evidence that the insurer received Dr. Davis' July 8, 1994 chart note (which opined that claimant's condition was "chronic") prior to the expiration of her aggravation rights. Therefore, we concluded that the insurer was not notified of a "worsening" prior to the expiration of claimant's aggravation rights, and thus, the claim was properly processed under the Board's own motion jurisdiction. Finally, based on the record, we affirmed the insurer's June 3, 1995 Notice of Closure in its entirety.

As set forth in SAIF v. Reddekopp, 137 Or App 102 (1995), if claimant's claim is processed as an aggravation claim, she is entitled to a full hearing as well as all of the substantive benefits under the Workers' Compensation Law. If claimant's condition worsened after the expiration of the aggravation period, the matter must be considered by the Board on its own motion, and the only benefits available to claimant are for medical treatment for the compensable injury and temporary disability compensation from the date of surgery or hospitalization until the condition becomes medically stationary. See Reddekopp, supra. The court has held, however, that the Board's determination that it has own motion jurisdiction is subject to judicial review. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

Here, the Board determined that claimant's aggravation rights had expired, and we issued our Own Motion Order authorizing the reopening of claimant's 1988 claim on October 18, 1994. Claimant did not seek review of that determination. See Miltenberger, supra. Accordingly, the Board's order

became final, with the force and effect of a judgment. See Reddekopp, supra. Thus, we conclude that the Board, rather than the Hearings Division, has exclusive jurisdiction to process this claim under our own motion authority pursuant to ORS 656.278.

Therefore, as claimant submits no further medical evidence to the rebut Dr. Davis' May 24, 1995 opinion that she was medically stationary on that date, we continue to find that the insurer's June 3, 1995 closure of the claim was proper.

Accordingly, our October 12, 1995 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 12, 1995 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

---

November 30, 1995 Cite as 47 Van Natta 2298 (1995)

In the Matter of the Compensation of
**NICOLAI D. MATHIESEN, Claimant**
WCB Case No. 95-04029
ORDER REMANDING
Nancy F.A. Chapman, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney

Claimant has requested Board review of Administrative Law Judge (ALJ) Hazelett's August 21, 1995 order that: (1) dismissed claimant's hearing request regarding the SAIF Corporation's alleged "de facto" denial of a right fibula fracture; (2) assessed a 20 percent penalty (shared equally by claimant and his counsel) for a stipulated late payment of benefits; and (3) declined to consider claimant's request for an attorney fee for an allegedly unreasonable resistance to the payment of compensation. The hearing was electronically recorded.

Following claimant's request for review, a transcription of the proceeding was requested. See ORS 656.295(3). However, the tape used to record the proceeding in the June 26, 1995 hearing before ALJ Hazelett was faulty and, therefore, cannot be transcribed. Consequently, the Board is persuaded that a hearing transcript is presently unobtainable. Moreover, the parties have been unable to reach a stipulation regarding all relevant facts developed by the testimony given at the hearing. In light of such circumstances, the parties "reluctantly request" remand to the ALJ "to develop a new hearing record."

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the ALJ for further evidence taking, correction or other necessary action. See ORS 656.295(5). Considering the aforementioned circumstances, we conclude that remand is an appropriate action.

Accordingly, the ALJ's August 21, 1995 order is vacated and this matter is remanded to ALJ Hazelett with instructions to reconvene a hearing. At this new hearing, the parties shall be entitled to present testimonial evidence concerning the issues that were addressed at the prior hearing. Only those witnesses who testified at the prior hearing shall be permitted to testify at the reconvened hearing.

Upon completion of the reconvened hearing and closure of the record, ALJ Hazelett shall issue a final, appealable, Order on Remand addressing the effect, if any, the "reconvened" testimony and hearing has had upon his prior order.

IT IS SO ORDERED.

---

In the Matter of the Compensation of
**JOHN F. O'NEALL, JR., Claimant**
WCB Case Nos. 94-10204 & 94-06831
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Kevin L. Mannix, Defense Attorney

On November 22, 1995, we withdrew our October 30, 1995 order which had affirmed an Administrative Law Judge's order that: (1) set aside the insurer's denials of claimant's new low back injury claim; (2) determined that claimant's Grade 1 spondylolisthesis was a compensable component of the low back injury claim; (3) upheld the insurer's denial of claimant's aggravation claim for a mid-back condition; and (4) declined to award a penalty for the insurer's allegedly unreasonable denial of claimant's low back injury claim. We took this action to retain jurisdiction to consider the parties' forthcoming proposed settlement. Having received the parties' agreement, we proceed with our reconsideration.

The parties' proposed "Settlement Stipulation and Order" is designed to resolve all issues raised or raisable between them, in lieu of all prior orders. Pursuant to the settlement, claimant agrees that the insurer's denials, as supplemented in the agreement, "shall be reinstated and shall become final." The agreement further provides that claimant's hearing requests "shall be dismissed with prejudice as to any and all issues raised or which could have been raised."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
**ROSEMARY MINARD, Claimant**
WCB Case No. 95-01603
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Claimant has requested abatement and reconsideration of the Board's Order on Review dated November 2, 1995 which reversed the Administrative Law Judge's (ALJ's) order that found claimant's claim was prematurely closed. In our order, we determined that the competent medical evidence supported a finding that claimant was medically stationary at the time of claim closure.

On reconsideration, claimant relies upon ORS 656.245(3)(b)(B) to contend that only the attending physician can determine her medically stationary date. Therefore, claimant asserts that she could not have been medically stationary on August 12, 1994 because there was no attending physicians' opinion so stating. Additionally, claimant asserts that the opinion of Dr. Steinhauer does not support a finding that she was medical stationary at the time of closure. Based on the following reasoning, we are not persuaded by claimant's contentions.

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 October 4, 1994, Notice of Closure considering claimant's condition at the time of closure but not subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. See, e.g., Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980). Nothing restricts consideration of opinions regarding medically stationary status to those opinions rendered by attending physicians. See Patricia M. Knupp, 46 Van Natta 2406 (1994); Francisco Villagrana, 45 Van Natta 1504 (1993); Timothy H. Krushwitz, 45 Van Natta 158 (1993).

Here, claimant's reliance on ORS 656.245(3)(b)(B) is misplaced. This statute is applicable to determining the worker's impairment for purposes of rating disability, as a result of a compensable injury. It is well settled that for purposes of determining whether claimant is medically stationary at the time of closure, we rely upon all competent medical evidence and not just the opinion of the attending physician. See Patricia M. Knupp, supra; Francisco Villagrana, supra; Timothy H. Krushwitz, supra. As such, we are not restricted to the opinion of claimant's attending physician when determining her medically stationary date.

Further, we adhere to our reliance upon the opinions of Drs. Steinhauer and Quarum. On August 4, 1994, Dr. Steinhauer projected that claimant would be medically stationary as of August 12, 1994. While a "projection" of when claimant may be medically stationary is not dispositive, Dr. Quarum's October 3, 1994 examination and opinion confirmed that claimant was medically stationary on the date of closure. See James Canton, 44 Van Natta 2435 (1992). Consequently, we find that claimant's claim was properly closed on October 4, 1994. Accordingly, we continue to support our November 2, 1995 order.

Accordingly, our November 2, 1995, Order on Review is withdrawn. On reconsideration, as supplemented herein, we republish our November 2, 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
**EUGENE C. APA, Claimant**
WCB Case No. 94-12166
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order which: (1) found claimant's right arm condition claim was not prematurely closed; (2) affirmed an Order on Reconsideration that did not award scheduled permanent disability for the right arm; and (3) affirmed an order from the Director denying claimant vocational assistance. On review, the issues are premature closure, extent of unscheduled permanent disability and vocational assistance. We affirm in part and vacate in part.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Premature Closure

The ALJ determined that claimant's claim was not prematurely closed. In so doing, the ALJ relied on the medical reports of Drs. Soot and Nathan.

On review, claimant contends that his claim was prematurely closed because his right arm condition materially improved after closure. Claimant relies on the opinion offered by Dr. Long.

A claim shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). Claimant's has the burden to establish that he was not medically stationary on the date of closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). "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's condition and the reasonable expectation of improvement are to be evaluated as of the date of closure (March 4, 1994), without consideration of subsequent changes in the claimant's condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Service, 72 Or App 524 (1985).

Dr. Nathan, on behalf of the insurer, examined claimant on January 24, 1994. Dr. Nathan could find no objective evidence to substantiate claimant's "excessive" pain complaints. Dr. Nathan explained that in the absence of any work activity/duties to initiate or alter claimant's symptoms, he opined that the major contributing cause of claimant's neuropathies was an "underlying, intrinsic process." (Ex. 48-7). As such, Dr. Nathan opined that in January 1994, claimant was medically stationary in regard to his right upper extremities with no evidence of permanent impairment secondary to claimant's surgeries. Id.

Dr. Soot performed three surgeries on claimant, consisting of a carpal tunnel release of claimant's right hand in March 1992, right elbow surgery in May 1992 and right shoulder surgery in March 1993. (Exs. 21, 23, 32). On February 28, 1994, he concurred with Dr. Nathan's opinion that claimant was medically stationary as of January 28, 1994. (Ex. 50).

In May 1994, claimant began treating with Dr. Long, who prescribed physical therapy for claimant. (Ex. 59, 60). In January 1995, Dr. Long stated that it was clear from reviewing Drs. Nathan's and Soot's pre-closure reports that claimant was still having significant pain and parasthesias in the right upper extremity prior to the March 1994 closure. (Ex. 79-1). Finally, Dr. Long opined that, based on claimant's positive response to the physical therapy (he prescribed) subsequent to closure, on May 11, 1994, claimant had "potential for material improvement." (Ex. 61-3).

Here, we find that the preponderance of the medical evidence supports a finding that claimant's claim was not prematurely closed. In particular, as the physician who performed all three surgeries on claimant, we find that Dr. Soot was in the best position to provide an opinion regarding claimant's condition and status. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Dr. Soot concurred with Dr. Nathan's opinion that claimant was medically stationary in January 1994. Dr. Long noted that prior to closure, both Drs. Nathan and Soot reported claimant to be experiencing pain on his right side (which supports a finding that claimant may have not been medically stationary at closure). However, Dr. Long did not address both physician's observations that claimant's complaints were subjective with no objective findings to substantiate claimant's pain complaints. (Exs. 48, 56, 57). As such, based on Dr. Soot's and Nathan's persuasive "pre-closure" reports, we find that claimant was medically stationary at the time of claim closure.

Further, even though claimant's condition may have improved after closure, such evidence relates to a post-closure change in claimant's condition and, therefore, is not applicable to determine claimant's medically stationary condition on March 4, 1994. See Sullivan v. Argonaut Ins. Co., supra. Consequently, claimant's claim was not prematurely closed.

Permanent Disability

The ALJ found that claimant did not have any permanent right arm impairment due to his January 1991 injury. The ALJ relied on the medical reports of Dr. Soot, treating physician at the time of closure, and the medical arbiter's report.

On review, claimant asserts that he is entitled to scheduled permanent disability. According to claimant, the fact that he has had two surgeries on his right arm is an indication that some permanent impairment has occurred. (App. Reply Br. 1).

Dr. Soot, claimant's attending physician, and Dr. Stanford, the medical arbiter, acknowledged claimant's multiple surgeries. Nevertheless, after conducting their examinations and performing their testing, neither physician found objective findings to support a conclusion that claimant had sustained permanent impairment due to his compensable injury. (Exs. 74-4, 56, 57). In light of these circumstances, we concur with the ALJ's conclusion that claimant is not entitled to a permanent disability award.

Vocational Assistance

Claimant requested a hearing regarding a Director's order which found that claimant was not entitled to vocational assistance. The ALJ affirmed the Director's order and claimant requested Board review.

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 656.283(2), which now provides only for Director review of vocational assistance disputes. Or Laws 1995, ch 332, § 34(2) (SB 369, § 34(2)).

In Ross Enyart, 47 Van Natta 1540 (1995), we relied on Volk v. America West Airlines, 135 Or App 565 (1995), and determined that amended ORS 656.283(2) retroactively applied. We further concluded that the statute placed exclusive jurisdiction to decide vocational assistance disputes with the Director rather than the Board and Hearings Division. 47 Van Natta at 1541.

This case is controlled by our holding in Enyart. Inasmuch as this pending dispute concerns claimant's entitlement to vocational assistance, jurisdiction over this matter rests with the Director. Consequently, we vacate that portion of ALJ's order upholding the Director's order which denied claimant vocational assistance.

Finally, we note that, pursuant to § 42(d)(5) of Senate Bill 369, neither the ALJ nor the Board may award penalties or attorney fees for matters arising under the review jurisdiction of the Director. Or Laws 995, ch 332, § 42(d) (SB 369 § 42(d)). Because claimant sought penalties and an attorney fees for the insurer's conduct regarding claimant's vocational assistance claim and since jurisdiction over vocational assistance matters rests with the Director, it follows that neither we nor the ALJ are authorized to consider claimant's penalty/attorney fee request.

ORDER

The ALJ's order dated February 1, 1995, is vacated in part and affirmed in part. That portion of the ALJ's order pertaining to the issue of vocational assistance is vacated. The remainder of the order is affirmed.

**Board Member Hall dissenting in part.**

Because I find that the medical arbiter's report supports a finding that claimant's is entitled to 5 percent scheduled chronic condition impairment for loss of repetitive use of his elbow and shoulder, I respectfully dissent from the majority's decision regarding extent of permanent disability.

Under OAR 436-35-010(6) and OAR 436-35-320(5), a claimant is entitled to scheduled and unscheduled chronic condition impairment when a preponderance of medical opinion establishes that the claimant is unable to repetitively use a body part (i.e. elbow and shoulder) due to a chronic and permanent medical condition.

Here, the arbiter concluded because of claimant's surgeries to his elbow and shoulder, one would not want claimant to perform repetitive motions that were loaded. (Ex. 74-4). While the arbiter expressed reservations about claimant's pain behavior and inconsistencies, the arbiter nevertheless concluded:

> "Based on the examination and objective findings, it is very difficult to find something that would preclude this gentleman from using his right elbow and shoulder. Because [claimant] has had surgery to both, one would not want him to perform repetitive motions that were loaded. This would be especially true in the shoulder above the parallel level." (Ex. 74-5).

Further the arbiter stated that, "[Claimant] should be able to work at the 30-40 pounds level except repetitively at the elbow or at the shoulder, especially above the parallel plane." Id. (Emphasis added).

Claimant's surgery is definitely an objective finding which the arbiter believed precluded claimant from repetitively using his elbow and shoulder, above the parallel plane. As such, under OAR 436-35-010(6)(b) and OAR436-35-320(5) claimant is entitled to 5 percent chronic condition impairment for his elbow and 5 percent for his shoulder. Based on the foregoing discussion, I respectfully dissent.

---

December 5, 1995 Cite as 47 Van Natta 2303 (1995)

In the Matter of the Compensation of
**JOHN W. GRAY, JR., Claimant**
WCB Case Nos. 94-00860, 93-12638, 94-00858 & 94-00859
ORDER ON REVIEW (REMANDING)
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Great American Insurance (Great American), on behalf of Lonestar Northwest, Inc., requests review of those portions of Administrative Law Judge (ALJ)[1] Herman's order that: (1) set aside its denial and disclaimer of responsibility for claimant's left shoulder injury; and (2) upheld Liberty Northwest Insurance Company's (Liberty's) denial and disclaimer of responsibility for the same injury on behalf of the same employer. On review, the issues are responsibility, disclaimer notice and remand. We vacate the ALJ's order and remand.

---

[1] Under former ORS 656.307, the factfinder was called an arbitrator. Under amended ORS 656.307, they are called Administrative Law Judges. Or Laws 1995, ch 332, § 36; Dan J. Anderson, 47 Van Natta 1929 (1995).

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with one change. In the first paragraph on page 2, we change the date of Liberty's disclaimer to September 15, 1993.

## CONCLUSIONS OF LAW AND OPINION

### Standard of Review

This case arose under former ORS 656.307. Under former ORS 656.307(2), our review was limited to questions of law. Under amended ORS 656.307(2), "307" proceedings "shall be conducted in the same manner as any other hearing and any further appeal shall be conducted pursuant to ORS 656.295 and 656.298." Or Laws 1995, ch 332, § 36 (SB 369, § 36). Under ORS 656.295, we review de novo. Since this matter has not been finally resolved on appeal, amended ORS 656.307 applies here. See Dan J. Anderson, supra. Accordingly, under amended ORS 656.307(2), we review this matter de novo.

### Retroactive Application of Amended ORS 656.308(2)

Great American contends that we should retroactively apply the amendments in Senate Bill 369. Since ORS 656.308(2) no longer requires carriers to issue disclaimers within 30 days, Great American asserts that failure to issue such a disclaimer should not bar an insurer from arguing that responsibility lies with another party. Claimant objects to the retroactive application of amended ORS 656.308.

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). However, one exception to the retroactive effect of SB 369 applies 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." SB 369, § 66.

In Motel 6 v. McMasters, 135 Or App 583 (1995), the carrier argued that the claimant's aggravation claim was time-barred under former ORS 656.308(2) because it was not filed within 60 days of another carrier's notice to the claimant.The court held that, because the case involved a procedural time limit, the changes made by Senate Bill 369 did not apply.

Here, the issue is whether Great American issued a timely disclaimer pursuant to former ORS 656.308(2), which provided that a carrier that intended to disclaim responsibility for a claim on the basis of an injury or exposure with another carrier "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." Because the issue of the timeliness of the Great American's issuance of a disclaimer involves a procedural time limit, we conclude that the changes made by Senate Bill 369 do not apply to this case. See Motel 6 v. McMasters, supra.

### Disclaimer of Responsibility

Claimant has worked for the same employer at least since 1991. The employer was insured by Great American until August 31, 1991, and was insured by Liberty from September 1, 1991 forward.

Claimant has an accepted left shoulder injury claim with the employer for an injury sustained on July 16, 1991. On February 5, 1992, the claim was closed by a Notice of Closure issued by Great American West c/o GAB Business Services, Inc. (Ex. 21). On September 7, 1993, claimant injured his left shoulder while working for the employer. Both Great American and Liberty denied responsibility and issued disclaimers of responsibility.

At the beginning of the hearing, claimant moved for "summary judgment,"[2] arguing that Great American had failed to issue a timely disclaimer of responsibility under former ORS 656.308(2), and, therefore, was barred from using a responsibility defense with regard to any other insurer.[3] Liberty joined claimant's motion. Great American responded with a similar motion with regard to Liberty.

The ALJ admitted evidence for the purpose of ruling on the "summary judgment" motions and heard oral argument. The ALJ also allowed Great American to respond by written argument after the hearing. The ALJ found that the employer had notice of claimant's September 7, 1993 claim on September 8, 1993, September 15, 1993 and again on October 21, 1993. The ALJ reasoned that the employer's knowledge of the claim was legally attributable to its insurer and that Great American had constructive knowledge of the claim on September 8, 1993, September 15, 1993 and again on October 21, 1993. Great American, through its claims administrator, Giesy, Greer & Gunn, did not issue a disclaimer of responsibility until January 14, 1994. (Ex. 53). The ALJ concluded that, since Great American did not issue a timely disclaimer pursuant to former ORS 656.308(2), it was precluded from arguing that Liberty was responsible for the September 7, 1993 claim.

Great American argues that there is no evidence that it had "actual knowledge" of being named or joined in the claim, until January 7, 1994, when notified by the Department pursuant to Liberty's request for the designation of a paying agent under ORS 656.307. Furthermore, Great American contends that it complied with former ORS 656.308(2) within 30 days of receiving actual knowledge of the claim.

Former ORS 656.308(2) provided, in part:

> "Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim." (Emphasis added).

Failure to follow the requirements of former ORS 656.308(2) precludes a carrier from asserting a responsibility defense. See Donald A. James, supra; Jon F. Wilson, 45 Van Natta 2362 (1993). In Gene R. Jones, 47 Van Natta 238 (1995), we analyzed the meaning of the language "actual knowledge of being named or joined in the claim." We concluded that the 30-day period for disclaiming responsibility is triggered by either: (1) actual knowledge that the insurer/employer is being designated as the responsible party (defendant) in an injury or occupational disease claim; or (2) actual knowledge that the insurer/employer is being united with other employers/insurers as a potentially responsible party (co-defendant) in an injury or disease claim.

Since the plain and unambiguous language of former ORS 656.308(2) requires "actual knowledge" to trigger the 30-day period for disclaiming responsibility, the fact that Great American may have had constructive knowledge of claimant's September 7, 1993 claim is immaterial. There is no

---

[2] In other forms of civil litigation under Oregon law, 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, however, the workers' compensation statutes and rules did not provide a similar procedure. We note that ORS 656.308(2)(c) now provides, in part: "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." SB 369, § 37. For the reasons that follow, we find that, in any event, "summary judgment" was not appropriate because there are genuine issues of material fact.

[3] We construe claimant's motion for "summary judgment" as a motion to dismiss Liberty and proceed only against Great American. See Donald A. James, 46 Van Natta 1898 (1994) (the claimant moved for dismissal of all insurers except one, arguing that the remaining carrier had not issued a timely disclaimer of responsibility under former ORS 656.308(2) and was thereby precluded from denying responsibility as to any other insurers); see also Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994) (the carrier's failure to comply with the disclaimer notice of former ORS 656.308(2) did not preclude the claimant from pursuing the compensability of the claim against the other carrier).

evidence, other than Great American's assertion in its written closing argument to the ALJ, as to when Great American had "actual knowledge" of being named or joined in the claim.[4]

Because the ALJ found that "constructive knowledge" to Great American was sufficient, the record was not sufficiently developed regarding the issue of when Great American had actual knowledge of claimant's claim. In light of our conclusion that "actual knowledge" is required to trigger the 30-day period for disclaiming responsibility under former ORS 656.308(2), we conclude that the record is not adequately developed for purposes of review and a compelling reason exists for remand. See ORS 656.295(5); Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Therefore, we remand this matter to the ALJ for further proceedings. Depending on the ALJ's determination of the "actual knowledge" issue, it may also be necessary to proceed to a hearing on the merits of the responsibility dispute. In any event, whether such proceedings should be held separately or concurrently is a determination within the ALJ's discretion.

Accordingly, the ALJ's order dated February 16, 1995 is vacated. This matter is remanded to ALJ Herman for further proceedings consistent with this order. Those proceedings shall be conducted in any manner which, in the ALJ's discretion, achieves substantial justice. Following these proceedings, the ALJ shall issue a final appealable order addressing all relevant issues.

IT IS SO ORDERED.

---

[4] In its January 27, 1995 closing argument, Great American's attorney explained that, when claimant's July 1991 claim was originally filed, GAB Business Services was acting as the processing agent for Great American. Great American's attorney also asserted that, sometime after the claim was closed on February 5, 1992, Johnston & Culberson became the processing agent for Great American. Giesy, Greer & Gunn subsequently became the claims administrator for Great American, although there is no evidence in the record as to when that occurred.

The record indicates that, on October 21, 1993, claimant's attorney sent a letter to the employer and GAB Business, notifying them of claimant's aggravation claim. (Ex. 51A). The letter stated that a copy of Liberty's September 15, 1993 disclaimer of responsibility was enclosed, as well as claimant's request for hearing on Liberty's denial. That letter was received by GAB on October 29, 1993 and by Johnson & Culberson on November 2, 1993. (Id.) There is no evidence in the record whether or not the employer or GAB or Johnson & Culberson forwarded any information about the claim to Great American.

---



In the Matter of the Compensation of
**PAMELA McGEE, Claimant**
WCB Case No. 94-01450
ORDER ON RECONSIDERATION
Susak, Dean & Powell, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Claimant requests reconsideration of our September 19, 1995 order that affirmed an Administrative Law Judge's (ALJ's) 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. Contending that she raised at hearing arguments regarding the Americans With Disabilities Act (ADA), 42 USCA § 12101 et seq., claimant asks that we evaluate the compensability of her low back condition without considering her preexisting degenerative spinal condition. On October 12, 1995, we abated our order to allow the employer an opportunity to respond. Having received that response, we proceed with our reconsideration.

After considering claimant's request and the employer's response, we continue to decline to address claimant's ADA arguments. In our prior order, we determined that, because claimant had first raised the ADA arguments on review, we would not address them. As claimant correctly notes, she raised those arguments in a pre-hearing brief memorandum to the ALJ. Claimant did not, however, continue to press those arguments at hearing or in her written closing arguments. Therefore, it appears that, although claimant may have raised the ADA arguments at hearing, she did not preserve them for appeal. For that reason, we are not inclined to address those arguments now.

In any event, both at hearing and on review, claimant's ADA arguments consisted of brief references to selected provisions of the ADA, without any meaningful analysis. Because we find those arguments inadequately developed for review, we continue to decline to address them. E.g., Ronald B. Olson, 44 Van Natta 100 (1992) (Board declined to address issue inadequately developed for review).

Accordingly, on reconsideration, as supplemented herein, we republish our September 19, 1995 order in its entirety. The parties' appeal rights shall begin to run from the date of this order.

IT IS SO ORDERED.

---

December 5, 1995 Cite as 47 Van Natta 2307 (1995)

In the Matter of the Compensation of
**DAVID F. MEISSNER, Claimant**
WCB Case No. 91-04509
ORDER ON REMAND
Schneider,et al, Claimant Attorneys
John E. Snarskis, Claimant Attorney

This matter is on remand from the Court of Appeals. All American Air Freight v. Meissner, 129 Or App 104, rev allowed 320 Or 453 (1994), rev dismissed 321 Or 417 (1995). The court reversed our prior order, David F. Meissner, 45 Van Natta 249, recon den 45 Van Natta 384 (1993), that modified an Administrative Law Judge's (ALJ's) order setting aside the Director's order finding that the Director lacked jurisdiction to review claimant's eligibility for vocational assistance. Citing to Harsh v. Harsco Corp., 123 Or App 383, rev den 318 Or 661 (1994), the court has remanded for reconsideration.

## FINDINGS OF FACT

We republish the "Findings of Fact" from our previous order.

## CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted 1983 left leg and foot injury claim. In May 1990, following claimant's expiration of his "aggravation rights," we reopened the claim pursuant to our own motion authority. The insurer denied claimant's subsequent request for vocational assistance and claimant requested administrative review by the Director to determine his likely eligibility for such benefits.

The Director found a lack of jurisdiction to review the matter, reasoning that our Own Motion reopening of the claim could not be a basis for awarding vocational assistance. The ALJ found a likelihood of eligibility and remanded the case to the Director for an order directing the insurer to determine claimant's entitlement to vocational assistance.

On review, we first found that the Director had jurisdiction to determine claimant's eligibility for vocational services. Further concluding that the Director's rules which prevented workers whose aggravation rights had expired from being eligible for vocational assistance contravened the relevant statute, we modified the Director's order and instructed the insurer to provide claimant the same vocational assistance benefits he would receive if his aggravation rights had not expired. David F. Meissner, supra.

The Court of Appeals reversed and remanded, citing to Harsh v. Harsco Corp., supra. In that case, the court held that "the only benefits available to a claimant whose aggravation rights have expired are those referred to in ORS 656.278(1)." 123 Or App at 387. Because that statute was limited to providing only certain medical services and temporary disability benefits, and not vocational assistance, the court concluded that the Director was correct in denying the claimant's vocational assistance following expiration of his aggravation rights. Id.

The Supreme Court, after initially allowing the petition for review in this case, dismissed its review as having been improvidently granted. Thus, we proceed with our reconsideration pursuant to the Court of Appeals' decision.

Subsequent to the court's decision, the Legislature amended ORS 656.283(2) by charging the Director "with the duty of creating a procedure for resolving vocational assistance disputes in the manner prescribed in this subsection." Or Laws 1995, ch 332, § 34(2) (SB 369, § 34(2)). Based on the retroactive application of this statute, we have held that exclusive jurisdiction over vocational assistance disputes rests with the Director. Ross M. Enyart, 47 Van Natta 1540 (1995). Therefore, we vacated the ALJ's order and dismissed claimant's hearing request for lack of jurisdiction.

Because no order or decision in this case has become final, amended ORS 656.283(2) applies to this case. SB 369, § 66; see Manuel Altamirano, 47 Van Natta 1499, 1500 (1995) (Board applied amended statute on remand rather than court's holding). Inasmuch as we have held that the statute places exclusive jurisdiction to resolve vocational assistance disputes with the Director, we conclude that we lack jurisdiction to consider the vocational assistance matter in this case.

Accordingly, on reconsideration, we vacate the ALJ's January 17, 1992 order, as reconsidered February 12, 1992, and dismiss claimant's hearing request from the Director's order.

IT IS SO ORDERED.

---

December 5, 1995 Cite as 47 Van Natta 2308 (1995)

In the Matter of the Compensation of
**RICHARD G. SHIELDS, Claimant**
WCB Case No. 94-09444
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Thomas J. Dzieman (Saif), Defense Attorney

On November 20, 1995, we withdrew our October 27, 1995 order which had affirmed that portion of an Administrative Law Judge's (ALJ's) order which set aside the SAIF Corporation's denial of claimant's left leg condition, but reversed that portion of the ALJ's order which assessed a penalty for an allegedly unreasonable denial. We took this action to retain jurisdiction to consider the parties' forthcoming settlement. Having now received that agreement, we proceed with our reconsideration.

The parties have submitted a proposed "Stipulation and Disputed Claim Settlement Agreement," which is designed to resolve all issues raised or raisable in this case, in lieu of all prior orders. Pursuant to the settlement, the parties agree that SAIF's denial "shall remain in full force and effect." The settlement further provides that claimant's hearing request and SAIF's request for Board review are withdrawn and "shall be dismissed with prejudice."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

---

In the Matter of the Compensation of
**NANCIE L. SMITH, Claimant**
WCB Case No. TP- 95009
THIRD PARTY DISTRIBUTION ORDER
Schneider, et al, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Claimant has petitioned the Board for resolution of a dispute regarding a "just and proper" distribution of proceeds of a third-party settlement. See ORS 656.593(3). Specifically, the dispute concerns the paying agency's (Johnston & Culbertson, hereafter J & C) entitlement to receive reimbursement from the remaining balance of settlement proceeds for claim costs attributable to a medical arbiter examination/report. We conclude that a distribution in which J & C receives reimbursement for the medical arbiter examination/report from the remaining balance of the settlement proceeds would be "just and proper."

## FINDINGS OF FACT

Claimant sustained a compensable cervical strain on December 1, 1993, when she was injured in the course and scope of her employment. With J & C's approval, claimant settled her third-party action against the allegedly negligent third party for $7,500. J & C initially asserted a lien of $2,503.92, but later agreed to waive $350 in expenses related to an insurer-arranged medical examination (IME). However, J & C continues to assert a lien in the amount of $2,153.92.

Claimant does not dispute any portion of the employer's lien, with the exception of $250 attributable to the cost of a medical arbiter's examination. This examination was performed at claimant's request when she requested reconsideration of an August 23, 1994 Determination Order. Claimant has now petitioned the Board pursuant to ORS 656.593(3) for resolution of the parties' dispute over the "just and proper" distribution of the third party settlement proceeds.

## CONCLUSIONS OF LAW AND OPINION

If the worker settles a third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided that the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593( 3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

In determining a "just and proper" distribution, we judge each case based on its own merits. Urness v. Liberty Northwest, 130 Or App 454 ( 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) 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.

Here, after deduction of claimant's attorney fee and 1/3 statutory share under ORS 656.593(1) and (2), a balance of $2,153.92 remains. Claimant does not challenge J & C's lien with the exception of the amount of the medical arbiter's examination/report. J & C contends that, under Jack S. Vogel, 47 Van Natta 406 (1995), it is "just and proper" for it to receive reimbursement for its costs attributable to the medical arbiter examination/report. We agree.

It is well settled that claim evaluation reports are analogous to litigation reports and, as such, are not properly includable in a paying agency's lien against a third party recovery. See David G. Payne, 43 Van Natta 918 (1991). In Vogel, we rejected the paying agency's request for reimbursement of its claim costs attributable to an IME. Although the paying agency in Vogel sought to distinguish Payne on the basis that the attending physician had concurred with the IME findings, and, therefore, the IME was allegedly merely a substitute for a closing examination, we held that the attending physician's concurrence did not transform the IME report from its original status as a claim evaluation report. We noted that the claimant had been referred to the examining physician to address questions, such as medically stationary status, impairment findings and physical limitations, posed by the paying agency. Under those circumstances, we concluded in Vogel that, consistent with Payne, it was not "just and proper" for the paying agency to receive reimbursement for its claim costs attributable to the IME.

In Vogel, we also considered the issue of whether the paying agency was entitled to reimbursement of its expenses related to a medical arbiter's report. We noted that, unlike the IME report, a medical arbiter's report is not intended for litigation purposes and that the medical arbiter's report in that case was obtained at the claimant's request, not the paying agency's. In light of these circumstances, we were inclined to conclude it was "just and proper" for the paying agency to receive reimbursement for its costs attributable to the medical arbiter examination. However, we determined that resolution of the issue was unnecessary, inasmuch as permanent disability expenses exceeded the balance of the settlement proceeds.

In this case, we are squarely faced with the issue of reimbursement for costs of a medical arbiter's examination/report. As was true in Vogel, claimant, here, requested the medical arbiter's examination. Moreover, our reasoning in Vogel that an arbiter's examination is not intended for litigation remains valid. As we explained in Vogel, the medical arbiter process was expressly designed to eliminate or reduce litigation concerning extent of disability. See Daniel L. Bourgo, 46 Van Natta 2505 (1994). Therefore, consistent with the reasoning that we articulated in Vogel, we hold that the paying agency in this case is entitled to reimbursement from the third party settlement proceeds for expenses related to the medical arbiter's examination/report.[1]

Accordingly, we hold that it is "just and proper" for J & C to receive the remaining balance of the settlement proceeds ($2,153.92), including the $250 attributable to the cost of the medical arbiter's examination/report. Claimant's attorney is directed to forward the aforementioned sum to J & C.

IT IS SO ORDERED.

---

[1] Claimant contends that, because former ORS 656.268(7) (now ORS 656.268(7)(e)) provided that the costs of a medical arbiter's examination are to be borne by the insurer or self-insured employer, she should not be held responsible for payment of the medical arbiter report. Claimant misconstrues the statutory scheme regarding the distribution of a third party recovery. Our holding in this case does not require claimant to bear the cost of the medical arbiter's examination. To the contrary, the third party tort-feasor is the party that is ultimately responsible for reimbursement of the claim cost through its settlement of claimant's third party action. This is in keeping with the underlying public policy of the third party distribution statutes and the purpose of the statutory liens. That policy is to allocate whatever the claimant recovers between her and the paying agency and to provide reimbursement to those responsible for statutory compensation of injured workers (the paying agency) when settlements are obtained against the persons or person whose act caused the injury. Allen v. American Hardwoods, 102 Or App 562, 567 (1990), rev den 310 Or 547 (1990). Moreover, based on our reasoning in Vogel, we do not consider, as claimant would have us, the medical arbiter's examination to be an administrative cost. Rather, this examination, which is statutorily authorized, has been performed at claimant's express request as a medical service provided for her compensable injury and is specifically intended to eliminate or reduce litigation in evaluating the extent of her permanent disability. As such, the paying agency is entitled to reimbursement of its statutorily-mandated claim expenses for this examination/report. Jack S. Vogel, supra.

---



In the Matter of the Compensation of
**CLIFFORD E. CLARK, Claimant**
WCB Case No. 95-01005
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members en banc.

The self-insured employer requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) set aside a Determination Order which classified claimant's injury claim as nondisabling; and (2) awarded a $700 attorney fee under ORS 656.382(1). In his brief, claimant seeks remand in light of the amendment to ORS 656.005(7)(c). On review, the issues are claim classification, remand and attorney fees. We decline to remand and reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on Sharman R. Crowell, 46 Van Natta 1728 (1994), the ALJ found that claimant's claim should be reclassified as disabling because claimant was restricted to modified work. On review, the employer contends that under amended ORS 656.005(7)(c), claimant's claim should be classified as nondisabling. We agree.

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."

In Karren S. Maldonado, 47 Van Natta 1535 (1995), we addressed the same issue presented by this case. There, the claimant was released to, and worked, modified employment. However, she was not entitled to temporary disability. Applying amended ORS 656.005(7)(c), we held that, because no temporary disability benefits were due and payable, the claimant's claim was not disabling unless there was a reasonable expectation of permanent disability. We held that the unambiguous language of the amended statute effectively overruled our holdings in Crowell and Guzman. We specifically found, in light of the statutory language providing that an injury is not "disabling" if no temporary benefits are due and payable, that it was not enough that a claimant be limited to modified work. To classify a claim as disabling, there must also be entitlement to temporary 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. Because no temporary 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).

On this record, we do not find proof of a reasonable expectation of permanent disability. Claimant compensably injured his left hand. The injury was diagnosed as a nondisplaced fracture of the carpal navicular. Claimant's left thumb was placed in a cast and he was released to modified work. X-rays later showed that the fracture had healed, but claimant was given four sessions of physical therapy to improve range of motion. There is no evidence concerning whether permanent disability is reasonably expected from the fracture. Based on this record, we are unable to conclude that there is a reasonable expectation of permanent disability.

Claimant contends that the law at the time of hearing did not require evidence of the potential for permanent disability to establish that the claim was disabling. Claimant further contends that the case should be remanded to the ALJ to reopen the record for additional evidence in light of the statutory change. We disagree and deny the motion for remand.

To merit remand for additional evidence, it must be shown that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). At the time of the April 12, 1995 hearing, OAR 436-30-045(7)(c) provided:

"A claim is disabling if any one of the following conditions apply:

"***

---

[1] 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).

"(c) The worker is not medically stationary, but there is a substantial likelihood that the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726 when the worker does become medically stationary."

Contrary to claimant's argument, under the law in effect at the time of the hearing, evidence of the potential for a permanent disability award was a means of establishing that a claim was disabling. In spite of OAR 436-30-045(7)(c), this record contains no evidence concerning the potential for a permanent disability award. We acknowledge that the new statute requires "a reasonable expectation of permanent disability" whereas the rule required "a substantial likelihood of permanent disability." Nevertheless, this record does not contain evidence that would meet the standard which existed at the time of hearing. Thus, this is not a situation where the record contains evidence which would satisfy the old standard, but not the new standard. Given that both the new law and the law in effect at the time of hearing provided that a disabling claim could be established with evidence that a permanent disability award was likely, we are not persuaded that such evidence was unobtainable with due diligence at the time of hearing.[2] Accordingly, we deny the motion for remand.

Concluding that the employer unreasonably resisted the payment of compensation, the ALJ awarded a $700 attorney fee under ORS 656.382(1). The employer seeks reversal of the attorney fee award.

Since no compensation is due claimant, we are unable to find that the employer unreasonably resisted the payment of compensation by classifying the claim as nondisabling. Accordingly, the ALJ's award of a $700 attorney fee under ORS 656.382(1) is reversed.

ORDER

The ALJ's order dated May 4, 1995 is reversed. The Determination Order is reinstated and affirmed. The ALJ's award of a $700 attorney fee is also reversed.

---

[2] We find this case to be distinguishable from Troy Shoopman, 46 Van Natta 21 (1994), and Betty S. Tee, 45 Van Natta 289 (1993). In those cases, we found a compelling reason to remand where the record was devoid of evidence regarding a legal standard which had changed while Board review of those cases was pending. Here, unlike in Shoopman or Tee, the new legal standard is similar to the old one and requires the same type of evidence, (i.e., evidence that a permanent disability award is likely or expected). In addition, here, unlike in Shoopman or Tee, we find that evidence concerning the potential for a permanent disability award was obtainable with due diligence at the time of hearing. In other words, we find that the absence of such evidence in the record is the result of a lack of due diligence rather than a change in the legal standard.

**Board Member Hall specially concurring.**

I write separately to express my belief that in certain cases, given the statutory amendment applicable to this issue, remand is appropriate in claim classification disputes. In those cases where the record contains some persuasive evidence that there is a reasonable expectation that permanent disability will result from the injury, I believe that remand is appropriate for further development of the record. In the present case, however, the evidence establishes that there is not a reasonable expectation of permanent disability as a result of the injury. Under these circumstances, I concur with the majority that remand is not appropriate.

The other manner of establishing a disabling claim is through evidence that temporary disability benefits are due and payable. See amended ORS 656.005(7)(B)(c). I agree with the majority that evidence that a claimant is performing modified work is not enough by itself to establish a disabling claim. However, where a claimant establishes a right to temporary disability (even if it is only temporary partial), the claim should be classified as disabling. In other words, there may be cases in which performance of modified work actually results in entitlement to temporary partial disability and while modified work by itself would not result in disability classification, entitlement to temporary partial disability would.

In the Matter of the Compensation of
**DONALD W. CRABB, Claimant**
WCB Case Nos. 94-05920, 94-04552, 94-05919, 94-02281, 94-05918 & 93-11610
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lundeen, et al, Defense Attorneys
Bostwick, et al, Defense Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

CNA Insurance Companies requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) set aside its denial, on behalf of Miller Structures (CNA/Miller Structures), of claimant's current left shoulder condition; (2) upheld Liberty Northwest Insurance Corporation's denial, on behalf of M & R Insulation (Liberty/M&R), of claimant's "new injury" claim for the same condition; and (3) upheld Hartford Insurance Company's denial, on behalf of Fleetwood of Oregon (Hartford/Fleetwood), of the same condition. Hartford/Fleetwood cross-requests review of that portion of the ALJ's order that: (1) directed it to pay interim compensation; and (2) assessed a penalty for allegedly unreasonable failure to pay such compensation. In his brief, claimant contends that he is entitled to an assessed attorney fee for prevailing over Hartford/Fleetwood's denial of compensability. In response, Hartford/Fleetwood moves to strike the "attorney fee" portion of claimant's brief. On review, the issues are responsibility, interim compensation, motion to strike, and penalties and attorney fees. We deny the motion to strike, reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Motion to Strike

Hartford/Fleetwood moves to strike that portion of claimant's brief, which seeks an assessed attorney fee for prevailing over its compensability denial. Hartford/Fleetwood contends that claimant failed to cross-request review.

Claimant responds that since neither CNA/Miller Structures nor Hartford/Fleetwood have withdrawn their requests for Board review, he may raise additional issues not addressed by the appellants, notwithstanding his failure to cross-request review. We agree. Richard D. Cloud, 46 Van Natta 2429 (1994).

In addition, claimant contended at hearing that he was entitled to an assessed attorney fee for obtaining a pre-hearing rescission of Hartford/Fleetwood's compensability denial. (Tr. 16). Inasmuch as the issue was raised at hearing and because the appellants have not withdrawn their requests for review, we consider claimant's request for attorney fees and deny Hartford/Fleetwood's motion to strike. Id., see also Alden D. Muller, 43 Van Natta 1246 (1991) (Board's review authority extends to all issues raised at hearing and decided by the ALJ).

### Standard of Review

Subsequent to the ALJ's order, the legislature, effective June 7, 1995, amended ORS 656.307(2) which now provides that proceedings under ORS 656.307 "shall be conducted in the same manner as any other hearing and any further appeal shall be conducted pursuant to ORS 656.295 and 656.298." Or Laws 1995, ch 332, § 36 (SB 369, § 36).

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). Because amended ORS 656.307(2) does not alter a procedural time limitation, we apply it retroactively. See Motel 6 v. McMasters, 135 Or App 583 (1995) (under SB 369 §66(6), amendments that alter procedural time limitations do not apply retroactively); Walter L. Keeney, 47 Van Natta 1387 (1995). Therefore, our review of the responsibility issue is de novo. ORS 656.295(5).

Responsibility

We adopt and affirm the ALJ's analysis and conclusions regarding the responsibility issue, with the following supplementation.[1]

In reaching this decision, we acknowledge claimant's supplemental brief, in which he contends that certain sections of SB 369 violate Article I, section 10, of the Oregon Constitution and the Americans with Disabilities Act (ADA), 42 USCA § 12101 et seq. Particularly, claimant asserts that the "major contributing cause" standard set forth in amended ORS 656.005(7)(a)(A) and (B) and 656.802(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 which insurer is responsible for his left shoulder condition. We do not address those arguments for the following reasons.

First, this is a responsibility case; therefore, we focus our analysis on amended ORS 656.308. That statute now provides that "[t]he 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" so as to shift responsibility to a subsequent employer. This language merely codifies the SAIF v. Drews, infra, decision. Thus, the ORS 656.005(7)(a)(B)'s "major contributing cause" standard and its preexisting disease or condition language, as applied to ORS 656.308(1), was in effect when the ALJ heard this case. SAIF v. Drews, 318 Or 1 (1993) (the major contributing cause requirement of ORS 656.005(7)(a)(B) applies to the shifting of responsibility among employer under ORS 656.308(1)). Consequently, claimant's arguments regarding those provisions could have been raised at hearing. That the Legislature may have subsequently defined "preexisting condition," ORS 656.005(24), did not relieve claimant of the obligation of raising his constitutional and ADA arguments regarding ORS 656.005(7)(a)(B) at hearing if he wished to press them on appeal. Because claimant did not raise those arguments until now, we do not consider them. Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

Next, because this is a responsibility only case, we question Claimant's argument that he would be denied a remedy. Claimant has received benefits pursuant to the .307 order, as well as the ALJ's order. Likewise, he will be entitled to benefits as a result of this order. Moreover, the causation standard which claimant challenges affects which carrier is responsible for benefits, not whether claimant is entitled to such benefits.

Interim Compensation

The ALJ found that Hartford/Fleetwood had notice or knowledge of claimant's January 18, 1994 injury claim when it received Dr. Densmore's January 18, 1994 chart note relating claimant's shoulder condition to the January 1994 work injury and restricting claimant to right-hand work only. The ALJ further found that claimant was unable to continue in light duty work and that the employer failed to provide a written offer of modified work within the restrictions imposed by Dr. Densmore. The ALJ, therefore, concluded that claimant was entitled to interim compensation from the period claimant discontinued modified work until issuance of Hartford/Fleetwood's denial.

Hartford/Fleetwood contends that claimant was not entitled to interim compensation because he did not leave work due to his injury, but rather he chose to leave work. We disagree.

Claimant sought treatment from Dr. Densmore on the day of his injury at Fleetwood. Dr. Densmore restricted claimant to right-handed work only. (Exs. 55, 55Ab). Claimant worked two and one-half days the following week at light duty work. He continued to have shoulder problems and advised his employer that he was leaving work until he could see Dr. Colville. The employer placed claimant on leave of absence from February 3 to February 21, 1994 in order to give claimant ample time to see Dr. Colville about his shoulder. (Tr. 115-116). Dr. Colville saw claimant on February 7, 1994 and released him to medium/light work with no overhead use of the left arm. (Exs. 55B, 56). Claimant did not return to work at Fleetwood, but desired vocational training to avoid reinjuring his shoulder. (Tr. 117, 123).

---

[1] Since we have found that CNA remains responsible, we need not decide whether CNA's denial was an invalid preclosure denial under amended ORS 656.262(7)(b).

Considering such circumstances, we conclude that, under ORS 656.210(3), claimant "left work" due to his injury. See RSG Forest Products v. Jensen, 127 Or App 247 (1994). Whether claimant left work to seek vocational training or because he was unable to do the light duty work, it was because of his shoulder condition. We, therefore, agree with the ALJ that claimant is entitled to interim compensation.

The ALJ also found that Hartford/Fleetwood failed to provide an explanation for its failure to pay interim compensation. The ALJ, therefore, assessed a 20 percent penalty on the amount of interim compensation due. We disagree.

Hartford/Fleetwood's liability for interim compensation attached when it received notice of the claim, although it was not obligated to begin payment of interim compensation until claimant left work. ORS 656.262(4). The employer testified that because it could make work available for claimant, there was no medical reason for him to quit work. Furthermore, at the time claimant left work, claimant informed the employer that he desired to seek vocational training through his claim with CNA. Such evidence reasonably led the employer to believe that claimant left work for reasons unrelated to his January 1994 injury.

We, therefore, find that Hartford/Fleetwood had a legitimate doubt concerning its liability for the payment of interim compensation. See International Paper Co. v. Huntley, 106 Or App 107 (1991); Nix v. SAIF, 80 Or App 656 (1986)(a claimant who leaves work for reasons unrelated to the injury is not entitled to interim compensation). Accordingly, because the employer's conduct was not unreasonable, the ALJ's award of a penalty is not warranted.

Attorney Fees Under ORS 656.386(1)

Claimant argues that Hartford/Fleetwood's March 8, 1994 denial should be deemed a denial of compensability as well as responsibility; and, therefore, he is entitled to an attorney fee under ORS 656.386(1)[2] for obtaining a pre-hearing concession of compensability. We agree.

Hartford/Fleetwood's denial stated that claimant's current left shoulder injury was not compensable as a "new injury." The denial also expressly stated that designation of a paying agent had not been requested. In addition, the denial contained "notice of hearing" provisions consistent with a denial of compensation, as well as a statement that it was a denial of a claim for benefits. Under such circumstances, we find that Hartford/Fleetwood's denial raised issues of compensability. James D. Lollar, 47 Van Natta 740 on recon 47 Van Natta 878 (1995); cf. James McGougan, 46 Van Natta 1639 (1994)(denial expressly stated that the claim was compensable, that it was only a denial of responsibility, and that a paying agent would be requested).

Inasmuch as claimant's attorney protected claimant's interests in securing the eventual rescission of the compensability denial, we conclude that claimant is entitled to an insurer-paid attorney fee award under ORS 656.386(1) for his services before the issuance of the .307 order. See Darrell W. Vinson, 47 Van Natta 356 (1995); Bonita J. Olson, 46 Van Natta 1731, 1735 (1994). 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 $750, payable by Hartford/Fleetwood.

Attorney Fee on Board Review

Claimant's attorney is entitled to an assessed fee for services on review regarding CNA/Miller Structures' request for review and Hartford/Fleetwood's cross-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

---

[2] Amended ORS 656.386(1) now provides that "[i]n such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the [ALJ], a reasonable attorney fee shall be allowed." It further 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 Hartford/Fleetwood, for overcoming the compensability portion of its denial.

a reasonable fee for claimant's attorney's services on review concerning CNA's appeal is $1,000, payable by CNA/Miller Structures. In addition, after considering the aforementioned factors, we find that a reasonable fee concerning the interim compensation issue raised by Hartford/Fleetwood's cross-request is $800, payable by Hartford/Fleetwood. In reaching our conclusions, we have particularly considered the time devoted to the issues raised by CNA's and Hartford's appeals (as represented by claimant's respondent's briefs), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee award for his counsel's services on review regarding the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Howard L. Rose, 47 Van Natta 345 (1995) (citing Amador Mendez, 44 Van Natta 736 (1992)).

ORDER

The ALJ's dated January 30, 1995 is reversed in part and affirmed in part. That portion of the order which assessed a 20 percent penalty against Hartford/Fleetwood is reversed. For services in obtaining the "pre-hearing" rescission of Hartford/Fleetwood's compensability denial, claimant's attorney is awarded $750, payable by Hartford/Fleetwood. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded assessed attorneys of $1,000, payable by CNA/Miller Structures, and of $800, payable by Hartford/Fleetwood.

---

December 7, 1995 Cite as 47 Van Natta 2316 (1995)

In the Matter of the Compensation of
**LARRY V. MARKER, Claimant**
WCB Case Nos. 93-11487 & 93-12697
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Poland's order which set aside its denial of claimant's anxiety and depression condition. In his respondent's brief, claimant contests that portion of the ALJ's order that upheld SAIF's denial of claimant's occupational disease claims for his mental and stomach disorders. On review, the issues is compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding the consequential anxiety/depression condition issue.

Claimant suffers from a compensable binaural, high frequency hearing loss. In January 1980, a Determination Order awarded claimant permanent disability for his loss of hearing. (Ex. 24). For the last ten years, claimant has worked, at the middle-school level, as an industrial arts teacher. During this time, claimant specialized in teaching wood products classes, with occasional assignments in teaching a reading class. (Tr. 18).

At the end of the 1992-1993 school year, claimant was told that wood product classes would be discontinued and that he was being assigned to teach a new curriculum of high school classes (personal finance, welding and sheet metal). In June 1993, claimant sought treatment for abdominal symptoms, diagnosed as nonulcer dyspepsia. (Ex. 7).

In June 1993, claimant stated on a "801" form that his "hearing loss caused job related stress which in turn caused his ulcer." (Ex. 6). He further reported that he had to resume taking ulcer medication. On August 18, 1993, claimant was examined by Dr. Klecan, who determined that claimant did not have a mental or emotional disorder. (Ex. 12-9). SAIF denied claimant's stress related ulcer claim on August 31, 1993. (Ex. 13).

Claimant began his high school teaching assignment at the end of August 1993. (Tr. 28). He had difficulty communicating with students and maintaining control in his personal finance classes. He also had difficulty in welding class because of the noisy machinery. In November 1993, claimant was examined by Dr. Johnson, psychiatrist. Dr. Johnson diagnosed claimant as having adjustment disorder with mixed emotional features (anxiety and depression). In Johnson's opinion claimant could not be gainfully employed as a teacher "primarily" because of his compensable hearing loss condition.

The ALJ concluded that claimant's accepted hearing loss condition was the major cause of his psychological condition (anxiety/depression). ORS 656.005(7)(a)(A). In so doing, the ALJ relied on the medical reports of Dr. Johnson.

On review, SAIF contends that the ALJ erred by finding claimant's mental condition was a consequence of his accepted hearing loss claim. According to SAIF, the medical opinion of Dr. Klecan supports its denial of claimant's psychological condition. Additionally, SAIF contends that the ALJ should have applied the provisions of ORS 656.802.

Initially we must 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.

After reviewing the medical opinions we find that claimant's psychological condition should be analyzed as a consequential condition related to his accepted hearing loss condition under ORS 656.005(7)(a)(A). See SAIF v. Freeman, 130 Or App 81 (1994) (the court held that a psychological condition remained compensable because the medical evidence established that the claimant became depressed and lost self esteem and confidence when his ability to work was diminished as a result of his compensable injury); Boeing v. Viltrakis, 112 Or App 396 (1992) (when a claimant merely seeks to recover benefits for the consequences of a compensable injury, but does not seek to establish independently the compensability of a mental disorder, the provisions of ORS 656.802 do not apply); see also Albert H. Olson, 46 Van Natta 1848 (1994) (the claimant's psychological condition was compensable as a "consequential condition" under ORS 656.005(7)(a)(A) because his compensable low back injury was the major contributing cause of his psychological condition).

Dr. Klecan, psychiatrist, was of the opinion that claimant was worried about his ability to teach his high school curriculum because of his hearing loss condition. (Ex. 12-9). He did not believe that claimant's subjective sense of stress was due to any non-work factors. Finally, Dr. Klecan opined claimant did not have a mental or emotional disorder. Id.

Claimant was examined by Dr. Johnson, psychiatrist, on two occasions in November 1993. Dr. Johnson diagnosed adjustment disorder with mixed emotional features (anxiety and depression) as confirmed by a MMPI. (Ex. 29-2). Dr. Johnson opined that claimant's continued attempt to teach the high school curriculum would aggravate his mental state and cause more depression and anxiety. He believed that claimant could not be gainfully employed as a teacher, "primarily because of [his] hearing loss and the emotional effect it has." Id.

Here, we find Dr. Johnson's medical opinion to be persuasive because he examined claimant after he began teaching his new curriculum of classes at the high school. Somers v. SAIF, 77 Or App 259 (1986). Dr. Johnson believed that claimant could not be gainfully employed as a teacher primarily because of his hearing loss. We interpret, as did the ALJ, Dr. Johnson's statement as an opinion that claimant's hearing loss was the major contributing cause of his psychological condition. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

Conversely, we decline to rely on Dr. Klecan's findings (that claimant did not have a mental disorder) because he examined claimant prior to the start of the 1993 school year, which was before claimant actually had to confront his "new" teaching assignment. (Tr. 28). Therefore, based on Dr. Johnson's opinion, we find that the major contributing cause of claimant's psychological condition was her accepted hearing loss condition. Accordingly, claimant has proven that his psychological condition is a compensable consequence of his accepted condition. ORS 656.005(7)(a)(A).

Finally, inasmuch as we have found claimant's psychological condition compensable as a consequence of his accepted hearing loss injury and since we adopt the ALJ's findings for claimant's nonulcer condition, we decline to address claimant's contention that his claims are also compensable as separate occupational diseases.

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 consequential condition issue is $1,000, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review devoted to his contention that the occupational disease claims should be found compensable.

ORDER

The ALJ's order dated April 5, 1995, as amended April 18, 1995, is affirmed. For services on review claimant's attorney is awarded $1,000, payable by the SAIF Corporation.

---



In the Matter of the Compensation of
**ERIC E. SMITH, DECEASED, Claimant**
WCB Case No. 93-13695
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's death claim; and (2) awarded an assessed fee of $23,460. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant worked as a flight instructor and maintenance test pilot. When claimant performed the test flights, which occurred once or twice a month, he routinely flew over his house in Battleground, Washington, flying one or two circles for his wife's observation.

On July 15, 1993, claimant was asked to test fly a Piper Seneca twin engine airplane; the plane had just undergone repairs in the left engine for a broken bolt and oil leak and magneto problem. Other than to return before a 3:00 p.m. flight lesson, claimant was not given specific flying instructions. Claimant departed Portland International Airport at 2:36 p.m. and flew north to Battleground.

In view of his wife, father-in-law and various neighbors, claimant flew the plane in a circle over his house. He was at an approximate elevation of 100 feet. While completing another circle, the plane's left wing dipped and the plane rolled. The plane then crashed at the edge of claimant's front yard; claimant died as a result of the accident.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, factually, claimant flew the airplane at above 1,000 feet while circling his house, in compliance with FAA and the employer's rules, and that the left engine failed, resulting in the crash. Thus, the ALJ found that claimant's death occurred in the course and arose out of his employment and found the claim compensable.

SAIF asserts that, based on testimony by neighbors who saw the flight, claimant was not flying above 1,000 feet, but rather at about 100 feet. According to SAIF, because flying at such a low level violated FAA and the employer's rules, claimant's death did not arise out of his employment. We agree.

At hearing, claimant submitted opinions from several expert witnesses indicating that the plane accident was caused by left engine failure. Phillip Mitchell, an aviation consultant who had previously worked with claimant, stated that the left engine failed while claimant was in a left turn and that the plane then entered into an accelerated stall from which claimant could not recover. (Ex. 10-16). Jerry Wells, an aircraft accident investigator, similarly attributed the accident to loss of left engine power. (Tr. 23). Finally, David Horwitz, a commercial airline pilot and claimant's longtime friend, testified that the plane had a "mechanical problem" from which it could not recover. (Id. at 414).

In reaching their opinions, claimant's experts relied on two sources of information. First, they were persuaded by testimony from claimant's widow, Elizabeth Smith, and her father, Roy Becker. Both stated that, while watching the plane completing a circle over the area, they witnessed the left wing suddenly dip and the nose of the plane drop to 30 degrees; the plane then plummeted from the sky and crashed. (Tr. 93-94, 97, 115, 116). They estimated that, until his descent, claimant was flying the plane between 1,000 and 1,500 feet. (Id. at 93, 115).

Claimant's experts discounted contradicting testimony from other persons who witnessed the flight and estimated the plane to be at 100 feet. For instance, Diane Goodboe testified that the plane flew directly over her while circling, (Tr. 344); she estimated the plane to be at 100 to 110 feet based on her observation that it barely cleared stands of trees that stood between 80 to 90 feet tall, (id. at 339, 344-45). Ms. Goodboe also testified that, during most of the time she saw the plane, its configuration was level. (Id. at 348-49). George Banks, an aircraft mechanic and private pilot, testified that he observed the plane while working at his home located approximately one-quarter mile from the accident site. Ex. 19-1, 19-2, 19-6). He also saw the plane fly at tree top level, which he estimated to be between 75 and 100 feet. (Id. at 8). Finally, Cloyd Nutter testified that he saw the plane directly overhead and, on its second pass over his property, estimated it to be at tree top level. (Ex. 13-22, 16-9). Mr. Nutter also stated that the plane was level. (Id. at 11-12).

Claimant's experts also relied on an investigative report from the National Transportation Safety Board (NTSB). The report, based on evidence at the accident site, found that, at impact, the plane's left engine was operating at a lesser rpm rate than the right engine. (Ex. 1C-7). Mr. Wells in particular found that such proof showed that the left engine had failed and was merely "windmilling" when it crashed. (Tr. 24, 27, 30).

The NTSB, however, after considering the same investigative report, found that the probable cause of the accident was claimant's "failure to maintain adequate altitude during his maneuver." (Ex. 1B-2). The NTSB, after noting evidence of disparate rpm rate between the left and right engines, also stated that "post crash exam revealed no evidence of any control malfunction within the [aircraft]." (Id. at 2).

We are more convinced by the NTSB's finding that the cause of the accident was due to claimant's failure to maintain adequate altitude rather than the opinion of claimant's experts attributing it to left engine failure. First, we find more persuasive those witnesses who estimated claimant to be flying at 100 feet. Claimant's experts apparently rejected such evidence because they considered the witnesses to be unqualified to render an opinion concerning the plane's altitude. (See Tr. 61-67, 428-29). We disagree. Ms. Goodboe and Mr. Nutter both saw the plane directly overhead and, therefore, were in as good a position to view the plane as Ms. Smith and Mr. Becker. Furthermore, Ms. Goodboe had experience and training to estimate plane altitude based on her previous position with the Forest Service. (Tr. 336). Mr. Banks, as a private pilot and airline mechanic, also demonstrated knowledge in aviation matters.

Furthermore, although there was evidence that the left engine was operating at a lower rpm rate than the right engine at the time of impact, we are not convinced that such proof establishes that the left engine failed. As found by the NTSB, there was no physical evidence of control malfunction. Instead, the NTSB found that the sole cause of the accident was claimant's failure to maintain adequate control without implicating any loss of engine power.

Therefore, based on the strong witness evidence that claimant was flying at approximately 100 feet, as well as the NTSB's conclusions, we find a lack of persuasive evidence that the accident resulted from plane malfunction. Rather, we agree with the NTSB that the cause was claimant's failure to maintain an adequate altitude.

In order to establish a compensable injury, it must arise out of, and occur in the course of, employment. ORS 656.005(7)(a). Whether an injury occurred "in the course of employment" concerns the time, place and circumstances of the injury; whether the injury "arose out of employment" conerns the causal connection between the injury and the work. Norpac Foods, Inc. v. Gilmore, 318 or 363, 366 (1994). In addressing the latter element, 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).

According to FAA rules, the minimum altitude for operation of aircraft is 500 feet. (Ex. 6-1). The employer's policy required all personnel to conduct aircraft operations in compliance with FAA regulations. (Ex. 6-3). Claimant's operation of the plane at 100 feet, therefore, was not a condition of employment but rather transgressed the employer's policy. Thus, we conclude that claimant's injury did not arise out of his employment because no condition of his work was related to the cause of the accident. Hence, even assuming that the injury occurred in the course of claimant's employment, because it did not arise out of the employment, we conclude that claimant failed to prove compensability. ORS 656.005(7)(a); Norpac Foods, Inc. v. Gilmore, supra.

Inasmuch as claimant did not prove compensability, we reverse the ALJ's attorney fee award. Thus, we need not address the reasonableness of that award.

ORDER

The ALJ's order dated February 24, 1995 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

**Board Member Gunn dissenting.**

This claim is for a pilot who, when test-flying a plane for his employer, crashed and died in his own front yard while his wife and father-in-law watched. The majority decides that this claim is not compensable, finding that claimant was flying at an altitude of 100 feet, in transgression of FAA and employer's rules, and, thus, claimant's death did not arise out of his employment.

I strongly disagree with this decision. The record convinces me that the ALJ correctly found that the Claimant was flying at least 1,000 feet. First, testimony by the defense witnesses, relied up by the majority, show that their views of the plane at times were obstructed by the surrounding trees. One witness was not even in the immediate area but approximately one-quarter mile from the crash; another witness could not even estimate the height of the plane. These witnesses' testimony also were inconsistent in significant matters.

Claimant's widow and father-in-law, on the other hand, testified that claimant was in their view the entire time. This fact gives more weight to their testimony that claimant was flying at 1,000 feet. Added to this testimony the evidence that radar also showed claimant flying at 1,000 feet, claimant proved his case beyond a preponderance of the evidence.

The majority also relies heavily on the NTSB report. As discussed by the ALJ, SAIF did not call the author of the report to testify and further explain his findings. The report is very brief and vague; it neither finds that claimant was flying at 100 feet nor states that there was not an engine failure. In the absence of the investigator's testimony and the vagueness of the report, I am not persuaded that the NTSB necessarily supports the conclusions reached by the majority.

Finally, there was the testimony from claimant's witnessed, each of whom displayed expertise in evaluating airplane accidents. Jerry Wells is an aircraft accident investigator with experience in over 200 accidents. (Tr. 11). Philip Mitchell is an aviation consultant with experience in aircraft accident evaluation. (Id. at 205, 214). David Horwitz has been a commercial airline pilot for over 30 years and an FAA designated examiner for the aircraft flown by claimant. (Id. at 409). Each of these experts reviewed the NTSB investigator's report and the eye witness testimony. Each expert, without reservation, attributed the accident to airplane failure. These experts' opinions that the crash was due to plane failure overcome the NTSB investigator's report. We know the qualifications and the foundations of the opinions of claimant's experts; significantly, in the absence of the NTSB's investigator's testimony, we cannot evaluate that person's expertise, if any, and whether he examined all the available evidence in reaching his conclusions.

In sum, the eye witness testimony by the widow and father-in-law, the radar, and claimant's expert witnesses convince me that claimant was flying at 1,000 feet when the plain he was piloting (as part of his job duties) experienced an engine failure, resulting in a fatal crash. This claim in compensable, By deciding to the contrary, the majority compounds the tragedy of claimant's death.

In the Matter of the Compensation of
**TRAVIS W. THORPE, Claimant**
WCB Case No. 92-06349
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to its April 24, 1995 order, the court has reversed our prior order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that held that the Hearings Division lacked jurisdiction to consider a claim for palliative medical services. Citing Meyers v. Darigold, Inc., 123 Or App 217 (1993), rev den 320 Or 453 (1994), the court has reversed and remanded this matter for further proceedings. Subsequent to the court's remand order, the Legislature amended the Workers' Compensation Act. Or Laws 1995, ch 332 (SB 369). Based on those amendments, we vacate the ALJ's order and dismiss claimant's hearing request.

## FINDINGS OF FACT

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

The SAIF Corporation entered into an agreement with CareMark Comp, a managed care organization (MCO), after Dr. Becker prescribed the contested medical services.

## CONCLUSIONS OF LAW AND OPINION

Dr. Becker prescribed physical therapy for claimant's compensable paraplegia. When SAIF failed to pay for those services, claimant requested a hearing contesting SAIF's "de facto" denial. At hearing, SAIF contended that the ALJ lacked jurisdiction over this matter and, on the merits, that the physical therapy had not been conducted pursuant to an attending physician's written treatment plan in accordance with former OAR 436-10-040(3)(a). (Tr. 6-7).

Relying on our decision in Stanley Meyers, 42 Van Natta 2643 (1990), an ALJ dismissed the hearing request for lack of jurisdiction. We adopted and affirmed the ALJ's order. SAIF requested judicial review of our decision. Thereafter, in Meyers v. Darigold, Inc., supra, the Court of Appeals reversed our decision in Stanley Meyers, holding that, under former ORS 656.327(1), the Board had jurisdiction to consider medical treatment disputes if no party requested that the Director resolve the dispute. Citing its decision in Meyers v. Darigold, Inc., the court has remanded this matter to us for further proceedings.

The first issue is whether we have jurisdiction over this matter. Claimant asserts that, because no one requested Director review of this matter, under Meyers v. Darigold, Inc., we retain jurisdiction over this matter.[1] SAIF asserts that, under either amended ORS 656.245(6)[2] or 656.260(6)[3], the Director has exclusive jurisdiction over this matter. We agree with SAIF.

---

[1] Claimant also argues that amended ORS 656.245(1)(c)(A) vests jurisdiction over this matter in the Board and the Hearings Division. Amended ORS 656.245(1)(c)(A) provides that compensable medical services include "[s]ervices provided to a worker who has been determined to be permanently and totally disabled." That statute defines a type of compensable medical service; it does not address who has jurisdiction over disputes regarding such services.

[2] 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.

[3] Amended ORS 656.260(6) provides, in part, that "any issue concerning the provision of medical services to injured workers subject to a managed care contract * * * shall be subject solely to the review of the director * * *."

The Legislature has amended the Workers' Compensation Act. SB 369. ORS 656.327(1) is among the amended statutes. SB 369, § 41. It now vests in the Director exclusive jurisdiction over medical services disputes arising under the former and present versions of ORS 656.327(1). Walter L. Keeney, 47 Van Natta 1387 (1995). Because the court's decision in Meyers holds to the contrary, it is no longer good law. See Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413 (1995) (court held that Board lacked jurisdiction over proposed medical services case that relied on Meyers). Accordingly, if this matter falls under ORS 656.327(1), we lack jurisdiction over it.

We reach the same conclusion if this is characterized as a "245" case. Under ORS 656.245(6), which was added as part of the June 1995 amendments, the Director has exclusive jurisdiction over all pending and future 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 contends that the disputed medical services are unrelated to claimant's compensable condition. Rather, SAIF's challenge is based on claimant's physician's alleged failure to comply with a Director's rule regarding the implementation of a written treatment plan. Thus, the compensability of claimant's underlying claim is not contested. Accordingly, if this is characterized is a "245" case, ORS 656.245(6) applies and the Director now has exclusive jurisdiction over it.

Finally, we reach the same conclusion if this is characterized as a "260" case. Under amended ORS 656.260(6), the Director now has jurisdiction over all pending and future medical services disputes involving MCOs. Ronald R. Streit, 47 Van Natta 1577 (1995). There is some evidence that this case may have involved an MCO. Assuming, without deciding, that that was the case, amended ORS 656.260(6) applies and the Director has exclusive jurisdiction over this matter.

In sum, regardless of whether this claim arises under amended ORS 656.327, 656.245 or 656.260, neither we nor the Hearings Division has jurisdiction over it. Consequently, we affirm the ALJ's dismissal of claimant's hearing request for lack of jurisdiction. In light of this decision, we do not reach the merits of the medical services issue.

Claimant raises a due process argument in opposition to the retroactive application of SB 369's amendments to this case.[4] Claimant asserts that the retroactive application of SB 369's amendments to this case will deprive him of a property interest in violation of the Due Process Clause of the United States Constitution. US Const, Am XIV, § 1.[5] Claimant fails, however, to identify what property interest is at issue, and how SB 369's amendments will deprive him of that interest. Under the circumstances, we are inclined to find claimant's argument inadequately developed for review. E.g., Ronald B. Olson, 44 Van Natta 100, 101 (1992) (Board declined to consider constitutional argument not adequately developed for review).

In any event, the amendments to ORS 656.327, 656.245 and 656.260 have not deprived claimant of any substantive benefit; they have simply clarified that the Director is the proper entity before which these matters are now to be litigated. Indeed, SB 369 makes it clear that the Director will have the same authority as the Board had to award benefits in medical services disputes such as this case. See Liberty Northwest Ins. Corp. v. Yon, supra, (amendments to ORS 656.245, 656.327 and 656.704 eliminated claimant's choice to have medical services dispute resolved by Board, but did not deny him opportunity to have claim reviewed) 137 Or App at 417; Kathleen M. Butler, 47 Van Natta 2202 (1995) (amendments to ORS 656.260 clarified that Director, and not Board, is proper entity before which managed care organization disputes are now to be litigated); see generally amended ORS 656.327, 656.245 and 656.260; see also SB 369, § 42d(1) (authorizing Director to award attorney fees in disputes arising under amended ORS 656.245, 656.260 and 656.327). For these reasons, we reject claimant's due process arguments.

---

[4] Claimant also asserts that, under Whipple v. Howser, 291 Or 475 (1981), the Legislature lacked authority to "destroy jurisdiction in a pending case * * *." Claimant's Supplemental Brief at 1. We reject claimant's argument. First, the Legislature did not "destroy" any jurisdiction; it merely indicated its preference that the Director, rather than the Board or the Hearings Division, have jurisdiction over certain matters. Second, Whipple involved the retroactive application of a statute with a litigation "savings clause" that exempted from coverage actions "commenced" before the statute's effective date. SB 369 has no such savings clause. See SB 369, § 66 (enumerating retroactivity provisions). Therefore, Whipple is for this purpose, inapposite.

[5] Claimant's argument revolves around the assertion that "[r]etroactive substantive amendments in cases such as this one deprive [c]laimant of a federally protected interest in a substantive and meaningful opportunity to be heard." Claimant's Appellant's Supplemental Brief at 7.

In sum, we conclude that we are without jurisdiction to address the merits of this medical services dispute. Accordingly, we affirm the ALJ's dismissal of claimant's hearing request.[6]

ORDER

The ALJ's order dated October 1, 1992 is affirmed.

[6] Although a signatory to this order, Member Gunn refers the parties to his dissenting opinion in Kathleen M. Butler, supra.

December 7, 1995 Cite as 47 Van Natta 2323 (1995)

In the Matter of the Compensation of
**G. J. TRENCHARD, Claimant**
WCB Case No. 94-08505
ORDER ON REVIEW
Michael M. Bruce, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order which set aside its denial of claimant's left shoulder injury claim. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but not his "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's shoulder injury occurred in the course and scope of his employment. In so doing, the ALJ determined that claimant was not an active participant in the confrontation, which resulted in his injury. See ORS 656.005(7)(b)(A).

On review, the insurer contends that claimant was an active participant in the fight which resulted in his injuries. As such, according to the insurer, claimant's active participation precludes his claim from being compensable. We agree.

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). Because claimant was an active participant, we find that compensability of his claim is barred under ORS 656.005(7)(b)(A). We base our finding on the following reasoning.

Claimant was employed as a autobody repairman. (Tr. 54). On the morning of June 15, 1994, claimant informed Steven Prewitt, supervisor, that the garbage cans had not been taken out of the shop (in order to be picked up). (Tr. 68).

After lunch, while returning to his work station, claimant noticed that the garbage cans still had not been "taken out." Subsequently, claimant left his work station, walked 20 feet to the "paint room door," and "yelled" that the garbage needed to be taken out. (Tr. 69). After claimant returned to his work station, Mr. Prewitt opened the paint room door and ordered claimant to take the garbage out. (Tr. 72). Claimant responded to Mr. Prewitt that taking the garbage out was not his job. Still standing by the paint room door, Mr. Prewitt challenged claimant to a fist fight. Id. Claimant told Mr. Prewitt that he would not fight him. Claimant and Mr. Prewitt exchanged obscenities. (Tr. 75, 93).

Approaching to within inches from claimant, Mr. Prewitt again challenged him to a fight. (Tr. 77). Claimant declined Mr. Prewitt's challenge and suggested that he return to work.

Mr. Caughey, co-worker, overheard claimant and Mr. Prewitt yelling obscenities at one another and came around the "corner" to find out what all the "yelling was about." (Tr. 101). Upon rounding the "corner," Mr. Caughey stated that Mr. Prewitt was standing about 4 feet from the paint shop door which was 20 feet from where claimant was located. (Tr. 101, 102). Believing that the confrontation between Mr. Prewitt and claimant was over, Mr. Caughey and Mr. Prewitt began walking towards the paint room. (Tr. 126). Immediately thereafter, Mr. Caughey heard a "clink, a whiz" and that something (later determined to be a wrench) passed between his face and Mr. Prewitt's face. (Ex. C; Tr. 102, 114). Mr. Caughey proceeded through the paint room door and Mr. Prewitt "went after" claimant. (Tr. 104). Mr. Caughey stated that the wrench put a hole in a car fender and dented a "wall post." (Tr. 106; Exs. D, E).

Claimant's version of the incident was as follows. While Mr. Prewitt and Mr. Caughey were walking towards the paint room, he said something to Mr. Prewitt and Mr. Prewitt responded by saying, "Okay this is it. Let's go outside and fight." Claimant said "No" and then threw the wrench in the direction of a cinder block wall. (Tr. 80). Claimant testified that he threw the wrench out of frustration and did not intentionally attempt to strike Mr. Prewitt with the wrench. (Tr. 83). The wrench hit a car fender (causing a loud bang) bounced off it and then struck the cinder block wall. (Tr. 81). Claimant observed Mr. Prewitt and Mr. Caughey duck when the wrench hit the fender. (Tr. 83). Mr. Prewitt then turned towards claimant and ran to him throwing punches. Claimant stepped back to avoid being hit by a punch. Claimant and Mr. Prewitt wrestled and, finally, claimant fell injuring his left shoulder. (Tr. 84).

In Kessen v. Boise Cascade Corp., 71 Or App 545 (1984), the court held the claimant was an active participant in a fight, even though he received the only blow struck, because he "was the one who, because of his anger, vocal tirade and threatening gestures, actually initiated the fight." 71 Or App at 548.

In this case, following his verbal exchange with claimant, Mr. Prewitt had began to go back to work. At this moment, any confrontation resulting from Mr. Prewitt's and claimant's vocal exchange had ended. This conclusion is also supported by Mr. Caughey who believed that the confrontation was over and began to walk with Mr. Prewitt to the paint room. Claimant stated that he had begun to calm down and started thinking about the car he was repairing, when he spoke out to Mr. Prewitt which resulted in another challenge to fight. (Tr. 80). Claimant then threw the 12 inch wrench which ricocheted in a direction close to Mr. Prewitt. The force of the throw punctured a fender and "chipped" the wall.

Under these circumstances, we find that claimant was an active participant in the "fight" because he re-initiated and further escalated a situation that appeared to have been defused, by calling out to Mr. Prewitt, (as Mr. Prewitt was walking away) and more particularly, by throwing the wrench. This latter behavior led directly to his physical confrontation and ultimately claimant's injury. In making this decision, we distinguish this case from Irvington Transfer v. Jasenosky, supra.

In Jasenosky, the claimant confronted his assailant, asking him why he wanted to fight. The assailant charged the claimant and assaulted him. In that case, the claimant was not an active participant because he did not have an opportunity to withdraw and he did not voluntarily assume an active or aggressive role in the confrontation.

This case is similar to Ronald A. Smith, 47 Van Natta 807 (1995). In Smith, supra, the claimant, a bus driver, was found to be an active participant because he voluntarily assumed an active or aggressive role in an altercation on the bus because he prepared to participate in the confrontation by unbuckling his seatbelt and reaching for a pair of nunchakus.

Here, Mr. Prewitt and claimant engaged in a vocal exchange. Mr. Prewitt challenged claimant to a fight. Claimant declined the challenge and suggested that Mr. Prewitt go back to work. Mr. Prewitt began to walk to the "paint room" (Mr. Prewitt's work area) when claimant re-initiated a vocal

exchange with Mr. Prewitt and then threw the wrench.[1] Thus, as was the claimant in Smith, we find that claimant was an active participant in the confrontation which led to his injuries.

Additionally, we conclude that the assault that claimant was involved in was not connected to his job assignment since claimant's duties as a repairman did not include physical assaults. Finally, there is no evidence to support a finding that throwing wrenches was a customary duty of claimant's job. ORS 656.005(7)(b)(A). Accordingly, claimant's claim is not compensable. Consequently, the insurer's denial is reinstated and upheld.

ORDER

The ALJ's order dated May 26, 1995 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

---

[1] We acknowledge claimant's testimony that he did not intend to hit Mr. Prewitt. Nevertheless, regardless of his unspoken intention, his actions conveyed a much more hostile and aggressive purpose. Considering the force and proximity of the "flying wrench" to Mr. Prewitt, we find it understandable that such an action would reasonably be interpreted (by Mr. Prewitt) as a further escalation of their confrontation.

**Board Member Gunn dissenting.**

The majority concludes that claimant was an "active participant" in the altercation with his employer, Mr. Prewitt. Because I find that claimant's throwing of the wrench was an act of frustration brought about by Mr. Prewitt's violent propensities, I respectfully dissent.

An "active participant" under the statute is one who voluntarily assumes an active or aggressive role in the altercation or has an opportunity to withdraw from the encounter and does not do so. Irvington Transfer v. Jasenosky, 116 Or App 635, 640 (1992).

Here, claimant was confronted by Mr. Prewitt after claimant refused to take the garbage cans out for pick-up. Mr. Prewitt challenged claimant to go outside and fight repeatedly. Claimant declined to do so. Mr. Prewitt then began to walk back to work. Claimant testified that he had never had an encounter like the one he had with Mr. Prewitt. Claimant stated that he was shaking with adrenaline and was dumbfounded over the verbal exchange with Mr. Prewitt. (Tr. 79). It was at this time, after being verbally abused and threatened by Mr. Prewitt, that claimant threw the "wrench" out of frustration.

As such, I find that claimant was not an "active participant" in the physical encounter which resulted in his injuries. For instance, claimant credibly testified that he threw the wrench out of frustration. Claimant did not attempt to strike Mr. Prewitt with the wrench. As such, claimant's actions were not "voluntary" in the sense that he wished to escalate or re-initiate a confrontation with Mr. Prewitt. Claimant's throwing the wrench was a response to the manner in which Mr. Prewitt confronted claimant. Therefore, I find that claimant did not "voluntarily" assume an "active" role in the confrontation which resulted in his injuries.

Additionally, I note that claimant was injured while trying to "withdraw" from Mr. Prewitt's attack (claimant tripped injuring his shoulder while trying to avoid Mr. Prewitt) which lends further credence to my position that claimant was not "actively participating" in the assault by Mr. Prewitt. Based on the foregoing discussion, I respectfully dissent from the majority's decision.

In the Matter of the Compensation of
**MAX WALTON, Claimant**
WCB Case No. 94-13340
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, 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) Lipton's order that: (1) set aside its partial denial of claimant's generalized rheumatoid arthritis condition; and (2) assessed a penalty for the employer's allegedly unreasonable denial of that condition. On review, the issues are compensability and penalties. We affirm.

## FINDINGS OF FACT

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

By letter dated May 26, 1981, the employer denied reopening of claimant's 1974 left foot injury claim and stated, *inter alia*:

> "In reviewing the information we have, including all the medical evidence, there is no indication that your August 6, 1974 work injury caused a significant worsening of your underlying condition which has given rise to your need for this further time off and medical treatment.
>
> "The underlying condition appears to be a type of rheumatic disease. Your ongoing work involving walking, bending, going up and down stairs, lifting, climbing, etc. may well have occasioned a worsening of the symptoms that you have. These symptoms may well be severe enough to cause you to stop working as your doctor has recommended but when they occur, the employer should be informed and a report should be filed so that it my be referred to their current workers' compensation carrier at the time disability commences for their necessary attention.
>
> "My understanding of the factual, medical and legal complications of your claim lead me to the decision that I am justified in denying your request to re-open your claim resulting from the August 6, 1974 incident. I am therefore hereby denying your request for that claim re-opening." (Ex. 34)

By order dated March 9, 1982, ALJ Mulder set aside the self-insured employer's denial and ordered it to accept claimant's claim. (Ex. 44).

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The ALJ concluded that the employer's denial of claimant's generalized rheumotoid arthritis condition was precluded by virtue of ALJ Mulder's March 9, 1982 order, as well as ALJ Pferdner's February 9, 1983 order (concerning extent of permanent disability). Therefore, the ALJ set aside the denial. We agree, but do so based on the following reasoning.

Under the res judicata doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined in a valid and final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. Drews v. EBI Companies, 310 Or 134, 139-40 (1988); North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988).

In July 1979, Dr. Burroughs, claimant's treating physician, reported that claimant had rheumatoid disease involving several joints, including the left ankle. (Ex. 26). Dr. Burroughs opined

that claimant's "illness" was associated with his on-the-job injury. (Ex. 26). In March 1981, Dr. Burroughs released claimant from work due to left ankle, right knee, and bilateral hand/wrist symptoms. (Ex. 29-5). In May 1981, the employer denied reopening of claimant's claim on the basis that the 1974 compensable injury did not cause a "significant worsening of [claimant's] underlying condition." (Ex. 34). The employer's denial defined the underlying condition as "a type of rheumatic disease." (Ex. 34). Claimant requested a hearing on the denial and by a March 9, 1982 order, ALJ Mulder set aside the denial and ordered the employer to accept claimant's claim. (Ex. 44).

At the time of the 1982 order, claimant had rheumatoid symptoms in several joints of his body, which Dr. Burroughs indicated were related to claimant's compensable injury. The employer's denial did not specify a particular body part, but indicated that it was denying claimant's underlying condition which it described as "a type of rheumatic disease." (Ex. 34). Under the doctrine of issue preclusion, the March 1982 order establishes as a matter of law that claimant's underlying rheumatic disease is compensably related to his August 1974 injury. In other words, the connection between claimant's generalized rheumatoid arthritis condition and the work injury were determined when ALJ Mulder set aside the employer's prior denial. See Eileen A. Edge, 45 Van Natta 2051 (1993).

Therefore, the employer is precluded from denying claimant's generalized rheumatoid arthritis on the basis that it is unrelated to the industrial injury.[1] Inasmuch as the employer's denial denies claimant's rheumatoid arthritis on that basis, we agree with the ALJ that it must be set aside. Id.

Penalty

We adopt the ALJ's conclusions and reasoning concerning the penalty issue with the following supplementation.

At the time the employer issued its denial, it had Dr. Montanaro's report indicating that claimant's rheumatoid arthritis condition was unrelated to claimant's compensable injury. (Ex. 66). However, Dr. Montanaro's opinion is contrary to the law of the case, i.e., claimant's rheumatoid arthritis condition is related to the 1974 compensable injury. Under these circumstances, Dr. Montanaro's report does not provide the employer with a legitimate doubt as to its liability. Consequently, we agree with the ALJ that a penalty is warranted.

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 compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Finally, we note that claimant is not entitled to an assessed attorney fee for services on review in responding to the employer's appeal of the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 22, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, payable by the self-insured employer.

---

[1] Subsequent to the ALJ'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 Laws 1995, ch 332, § 1 (SB 369, § 1). However, both the former and amended version of the statute require a combined condition. Since we have determined that claimant's rheumatoid condition is compensable and there is no evidence that that condition combined with any other preexisting condition, ORS 656.005(7)(a)(B) does not apply. See Ronald L. Ledbetter, 47 Van Natta 1462 (1995). ORS 656.262(6)(c) is likewise not applicable as it too requires a combined condition." Ledbetter, supra; James M. King, 47 Van Natta 1563 (1995).

In the Matter of the Compensation of
**ROBERT L. BROOKS, Claimant**
WCB Case Nos. 94-06500 & 94-04920
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld AIAC's denial of claimant's aggravation claim for his current left foot condition; and (2) upheld Kemper Insurance's denial of claimant's "new injury" claim for the same condition. On review, the issues are compensability, aggravation and responsibility. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant suffered multiple fractures of the toes of his left foot in December 1988 when a forklift fork fell on his foot. AIAC, the insurer for the employer at the time of the injury, accepted the claim. Claimant subsequently developed corns on the fourth toe, which he usually removed himself. In March 1994, he sought medical treatment for pain and recurring corns. Dr. Jensen, podiatrist, diagnosed exostosis of the distal part of the left fourth toe. Dr. Jensen excised the exostosis on March 24, 1994.

Dr. Farris performed a records review and opined that claimant had a varus deformity of the fourth and fifth toes, which preexisted the 1988 injury and which was likely congenital. He concluded that the preexisting varus deformity, along with shoe wear and normal weight bearing was the major contributing cause of claimant's corns. Dr. Farris further reported that, based on the December 1988 x-rays, the exostosis preexisted the December 7, 1988 injury, and therefore, was not caused by the December 1988 injury. (Exs. 23, 24).

Dr. Craven, on the other hand, opined that claimant's need for surgery was related to the December 1988 injury and was a secondary complication of the fracture from which claimant developed a bone spur. (Ex. 27).

Applying ORS 656.005(7)(a)(B), and relying on the opinion of Dr. Farris, the ALJ concluded that a preexisting congenital deformity was the major contributing cause of claimant's disability and need to seek treatment. The ALJ, therefore, upheld both AIAC's denial of claimant's current condition and Kemper's denial of a "new injury" claim for claimant's current foot condition.

Citing Iocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), claimant contends that he is required to prove that his 1988 compensable injury with AIAC is a material contributing cause of his current left foot condition and need for treatment. In Iocelyn, the court held that ORS 656.005(7)(a)(B) did not apply to a claim for aggravation under ORS 656.273(1). The court concluded that the legislature intended to keep the material contributing cause standard of proof for aggravation claims, even if the claimant had a preexisting condition.

We do not find Iocelyn controlling, since claimant sought treatment for corns and for an exostosis, which are different conditions from the accepted 1988 foot fracture claim. See e.g. David L. Dodson, 47 Van Natta 1523 (1995) (Beck inapplicable where disputed condition was not accepted); Joseph R. Klinsky, 47 Van Natta 872 (1995) (major contributing cause standard applied where the condition requiring treatment had not been accepted).[1] Instead, we agree with the ALJ that an initial determination of compensability must be made. See Daniel S. Field, 47 Van Natta 1457 (1995) (Board obligated to apply the appropriate statutory provisions to determine the compensability of a worker's claim).

[1] Even if the material contributing cause standard applied, Dr. Farris' persuasive opinion establishes no causal relationship between claimant's accepted condition and his exostosis.

As discussed below, there is no evidence that the December 1988 injury combined with or aggravated the preexisting exostosis condition. Accordingly, ORS 656.005(7)(a)(B) does not apply. See Gary Stevens, 44 Van Natta 1179 (1992) (former ORS 656.005(7)(a)(B) inapplicable where evidence failed to show that the preexisting condition had "combined" with the compensable injury to produce a "resultant condition."). Rather, the medical evidence in this record supports a finding that claimant's compensable toe fractures have healed and that his current treatment is solely directed to his preexisting exostosis condition.

We, therefore, apply SB 369, § 3, which provides:

> "In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless: (1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition."

Or Law 1995, ch 332 § 3 (SB 369, § 3).

Based on a comparison of the December 1988 x-rays and 1994 x-rays, Dr. Farris opined that the exostosis preexisted, and was unrelated to, the December 7, 1988 injury. To the contrary, Dr. Craven opined that the exostosis was a secondary complication of claimant's toe fracture.

When medical experts disagree, more weight should be given to those opinions that are well reasoned and based on the most complete information. Somers v. SAIF, 77 Or App 259 (1986). We also find that this case involves expert analysis rather than expert external observations. Allie v. SAIF, 79 Or App 284 (1986).

We find persuasive reasons not to defer to Dr. Craven's opinion. Dr. Craven failed to address Dr. Farris' conclusion that the exostosis preexisted the 1988 injury. We also find Dr. Craven's opinion unpersuasive because it is conclusory regarding causation. Moe v. Ceiling Systems, 44 Or App 429 (1980). Dr. Craven only examined claimant one time, and therefore, was in no better position than Dr. Farris to evaluate the cause of claimant's exostosis. Dr. Craven essentially deferred to Dr. Jensen[2] for determining the diagnosis and course of treatment for claimant's toe condition. We, therefore, find that the persuasive medical evidence establishes that claimant's exostosis preexisted his December 1988 injury.

As discussed above, we find, based on Dr. Farris' persuasive opinion, that claimant's exostosis preexisted his compensable injury and that claimant's current need for treatment is solely directed to this preexisting condition. Claimant has, therefore, failed to establish compensability. SB 369, § 3, See also Lucy E. Buckallew, 46 Van Natta 115 (1994) (compensable strain injury no longer the major contributing cause where strain had resolved and sole cause of current disability and need for treatment was the preexisting condition).[3]

## ORDER

The ALJ's order dated March 20, 1995 is affirmed.

---

[2] Dr. Jensen did not provide an opinion on causation.

[3] Claimant raises several constitutional issues contending that SB 369 does not retroactively apply. We reject these arguments outright, as they are not adequately developed for review. Therefore, we will not address claimant's constitutional arguments. Carl M. Keeton, 44 Van Natta 664, 665 (1994) (the claimant failed to demonstrate how retroactive application violated his constitutional rights); Ronald B. Olson, 44 Van Natta 100, 101 (1992) (Board declined to address constitutional argument not adequately developed for review). Moreover, even if we considered claimant's constitutional arguments, we would reject them because, even under the material contributing cause standard, claimant failed to establish the compensability of his claim.

In the Matter of the Compensation of
**RONALD L. BRYANT, Claimant**
WCB Case No. 94-06108
ORDER ON REVIEW
David C. Force, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Crumme's order that found that claimant's low back and cervical injury claim was prematurely closed. Claimant has moved for an order dismissing SAIF's request for review based on SAIF's "post-order" acceptance of claimant's C5-6 disc condition. Claimant also seeks an attorney fee related to that acceptance. On review, the issues are motion to dismiss, premature closure, and attorney fees. We affirm.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Motion to Dismiss

As a preliminary matter, we consider claimant's motion to dismiss SAIF's request for review, which is based on SAIF's "post-order" acceptance of claimant's C5-6 disc condition.

We acknowledge that, if SAIF had denied the C5-6 condition, its "post-order" acceptance would have rendered compensability of that condition moot. See SAIF v. Mize, 129 Or App 636 (1994). Under such circumstances, dismissal of an appeal from an order finding the claim compensable would have been appropriate. See id.

However, in the present case, the record does not indicate that claimant's cervical condition was in denied status at the time of hearing. (See Ex. 63). Moreover, recorded discussion of the issues at hearing convinces us that compensability was not an issue before the ALJ. Instead, we find that the parties and the ALJ agreed that premature closure or, alternatively, aggravation were the only issues to be litigated. (Tr. 1, 7-8, 11-17). Our conclusion in this regard is further supported by claimant's Respondent's Brief on review which asserts: "This remains a premature closure case and not a compensability case." (Res. Br. at p. 2, emphasis added).

We further find that SAIF's "post-order" acceptance does not resolve the premature closure and aggravation issues,[1] which were raised and litigated at hearing. Finally, because compensability was not an issue, claimant is not entitled to an attorney fee at hearing or on review for services associated with SAIF's "post-order" acceptance under ORS 656.386.[2]

### Premature Closure, Aggravation, and Penalties

We adopt and affirm the ALJ's order regarding the premature closure, aggravation, and penalties issues, with the following exception and supplementation.

The ALJ found that claimant's December 1991 injury claim was prematurely closed because claimant's cervical condition was reasonably likely to improve (due to further treatment or the passage of time) when SAIF issued its September 2, 1993 Notice of Closure. In reaching this conclusion, the ALJ relied on medical evidence generated before and after the reconsideration proceeding. In addition, the ALJ reasoned that SAIF was precluded from denying that claimant's current cervical condition is part of the accepted condition, because the Notice of Closure awarded permanent disability based on lost

---

[1] These issues require determining whether the compensable conditions were medically stationary at claim closure and/or whether those conditions worsened since claim closure.

[2] This does not necessarily mean that claimant would never be entitled to an attorney fee. Rather, such an issue would be a matter for another proceeding, if the parties cannot resolve it.

cervical range of motion. See Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 120 Or 507 (1995). Because we find claimant's cervical condition causally related to his compensable injuries, we need not address nor adopt the ALJ's reasoning regarding Messmer, supra.

To begin, we agree with the ALJ that the persuasive medical evidence establishes that claimant's current cervical condition is compensably related to his accepted December 1991 injury claim. (See O&O pp. 4-5, "Discussion of Findings, b. Cause of Neck Disc Pathology").[3] In addition, we note the medical arbiter's uncontradicted opinion: "The possibility of a C6 radiculopathy cannot be excluded based on today's evaluation and, in my opinion, this needs to be evaluated further by [claimant's] attending physician." (Ex. 43-5). Based on this uncontroverted evidence of the need for further evaluation of the compensable cervical condition (and for the reasons stated by the ALJ), we agree that claimant's December 1991 and January 1992 low back and neck injury claims were prematurely closed. See Edith N. Carter, 46 Van Natta 2400 (1994) (Medical arbiter's impairment findings "reasonably construed" to be injury-related where treating doctor's opinions not found contrary); David J. Schaffer, 46 Van Natta 2298 (1994) (Where medical arbiter did not expressly relate the claimant's impairment to the compensable injury, but did not ascribe it to noncompensable causes, impairment findings were "due to" compensable injury).

Claimant's attorney is entitled to an assessed fee for services on review regarding the premature closure 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 is $1,750, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 4, 1995 is affirmed. For services on review, claimant is awarded a $1,750 attorney fee, payable by the SAIF Corporation.

---

[3] Under ORS 656.283(7), "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. . . ." See Duane B. Onstott, 47 Van Natta 1429 (1995). We need not address the effect of that statute, because we would reach the same result based solely on a "pre-reconsideration" record, as explained above.

---

December 8, 1995 Cite as 47 Van Natta 2331 (1995)

In the Matter of the Compensation of
**CONNIE M. JOHNSON, Claimant**
WCB Case No. 92-06467
ORDER OF ABATEMENT
Lavis, Alvey, et al, Claimant Attorneys
Craig Creel, Defense Attorney

On November 9, 1995, we issued an Order on Remand, concluding that claimant had implicitly waived a medical services issue while litigating at hearing an aggravation issue. Connie M. Johnson, 47 Van Natta 2191 (1995). Seeking an opportunity to supply further argument, claimant asks that we withdraw our November 9, 1995 order and implement a supplemental briefing schedule.

As noted in our prior order, a briefing schedule was previously implemented, which automatically commenced with the issuance of the court's September 7, 1995 appellate judgment. When no supplemental briefs were received after issuance of the appellate judgment, we proceeded with our review without further argument. Although such an action was appropriate, in light of the court's decision, as well as in the interests of allowing each party an opportunity to present their respective written positions regarding the issue before us on remand, we grant claimant's motion.

Accordingly, our November 9, 1995 order is withdrawn. The following supplemental briefing schedule is implemented. Claimant's opening brief is due 21 days from the date of this order. The insurer's respondent's brief is due 21 days from the date of mailing of claimant's brief. Claimant's reply is due 14 days from the date of mailing of the insurer's brief. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

---

December 8, 1995 Cite as 47 Van Natta 2332 (1995)

In the Matter of the Compensation of
**TIFFANY G. KARUSSOS, Claimant**
WCB Case No. 94-10037
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Daughtry's order that declined to assess a penalty and attorney fee against the SAIF Corporation for allegedly unreasonable claim processing. On review, the issues are penalties and attorney fees.

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

Claimant contends that SAIF's November 8, 1994 amended denial and disclaimer of responsibility was unreasonable and untimely. We disagree.

SAIF initially denied claimant's claim on August 15, 1994. This denial was issued within 90 days of notice of the claim as required by former ORS 656.262(6). On November 8, 1994, SAIF received notice that claimant had filed a claim for her condition with another employer and that the other employer had issued a claim denial and disclaimer of responsibility naming SAIF as a potentially responsible insurer. In response to this information, SAIF issued its amended denial and disclaimer of responsibility on the same date it received notice that it was being named as a potentially responsible insurer. SAIF's action in issuing the amended denial and disclaimer is consistent with former OAR 656.308(2) which required an insurer to disclaim responsibility within 30 days of being named or joined in the claim.

Because SAIF's November 8, 1994 amended denial and disclaimer was issued in accordance with former ORS 656.308(2), we do not find the denial to be unreasonable.

ORDER

The ALJ's order dated February 2, 1995, as amended on March 21, 1995, is affirmed.

---

December 8, 1995 Cite as 47 Van Natta 2332 (1995)

In the Matter of the Compensation of
**SANDRA LINDEKUGEL, Claimant**
WCB Case No. 94-11510
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that awarded claimant's counsel a $2,400 attorney fee pursuant to ORS 656.386(1) for prevailing over a denied claim without a hearing. On review, the issue is attorney fees.

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

The only dispute in this case is the amount of an attorney fee under ORS 656.386(1) for claimant's counsel's services in obtaining a rescission of the insurer's denial without a hearing. The ALJ found that a reasonable attorney fee for claimant's counsel's services was $2,400, which was the amount claimant's attorney requested in her statement of services.

On Board review, the insurer contends that the ALJ's award of a $2,400 attorney fee is excessive. The insurer argues that claimant's attorney's statement of services failed to specifically itemize the time allegedly devoted to the case and that the statement of services submitted by claimant's attorney does not comply with OAR 438-15-029(2), and should not be considered. In addition, the insurer argues that delays and additional time spent on the case as the result of claimant's motion to postpone should not be considered in determining the amount of a reasonable attorney fee.

OAR 438-15-029(2) provides that a request for fees at the Board level will be considered if, among other things, the request describes in detail the manner in which the factors set forth in OAR 438-15-010(4) apply to the case, as well as any other information deemed relevant. By its plain language, OAR 438-15-029 applies to requests for fees at the Board level, not at the hearing level. Consequently, the rule is not applicable here. In addition, we are aware of no requirement that statements of services submitted at hearing be itemized. Accordingly, we decline to reject the statement of services on this ground.

The statement of services submitted by claimant's attorney indicates that the attorney spent 14 hours on the case. This time was spent conferring with claimant and her attending physician, reviewing correspondence from the insurer's counsel and preparing correspondence to the insurer's counsel. In addition, time was spent attending the hearing scheduled for December 19, 1994 and reviewing the file. Although a more detailed statement of services would no doubt be helpful, we find no reason why the statement of services could not be considered by the ALJ.

The insurer next contends that claimant's attorney's successful efforts to postpone the hearing in order to obtain an additional medical report from claimant's attending physician should not be considered in determining a reasonable fee. Claimant's attorney moved for a postponement at the December 19, 1994 hearing in order to obtain an additional report from claimant's attending physician. The insurer opposed the motion. ALJ Black granted claimant's motion for postponement in an order dated December 27, 1994.

The insurer does not challenge ALJ Black's order granting the postponement. In addition, we find no authority to support the insurer's assertion that claimant's attorney's work in obtaining the postponement should not be considered in determining the amount of the fee. Claimant's attorney sought the postponement in order to obtain additional medical evidence concerning the compensability of claimant's chondral fracture and meniscus tear. Subsequent to the postponement, the insurer rescinded its denial and accepted the chondral fracture and meniscal tear. Under such circumstances, we conclude that these efforts on the part of claimant's attorney to obtain a postponement are properly considered in determining the amount of a reasonable fee for obtaining rescission of the denial without a hearing.

In determining the amount of a reasonable fee, we consider the factors set out in OAR 438-15-010(4). Those factors to be considered are: (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.

After reviewing the hearing record and considering the above factors, we conclude that $2,400 is a reasonable attorney fee. In reaching this conclusion, we have particularly considered the time devoted to the case, the benefit secured for claimant and the risk that claimant's attorney's efforts might go uncompensated.

Claimant's counsel is not entitled to a fee for services on review regarding the ALJ's attorney fee award. Saxton v. SAIF, 80 Or App 631 (1986).

Claimant attached a new statement of services to her respondent's brief. The insurer objects to the new statement of services and argues that the submission of the new statement of services should be treated as a motion to remand to the ALJ. We need not resolve the remand argument because, even without consideration of the new statement of services, we have concluded that the ALJ's attorney fee award was reasonable.

ORDER

The ALJ's order dated July 18, 1995 is affirmed.

---

December 8, 1995 Cite as 47 Van Natta 2334 (1995)

In the Matter of the Compensation of
**WALTER J. REZNICSEK, Claimant**
Own Motion No. 93-0572M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Scott McNutt, Claimant Attorney
John M. Pitcher, Defense Attorney

On December 4, 1995, the Board received claimant's undated letter, in which claimant stated that "I would like to appeal the decision made on my claim against Weyerhaeuser Co." We treat this submission as claimant's pro se request for reconsideration of our August 2, 1995 Own Motion Order Reviewing Carrier Closure, as reconsidered on November 2, 1995.

After reviewing claimant's motion, we have nothing further to add to our previous orders which: (1) affirmed the self-insured employer's December 1, 1994 Corrected Notice of Closure; and (2) declined to assess penalties for any procedural temporary disability benefits due for the employer's allegedly unreasonable failure to pay those benefits.

In the event that claimant intended to appeal our decision to the Court of Appeals, we advise claimant that, pursuant to the "Notice to All Parties" included in our prior orders, any appeal must be filed with the Court of Appeals, Supreme Court Building, Salem, Oregon 97310 within 30 days after the date of that order. However, inasmuch as our prior order disallowed penalties (and did not reduce claimant's compensation), it is questionable whether the Court is authorized to conduct a review of our decision pursuant to ORS 656.278.

Finally, claimant apparently did not send his request for reconsideration to the employer or to any other interested parties. Therefore, attached to the employer's attorney's copy of this order is a copy of claimant's letter received by the Board on December 4, 1995.

Accordingly, on reconsideration and as supplemented herein, we adhere to and republish our August 2, 1995 order, as reconsidered on November 2, 1995, in its entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---

December 8, 1995 Cite as 47 Van Natta 2334 (1995)

In the Matter of the Compensation of
**JOHN L. WILLHITE, Claimant**
WCB Case No. 91-01116
ORDER ON REMAND
Karen M. Werner, Claimant Attorney
Roberts, et al, Defense Attorneys

This matter is before the board on remand from the Court of Appeals. Willhite v. Asplundh Tree Experts, 136 Or App 120 (1995). The court reversed our prior order that vacated an Administrative Law Judge's (ALJ) order which had found claimant's request for proposed surgery reasonable and necessary. The court also remanded for reconsideration pursuant to Or Laws 1995, ch 332 (SB 369).

## FINDINGS OF FACT

We republish the "Findings of Fact" from our previous order.

## CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back injury in 1982. He underwent bilateral L5-6 decompression, foraminotomies and discetomy in 1984. The claim was closed in 1985.

In 1988, claimant had a L4-5, L5-S1 decompression. Claimant's condition worsened and additional surgery (bilateral L4-5, L5-S1 decompression and neurolysis) was suggested. Claimant requested authorization from the insurer for the proposed surgery. When no authorization was provided, claimant requested a hearing.

The ALJ found that claimant's proposed surgery was reasonable and necessary. In so doing, the ALJ determined that former ORS 656.327(1) gave the Director exclusive jurisdiction only over medical services claimant was currently "receiving." Because claimant's surgery request involved "proposed" medical services, the ALJ reasoned that the Hearings Division had jurisdiction to decide the matter.

On review, we vacated the ALJ's order, finding that former ORS 656.327(1) applied to medical treatment that claimant was "receiving," as well as to medical services that may be "proposed." As such, we determined that the Director had original jurisdiction over the parties' dispute.

The Court of Appeals reversed our order and has remanded this matter for reconsideration in light of Senate Bill 369. We proceed with our reconsideration.

Subsequent to the ALJ's order, the legislature amended ORS 656.327(1) and added ORS 656.245(6), each of which requires review of medical services disputes by the Director, unless a claim for medical services is denied on the basis that the underlying claim is not compensable. SB 369, §§ 41, 25. In Walter L. Keeney, 47 Van Natta 1387, 1389, recon den 47 Van Natta 1525 (1995), we concluded that these statutes apply retroactively to pending cases and that the Director now has exclusive jurisdiction over such medical services disputes. See also Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995).

Here, the dispute pertains to whether claimant's proposed surgery for his compensable low back condition is reasonable or necessary. There is no dispute regarding the compensability of his underlying claim (low back condition). ORS 656.245(6); Richard L. Wheeler, 47 Van Natta 2011 (1995). Accordingly, review of this dispute lies with the Director, not the Hearings Division. Consequently, we vacate the ALJ's August 23, 1991 order, and dismiss claimant's request for hearing for lack of jurisdiction.

IT IS SO ORDERED.

**Board Member Hall specially concurring.**

There is no doubt that the legistlature intended for the amendments contained in SB 369 to be applied retroactively, with few exceptions. It is not, however, clear that the legislature also intended each and every consequence resulting from such retroactive application. With due respect for the specific intentions of the legislature, there are, nevertheless, unintended results which are objectionable. Here, I write separately to point out the unjust result which occurs in this case from the retroactive application of Senate Bill 369. This dispute stems from a 1990 request for surgery which was found reasonable and necessary by an Opinion and Order which issued in August 1991. Today, we dismiss this case for presentation to the Director pursuant to amended ORS 656.327(1). As such, the resolution of the parties' dispute has now entered its fifth year and counting. The retroactive application of Senate Bill 369 has resulted in further denying the parties' the right to resolve their dispute. Justice delayed is justice denied.

In the Matter of the Compensation of
**DAVID S. WOODSON, Claimant**
WCB Case No. 94-11160
ORDER OF DISMISSAL
Hollander, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

The Director of the Department of Consumer and Business Services (Director), by and through the Department of Justice (Department), requests review of Administrative Law Judge (ALJ) Bethlahmy's interim order that denied the Director's motion to intervene in claimant's hearing request concerning a proposed medical services dispute. On review, the issues are dismissal and, alternatively, the propriety of the ALJ's denial of the Director's motion to intervene. We dismiss the Director's request for review.

FINDINGS OF FACT

On September 15, 1994, claimant's attorney requested a hearing regarding the insurer's denial of proposed medical services. On November 25, 1994, the Director moved to intervene in the proceeding on the ground that ORS 656.260, the managed care organization (MCO) statute, vested exclusive jurisdiction in the Director. On December 20, 1994, the ALJ issued an interim order denying the Director's motion, noting that the case did not involve an MCO.

On December 6, 1994, the Director requested Board review of the interim order. On January 12, 1995, the Board notified the Director that it would wait for the ALJ's final order before taking the Director's request for review under advisement.

On July 10, 1995, the ALJ issued a final order dismissing claimant's hearing request for lack of jurisdiction. The ALJ reasoned that, under ORS 656.245, as amended by Senate Bill 369, Or Laws 1995, ch 332, § 25, the Director now had exclusive jurisdiction over the matter. No one appealed that order.

On October 18, 1995, the Board, though its staff counsel, inquired of the Department regarding whether the Director wished to proceed with his appeal or whether the request for Board review could be dismissed. The Board gave the Department 14 days to respond. The Department did not reply.

CONCLUSIONS OF LAW AND OPINION

The first issue is whether we should dismiss the Director's request for Board review. In addressing that issue, we consider two queries: whether the ALJ's interim order constitutes a final, appealable order, and whether the matter has been rendered moot.

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision that neither denies a claim, nor allows it and fixes the amount of compensation, is not a final, appealable order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Maureen H. McCarthy, 46 Van Natta 1633, 1634 (1994).

Here, the ALJ's interim order denying the Director's motion to intervene neither denies nor allows a claim. Consequently, it is not a final, appealable order. Because the ALJ's final order regarding the merits of this claim has become final by operation of law, and because the interim order is not, by itself, a final, appealable order, we dismiss the Director's request for review of the interim order.

In any event, even if the ALJ's interim order were a final, appealable order, we would dismiss the Director's request for review as moot.

The purpose of the Director's request for review, and the underlying motion to intervene, was to press his argument that he had exclusive jurisdiction over the merits of this case. In light of the ALJ's final, unappealed order holding just that, we conclude that there no longer exists a justiciable controversy regarding the issue underlying the motion to intervene and the ensuing request for review. Because issuing a decision now about the intervention issue would have no practical effect on this controversy, the Director's request for review is moot. See, e.g., Brumnett v. PSRB, 315 Or 402, 406 (1993) ("Cases that are otherwise justiciable, but in which a court's decision no longer will have a practical effect on or concerning the rights of the parties, will be dismissed as moot."). Consequently, for that additional reason, we dismiss the Director's request for Board review.[1]

The remaining issue concerns the propriety of the ALJ's denial of the Director's motion to intervene. Because we have dismissed the Director's request for review for the reasons stated above, we do not address the propriety of the ALJ's ruling regarding the intervention issue.

IT IS SO ORDERED.

[1] We also note that ORS 656.726(3)(h), which was added to the Workers' Compensation Act as part of Senate Bill 369, now authorizes the Director to participate fully in any proceeding before the Hearings Division, Board or Court of Appeals that the Director determines involves a matter that affects or could affect the discharge of the Director's duties of administration, regulation and enforcement of the Workers' Compensation Act and portions of ORS Chapter 654. Or Laws 1995, ch 332, § 55. That subsection grants the Director the right to intervene in particular matters before the Hearings Division. Consequently, it arguably provides an additional basis for concluding that the intervention controversy presented by the Director's request for review in this case has been rendered moot.

---



In the Matter of the Compensation of
**LYNDA J. ZELLER, Claimant**
WCB Case No. 93-13381
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

On September 29, 1995, we abated our September 6, 1995 Order on Review that affirmed an Administrative Law Judge's order that set aside the insurer's denial of claimant's neuroma and reflex sympathetic dystrophy conditions. We took this action to consider the insurer's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

To begin, we change the ALJ's findings of fact to delete the fifth, sixth, seventh and eighth sentences of the third paragraph on page 2.

The insurer contends that our order appears to shift the burden of proof to the insurer. The insurer asserts that we described its position as a contention that "the preponderance of medical evidence establishes that claimant does not have neuroma or reflex sympathetic dystrophy." (Order on Review at 3). Our reference to the insurer's argument is simply a summary of one of the insurer's arguments.[1] In its brief on review, one of the insurer's arguments was that "[t]he strong preponderance of the medical evidence establishes that claimant does not have a neuroma * * *." (Appellant's brief at 17). Contrary to the insurer's assertion, we did not shift the burden of proof to the insurer. In fact, we concluded that "claimant has established the compensability of the consequential neuroma and reflex sympathetic dystrophy conditions." (Order on Review at 5; emphasis added).

The insurer argues that we erred by "inferring" that Dr. Nye believed that claimant's symptoms had changed after the third surgery. The insurer relies on claimant's testimony that her symptoms were the same that she had experienced since her injury in 1990.

Although claimant's testimony may be probative, it is not controlling when the claim involves a complex medical question. Since claimant's original injury was in August 1990, the issue of whether claimant's current conditions are causally related to her compensable injury presents a complex medical question. Therefore, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

In our order, we referred to Dr. Nye's October 15, 1992 report, in which he documented claimant's three surgeries and stated that "[claimant's] complaints today are basically different than they originally were." (Ex. 40). Claimant no longer had numbness and tingling of median nerve compression at the wrist, trigger thumbs or complaints of deQuervain's tenosynovitis. (Id.) 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

[1] The insurer also contends that we shifted the burden of proof and found that the insurer failed to prove that claimant's complaints were unreliable. Once again, our reference to the insurer's argument is stated as a reason for reversing the ALJ's order. Although the insurer relied on reports suggesting that claimant's subjective complaints were unreliable, we were not persuaded by those reports.

satisfactory treatment" was to "divide the superficial branch of the radial nerve and translocate the stump proximally and bury it in muscle." (Id).

After conducting our additional review and considering the insurer's arguments, we adhere to the reasoning and conclusions contained in our prior order. 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. We adhere to our prior conclusion that claimant has established the compensability of the consequential neuroma and reflex sympathetic dystrophy conditions.

Claimant also requests reconsideration of our decision that she was not entitled to a penalty. Claimant asserts that the insurer unreasonably delayed issuing a compensability denial. Although the insurer's eventual denial was not issued until August 12, 1994, we do not consider its conduct to have been unreasonable.

We have previously ruled that, where a carrier has reasonably concluded that a medical service dispute was confined to former ORS 656.260 and that the acceptance or denial requirements of ORS 656.262 were not applicable, a carrier's failure to timely accept or deny the claim was not unreasonable. See Richard R. Elizondo, 47 Van Natta 377 (1995).

Here, Dr. Layman's February 8, 1993 chart note indicates that he had requested authorization for claimant's surgery and he was waiting for the managed care organization (MCO) to authorize the surgery. The insurer received a copy of the chart note on February 17, 1993. (Ex. 40A). On March 5, 1993, the MCO notified Dr. Layman that the proposed services could not be approved as medically indicated. (Ex. 42). On March 17, 1993, the insurer notified claimant's attorney that the MCO had denied pre-certification of claimant's surgery. (Ex. 42A). Dr. Layman appealed the denial to the MCO. (Ex. 43).

Since the insurer was also disputing the causal relationship between claimant's proposed surgery for her current conditions and her compensable injury, it was obligated to either accept or deny the claim within the statutorily required 90-day period. See ORS 656.262. Nevertheless, when the insurer received notice of this claim, the interplay between the "MCO" provisions of former ORS 656.260 and the other claim processing statutes had not been addressed by case precedent. In light of such circumstances, we do not consider it unreasonable for the insurer to have determined that reliance on the MCO process satisfied its statutory claim processing obligations.[2] See Richard R. Elizondo, supra; cf. Marie E. Kendall, 46 Van Natta 2520 (1994), on recon 47 Van Natta 335 (1995) (carrier's conduct held reasonable where case law at the time supported propriety of that conduct); Maria R. Porras, 42 Van Natta 2625 (1990) (penalty and attorney fee not appropriate when the carrier's reliance on a former rule was unreasonable).

Finally, for the reasons discussed in our previous order, we adhere to our conclusion that the Director has jurisdiction over penalties related to the alleged delay in the denial of surgery. 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, we adhere to our conclusion that, at the time the insurer issued its denial, the insurer had legitimate doubt as to its liability, and therefore, its denial was not unreasonable.

Claimant's counsel is entitled to an additional assessed attorney fee for time spent responding to the insurer's reconsideration request. See ORS 656.386(1); Susan A. Michl, 47 Van Natta 162 (1995). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that an additional reasonable fee for claimant's counsel's services on reconsideration regarding the compensability issue is $200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the claimant's response to the reconsideration request), the complexity of the issue, and the value of the interest involved.

On reconsideration, as supplemented herein, we republish our September 6, 1995 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---

[2] In making this determination, we emphasize that we are addressing only the insurer's allegedly unreasonable delay in issuing a compensability denial. We do not address the propriety of the insurer's conduct concerning the MCO process itself, since that matter arises under the review jurisdiction of the Director. Or Laws 1995, ch 332, § 42d(5) (SB 369, § 42d(5)).

In the Matter of the Compensation of
**GEORGIA COLE, Claimant**
WCB Case No. CV-95004
CRIME VICTIM ORDER OF DISMISSAL (REMANDING)
Mary H. Williams, Assistant Attorney General

Applicant requested Board review of the Department of Justice's September 20, 1995 Order on Reconsideration denying her claim for benefits under the Compensation Act for Victims of Crime. In response to the Board's acknowledgment of the request for review, applicant asserted that hospital and other medical reports were available to corroborate her injuries that resulted from the alleged crime. Applicant further stated that an eye witness possibly could testify regarding the incident.

We granted the Department an opportunity to respond to applicant's letter, noting that applicant referred to evidence that was not contained in the record previously considered by the Department and, thus, applicant's statements could be interpreted as a request to remand the case to the Department for consideration of additional evidence. In response, the Department conceded that applicant's letter contained references to additional evidence not considered by the Department and that, if applicant provided the cited evidence to the Department, it "would be willing to issue a second order on reconsideration."

Based on the Department's response, we dismiss applicant's request for Board review and remand this matter to the Department to reconsider its prior decision in light of the additional information that applicant apparently is willing to provide. In the event that applicant is dissatisfied with the Department's eventual reconsideration order, he may request Board review of that decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
**JAMES L. BURKE, Claimant**
WCB Case No. 94-15422
ORDER ON REVIEW
Michael G. Balocca, Claimant Attorney
Marsha Barton (Saif), Defense Attorney

Reviewed by Board Members en banc.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's back injury claim. On review, the issue is whether claimant's injury arose out of and occurred in the course of employment. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Applying the seven-factor test set forth in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985), the ALJ concluded that claimant had established that his back injury arose out of and occurred in the course of his employment. We agree with that conclusion, but offer the following analysis.

To establish the compensability of an injury, the claimant must show that the 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. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). Neither element is dispositive; rather, we consider all the circumstances to determine if the claimant has satisfied the work-connection test. Id. at 366, 369. Further, we no longer rely on the Mellis factors as an independent and dispositive test of work connection; instead, we consider those factors that remain helpful under the Norpac Foods' analysis. First Interstate Bank of Oregon v. Clark, 133 Or App 712, 717 (1995); Mark Hoyt, 47 Van Natta 1046, 1047 (1995).

Relying on the "rescue doctrine," the parties dispute whether claimant's injury arose out of his employment. SAIF asserts that, because the employer did not have an interest in claimant's rescue efforts, claimant's claim fails. We disagree.

No Oregon case has expressly adopted the workers' compensation "rescue doctrine." According to Professor Larson,

> "Any emergency or rescue activity is within the course of employment if the employer has an interest in the rescue. Injury incurred in the rescue of a stranger is compensable if the conditions of employment place claimant in a position which requires him [or her] by ordinary standards of humanity to undertake the rescue." 1A Larson, Workmen's Compensation Law 5-441, § 28.00 (1995) (1A Larson 5-441, § 28.00).[1]

Therefore, to the extent that the rescue doctrine applies, it pertains to whether claimant's injury occurred in the course of his employment. See Ritz v. Oregon Title Insurance, 92 Or App 274 (1988) (court addressed rescue doctrine argument in process of determining whether worker had been acting in the course of his employment when he was injured).

We consider the "employer interest" prong of the rescue doctrine first. "[T]he scope of an employee's employment is impliedly extended in an emergency to include the performance of any act designed to save life or property in which the employer has an interest." 1A Larson 5-441, § 28.11. An employer is deemed to have an interest in a rescue if "the claimant acts to save a stranger imperiled

---

[1] Professor Larson also states that, "when the conditions of employment lead claimant to be pressed into public service to aid in the pursuit of fugitives or the like, under circumstances in which claimant must perform the service as a public duty, he [or she] remains within the scope of his [or her] employment." 1A Larson 5-441, § 28.00. The parties agree that that language does not apply here.

under circumstances creating potential liability for the employer[.]" 1A Larson 5-446, § 28.11. By acting under such circumstances, the claimant is "not only doing the humane thing but also minimizing possible damages for which his [or her] employer might later be held liable." Id.

Here, claimant, an Oregon Shakespeare Festival (OSF) stage manager, was at work, engaged in a conversation with several co-workers on a cobblestone courtyard located between two of OSF's buildings. Although there is no definitive proof of who owned the courtyard, the parties do not dispute that OSF exercises control over it.

After the conversation ended, claimant began walking toward the stage manager's office. He saw a man on a three-wheeled motorized cart cross the courtyard, heading in the general direction of the building that houses OSF's ticket booth and some public rest rooms. The cart hit a bump and started to tip over. Claimant dove to prevent the man's head from striking the ground, and twisted his back in the process.

On this record, we find that claimant acted to save a stranger imperiled under circumstances creating potential liability for OSF. The man who claimant helped was on premises that OSF controlled. Had the man fallen and been injured, OSF potentially could have been liable for those injuries. By preventing the fall, claimant acted humanely and also minimized possible damages for which OSF might later be held liable. Under the circumstances, we find that the OSF had an interest in claimant's rescue efforts. Consequently, we agree with the ALJ that claimant's injury occurred in the course of his employment.

SAIF asserts that, because there is no evidence that claimant acted with the intent of protecting OSF from potential liability, the "employer interest" prong of the rescue doctrine does not apply. We disagree. That prong does not require proof that a worker acted with the intent of protecting his or her employer from potential liability; it requires only that the worker's actions afford such protection. Here, as explained above, claimant's actions had precisely that effect.

SAIF next asserts that, because there is no evidence that the man claimant rescued was an OSF patron, the "employer interest" prong does not apply. We disagree. The medical and claim processing documents consistently refer to the man as a "patron." (Exs. 4, 5, 6, 7).[2] Moreover, the record reveals that, before claimant intervened, the man had been traveling toward the building that houses the OSF ticket office and public rest rooms. That evidence suggests that the man was an OSF patron. In any event, even if the man was not a theater patron, by virtue of his presence on the courtyard, he was a "patron" of those premises. Because OSF exercised control over that area, we reject SAIF's "patron" argument.[3]

Alternately, we conclude that, under the "stranger" prong of the rescue doctrine, claimant's injury occurred in the course of his employment. Under that prong, we must determine whether claimant's rescue efforts were "a natural incident to be expected in the course of employment of this kind." 1A Larson 5-457, § 28.22. We are more inclined to answer that question in the affirmative if there is proof that claimant had been instructed to aid persons such as the man that he rescued. See 1A Larson 5-420, -421, § 28.22. Finally, there must be evidence that claimant responded to an emergency that involved "grave danger to life or persons and not merely to property." Ritz v. Oregon Title Insurance, supra, 92 Or App at 278 (citing 1A Larson, Workers' Compensation Law [sic] 5-432, § 28.24 (1985)).

Here, claimant testified that the executive director had encouraged him to be considerate of and helpful to patrons (Tr. 19-20), and that, although his job description did not specifically require it, he often assisted the public during performances because of house staff shortages. (Tr. 6). That testimony is bolstered by OSF's written values, which state, in part, "We want to exceed our patron's [sic] expectations in every way by providing them with the highest level of service possible." (Ex. 12).[4] SAIF did not refute that evidence.

---

[2] On the "801" form, both claimant and OSF referred to the man as a "patron." (Ex. 7).

[3] SAIF also refers us to Napier v. SAIF, 31 Or App 261 (1977), stating that, there, the court rejected compensability where the rescue doctrine could have been applied. Napier did not mention the rescue doctrine; consequently, we find it of no assistance here.

[4] Claimant received a copy of the OFS handbook that included the values. (Tr. 21).

On this record, we find that claimant's rescue efforts were a natural incident of his employment, because the man who claimant assisted was, at minimum, a "patron" of OSF-controlled premises, and because claimant acted in accord with his employer's instructions to be considerate of and helpful to such persons. Further, we find that claimant responded to an emergency that involved a potentially grave danger to the man he helped, namely, a head injury. In light of those circumstances, we conclude that, under the "stranger" prong of the rescue doctrine, claimant's injury occurred in the course of his employment.[5]

The remaining issue is whether claimant's injury arose out of his employment. It did.

To analyze the "arising out of employment" prong of the work-connection test, we must 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. In reaching that conclusion, we rely on the evidence that claimant was encouraged to provide high level service and to be considerate of and helpful to patrons and that claimant had often assisted OSF patrons in the past. (Tr. 6, 19-20). That is sufficient to establish that claimant's work put him in a position to be injured when he acted accordingly.

In sum, claimant has established that his back injury arose out of and occurred in the course of employment. Therefore, we affirm the ALJ's decision setting aside SAIF's denial of that condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his attorney's statement of services), the complexity of the issue, and the value of the interest involved.

## ORDER

The ALJ's order dated April 13, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the SAIF Corporation.

---

[5] We disagree with the dissent's assertion that we are abdicating our responsibility to determine the compensability of this claim to Professor Larson. To the contrary, as explained in our decision, we are applying the analytical framework prescribed by the Supreme Court in Gilmore. Such an analysis is consistent with our statutory obligation to determine whether claimant has sustained a "compensable injury"; i.e., an injury which arose out of and occurred in the course of his employment. In making such a determination, as we (and the courts) have done oftentimes in the past, we have cited various portions of Professor Larson's text. We do not consider such reasoning to constitute an abdication of any of our appellate review responsibilities.

**Board Members Haynes and Neidig dissenting.**

We strongly disagree with the majority's decision finding this claim compensable under the "rescue doctrine." Because no statute provides for the "rescue doctrine," the majority relies on Professor Larson's treatise. First, we object to the adoption of the "rescue doctrine." It is axiomatic that benefits awarded under Oregon's workers' compensation law are purely statutory. E.g., ORS 656.012(1)(c) (providing for an "exclusive, statutory system of compensation"); Nelson v. SAIF, 43 Or App 155 (1979). The Board's duty is to impartially apply this law. ORS 656.712(1).

Especially in recent years, the Oregon Legislature has been active in reviewing and amending the workers' compensation statutes. We are aware of no occasion when the Legislature conferred its authority to Professor Larson. Thus, we find no ground for adopting the "rescue doctrine" merely because it is described and advocated by Professor Larson. Rather, the majority should do what it is supposed to--apply the statutes. Therefore, this case should be limited to determining whether claimant showed that the injury occurred "in the course of employment" and "arose out of employment", as required by statute. ORS 656.005(7)(a); Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994).

Furthermore, we see no reason to apply the "rescue doctrine" in this case. According to the majority, the "rescue doctrine" "pertains to whether claimant's injury occurred in the course of his employment." Thus, the majority's entire extended discussion of the "rescue doctrine" is only to decide that claimant's injury occurred in the course of employment; there is no citation or reliance on the doctrine in discussing whether the injury arose out of claimant's employment.

The majority either overlooks or ignores SAIF's concession on review that claimant's injury occurred in the course of employment. In its brief, SAIF argues only that the injury did not arise out of the employment. Consequently, since the majority limits application of the "rescue doctrine" to whether the injury was in the course of employment and this issue is not contested, we are at a loss concerning why the majority finds it necessary to adopt and apply the doctrine.

Finally, we are not convinced that the "rescue doctrine" is satisfied in this case. The majority relies heavily on its finding that OSF exercised control over the courtyard; in coming to this conclusion, the majority states that, "[a]lthough there is no definitive proof of who owned the courtyard, the parties do not dispute that OSF exercises control over it." Based on our reading of the record and the briefs, the parties "do not dispute" control because such an issue is not discussed or even cited. By giving the impression that such a fact was conceded by the parties, the majority's treatment of the record in disingenuous. An honest appraisal of the record shows that there is not even a scintilla of evidence concerning whether OSF controlled the courtyard. Thus, there is no ground for concluding that OSF would have been liable for any injuries the fallen man could have sustained had not claimant aided him.

In our opinion, the majority's desire to reward claimant's act of kindness with workers' compensation benefits has resulted in an unnecessary expansion of the law and a distorted reading of the record. This claim should fail because, simply put, there simply is no causal connection between claimant's particular job as a stage manager and the injury since claimant's employment did not put him in a position to be injured by assisting in an accident. Instead, happenstance (by being present at the time of the accident) and claimant's personal humanitarianism caused his injury.

Claimant acted as we hope everyone would when another person apparently may be injured. Workers' compensation, however, is not a social service for rewarding "good acts." We have statutes for deciding compensability in order to confine injuries payable under workers' compensation to those arising out of employment. Claimant is to be commended; however, because his injury does not satisfy the statutes, claimant's award should not be with workers' compensation benefits.

---

December 11, 1995 Cite as 47 Van Natta 2343 (1995)

In the Matter of the Compensation of
**DAN D. CONE, Claimant**
WCB Case Nos. 94-01799 & 94-01423
SECOND ORDER ON RECONSIDERATION
Terry & Wren, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Claimant requests reconsideration of our November 15, 1995 Order on Reconsideration. In this order, we found that claimant did not prove compensability of his occupational disease claim, but established a medical services claim for a herniated disc. According to claimant, the disc herniation condition is disabling and, thus, we should remand the claim to the insurer to close the claim under ORS 656.268.

Claimant has an accepted 1985 low back injury claim. Because it was classified as nondisabling, the claim was not closed. As indicated above, in our Order on Reconsideration, we set aside the insurer's denial of claimant's medical services claim for a herniated disc, finding that claimant proved that the 1985 injury was the major contributing cause of the herniated disc. In requesting that we remand the claim to the insurer for processing to closure, we understand claimant as contending that we should treat the disc herniation as a "new injury" claim, entitling him to additional benefits under ORS 656.268.

We considered a similar question in Mark D. Fuller, 46 Van Natta 63 (1994). There, we found that a consequential psychological condition should be treated as an "aggravation" claim for a previously accepted claim. We further noted, however, that aggravation claims filed after five years of the first claim closure fall under the Board's exclusive own motion jurisdiction. Because the "aggravation" claim had been filed outside the five-year limit, we denied claimant's request to remand to the Department for rating of permanent disability because the claim was in own motion status. Id. at 65.

The same reasoning applies here. The herniated disc claim falls under our own motion status. Thus, we deny claimant's request to remand the case for processing to closure.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we adhere to and republish our November 15, 1995 Order on Reconsideration. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---

December 11, 1995 Cite as 47 Van Natta 2344 (1995)

In the Matter of the Compensation of
**DEBRA DALE, Claimant**
Own Motion No. 95-0244M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Schneider, Hooton, et al, Claimant Attorneys
Continental Casualty, Insurance Carrier

Claimant requests review of the insurer's October 5, 1995 Notice of Closure, which closed her claim with an award of temporary disability compensation from April 6, 1995 through June 6, 1995. The insurer declared claimant medically stationary as of September 5, 1995. Claimant contends that she is entitled to additional benefits from June 6, 1995 through September 5, 1995.

The parties do not dispute that claimant was medically stationary on September 5, 1995, and claimant is not requesting additional benefits beyond the medically stationary date. Rather, claimant contends that she is entitled to additional temporary disability benefits after June 6, 1995, because she returned to work only in a light duty capacity.

On October 18, 1995, the Board advised the parties of claimant's request for review of her claim closure, and requested that the parties submit materials and evidence used in closing the claim. On October 19, 1995, the insurer notified claimant that, if she would submit payroll verification for the period from June 7, 1995 through June 27, 1995, it would "calculate any additional benefits that may be due." On November 3, 1995, we requested the parties' positions regarding resolution of the payment of additional time loss. On November 3, 1995, the insurer submitted the materials it used in closing the claim as requested. In a November 22, 1995 letter, claimant advised the parties that "[o]ur reading of the medical records continues to support our assertion that at least temporary partial disability should have continued through the medically stationary date." Inasmuch as the parties have responded, we will proceed with our review.

Claimant is substantively entitled to temporary disability compensation from the date of surgery or hospitalization until her condition is medically stationary. A claimant's substantive entitlement to temporary disability benefits is determined on claim closure, and is proven by the establishment from the evidence in the record that claimant was disabled due to the compensable claim before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

In a May 31, 1995 chart note, Dr. Harris, claimant's treating physician, noted that "[claimant] will start work on 6-5-95, part-time for the first two weeks." In his June 16, 1995 chart note, Dr. Harris noted that claimant was using crutches, but that "[s]he will continue working as tolerated." On June 27, 1995, Dr. Harris again noted that claimant "is continuing to work." On September 5, 1995, Dr. Harris noted that claimant "is back to work at her usual job as a dental hygentist [sic]," and he opined that claimant was "medically stationary with respect to her knee injury and surgery."

In a June 14, 1995 letter, Dr. Harris opined that claimant "was off work from the day of injury to 6-5-95" (emphasis added). Thus, we conclude that the record establishes that claimant returned to work on June 5, 1995. In a June 16, 1995 chart note, Dr. Harris noted that claimant "will continue working as tolerated." It does not appear that Dr. Harris examined claimant on June 5, 1995, but rather, his examinations occurred a week prior to that date, and again nearly two weeks after she returned to work. Subsequent to June 5, 1995, Dr. Harris does not verify or substantiate that claimant returned to work on a part-time basis.

Hence, we are not persuaded that claimant was disabled due to her work injury after June 5, 1995, as the evidence in the record establishes that she returned to work on June 5, 1995, albeit, claimant contends, in a "modified" capacity. In addition, the record does not support that any "modifications" to her work might be due to the compensable injury.

The insurer terminated temporary disability benefits on June 7, 1995. In our review of the record, we note that, on May 12, 1995 and on June 7, 1995, the insurer requested that claimant advise "what dates of time you have missed due to this injury." In its October 19, 1995 letter, the insurer advised claimant's attorney that:

> "If you would have your client provide me with payroll verification for June 07, 1995 through June 27, 1995 I will be more than happy to calculate any additional benefits that may be due and advise."

The insurer notified claimant that she might qualify for benefits for any additional time missed during the period from June 7 through June 27, 1995, if she submitted the requested documentation to support her request. The record does not establish that claimant responded to the insurer's request to submit that information.

To determine whether claimant is entitled to additional temporary disability compensation in this case, the record must demonstrate that: (1) she was disabled from work due to the compensable injury for the period in question; and (2) that the insurer was notified of any loss of wages (due to the compensable injury) after she returned to work. The Legislature recently amended ORS 656.212. Or Laws 1995, ch 332, § 16 (SB 369, § 16). Amended ORS 656.212 provides, in part:

> "When the disability is or becomes partial only and is temporary in character:
>
> "*****
>
> "(2) The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive for an aggregate period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of wages bears to the wage used to calculate temporary disability pursuant to ORS 656.210."

See Lonnie L. Dysinger, 47 Van Natta 2282 (1995).

The insurer was notified that claimant had returned to work, and it terminated temporary total disability. However, two days after claimant returned to work, the insurer offered to re-evaluate her benefits for any work time missed after she returned to work on a part-time basis. Claimant's entitlement to additional temporary disability compensation, "less time worked" (only "loss of earnings" may be compensated), during the period in question is contingent on establishing how much, if any, wage loss claimant sustained due to her compensable condition. However, whether she missed any work or lost any wages at all during that time is only speculation, as claimant has not submitted that information into the record.

Therefore, contrary to claimant's contention, we find insufficient evidence in the record to show that claimant did not "return to work" on June 5, 1995, nor that she was disabled or lost wages due to the compensable injury from June 5, 1995 until she became medically stationary on September 5, 1995.

On the record, we do not find that the evidence establishes that claimant was disabled due to the compensable injury during the period in question, nor that she was entitled to additional temporary disability compensation after June 5, 1995 until the medically stationary date. Therefore, we conclude that the insurer's closure was proper, and no additional temporary disability compensation is due.

Accordingly, we affirm the insurer's October 5, 1995 Notice of Closure in its entirety.

IT IS SO ORDERED.

---

December 11, 1995 Cite as 47 Van Natta 2346 (1995)

In the Matter of the Compensation of
**JIMMY L. HOLSAPPLE, Claimant**
WCB Case No. 94-13902
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that affirmed the Director's "Order on Reconsideration on Remand" awarding no additional scheduled permanent disability for loss of use or function of the left hand. On review, the issue is extent of scheduled permanent disability.

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

Claimant compensably injured his left hand, including amputation of several fingers. A Notice of Closure awarded 33 percent scheduled permanent disability for the left hand. Eventually, an ALJ remanded the case to the Director for a determination whether claimant's disability was not addressed by the existing standards and, if not, for promulgation of a temporary rule.

Based on existing standards, the Department found claimant entitled to 34 percent scheduled permanent disability. The Director also "recommend[ed] promulgation of a temporary rule," finding that "the loss of [hand] dominance is not considered within the rating scheme set forth by statute." Apparently on the basis that there was "no clear medical consensus regarding the effect of dominance on work function," however, the Director concluded that "the impairment value for loss of use of the dominant hand shall be a value of zero." The temporary rule itself provided:

> "This worker has suffered traumatic amputations on the dominant left hand. The rules do not provide a value for loss of use of the dominant extremity. The statute does not contemplate dominance in assigning degree values to extremity areas. In this case, the impairment value for loss of use of the dominant hand shall be a value of zero. * * *"

The ALJ first found that, because the prior ALJ had "determined that the disability was not addressed by the standards, it was incumbent upon the Director to craft a rule which rated that disability beyond the assignment of a zero value." The ALJ further concluded, however, that the Hearings Division lacked jurisdiction to amend a temporary rule and that it could only apply the standards adopted by the Director. Thus, the ALJ applied the temporary rule and affirmed the Department's order.

Claimant asserts that the Director failed to follow ORS 656.726(3)(f)(C)[1] by not adopting a rule "to accommodate the worker's impairment" since the temporary rule resulted in no additional impairment. Citing Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993), claimant asserts that we should again remand the claim to the Director for adoption of another temporary rule.

---

[1] ORS 656.726(3)(f)(C) provides:

"When, upon reconsideration of a determination order or notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment."

Subsequent to the ALJ's order, we issued our order in Milan F. Shubert, 47 Van Natta 1297 (1995). In Shubert, pursuant to the Board's order remanding the claim, the Director promulgated a temporary rule to address a surgical procedure but, after applying the rule, found that claimant was not entitled to an impairment value for the surgery. We found that the Hearings Division and Board lacked jurisdiction to declare a temporary rule invalid and that our review was limited to applying the Director's "standards." 47 Van Natta at 1298. We also noted that the Director's action was not inconsistent with ORS 656.726(3)(f)(C) since "not all impairment necessarily results in a worker receiving an impairment value under the 'standards.'"

Thus, pursuant to Shubert, we agree with the ALJ that our review is limited to determining whether the Director properly applied the temporary rule and not whether the temporary rule itself is invalid. Inasmuch as the rule provides that loss of hand dominance does not result in any impairment, we agree with the ALJ that the Director's order should be affirmed.

ORDER

The ALJ's order dated March 21, 1995 is affirmed.

**Member Hall dissenting.**

Relying on Milan F. Shubert, 47 Van Natta 1297 (1995), the majority concludes that our review of the Director's order is limited to determining whether the Director properly applied the temporary rule and we cannot address whether the temporary rule is valid. Because I disagree with the holding in Shubert and its application to this case, I dissent.

As provided in the majority's order, ORS 656.726(3)(f)(C) provides that, when it is found that a worker's disability is not addressed by the existing standards, "the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment." (Emphasis supplied.) The unambiguous language of the statute requires the Director to adopt a rule that provides compensation for the worker's impairment. Any other interpretation of the statute renders it not only meaningless but absurdly results in finding that the legislature intended the Director to enact useless standards. I cannot imagine that the legislature desired that the Director expend time and energy in such a pointless endeavor.

We should apply the law as it is stated. Here, as found by a prior ALJ, claimant is impaired because two of his fingers from his dominate left hand were amputated. By adopting a temporary rule, the Director necessarily also found that claimant is disabled by this condition since ORS 656.726(3)(f)(C) requires the Director to amend the standards only when it is found that a worker's disability is not addressed by the standards. The Director did not satisfy the statute, however, because the temporary rule did not "accommodate" claimant's impairment inasmuch as it provided an impairment value of zero.

We have the authority to remand the case to the Director to grant the relief requested. Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538, 542 (1993). By failing to assert this authority, we are compounding the Director's contravention of ORS 656.326(3)(f)(C). Because I would remand this case to the Director to enact a proper temporary rule, as the statute requires, I dissent.

In the Matter of the Compensation of
**GLORIA T. OLSON, Claimant**
WCB Case No. 91-16193
ORDER ON REMAND
Karen M. Werner, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by the Board en banc.

This matter is before the Board on remand from the Court of Appeals. Olson v. Safeway Stores, Inc., 132 Or App 424 (1995). The court reversed our prior order, Gloria T. Olson, 44 Van Natta 2519 (1992), in which we held, applying former ORS 656.005(7)(a)(B) in the context of an aggravation claim, that claimant's compensable 1988 injury was not the major contributing cause of her worsened right shoulder condition. Relying on Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994) and Beck v. James River Corp., 124 Or App 484 (1993), rev den 318 Or 78 (1994), the court reasoned that claimant need only prove that her worsened condition and need for treatment was caused in material part by her compensable injury. Consequently, the court has remanded for reconsideration.

The relevant facts are as follows. Claimant sustained a compensable injury to her right shoulder in 1988, which the employer accepted as a right shoulder strain. Claimant ultimately was awarded 31 percent unscheduled permanent disability pursuant to a June 11, 1990 Stipulation and Order.

Claimant sought additional right shoulder treatment in 1990 and 1991. In 1991, Dr. Jones ordered an arthrogram, which revealed a small rotator cuff tear. Dr. Jones requested authorization to perform subacromial decompression and rotator cuff repair.

On November 1, 1991, the employer denied claimant's aggravation claim, asserting that her current condition was not compensably related to her industrial injury. It also denied claimant's medical services claim for right rotator cuff surgery as not reasonable and necessary medical treatment. Claimant timely requested a hearing.

The Administrative Law Judge (ALJ) (formerly Referee) held that the compensable work injury was not the major contributing cause of claimant's right rotator cuff tear. Reasoning that under either former ORS 656.005(7)(a)(A) or (B) claimant failed to prove by a preponderance of the medical evidence that her compensable shoulder injury was the major contributing cause of her rotator cuff tear, the ALJ upheld the employer's denial of claimant's aggravation claim. With respect to the medical services claim, the ALJ held that the Hearings Division lacked jurisdiction over any dispute involving the appropriateness of medical treatment. Claimant timely requested review of the ALJ's order.

On review, we found that claimant's right shoulder condition had worsened. Gloria T. Olson, supra. We defined the issue on review as whether the relationship between the worsening and the original injury was sufficient to establish compensability. We held that because claimant's worsened condition was the result of a combination of her compensable injury and a preexisting degenerative shoulder condition, claimant must prove, pursuant to former ORS 656.005(7)(a)(B), that the original injury remained the major contributing cause of her worsened condition, rather than merely a material contributing cause of the worsened condition. We found that claimant failed to establish that her original injury was the major contributing cause of her worsened condition.

With respect to the medical services issue, we held that we had jurisdiction to the extent the dispute concerned the causal relationship between the original injury and the proposed surgery. However, having found that the injury was not the major contributing cause of the current condition, we concluded that claimant was not entitled to medical services for that condition. Claimant appealed our order.

The court reversed our decision, relying on Jocelyn, supra, and Beck, supra. Olson v. Safeway Stores, Inc., supra. The court found that there was no dispute that claimant's right shoulder condition had worsened since claim closure. However, the court concluded that we erred in applying the major contributing cause standard of ORS 656.005(7)(a)(B) to claimant's aggravation claim. Citing Jocelyn and Beck, the court reasoned that claimant need only prove that her worsened condition and need for medical treatment was caused in material part by her compensable injury. Consequently, the court has remanded for reconsideration. Accordingly, we proceed with our reconsideration.

We are mindful of the court's mandate to us. However, subsequent to the court's decision in this case, effective June 7, 1995, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656.[1] Among the amended provisions were ORS 656.245 and ORS 656.273. Or Laws 1995, ch 332 §§ 25, 31 (SB 369, §§ 25, 31). Finding no relevant exceptions to these amendments, we conclude that Sections 25 and 31 apply 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).

Before we turn to the merits, we first address claimant's request that this case be remanded to the ALJ for a new hearing.[2] Specifically, claimant contends that if the SB 369 amendments apply to this case, the case should be remanded to the ALJ for a new hearing to develop evidence to meet the new statutory requirements. The employer contends that claimant is not entitled to remand for a new hearing.

We may remand to the ALJ should we find 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).

Here, claimant contends that the SB 369 amendments "changed the goalposts" in this case, and that, therefore, claimant is entitled to remand to develop evidence consistent with the new standards. We disagree.

First, we observe that SB 369 did not "change the goalposts" in aggravation cases. At the time of the hearing and Board review in 1992, we interpreted ORS 656.273 as first requiring proof of a compensable injury, which could make ORS 656.005(7)(a)(A) or (B) applicable, depending on the circumstances of each case. See Bertha M. Gray, 44 Van Natta 810 (1992), aff'd Gray v. SAIF, 121 Or App 217 (1993); Lareta C. Creasey, 43 Van Natta 1735 (1991). It was not until December 28, 1994 that the court decided Iocelyn, holding that ORS 656.005(7)(a)(B) is not applicable in an aggravation claim under ORS 656.273. Therefore, the interpretation in effect at the time of hearing and review in this case was that the major contributing cause standard of ORS 656.005(7)(a)(B) applied in aggravation claims. Moreover, even if SB 369 did "change the goalposts," we do not find that to be a compelling reason to remand. See Rosalie S. Drews, 46 Van Natta 408, recon denied 46 Van Natta 708 (1994) (argument that court allegedly "moved the goal post" in responsibility law not a compelling basis for remand when medical evidence sufficiently developed to resolve responsibility dispute under appropriate legal standard).

We distinguish the present case from the circumstances in Helen M. Callander, 47 Van Natta 1626 (1995). In Callander, the critical issue was whether claimant had proved an "actual" worsening under amended ORS 656.273(1). We noted that the modifier "actual" was a new term in the statute, whereas under former ORS 656.273(1), a symptomatic or pathologic worsening was sufficient to establish an aggravation. We found that the record was devoid of evidence regarding whether claimant's condition "actually" worsened. Under such circumstances, we considered the record incompletely developed, and we remanded the case to the ALJ for further proceedings.

Here, by contrast, there is no dispute that claimant's shoulder condition worsened. See Olson, supra, 132 Or App at 427; Gloria T. Olson, supra, 44 Van Natta at 2520. Instead, the dispute concerns the applicability of material versus major contributing cause standards. Unlike the term "actual" worsening, the material and major contributing cause are not new standards of proof introduced in SB 369. Therefore, we conclude, distinguishing Callander, that claimant in this case had sufficient notice and opportunity to develop evidence to meet the relevant standards.

---

[1] In order to be fully apprised of the parties' positions regarding the effects of Senate Bill 369 on this case, we gave the parties the opportunity to submit supplemental briefing. Having received the parties' supplemental arguments, we proceed with our reconsideration.

[2] On September 14, 1995, we received claimant's supplemental argument in support of her motion to remand. We have considered claimant's submittal in our review.

We find that the record in this case contains sufficient evidence to analyze the compensability of the claim, even under the SB 369 amendments, if we were to find that evidence persuasive. Therefore, we do not consider the record to be incompletely, improperly, or otherwise insufficiently developed. Accordingly, we find no compelling reason to remand, and we deny claimant's motion.

We turn now to the merits of our reconsideration. The legislature amended ORS 656.273(1), which now provides, in pertinent 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 medical evidence of an actual worsening of the compensable condition supported by objective findings." (Emphasis added).

The statute requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening;" and (2) a compensable condition. Both elements must be satisfied in order to establish "a worsened condition resulting from the original injury."

We find that the unambiguous language of the statute modifies the court's holding in Iocelyn by specifically defining the elements of proof which establish a "worsened condition resulting from the original injury." The legislature did not amend the phrase "resulting from," which the court interpreted as requiring a claimant to prove only that the original compensable injury was a material contributing cause of the worsened condition. Iocelyn, supra, 132 Or App at 171. However, the legislature inserted the phrase "of an actual worsening of the compensable condition" following the phrase "[a] worsened condition resulting from the original injury is established by medical evidence. . ." The plain meaning of the inserted language is to define what evidence constitutes proof of "a worsened condition resulting from the original injury."

In Iocelyn, the court reasoned that since former ORS 656.273(1) did not refer to the term "compensable injury" or otherwise reference ORS 656.005(7)(a)(B), the latter statute did not apply to aggravation claims. Iocelyn, supra, 132 Or App at 171. However, the legislature has now inserted the term "compensable condition" in the aggravation statute.

Since the compensability of a condition is established under ORS 656.005(7)(a), we conclude that the statute requires that a condition which is not already compensable be established as compensable in order to prove "a worsened condition resulting from the original injury" under ORS 656.273. Accordingly, we turn now to a determination of claimant's compensable condition.

Claimant's accepted right shoulder condition was diagnosed as a strain, or tendinitis. (Exs. 14-4, 17, 28-1). The worsened condition is a right rotator cuff tear. (Ex. 30). The rotator cuff tear is not an accepted condition; rather, it developed some three years after the original 1988 injury. (Compare Exs. 6, 29A, 29B-2 with Ex. 30). Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the rotator cuff tear is a compensable condition.

The legislature also amended ORS 656.005(7)(a)(B), which now provides that if a compensable injury "combines at any time with a preexisting condition[,]" the combined condition is compensable only if the otherwise compensable injury is the major contributing cause of the combined condition. (Emphasis added). Since the legislature added the phrase "at any time," we conclude that amended ORS 656.005(7)(a)(B) no longer applies solely to the determination of the compensability of initial claims. See Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590, 594, rev den 318 Or 27 (1993).

Our conclusion is supported by the legislature's addition of a statutory definition of "preexisting condition." Amended ORS 656.005(24) defines "preexisting condition" as any injury, disease or similar condition that contributes to disability or need for treatment and that precedes the onset of an initial claim, "or that precedes a claim for worsening pursuant to ORS 656.273." Or Laws 1995, ch 332 § 1(24) (SB 369, § 1) (emphasis added). Inasmuch as amended ORS 656.005(24) defines "preexisting condition" with reference to a claim for worsening under ORS 656.273, and amended ORS 656.005(7)(a)(B) specifies how preexisting conditions are to be considered in establishing compensability, we conclude that the statutory context confirms our conclusion that amended ORS 656.005(7)(a)(B) is applicable in aggravation claims.

Having identified the appropriate legal standards for application to this case, we proceed with our review. Examining physicians Drs. Fuller and Peterson opined that claimant's 1988 injury "added to the pre-existing, underlying degenerative condition and probably hastened its progress." (Ex. 38). Claimant's attending physicians, Drs. Jones and Bert do not ascribe a specific role in claimant's current condition to her underlying degenerative disease. (See Exs. 33-1, 40-3). Dr. Jones acknowledged that he did not know the etiology of claimant's current shoulder condition. (Ex. 33-1). Dr. Bert agreed that claimant's work activities hastened the degeneration of her shoulder, but he expressed no other specific opinion regarding the relationship, if any, between claimant's 1988 injury and her underlying degenerative condition. Under such circumstances, we consider the opinion of Drs. Fuller and Peterson more persuasive, and we interpret their opinion as establishing that claimant's 1988 shoulder injury combined with her degenerative condition to cause or prolong her disability and need for treatment. Because claimant's compensable shoulder injury combined with her preexisting degenerative condition, we conclude that claimant must establish that her compensable injury was the major contributing cause of her worsened condition. Amended ORS 656.005(7)(a)(B).

Because claimant's rotator cuff tear developed several years after the original injury, and because the worsened condition combined with a preexisting condition, the question of causation is medically complex and requires expert medical opinion to resolve. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). When there is a dispute between medical experts, we give greater weight to those opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Here, claimant's initial treating physician, Dr. Jones, explained that he did not have specific information regarding the etiology of claimant's rotator cuff tear. He opined that "in all likelihood" it was the result of an injury. (Ex. 33-1). Claimant's subsequent treating physician, Dr. Bert, opined, in response to claimant's counsel's interrogatories, that claimant's 1988 injury and subsequent treatment were the major contributing factors to her worsened shoulder condition. (Ex. 40-3).

Claimant was also examined by Drs. Fuller and Peterson at the employer's request. They noted no significant incident or injury since the 1988 injury. (Ex. 36-8). They opined that the rotator cuff tear was most likely due to claimant's preexisting, underlying degenerative condition in her right shoulder. (Id.). They explained that, since claimant gave no history of a subsequent injury, her current condition was most likely due to the natural progression of her preexisting condition, causing a spontaneous rotator cuff tear. (Id. at 9). They opined that the 1988 injury was not the major contributing cause of her current condition. (Ex. 38).

We find Dr. Jones' opinion unpersuasive because it is based on speculation, rather than reasonable medical probability. Gormley v. SAIF, 52 Or App 1055, 1059-60 (1981). Neither do we give much weight to Dr. Bert's opinion, which we find conclusory. Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). By contrast, we find the opinion of the examining physicians, Drs. Fuller and Peterson, to be more persuasive because it is more thorough and more fully explained. Somers, supra. Therefore, we give greater weight to the opinion of Drs. Fuller and Peterson. Relying on their opinion, we find that claimant failed to prove that the 1988 work injury was the major contributing cause of her current rotator cuff tear.

Accordingly, we conclude that claimant failed to establish that she has a "compensable condition" under amended ORS 656.273. Therefore, her aggravation claim fails.

With respect to medical services for a compensable injury, the legislature also amended ORS 656.245(1)(a), which now provides that "for consequential and combined conditions described in ORS 656.005(7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury." SB 369, § 25. The legislature added this language to the statute subsequent to the court's decision in Beck, supra. Moreover, the condition that required treatment in Beck was the same, compensable condition that had previously been accepted. By contrast, in the present case, claimant seeks treatment for a new condition (rotator cuff tear) which we have found was not caused in major part by the compensable injury. Therefore, we conclude that Beck is not applicable to the medical services issue in this case. Instead, pursuant to the unambiguous language of the statute, we conclude, based on the opinion of Drs. Fuller and Peterson, that the requested medical services are not compensable because claimant failed to prove that they would be directed at a medical condition caused in major part by the compensable 1988 injury.

Accordingly, on reconsideration, we republish our December 29, 1992 order, as supplemented and modified herein.

IT IS SO ORDERED.

---

December 11, 1995 Cite as 47 Van Natta 2352 (1995)

In the Matter of the Compensation of
**THERESA G. PETERSON, Claimant**
WCB Case No. 94-13562
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Neal's order that failed to award an attorney fee under ORS 656.386(2) out of the increased temporary disability award. On review, the issue is attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her right knee in December 1990. The claim was closed in July 1991, with an award of permanent disability.

On March 3, 1994, claimant returned to her treating physician, Dr. Baldwin, with knee complaints. Dr. Baldwin took claimant off work and requested authorization for surgery. On March 30, 1994, the employer denied the requested surgery on the ground that claimant must treat through the employer's MCO.

On June 8, 1994, claimant began treating with Dr. Brenneke, an approved MCO physician, who took claimant off work pending surgery. On November 2, 1994, the employer accepted claimant's aggravation claim and paid time loss for the period June 8, 1994 through November 1, 1994. Claimant, through her counsel, requested a hearing on November 3, 1994 seeking temporary disability from March 1994 to June 1994. On January 23, 1995,[1] after receiving Dr. Baldwin's medical verification of claimant's inability to work due to her compensable injury, the employer paid claimant temporary disability benefits for the period March 3, 1994 to March 31, 1994.

Finding that the employer had no unilateral basis for terminating time loss, the ALJ ordered the employer to pay temporary disability from April 1, 1994 to June 7, 1994. The ALJ further assessed a 25 percent penalty for the employer's unreasonable failure to pay such compensation.

Claimant contends that she is entitled to an "out-of-compensation" attorney fee, under ORS 656.386(2), for her counsel's efforts in obtaining temporary disability compensation for the period April 1, 1994 through June 7, 1994. We find that claimant's counsel is entitled to an attorney fee regarding the increased compensation awarded by the ALJ's order.[2] However, to the extent that this compensation has already been paid to claimant, claimant's counsel must collect this attorney fee from claimant.

---

[1] Claimant does not dispute the ALJ's finding that the employer first had notice or knowledge, in January 1995, that claimant was off work due to her compensable injury.

[2] The amendments to ORS 656.386(2) do not alter the result of this case.

Where claimant's attorney failed to take preventive action to secure the out-of-compensation fee, we have held that the attorney must seek payment of the fee from the claimant. Joslin A. McIntosh, 46 Van Natta 2445 (1994); Gabriel M. Gonzales, 44 Van Natta 2399 ( 1992); Kenneth V. Hambrick, 43 Van Natta 1636 (1991); cf. Ana J. Calles, 46 Van Natta 2195 (1994) (where the claimant's attorney took all reasonable precautions to secure the out-of-compensation fee, the insurer was required to pay the fee to the attorney).

We find Hambrick, supra, analogous to the present case. In Hambrick, an ALJ's order granted increased compensation, but neglected to award an "out-of-compensation" fee from that increase. On review, we ultimately held that, although the claimant's counsel was entitled to an attorney fee, it would be inequitable to require the carrier to pay the fee "as a result of the [ALJ's] error and claimant's failure to timely request correction of that error." In reaching this conclusion, we disavowed our holding in Teresa R. Harmon, 42 Van Natta 1 (1990), in which we held that where an ALJ erred by not awarding the claimant's counsel an approved fee, we may, because of our de novo review, correct the error by awarding the claimant's counsel a fee.

Here, as in Hambrick, claimant failed to take preventative action to secure the out-of-compensation fee by timely requesting reconsideration of the ALJ's order. We conclude that it would be inequitable to require the employer to now pay a fee as a result of the ALJ's error and claimant's failure to timely request correction of the error. Thus, in the event that the increased temporary disability award has already been paid to claimant pursuant to the ALJ's February 14, 1995 order, claimant's counsel should seek his fee directly from claimant, rather than from the employer. Hambrick, supra, at page 1637; see 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 February 14, 1995 is reversed in part and affirmed in part. That portion of the order that declined to award an "out-of-compensation" attorney fee is reversed. Claimant's attorney is awarded 25 percent of the temporary disability compensation for the period April 1, 1994 through June 7, 1994 created by the ALJ's order, not to exceed $3,800, to be paid out of the increased compensation. In the event that all or a portion of the increased temporary disability compensation has already been paid to claimant, claimant's counsel's attorney fee shall be recoverable from claimant in the manner set forth in Jane A. Volk, supra. The remainder of the order is affirmed.

**Board Member Hall dissenting.**

I agree with the majority that claimant is entitled to an out-of-compensation attorney fee. However, I depart with the majority to the extent that the majority prematurely addresses the issue of collecting that fee.

Here, the only issue on review is claimant's entitlement to a fee. On this record, there is no issue that needs to be addressed regarding the method of collecting the attorney fee award. Furthermore, the record is not adequately developed to determine the preventive actions taken by claimant's attorney to secure the fee. The majority is also making assumptions[1] that are not supported by the record regarding whether the full amount of time loss due has already been paid to claimant.

Because I would find that the Volk, supra issue is premature and because the record is not adequately developed to address that issue, I respectfully dissent.

[1] The employer withheld an out-of-compensation attorney fee, from the temporary disability benefits it had paid for the period March 3, 1994 through March 31, 1994, until ordered by the ALJ to pay the fee. How does the majority know that the employer is not withholding an attorney fee for the second period of time loss it has been ordered to pay?

In the Matter of the Compensation of
**KEVIN P. SILVEIRA, Claimant**
WCB Case No. 91-05623
ORDER ON REMAND
Coughlin, et al, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by the Board en banc.

This matter is before the Board on remand from the Court of Appeals. Silveira v. Larch Enterprises, 133 Or App 297 (1995). The court has reversed our prior order, Kevin P. Silveira, 45 Van Natta 1202 (1993), that found that claimant's work activities during his out-of-state employment could not be considered in determining the compensability of his claim. For purposes of establishing that an occupational disease is work related, the court reasoned that a claimant may rely on employment not subject to Oregon's workers' compensation laws. The court has remanded for reconsideration.

## FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact with one exception. There is no evidence that claimant missed work subsequent to an injury in November 1988.

## CONCLUSIONS OF LAW AND OPINION

In April 1983, claimant, a logger, began working for employer Larch Enterprises (Larch) in California. He suffered back pain on November 7, 1988, after changing tires at work. At that time, Larch was not an Oregon employer. Claimant sought treatment from a chiropractor, but he never missed work. Claimant did not file a work injury claim.

In October 1990, Larch moved its operations to Oregon and became an Oregon employer. In late December 1990, claimant began to experience severe back pain, but continued to work. Claimant's employment with Larch ended in early February 1991.

Claimant sought treatment from Dr. Driver in February 1991. X-rays revealed degenerative disc disease in the low back. Claimant filed a claim for his low back on April 4, 1991.

The ALJ concluded that claimant's work activities in late 1990 and early 1991 were the major contributing cause of claimant's degenerative back condition and its worsening. On Board review, we reversed. Kevin P. Silveira, supra. Reasoning that claimant's work activities during his out-of-state employment could not be considered, we found that claimant had not established that his Oregon employment was the major contributing cause of his occupational disease. Claimant contended that the "last injurious exposure rule" relieved him of the burden of proving that any specific employment or exposure caused his occupational disease.

The court agreed with claimant's assertion, concluding that for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws. Silveira v. Larch Enterprises, supra. The court cited Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994), which had held that in determining whether a disease is work related, the rule of proof aspect of last injurious exposure rule allows consideration of all employments, even those that could not ultimately be held responsible for the claim. The court also relied on Progress Quarries v. Vaandering, 80 Or App 160 (1986), for the proposition that a claimant is not required to file a claim with other potentially causative out-of-state employers in order to receive compensation in Oregon. In accordance with the court's instruction, we proceed with our reconsideration.

### Compensability

In order to establish the compensability of his degenerative disc disease, claimant must prove that employment conditions were the major contributing cause of the disease. Amended ORS

656.802(2)(a); Or Laws 1995, ch 332 § 56(2)(a) (SB 369, § 56 (2)(a)).[1] For purposes of determining compensability, claimant's out-of-state employment can be considered in determining whether his condition was caused by his employment. Silveira v. Larch Enterprises, supra.

Claimant suffered back pain on November 7, 1988, after changing tires while working for the employer in California. Although claimant saw a chiropractor two or three times for the pain, he never missed any time from work as the result of back pain. (Tr. 9). The back pain did not entirely go away. (Tr. 35).

In October 1990, Larch moved its operations to Oregon. In December 1990, claimant first noticed back pain while driving tractors over frozen ground and rocks. (Tr. 15). Initially, claimant did not "pay much attention to it" but, by the end of December, his back pain did not ease up. (Id.) Each morning and evening, claimant would sit in hot water for a half hour to an hour in order to "loosen up" enough to change clothes. (Tr. 17).

Claimant told his employer about his back problem in early January 1991, but the employer wanted him to keep going until spring. (Tr. 19-20). Later in the month, claimant again spoke to the employer about his back pain and the employer asked him to keep going until February 15, 1991. (Tr. 22). Claimant's employment was terminated on February 1, 1991. (Tr. 22-23).

Dr. Driver examined claimant on February 12, 1991. (Ex. 3). Dr. Driver diagnosed severe degenerative disease in his lower lumbar spine. (Ex. 13). Dr. Driver initially reported that claimant's "work activities beginning in 1988 were the cause of his back condition" and his degeneration was due to continuous work rather than a specific injury. (Id.) Dr. Driver subsequently reported:

> "I do agree that [claimant's] heavy work driving skidder and tractor in October, November, December of 1990 and January 1991, certainly contributed to his medical attention in February of 1991. In fact, this was probably a major contributor toward his need for medical attention." (Ex. 15)

There is no evidence in the record that claimant's degenerative disc disease was a preexisting condition. Based on Dr. Driver's reports, we are persuaded that claimant's employment conditions, including his out-of-state employment, were the major contributing cause of his degenerative disc disease. See amended ORS 656.802(2)(a). In reaching this conclusion, we acknowledge that Dr. Driver did not expressly state that claimant's work activities were the major contributing cause of the degenerative disc disease. Nevertheless, it is well-settled that medical opinions need not mimic statutory language or use " magic words." See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). We further note that there are no contrary medical opinions, nor did Dr. Driver attribute claimant's condition to an off-work activity. Consequently, we conclude that claimant's degenerative disc disease is compensable.

Responsibility

The "last injurious exposure rule" provides that where, as here, 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, 241 (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).

SAIF argues on remand that the date of disability for claimant's back condition occurred in California when he sought chiropractic treatment. See Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994) (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

---

[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). We note that the outcome in this case would be the same under either the former or amended versions of ORS 656.802.

condition is determinative for the purpose of assigning initial responsibility for the claim). Under those circumstances, the California employer would be assigned initial responsibility for claimant's condition. According to SAIF, in order to prove a compensable claim in his subsequent Oregon employment, claimant had to prove that his Oregon employment caused a pathological worsening of the underlying condition.

On the other hand, claimant contends that the Board cannot fix initial responsibility on an out-of-state insurer not subject to Oregon Workers' Compensation laws. According to claimant, since the Board cannot assign initial responsibility to the California insurer, it is not possible to "shift" responsibility from the employer's California insurer to the employer's Oregon insurer. Claimant asserts that he has no burden of shifting responsibility to a subsequent employer. Furthermore, claimant contends that he need only prove that the Oregon employment was injurious and a potential cause of the disease. See Silveira v. Larch Enterprises, supra, 133 Or App at 302.

In Boise Cascade Corp. v. Starbuck, supra, 296 Or at 244, the Supreme Court said that "[o]nce a worker proves that the disability is work related, he or she need not prove that any one employment caused the disability." The last injurious exposure rule accomplishes that and "makes liable the last employer whose conditions of employment might have caused the disability." Id. The rule, however, does not prevent an employer from proving that the claimant's disability was caused by a different employment or that the disability did not arise from any work-related injury. Id.

In this case, we note that the Silveira court said that "[t]he consideration of claimant's out-of-state employment for the purpose of determining whether his condition is work related does not necessarily bear on which employer might ultimately be responsible for the claim." 133 Or App at 302. We interpret that language to mean that the court intended to keep the compensability analysis separate from the responsibility analysis.

In the usual situation, a carrier can use the last injurious exposure rule defensively to shift responsibility to another carrier. See Bracke v. Baza'r, supra, 293 Or at 250. However, in Progress Quarries v. Vaandering, supra, the court held that out-of-state employment could not be considered for purposes of determining responsibility. The court held that "basic overall fairness can be achieved only if application of the rule remains under control of the Oregon workers' compensation system." Progress Quarries v. Vaandering, supra, 80 Or App at 166. Compare Silveira v. Larch Enterprises, supra (out-of-state employment can be considered for purposes of determining compensability).[2] Although the Silveira court distinguished Progress Quarries v. Vaandering, supra, the court did not disavow that case and, in fact, considered its opinion consistent with Vaandering. Silveira v. Larch Enterprises, supra, 133 Or App at 302.

If a worker establishes that disability was caused by disease resulting from causal conditions at two or more places of employment, the last employment providing potentially causal conditions is deemed to have caused the disease. Boise Cascade Corp. v. Starbuck, supra, 296 Or at 241. Here, we cannot consider claimant's California employment for purposes of determining responsibility. See Progress Quarries v. Vaandering, supra. Therefore, we must determine whether the Oregon employment provided "potentially causal" conditions. See Boise Cascade Corp. v. Starbuck, supra; Silveira v. Larch Enterprises, supra, 133 Or App at 302.

---

[2] The dissent asserts that limiting the defensive use of the last injurious exposure rule of liability to only Oregon employers creates a "double standard" because claimant was permitted to also include out-of-state employers in applying the offensive use of the last injurious exposure rule of proof. We disagree with such an assertion. It is well-settled that a claim must first be determined to be compensable before proceeding to an evaluation of which carrier is responsible for that compensable claim. Thus, although the two rules are similarly titled, they have very different uses. As reasoned by the Silveira court, when determining the compensability of the claim under the rule of proof prong of the last injurious exposure rule, all employments are considered (regardless of whether those employments were within the state of Oregon or whether ). On the other hand, once the claim is found compensable, the defensive prong of the last injurious exposure rule limits its application to only those employers who are subject to the Oregon workers' compensation law. As explained by the Vaandering court, since the rule is designed as an arbitary method for assigning responsibility among Oregon subject employers when the actually responsible employer cannot be determined, fairness can only be achieved when only those employers subject to the Oregon workers' compensation system are included under the rule.

Based on claimant's testimony and Dr. Driver's medical reports discussed earlier, we conclude that claimant's Oregon employment was injurious and provided "potentially causal" conditions for his degenerative disc disease condition. Therefore, the Oregon employer is responsible for claimant's condition.

Alternatively, if we assume that the "date of disability" is November 1988, when claimant was employed by the California employer, and we assign presumptive responsibility for claimant's condition to the California employer, we conclude that the medical evidence is sufficient to establish that responsibility for claimant's condition shifted to the Oregon employer. For purposes of this analysis, we assume that claimant can attempt to shift responsibility to SAIF's insured. See Kristin Montgomery, 47 Van Natta 961 (1995) (presumptive responsibility was assigned to a carrier not joined in the litigation and we found that the claimant could attempt to shift responsibility to another "joined" carrier).

In order to shift responsibility to SAIF's insured, the later employment conditions must have "actually contributed to a worsening of the condition." Oregon Boiler Works v. Lott, 115 Or App 70, 74 (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").

Based on the medical evidence discussed earlier, we are persuaded by Dr. Driver's examination and his report, as well as claimant's testimony, that claimant's degenerative disc disease condition worsened in 1990 and 1991, while claimant was working for the Oregon employer.[3] Beginning in December 1990, claimant noticed back pain while driving tractors over frozen ground and rocks. His back pain became so severe that he had to soak in hot water in order to "loosen up" enough to change clothes. In February 1991, Dr. Driver diagnosed claimant with "severe" degenerative disease in the lower lumbar spine.

Under these circumstances, we find that claimant suffered more than a mere increase in symptoms while he was working in Oregon. We conclude that claimant's work activities with the Oregon employer independently contributed to a worsening of his degenerative disc disease. Consequently, responsibility shifts from the California employer to the Oregon employer. See Anne M. Maley, 46 Van Natta 1462 (1994), aff'd Timm v. Maley, 134 Or App 425 (1995).

Claimant has finally prevailed after remand with respect to his low back claim. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. At hearing, the ALJ awarded claimant's counsel an assessed fee of $2,200 for prevailing over SAIF's denial. ORS 656.386(1). We reinstate that award. Inasmuch as we have not disallowed or reduced the compensation awarded by the ALJ, claimant's counsel is entitled to an assessed attorney fee under ORS 656.382(2) for services on Board review. Furthermore, claimant's counsel is entitled to a fee for services before the Court of Appeals for prevailing against our previous decision which upheld SAIF's denial. 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 on Board review, before the Court of Appeals and on remand is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellate briefs), the complexity of the issues, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

---

[3] Although SAIF argues on remand that we have already determined that the medical evidence submitted by claimant is insufficient to establish anything more than a worsening of the symptoms of claimant's low back condition, SAIF's argument is based on an incorrect premise. SAIF apparently assumes that our previous order is the "law of the case." To the contrary, the court has reversed our previous order and remanded for reconsideration. The court did not address claimant's second assignment of error, in which claimant argued that our previous finding that claimant had failed to prove that his Oregon employment was the major contributing cause of his occupational disease was not supported by substantial evidence. In light of the court's reversal, our previous order is a nullity. See Dung T. Nguyen, 44 Van Natta 477 (1992) (order on remand reached different conclusions than the order on review); Nancy C. Evenhus, 42 Van Natta 2625 (1990) (since the court had remanded for the Board to review the remaining issues raised by the denial, no finding within an order had yet become final in the matter).

Accordingly, on reconsideration, the ALJ's order dated August 9, 1991 is affirmed. For services before the court and before the Board on review and remand, claimant's counsel is awarded $3,500, to be paid by SAIF. This attorney fee is in addition to the $2,200 granted by the ALJ's order.

IT IS SO ORDERED.

**Board Members Neidig and Haynes concurring in part and dissenting in part.**

Although we agree with the majority that claimant's degenerative disc disease is compensable, we disagree with the majority's analysis of the responsibility issue. As first explained in Bracke v. Baza'r, 293 Or 239 (1982), the last injurious exposure rule has two different functions: a substantive rule of liability and a rule of proof. As the Court further stated, although generally operating for the benefit of claimants' interests, the 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." 293 Or at 249-50. Thus, the Court went on to 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 they are not assigned disproportionate shares of liability relative to other employers who provide working conditions which generate similar risk." Id. at 250. Subsequent cases more definitively stated that, although employers could not invoke the rule of proof if the claimant established actual causation, the rule of assignment could be asserted as a defense whether or not the claimant chose to prove actual causation. E.g., Spurlock v. International Paper Co., 89 Or App 461, 464-65 (1988).

As discussed by the majority, the court in Progress Quarries v. Vaandering, 80 Or App 160 (1986), considered whether the defensive use of the rule of liability could include out-of-state employment. The court held:

> "The basic overall fairness can be achieved only if application of the rule remains under control of the Oregon workers' compensation system. If the out-of-state employment is considered, the systematic application of the rule breaks down. By reason of the analysis required under the last injurious exposure rule, only if the Oregon employment environment is injurious and a potential cause of the disease can the claimant be entitled to compensation under the rule of proof aspect of the doctrine. An individual employer escapes liability because Oregon has no apportionment provision and because of a policy to award compensation for occupational disability despite a lack of precision in the proof. The doctrine would not be served by requiring this claimant to file a claim in Washington to determine if that state would provide some measure of compensation." 80 Or App at 166.

A different result occurs, however, when the claimant seeks to consider out-of-state employment under the rule of proof. As discussed by the majority, in those cases, notwithstanding Progress Quarries, "for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws." Silveira v. Larch Enterprises, 133 Or App 297, 302-03 (1995).

This disparate treatment by the court of the offensive use of the rule of proof and the defensive use of the rule of liability has created a double standard. On the one hand, Silveira more easily allows the claimant to establish compensability by including all potentially causal employment. In asserting the rule of liability, however, employers are limited to Oregon employment.

Although the last injurious exposure rule is for the benefit of claimants, employers also can assert it in order to promote a consistent and apportionate application. The current state of the law under Silveira and Progress Quarries simply does not carry out this policy. Instead, Oregon employers unfairly can be responsible for claims for which the major contributing cause is out-of-state employment. Such a result simply is not consistent and apportionate. A better approach is to allow both claimant and the employer to consider out-of-state employment when asserting the last injurious exposure rule. We are hopeful that the Supreme Court may someday remedy this situation.

Furthermore, we disagree with the majority's alternative holding that claimant's work activities with the Oregon employer independently contributed to a worsening of his degenerative disc disease. It is not clear from Dr. Driver's July 23, 1991 report (exhibit 15) whether claimant's Oregon work activities actually worsened the degenerative disc disease itself or merely contributed to the symptoms of the disease. Specifically, Dr. Driver's opinion provided only that claimant's heavy work "contributed to" his seeking medical attention in February 1991. Without more, we would conclude that Dr. Driver's statement regarding work "contributing to" claimant's need for medical attention is not sufficient to establish a worsening of the underlying condition. We are not persuaded that Dr. Driver's opinion is sufficient to establish that claimant suffered more than a mere increase in symptoms during his Oregon employment. See Timm v. Maley, 134 Or App 245, 249 (1995); see Bracke v. Baza'r, 293 Or 239, 250 (1982) ("A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer").

Based on the foregoing reasons, we respectfully dissent from the majority's analysis of the responsibility issue.

---



In the Matter of the Compensation of
**DELORES L. HOLMES, Claimant**
WCB Case No. 94-08934
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) declined to award temporary disability benefits beginning July 13, 1992; and (2) declined to assess penalties and attorney fees for the self-insured employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are temporary disability, penalties and attorney fees. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact. In addition, we briefly summarize and supplement the pertinent findings.

In December 1987, claimant sustained compensable injuries to the neck, shoulders, right wrist, low back, and left leg while working for the employer. The claim was closed by Determination Order in July 1988. Thereafter, claimant returned to her at-injury job.

In September 1989, a prior ALJ set aside the employer's denial of claimant's April 1989 aggravation claim. The claim was reclosed by Determination Order in October 1989. Claimant again returned to her at-injury job.

On March 26, 1991, claimant sustained another aggravation. Dr. Erickson, claimant's attending physician, released claimant from work for about two weeks. Erickson returned claimant to her at-injury job in early April 1991. Shortly after claimant returned to work, the employer fired her for "absenteeism." Claimant filed a grievance, seeking her job back. When the employer lost the contract under which claimant was employed, claimant accepted a monetary settlement in lieu of job reinstatement.

In September 1991, another ALJ set aside the employer's denial of claimant's March 1991 aggravation claim; we affirmed that order in May 1992. Claimant's claim remains in open status.

Claimant continued to seek work until her condition further worsened in June 1992. In July 1992, Dr. Erickson notified the employer that claimant's upper back and neck pain had exacerbated. Dr.

Erickson did not, however, reauthorize time loss or otherwise indicate that claimant was incapable of working. Dr. Erickson referred claimant to Dr. Aversano. When diagnostic studies revealed a herniated disc at C6-7 related to claimant's compensable neck condition, surgery was recommended. Claimant must, however, lose a substantial amount of weight before she can undergo such surgery. (In June 1994, another ALJ set aside the employer's denial of a weight loss program for claimant.)

On June 29, 1994, in response to questions posed by claimant's counsel, Dr. Erickson for the first time opined that claimant had been "unemployable" due to her compensable neck condition since July 1992. Based on Dr. Erickson's letter, claimant's counsel requested that the employer resume paying temporary disability benefits. On July 19, 1994, the employer denied that claimant was entitled to such benefits. Claimant requested a hearing.

At the beginning of the hearing, the parties agreed that, inter alia, the issue was "claimant's appeal from the July 19, 1994 denial of time loss benefits . . . from July 13, 1992 forward." (Tr. 1). Noting that claimant's claim remained open, the ALJ reiterated that the issue before her was "not a worsening, but a denial of time loss from July 13, '92 forward." (Tr. 18). Notwithstanding the issue as framed by the parties at hearing, finding that claimant suffered a worsened condition in July 1992, the ALJ first concluded that claimant had suffered an aggravation in July 1992. Finding, however, that claimant was not in the work force at the time of the July 1992 "aggravation," the ALJ further concluded that claimant was not entitled to temporary disability benefits. This appeal by claimant followed.

## CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that she is entitled to temporary disability benefits from July 13, 1992 through the present. For the reasons discussed below, we agree that claimant is entitled to temporary disability benefits, but only after Dr. Erickson authorized time loss by confirming that claimant was again unable to work.[1]

The employer properly terminated claimant's TTD after Dr. Erickson again released claimant to return to her at-injury job in early April 1991. Dr. Erickson did not, in July 1992, reauthorize claimant's release from work. A worker whose temporary disability has been properly terminated becomes procedurally entitled to resumption of temporary total disability payment if, prior to claim closure, the attending physician again authorizes time loss. See former OAR 436-60-030(4)(a), (6)(a). A claimant's procedural entitlement to temporary disability for all periods of time during an open claim is contingent upon authorization of temporary disability by the attending physician. Effective June 7, 1995,[2] Section 28 of Senate Bill 369, 68th Leg., Reg. Sess. (1995) (SB 369), amended ORS 656.262(4)(f) 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."

---

[1] We note that the question presented is not whether claimant sustained a compensable aggravation in July 1992. In September 1991, a prior ALJ set aside the employer's denial of claimant's March 1991 aggravation claim. This Board affirmed the ALJ's order in May 1992. Claimant's March 1991 aggravation claim has never been closed. Because claimant's claim is in open status, the issue is not whether claimant was in the work force at the time of the July 1992 "aggravation" but, rather, claimant's entitlement to temporary disability. See Jack J. Ford, Jr., 44 Van Natta 1493 (1992) (aggravation is only an issue after a valid claim closure has been accomplished).

[2] Amended ORS 656.262(4)(f) applies to all claims or causes of action existing or arising on or after the effective date of the act. SB 369, § 66; see Volk v. America West Airlines, 135 Or App 565 (1995). 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).

Here, on June 29, 1994, attending physician Erickson reported that claimant was "unemployable" due to her compensable neck condition. Therefore, we find that Dr. Erickson authorized temporary disability during the period in question by confirming claimant's injury-related inability to work. There is no evidence Dr. Erickson "ceased" such authorization after that date. Accordingly, pursuant to amended ORS 656.262(4)(f), claimant is entitled to the reinstatement of temporary disability benefits.

The employer did not, however, receive notice sufficient to require it to resume paying temporary disability benefits prior to the date of Dr. Erickson's June 1994 letter. Thus, inasmuch as Dr. Erickson indicated that claimant was disabled as of July 1992, claimant's entitlement to temporary disability benefits began on June 15, 1994, 14 days prior to June 29, 1994, the date Dr. Erickson again authorized the payment of temporary disability. Amended ORS 656.262(4)(f). Consequently, we conclude that claimant is entitled to temporary disability benefits from June 15, 1994 until termination is authorized by law (see amended ORS 656.268(3)).

Claimant also seeks a penalty for the employer's allegedly unreasonable resistance to the payment of compensation. Claimant is entitled to a penalty up to 25 percent of the amounts due if the employer unreasonably refused to pay compensation. Amended ORS 656.262(11)(a) (formerly ORS 656.262(10)(a)). Because the employer was required to immediately reinstitute the payment of temporary disability compensation when claimant's attending physician again authorized time loss, we conclude that the employer unreasonably resisted the payment of compensation. See former OAR 436-60-030(4)(a), (6)(a); see also Rodgers v. Weyerhaeuser Company, 88 Or App 458, 460 (1987); Robert D. Gudge, 42 Van Natta 812 (1990).

Accordingly, finding no basis for termination of benefits prior to the date of hearing, we assess a 25 percent penalty based on the temporary disability benefits due from June 15, 1994 through October 18, 1994, the date of hearing. See Warren D. Battle, 45 Van Natta 1169 (1993). Such penalty is to be shared equally by claimant and her attorney. Amended ORS 656.262(11)(a).

Finally, claimant seeks an assessed attorney fee for her counsel's services at hearing and on review. 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 the employer's failure to pay temporary disability benefits. The employer did not deny the compensability of claimant's condition or medical services. 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).[3] Short v. SAIF, supra.

Although claimant's counsel is not entitled to an assessed attorney fee on the temporary disability issue, we conclude that he is entitled to an out-of-compensation attorney fee under amended ORS 656.386(2). SB 369, § 43(2).[4] Accordingly, we approve an attorney fee equal to 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel.

## ORDER

The ALJ's order dated November 17, 1994 is reversed. Claimant is awarded temporary disability benefits from June 15, 1994 until termination of such benefits is authorized by law. Claimant's counsel is awarded 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly by the employer to claimant's attorney. Claimant is also awarded a 25 percent penalty based on the temporary disability benefits due from June 15, 1994 through October 18, 1994, the date of hearing, to be shared equally by claimant and her attorney.

---

[3] ORS 656.386(1) was amended by SB 369. Or Laws 1995 ch. 332 § 43(1) (SB 369, § 43(1)). However, claimant is not entitled to an assessed attorney fee under either version of the statute.

[4] Amended ORS 656.386(2) is substantially identical to former ORS 656.386(2).

**Member Hall dissenting.**

I have previously expressed my concerns regarding the retroactive application of statutory amendments which implement additional procedural requirements which were not otherwise in existence at the relevant time. See Mark E. Cooper, 47 Van Natta 2223 (1995) (Member Hall concurring in part and dissenting in part). I submit that the retroactive application of such statutes is simply absurd and unjust.

Here, the majority retroactively applies amended ORS 656.262(4)(f) and finds that claimant's attending physician's retroactive authorization of temporary disability is limited to 14 days from its issuance rather than the two-year period advanced by the physician's authorization. Since such a retroactive authorization was neither prohibited when the physician issued the authorization nor at the time to which the authorization was effective, I submit that it would be absurd and unjust to require claimant to comply with the retroactive requirement of amended ORS 656.262(4)(f).

Because I consider the attending physician's report of claimant's "unemployab[ility]" sufficient to constitute an authorization for temporary disability, I would award claimant temporary disability retroactive to the July 1992 date noted in the physician's report. Consequently, I respectfully dissent.

---

December 13, 1995 Cite as 47 Van Natta 2362 (1995)

In the Matter of the Compensation of
**ROBIN L. JONES, Claimant**
WCB Case No. 94-14963
ORDER ON RECONSIDERATION
Philip H. Garrow, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Claimant requests reconsideration of our November 15, 1995 order that affirmed the Administrative Law Judge's (ALJ) order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a right wrist condition. On reconsideration, claimant asserts that we erred in concluding that claimant failed to establish compensability of her occupational disease claim.

Claimant filed a claim with SAIF alleging that her work activities driving a bus for SAIF's insured caused her right wrist condition. Claimant implicated a specific bus, bus number 74, as the cause of her condition. SAIF issued a denial of the claim which denied that claimant's work activity for its insured was the major contributing cause of her right wrist condition. Claimant requested a hearing on the denial.

At hearing, claimant challenged SAIF's denial of her occupational disease claim. Claimant alleged that her work activities as a bus driver at SAIF's insured were the major contributing cause of her right wrist condition. Claimant relied on the medical opinion of Dr. Thayer, her treating physician. In our original order, we concluded that Dr. Thayer had an incorrect history regarding claimant's prior employment as a baker which involved hand-intensive activities. On this basis, we found Dr. Thayer's opinion unpersuasive and upheld SAIF's denial of claimant's claim.

On reconsideration, claimant contends that there are no off-work exposures identified as contributing to her right wrist condition. On this basis, claimant asserts that she has established that her right wrist condition is compensable. Claimant further asserts that our order improperly addressed the issue of responsibility.

Claimant apparently believes that our order found claimant's claim to be work-related because we found Dr. Thayer's opinion unpersuasive on the basis that he lacked a history of claimant's hand-intensive employment at a prior employment. The flaw in claimant's argument is that her claim alleges that her work activities at SAIF's insured caused her right wrist condition. Claimant did not assert that her condition was caused by her work activities at another employer. As we concluded in our initial order, claimant's claim is not compensable against SAIF's insured. The issue of responsibility is not before us. The issue before us on Board review was whether claimant's work activities as a bus driver

at SAIF's insured were the major contributing cause of her right wrist condition. We have concluded that claimant's work activities at SAIF's insured were not the major contributing cause of her right wrist condition. If claimant believes that her work activities at another employer caused her condition, she could have raised that issue at hearing. She did not.

Accordingly, our November 15, 1995 order is withdrawn. As supplemented herein, we adhere to and republish our November 15, 1995 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---

December 13, 1995 Cite as 47 Van Natta 2363 (1995)

In the Matter of the Compensation of
**STEPHEN M. SNYDER, Claimant**
WCB Case No. 94-02568
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order which: (1) affirmed an Order on Reconsideration that awarded 8 percent (25.6 degrees) unscheduled permanent disability for a low back condition; (2) affirmed the Order on Reconsideration's temporary partial disability (TPD) award; and (3) assessed a penalty for allegedly unreasonable claim processing. In its brief, the employer contends that the ALJ erred by not admitting a "post-reconsideration" report from claimant's treating physician. On review, the issues are evidence, extent of unscheduled permanent disability, temporary disability, and penalties. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, but not the Findings of Ultimate Fact. In addition, we offer the following summary of pertinent findings and procedural history.

Claimant was compensably injured on December 2, 1992. At the time of injury, claimant was working part-time, earning $7.00 an hour.

Claimant left work at 11 a.m. on December 2, 1992. Dr. Matteri, treating surgeon, began treating claimant on December 4, 1992. On that date, Dr. Matteri released claimant to "sit down work only." The employer first knew of claimant's injury claim on December 4, 1992.

Claimant returned to work at a modified job on January 14, 1993. He worked five hours a day, two days a week. Claimant was paid his at-injury wage of $7.00 an hour.

By letter dated March 4, 1993, the employer accepted the claim as disabling. The employer had not paid temporary disability benefits (interim compensation) from the time claimant left work on December 2, 1992. On March 30, 1993, the employer terminated claimant from the modified job for reasons unrelated to the work injury. Claimant remained released for modified work only. The employer did not pay TPD after claimant was terminated from modified work.

Claimant requested a hearing. The ALJ, citing Safeway v. Owsley, 91 Or App 475 (1988), reasoned that claimant was entitled only to the amount of temporary disability compensation that he would have received if his employment had not been terminated. Because the modified work paid $7.00 an hour, the same hourly rate as the job at-injury, the ALJ concluded that that amount was zero.

Claimant appealed to the Board. Noting that subsequent to the ALJ's decision, the court issued Stone v. Whittier Wood Products, 124 Or App 117 (1993), we remanded to the ALJ. Stephen M. Snyder, 46 Van Natta 1201 (1994). In our original order, we instructed the ALJ to take evidence concerning claimant's proportionate loss of earning power at any kind of work, and to consider the effects, if any, of the Director's "post-Stone" rules on the interim compensation and TPD issues.

The ALJ convened a second hearing to receive written and testimonial evidence. On remand, the ALJ found that, although the administrative rules in WCD Admin. Order No. 94-055 do not expressly apply, those rules nevertheless embody the court's directive in Stone v. Whittier Wood Products, supra, and thus serve as useful guidelines for resolving TPD disputes. On the supplemented record, the ALJ concluded therefore that claimant's post-injury earning power was diminished, entitling him to TPD after he was terminated from modified work on March 30, 1993. The employer requested review, and claimant cross-requested review of the prior ALJ's order. That prior order was on review before the Board when claimant requested a hearing in this case.

On September 23, 1993, Dr. Matteri found claimant medically stationary without permanent impairment. An October 19, 1993 Notice of Closure, as corrected October 25, 1993, awarded temporary total disability from June 7, 1993 through June 28, 1993, and temporary partial disability from December 5, 1992 through June 6, 1993, and June 29, 1993 through September 23, 1993. The Notice of Closure did not award unscheduled permanent disability.

Claimant requested reconsideration. A medical arbiter's exam was performed on January 28, 1994. On February 16, 1994, an Order on Reconsideration affirmed the Notice of Closure with respect to the temporary disability award, but also awarded 8 percent unscheduled permanent disability for loss of range of motion in the lumbar spine.

Subsequent to the Order on Reconsideration, the employer sought, and received, a report from Dr. Matteri concerning the relationship of claimant's low back impairment to his accepted injury.

## CONCLUSIONS OF LAW AND OPINION

### Evidence

Relying on ORS 656.268(7), the ALJ declined to admit into evidence a "post-reconsideration" report from Dr. Matteri, claimant's treating physician. On review, the employer contends that the report addressed the causal relationship between claimant's compensable injury and his impairment, and therefore the report was admissible. We disagree.

Subsequent to the ALJ's order, we addressed a related evidentiary issue in David B. Weirich, 47 Van Natta 478 (1995). In Weirich, we disavowed our holding in Frank H. Knott, 46 Van Natta 364 (1994). Specifically, we held that a "post-medical arbiter" report, even if it solely concerns causation, falls within the "no subsequent medical evidence" limitation set forth in ORS 656.268(7).[1] We reasoned that this approach is consistent with the intent of the legislature to avoid "dueling doctors" and provide a "bright-line" for parties litigating extent of permanent disability issues. See ORS 656.268( 7); see also, Daniel L. Bourgo, 46 Van Natta 2505 (1994) (holding that " supplemental" medical arbiter reports are not admissible except where the Department or the arbiter indicate that the initial report was incomplete). Accordingly, we conclude that the ALJ properly excluded the "post-reconsideration" report.

### Temporary Disability

At hearing, claimant contended that he had been awarded temporary disability benefits by the Notice of Closure and Order on Reconsideration, but that those benefits had not yet been paid. The employer argues that claimant is not entitled to temporary partial disability benefits (TPD) after he was terminated from modified work because he failed to prove an actual loss of earning capacity as a result of the compensable injury. The employer further argues that claimant is not entitled to temporary disability benefits while the previous ALJ's order is on Board review.

---

[1] Subsequent to the ALJ's order, the Legislature amended ORS 656.268. Or Laws 1995, ch 332, § 30 (SB 369, § 30). Nevertheless, under either version of the statute, our decision would remain the same.

The ALJ concluded that the prior ALJ's order addressed only procedural entitlement to temporary disability benefits because claimant's claim was still open, whereas now it was appropriate to address substantive entitlement to temporary disability benefits. Furthermore, because the employer had failed to request reconsideration of the time loss granted by the Notice of Closure, the ALJ determined that a different award could not be granted.

Accordingly, the ALJ ordered the employer to pay the temporary disability benefits, and to compute the award in accordance with Stone v. Whittier Wood Products, 124 Or App 177 (1993). Additionally, the ALJ assessed a penalty for the employer's unreasonable failure to pay temporary disability benefits.

Subsequently, we issued our Order on Review of the previous ALJ's order. We found that claimant was entitled to interim compensation (in the form of temporary disability) through March 4, 1993 (the date of the employer's acceptance), and that claimant was entitled to temporary disability benefits from March 4, 1993 through June 6, 1993, and from June 29, 1993 through September 23, 1993. See Stephen M. Snyder, 47 Van Natta 1956 (1995). Here, because the issue involves entitlement to temporary disability benefits for the same periods of time, we affirm the ALJ's opinion awarding claimant temporary disability benefits for the period in question. Stephen M. Snyder, supra.

Subsequent to the ALJ's order, the legislature enacted Senate Bill 369, amending ORS 656.212. Or Laws 1995, ch 332, § 16. (SB 369, § 16). ORS 656.212(2) provides that TPD is calculated based on a comparison of claimant's wages at modified employment and his at-injury wages. Here, claimant's wages at modified work were the same as his wages at the time of injury. Therefore, a calculation of claimant's TPD equals zero under amended ORS 656.212(2). Inasmuch as there is no compensation "then due" on which to base a penalty under amended ORS 656.262(11), we reverse the ALJ's penalty assessment.

Furthermore, we disagree with the ALJ's reasoning that a penalty was due because the employer did not pay temporary disability benefits during the pendency of the prior appeal. We have previously held that a carrier's appeal of a prior order awarding compensation stays payment of those benefits that are subject to the appeal. Shannon K. Hartshorn, 46 Van Natta 18 (1994). Here, because all of the benefits awarded by the Notice of Closure were subject to the employer's appeal of the prior ALJ's order, the employer's appeal stayed payment of all benefits awarded by the Notice of Closure.

Permanent Disability

The October 19, 1993 Notice of Closure, as corrected October 25, 1993, did not award unscheduled permanent disability. Nevertheless, on reconsideration, claimant was awarded 8 percent (25.6 degrees) unscheduled permanent disability based on loss of range of motion impairment in his low back. The ALJ affirmed the Order on Reconsideration.

The employer contends that claimant is not entitled to an award of unscheduled permanent disability because the closing evaluation by Dr. Matteri did not address claimant's low back. Furthermore, claimant did not receive treatment or make any low back complaint, following his December 2, 1992 injury, between December 16, 1992 and the January 28, 1994 medical arbiter's report, when the arbiters reported slight loss of range of motion in claimant's low back. Thus, the employer contends that any low back impairment measured by the medical arbiters is not related to claimant's December 1992 accepted injury. We agree.

OAR 436-35-007(9) provides that impairment is determined by the attending physician, or by the medical arbiter when one is used, "except where a preponderance of medical opinion establishes a different level of impairment." We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994).

Here, claimant began treating with Dr. Matteri two days after his December 1992 injury. In his initial report, Dr. Matteri noted that claimant had back pain that came on gradually by the evening of the injury. (Ex. 20-1). On December 10, 1992, Dr. Matteri noted that claimant's back was still bothering

him, and that claimant would have x-rays. On December 16, 1992, Dr. Matteri noted "symptoms of a lumbar strain phenomena." Following Dr. Matteri's December 16, 1992 examination, however, the record contains no further reference to claimant's low back until the January 1994 arbiter's report. (See Ex. 41).

Moreover, in September 1993, claimant was specifically instructed by the carrier to see Dr. Matteri for a final evaluation. (Ex. 32-4). In his examination, Dr. Matteri noted normal range of motion in the right knee. He also stated that claimant had no limitations as the result of the injury. Id. Dr. Matteri made no reference to claimant's back.

The medical arbiters examined claimant on January 28, 1994. (Ex. 41). They noted that claimant had had low back pain right after his December 1992 injury, but that it did not require treatment. (Ex. 41-2). Claimant reported to the arbiters that he currently had some low back pain when sleeping.

The arbiter's lumbosacral range of motion measurements indicated slight loss of range of lumbar motion. (See e.g., Ex. 42-4). Nevertheless, they stated that, "based on the examination and other objective findings, [claimant] has lost 10 degrees of active flexion of the right knee[,] but otherwise has no objective abnormality." (Ex. 41-4) (emphasis added). Notwithstanding the arbiters' statement, the Order on Reconsideration granted unscheduled permanent disability based on the arbiters' range of motion findings.

Based on the aforementioned medical opinions, we are not persuaded that claimant sustained permanent impairment in his low back as a result of his compensable injury, particularly in light of Dr. Matteri's failure to address claimant's low back during his closing evaluation, and in light of the arbiters' reference to no objective findings. Consequently, we conclude that claimant is not entitled to an award of unscheduled permanent disability.

After affirming the Order on Reconsideration in response to employer's hearing request, the ALJ awarded a $650 attorney fee under ORS 656.382(2). Inasmuch as we have reversed claimant's permanent disability award, it follows that claimant's compensation has been "disallowed or reduced." Consequently, claimant is not entitled to the ALJ's attorney fee award pursuant to ORS 656.382(2).

## ORDER

The ALJ's order dated January 24, 1995 is reversed in part and affirmed in part. That portion of the order that affirmed the Order on Reconsideration's unscheduled permanent disability award is reversed. The Notice of Closure is reinstated and affirmed. The ALJ's $650 attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
**JAMES G. HARRIS, Deceased, Claimant**
WCB Case No. 93-11005
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Christian and Neidig.

Claimant[1] requests review of Administrative Law Judge (ALJ) Mills' order that: (1) upheld the self-insured employer's denial of death benefits; and (2) declined to award a penalty and attorney fee for allegedly untimely discovery. On review, the issues are compensability, penalties and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the last sentence of the first full paragraph on page 3. We modify the finding of ultimate fact to read as follows.

Claimant suffered a sudden death unrelated to his work.

## CONCLUSIONS OF LAW AND OPINION

Claimant, a long-haul truck driver, experienced sudden cardiac arrest and died while he was in the process of securing his load subsequent to unloading freight. No autopsy was performed to establish the exact mechanism of heart stoppage. The coroner's report attributed the cause of death to a myocardial infarction (heart attack). Claimant had high blood pressure that was controlled by medication. He had not been diagnosed with CAD or other heart disease. During the week prior to his death, he experienced an attack of food poisoning. The day before his death, he had complained to a co-worker about chest pain. The next morning, claimant did not feel well. He unloaded freight at two destinations prior to arriving at the Montana destination where he died. The manager at that destination noted that claimant showed no signs of distress while unloading or during the time between unloading and the incident.

The ALJ, applying the major contributing cause standard, found that the cause of death was ventricular fibrillation (VF) and concluded that claimant's work activity was not the major contributing cause of the VF condition. The ALJ upheld the employer's denial of death benefits to claimant's widow.

Claimant argues that there was no preexisting heart condition and that the other factors considered in the medical opinions (a family history of heart disease, claimant's personal history of cigarette smoking, high blood pressure, and an episode of food poisoning and its aftermath) were predispositions, not preexisting conditions. Thus, claimant contends, the proper burden of proof should be material, rather than major, contributing cause. Assuming rather than deciding that material contributing cause is the proper standard of proof, we conclude that claimant has nevertheless failed to establish the compensability of the claim.

Here, claimant had high blood pressure and had recently experienced severe food poisoning. The day before he died, he complained of chest pain. He also had risk factors for heart disease: a family history of heart disease and a history of smoking. (Ex. 22). Drs. Schutz and Rogers hypothesized that claimant probably had preexisting CAD or other heart disease, based on the risk factors and incident of chest pain. (Exs. 17-1, 25-12; Tr. 32).

However, there is disagreement among the doctors as to whether any of these conditions were actually involved in claimant's death. (See Exs. 14,16, 17, 19, 22, 25 and 27; Tr. 28, 32). We need not decide this matter, however, as the persuasive medical evidence indicates that under either a major or material cause standard, claimant fails to carry his burden to prove the compensability of the claim by a preponderance of the evidence. See ORS 656.266.

---

[1] Although we use the term "claimant" in reference to James G. Harris, the decedent, it is for ease of reference. The actual claimant is his widow, the potential beneficiary of his estate.

Dr. Gray, M.D., is claimant's attending physician. He is not a cardiologist. We ordinarily give great weight to the opinion of the attending physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons to do otherwise. No autopsy was performed that would definitively establish the cause of death. Due to the number of potential causes of claimant's sudden cardiac arrest and death, the causation issue is a complex medical question and resolution of the issue must be established by medical experts. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Consequently, we consider the opinions of Drs. Semler, cardiologist; Rogers, cardiovascular physician; Sutherland, cardiologist; and Schutz, cardiologist.

Dr. Schutz based his opinion that claimant's cardiac arrest was the result of his work on unsubstantiated assumptions that claimant had an electrolyte imbalance from the episode of food poisoning and that his work activities consisted of an excessive degree of exertion. Dr. Schutz then hypothesized a relationship between exertion, myocardial infarction and ventricular fibrillation, based on statistical studies. We do not find his opinion persuasive. Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

In contrast, Drs. Semler, Rogers, and Sutherland each persuasively concluded that claimant's death was not related to his work. (Compare Exs. 17, 18, 19, and 27 with Ex. 25 and Tr. 28, 32, 68 and 69). Each doctor eliminated food poisoning as having any relationship to claimant's sudden death. Each doctor also concluded that the exertion involved in claimant's work shortly before his death was not a likely cause of his death, based on the facts that claimant's work was usual for him and that there was an absence of symptoms or physical complaints either while unloading or thereafter. (Exs. 17, 18 and 19). Consequently, whether the burden of proof is material or major contributing cause, claimant has failed to establish, by a preponderance of the evidence, that the cardiac arrest and death were due to work.

Claimant next argues entitlement to a penalty for the employer's processing agent's failure to provide timely discovery. Here, however, even though the record establishes the occurrence of a discovery violation, the underlying claim is not compensable. Thus, there has been no unreasonable resistance to the payment of compensation. Under such circumstances, claimant is not entitled to a penalty pursuant to ORS 656.262(11) (formerly ORS 656.262(10)). Boehr v. Mid Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991).

ORDER

The ALJ's order dated June 16, 1994 is affirmed.

---

December 14, 1995 Cite as 47 Van Natta 2368 (1995)

In the Matter of the Compensation of
**DEANNA L. KLOCK, Claimant**
WCB Case No. 94-08902
ORDER OF ABATEMENT
Whitehead & Klosterman, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer requests reconsideration of our November 15, 1995 order that awarded temporary partial disability and assessed a penalty for unreasonable claim processing. Contending that we erroneously found that it had not challenged claimant's right to the resumption of temporary disability and, alternatively, asserting that we were necessarily obligated to address such entitlement, the insurer argues that its termination of claimant's temporary disability upon her return to work was reasonable and proper.

In order to further consider this matter, we withdraw our November 15, 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 proceed with our reconsideration.

IT IS SO ORDERED.

---

In the Matter of the Compensation of
**JAMES A. MARTIN, Claimant**
WCB Case Nos. 93-10717 & 93-10947
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) upheld the SAIF Corporation's responsibility denial, on behalf of Pierce Professional Temporary, of his "new injury" claim for a low back condition; and (2) declined to award claimant's counsel an assessed attorney fee for services rendered regarding SAIF/Pierce's concession of compensability of claimant's low back condition. On review, the issues are responsibility and attorney fees.

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

ORDER

The ALJ's order dated October 3, 1994, as reconsidered October 20, 1994, is affirmed.

---

[1] Subsequent to the ALJ's order, the Legislature enacted Senate Bill 369 which amended numerous portions of 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. Assuming the amendments to ORS 656.005(7)(a)(B) are applicable to this case, the result would not change since we agree with the ALJ that on this record, claimant has not established that his compensable injury is the major contributing cause of his resultant condition or need for treatment for that condition. This statement is not designed to suggest that "resultant condition" is necessarily considered to be synonymous with "combined condition." Rather, the statement is intended to convey its literal meaning; i.e., under either version of the statute, claimant did not suffer a "new compensable injury."

**Board Member Hall specially concurring.**

I agree that the medical evidence in this case does not establish that claimant sustained a new compensable injury under ORS 656.308(1) and amended ORS 656.005(7)(a)(B) and that responsibility for claimant's current condition remains with SAIF, on behalf of claimant's prior employer, Crown Zellerbach. See SAIF v. Drews, 318 Or 1 (1993). I write separately, however, to note my concern with the comment set forth in footnote 1 of the order.

In footnote 1, we indicate that under either version of ORS 656.005(7)(a)(B), claimant has not established that his June 15, 1994 compensable injury is the major contributing cause of his resultant condition or need for treatment for that condition. The problem is that amended ORS 656.005(7)(a)(B) no longer contains the term "resultant condition."[2] The statute now provides that the "combined condition" is compensable only if the "otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

In construing legislative amendments, it is presumed that material changes in language create material changes in meaning. See Fifth Avenue Corp. v. Washington Co., 282 Or 591, 597 (1978). Because the legislature saw fit to change the term "resultant condition" to "combined condition" in amended ORS 656.005(7)(a)(B), I must presume that this new term has a different meaning than the former term. However, the text of the statute does not provide insight into the meaning of this new term or the legislature's intent in making this particular change.

---

[2] Former ORS 656.005(7)(a)(B) provided, in pertinent part, that 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."

The legislative history of SB 369, on the other hand, reflects the legislature's desire to change terms because the prior use of "resultant" in ORS 656.005(7)(a)(B) seemed to be "confusing." I can also glean from the legislative history that the term "combined" was chosen to describe the situation in which a work-related injury or disease combines with a preexisting condition and is thus distinguishable from a "consequential" condition. Unfortunately, this legislative history does not make our interpretation of the term "combined condition" any easier than our former interpretation of the term "resultant condition."

Because I can foresee situations in which a worker's preexisting condition is compounded by a compensable injury to create a compensable "resultant condition," which may not necessarily be a "combined condition," I am troubled by the broad language used by the majority in footnote 1. For example, in this case, if the medical evidence had persuasively established that claimant's pseudoarthritis and/or need for refusion were caused in major part by the June 15, 1994 incident at Pierce rather than claimant's preexisting back condition, then claimant would have had a compensable "resultant condition" under former ORS 656.005(7)(a)(B) and, therefore, a "new compensable injury" under ORS 656.308(1). SAIF v. Drews, supra. However, given the amendments to ORS 656.005(7)(a)(B) and omission of the term "resultant condition," I am not convinced that (had claimant's current condition been proven to be causally related to the June 15, 1994 incident) his current condition would necessarily constitute a compensable "combined condition" under amended ORS 656.005(7)(a)(B). In other words, there may well be a difference between a claim seeking compensation for a condition which results from the combining of an injury and a preexisting condition versus a claim for the combined condition itself. Footnote 1 unnecessarily, and perhaps improperly, implies that the terms "combined condition" and "resultant condition" are synonymous.

In short, while it is not a problem in this case because I agree that claimant has failed to prove a "new" compensable injury under ORS 656.005(7)(a)(B), I do see the potential for different outcomes under the new law, depending upon whether the condition is framed as a "resultant" or "combined" condition.

---

December 14, 1995 Cite as 47 Van Natta 2370 (1995)

In the Matter of the Compensation of
**DURWOOD McDOWELL, Claimant**
Own Motion No. 95-0527M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our November 2, 1995 Own Motion Order, in which we authorized the reopening of claimant's claim for the payment of temporary disability benefits beginning May 20, 1995, the date he was hospitalized for treatment of the compensable injury.

SAIF contends that claimant's compensable condition did not worsen, but that he was hospitalized as a result of a "waxing and waning" of his symptoms. On November 8, 1995, we abated our order. Claimant has not responded to the motion. However, we have received SAIF's response, and 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.

SAIF contends that claimant's hospitalization from May 20, 1995 until his release on May 22, 1995, does not, in itself, prove a worsening of the compensable injury. We disagree. In his May 22, 1995 discharge diagnosis, Dr. Siebe, claimant's consulting physician, opined that claimant's "back pain got so bad that it couldn't be managed as an OP (out-patient)." In an August 1, 1995 letter, Dr. Euhus, claimant's treating physician, opined that "[claimant] was having unmanagable [sic] pain that was not responding as an outpatient."

In his August 1, 1995 letter, Dr. Euhus opined that "I think [claimant] is just living with [the pain] and has not had a major exacerbation." SAIF likens Dr. Euhus' opinion that claimant had not suffered "a major exacerbation" to a "waxing and waning" of the symptoms of claimant's compensable condition. However, Dr. Euhus opined that claimant had not suffered a major exacerbation, which persuades us that he did have, after all, an exacerbation of undetermined degree of his compensable condition. In addition, both Dr. Siebe and Dr. Euhus opined that claimant's condition at that time could not be managed as an outpatient, and "there just wasn't really anything else to do" other than to give claimant "intensive analgesic [and] maybe we could get this syndrome under control" (see Discharge Summary of 5-22-95). Therefore, we do not agree with SAIF's argument that Dr. Euhus' opinion that claimant had not suffered a major exacerbation to be tantamount to a "waxing and waning" of symptoms. To the contrary, we are persuaded that claimant's condition worsened to the extent that it could only be managed by treating the compensable condition during inpatient hospitalization.

Finally, we note that claimant was not hospitalized merely for diagnostic purposes (see Everett G. Wells, 47 Van Natta 1634 (1995); Phillip E. Hager, 43 Van Natta 2291 (1991)), nor was claimant treated in an emergency room and released (see Roger D. Jobe, 41 Van Natta 1506 (1989)). In his May 20, 1995 admitting record, Dr. Siebe opined that claimant was admitted to the hospital for "evaluation and treatment of lower back discomfort and muscle spasms." Because Dr. Siebe "treated" claimant's condition with the objective of trying "to control his pain," we differentiate this treatment from diagnostic evaluation, as Dr. Siebe's major objective was to get claimant's compensable condition under control, rather than to evaluate it.

On this record, we conclude that claimant's compensable injury worsened requiring inpatient hospitalization on May 20, 1995.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 2, 1995 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

---

December 14, 1995 Cite as 47 Van Natta 2371 (1995)

In the Matter of the Compensation of
**CARMEN C. NEILL, Claimant**
WCB Case No. 93-04858
ORDER ON RECONSIDERATION (REMANDING)
Bischoff & Strooband, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members en banc.

On June 29, 1995, we abated our June 7, 1995 order that directed the self-insured employer to reclassify claimant's neck and left shoulder injury claim as disabling. We took this action to consider claimant's and the self-insured employer's motions for reconsideration. Having received responses from both claimant and the employer, we proceed with our reconsideration and replace our prior order with the following order.

## FINDINGS OF FACT

We adopt the "Finding of Fact" as set forth in the Administrative Law Judge's (ALJ) order.

## CONCLUSIONS OF LAW AND OPINION

### Reclassification

Finding that claimant had sustained a compensable aggravation, the ALJ concluded that the reclassification issue was moot. We disagree.

Pursuant to ORS 656.277, a claimant has one year, from the date of injury, in which to seek reclassification of his or her claim. See Donald R. Dodgin, 45 Van Natta 1642 (1993). If a request for reclassification is not made within the one year time period, the claim cannot be reclassified and a claimant must make a claim for aggravation pursuant to ORS 656.273. ORS 656.277(1) and (2); Charles B. Tyler, 45 Van Natta 972 (1992). However, claimant must be notified of the classification of the claim, as well as the right to challenge that classification, within a sufficient time period that would allow the status of the claim to be challenged. ORS 656.262(6)(b) & (c); Degrauw v. Columbia Knit, Inc., 118 Or App 277 (1993).

Here, claimant sustained a neck and left shoulder injury on December 15, 1989. The injury was accepted by the employer by letter dated February 2, 1990, which informed claimant that her claim was nondisabling. (Ex. 2). However, the letter did not provide claimant with notice of her right to seek reclassification of her claim within one year of the date of injury as required by ORS 656.262(6). In fact, claimant was not informed of her right to object to her claim classification until the employer issued its June 7, 1993 Notice of Acceptance following ALJ Brown's Opinion and Order. (Exs. 33, 34).

At the time the employer accepted claimant's claim, former ORS 656.262(6)(b) (renumbered 656.262(6)(c)) provided that a notice of acceptance "shall: Inform the claimant of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries, including the right to object to a decision that the injury is nondisabling by requesting a determination thereon pursuant to ORS 656.268."

As noted above, the employer's acceptance did not conform with former ORS 656.262(6)(b) and therefore claimant was not informed that she could challenge the classification of her claim. Given the mandatory language of the provision, we conclude that a carrier's failure to comply with the provision has the effect of precluding a claimant, through no fault of her own, from seeking reclassification within the statutory time period. Consequently, since an objection to claim classification is a matter "concerning a claim," ORS 656.283(1) allows claimant the opportunity to object to her claim classification. Dodgin, supra, 45 Van Natta at 1645. Therefore, the Hearings Division has authority to entertain claimant's objection to her initial claim classification.[1] We now turn to the merits of claimant's request for reclassification.

At the outset, the employer argues that claimant is precluded from objecting to her claim classification, because that issue was raisable at the time of the prior litigation before ALJ Brown. We disagree.

The issues before ALJ Brown were compensability of claimant's then-current condition and penalties. The status of claimant's claim classification was not at issue. Moreover, the first time that claimant was notified that she could object to her claim classification was the employer's June 7, 1993 letter of acceptance which was issued approximately 1 1/2 months after the hearing before ALJ Brown. Under these circumstances, we conclude that the issue was not properly raisable at the time of the litigation before ALJ Brown. Therefore, the prior litigation does not preclude claimant from now raising the issue of claim classification.

In Sharman R. Crowell, 46 Van Natta 1728 (1994), 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).

---

[1] The employer contends that amended ORS 656.319(6) precludes claimant's request for hearing concerning the classification of her claim. That statute provides that a "hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction." See Or Laws 1995, ch 332, (SB 369, § 39). It is questionable whether that provision applies to the issue of claim classification. However, given our conclusion below that claimant's claim was properly classified as nondisabling, we need not reach this issue.

Subsequent to our prior order (which did not become final), effective June 7, 1995, the legislature enacted Senate Bill 369, amending ORS 656.005(7)(c).[2] 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."[3]

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. We specifically found, in light of the statutory language providing that an injury is not "disabling" if no temporary 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 benefits or a reasonable expectation of permanent disability.

Here, claimant was released to, and worked, modified employment. However, there is no evidence that claimant was paid less than her normal wage which would have entitled her to temporary disability.[4] 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). While Dr. Vranna did indicate that claimant's may suffer periodic flare-ups, no permanent impairment was indicated and claimant returned to her regular work by January 30, 1990. (Ex. 3, 4). In view of Dr. Vranna's reports, 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.

In light of this conclusion, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991). Consequently, neither a penalty or related attorney fee is warranted.

Aggravation

The ALJ found that claimant had sustained a compensable aggravation. In our prior order, we did not address this issue in light of our conclusion that claimant's claim should be reclassified. Inasmuch as we have herein concluded that claimant's claim was properly classified, we now address the aggravation issue. For the following reasons, we conclude that this portion of the ALJ's order should be vacated and this matter remanded for further development.

Former ORS 656.273(1) provided:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings." (Emphasis supplied).

---

[2] 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).

[3] In her response to the employer's request for reconsideration, claimant asserts that retroactive application of amended ORS 656.005(7)(c) is an unconstitutional impairment of her contract with her employer. However, claimant has not apprised us of the existence of or terms of any such contract, much less how it will allegedly be impaired by amended ORS 656.005(7)(c). In light of such circumstances, we decline to further address claimant's contention.

[4] Claimant asserts that retroactive application of amended ORS 656.005(7)(c) would deprive her of a "right" as opposed to a "remedy". To the extent that claimant is referring to her entitlement to temporary disability benefits, we note that inasmuch as the record indicates that claimant did not lose any wages following her injury, her rate of temporary partial disability benefits under the former law would have been zero. See OAR 436-60-030(2). Consequently, we are not persuaded that retroactive application of amended ORS 656.005(7)(c) has deprived claimant of any benefits to which she would have otherwise been entitled to under the former law.

Under that statute, "worsened conditions" occurred when a claimant's physical condition or symptoms became exacerbated and caused increased disability or diminished earning capacity. Perry v. SAIF, 307 Or 654, 657 (1989). A claimant could establish a "worsened condition" by showing worsened symptoms without showing a worsening of the underlying condition. Consolidated Freightways v. Foushee, 78 Or App 509 (1985), rev den 301 Or 388 (1986). Finally, if the last award or arrangement of compensation included consideration of anticipated future exacerbations of the condition or symptoms, the claimant had to prove that the "worsening" was greater than anticipated. Gwynn v. SAIF, 304 Or 345 (1987).

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 medical evidence **of an actual worsening of the compensable condition** supported by objective findings." SB 369, § 31 (added language in bold-face type).

In addition, SB 369 added 656.214(7) which provides that "all permanent disability contemplates future waxing and waning of symptoms of the condition. The results of waxing and waning may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization."

Except as provided otherwise, SB 369 applies 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. Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995). Because amended ORS 656.273(1) and 656.214(7) are not among the exceptions to this general rule, see SB 369, § 66 (listing exceptions to general retroactivity provision), the amended version of the statutes now governs this matter.[5]

In determining what the legislature intended by amending ORS 656.273(1) and adding ORS 656.214(7), 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, 317 Or 606, 611-12 (1993). If those sources do not reveal the legislature's intent, we resort to legislative history and other extrinsic aids. Id. The language of ORS 656.214(7) is unambiguous with regard to the legislature's intent that all permanent disability awards contemplate future periods of waxing and waning. However, with regard to amended ORS 656.273(1), the 1995 amendments do not define the term "actual worsening," nor is it a term defined by prior case law. Moreover, there is no mention in either statute of the interplay between ORS 656.214(7) and 656.273(1). Consequently, we look to the legislative history for guidance.

Representative Mannix, a co-sponsor of SB 369, testified before the Senate Labor Committee concerning amended ORS 656.273(1). He stated:

> "ORS 656.273(1) is a significant change in the law. All changes to .273 are significant in the sense that they are trying to tell the courts what we thought we told them many times over as to what is an aggravation. An aggravation is a worsening of the compensable condition; that is, it's attributable to the industrial injury. A worsening of the condition.
>
> "I would like to say the word condition a hundred times, but I won't. The courts keep insisting on coming up with alternatives, even though the last time I counted I think worsened condition is used seven times in the statutes to refer to aggravation. They keep coming up with alternative views of what is an aggravation. Doctors know what a worsened condition is. We should know what a worsened condition is and a worsened condition is not a flare-up of symptoms. Enough said." (Minutes of the Senate Labor and Government Operations Committee, Tape 15B, Side B, January 30, 1995).

---

[5] Under § 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 neither ORS 656.273(1) nor 656.214(7) alter a procedural time limitation, § 66(6) does not apply to this case.

Representative Mannix also discussed ORS 656.214(7) and stated:

"We then get to ORS 656.214(6) [sic]. This restates the assumption that the condition of workers with permanent disability may fluctuate without the condition itself worsening. That is, there can be a fluctuation of symptoms. When we amended the law in 1990 with the special session, we thought we took care of it and we stated specifically that the condition of a worker with permanent disability may be expected to wax and wane. Recent cases said that provision only applies if the anticipated waxing and waning of symptoms was specifically stated at the time of the previous closure.

"That gets around the intention of the 1990 reforms. The idea is if you get a permanent disability award, there is an assumption that you have a permanent condition, and you may have good days and bad days with waxing and waning of symptoms. That is why you receive compensation for permanent partial disability. There is then an assumption anytime you have such a permanent disability award that there will be some fluctuation of symptoms. If there is not any anticipated fluctuation of symptoms, then you shouldn't be getting a permanent disability award. You should have fully recovered, which happens to many workers." (Minutes of the Senate Labor and Government Operations Committee, Tape 16A, Side A, January 30, 1995).

In a later session, the following discussion took place between Senator Leonard, Representative Mannix, and Jerry Keene, a workers' compensation defense attorney.

"Sen. Leonard: Where do you draw the line between when you have an aggravation of a symptom and an injury?

"Rep. Mannix: The aggravation actually is of the condition and that's what we keep getting back to. A worsening of the condition as opposed to a flare-up of symptoms. And the physicians will tend to make that - we'll ask them to make that distinction. Was this a worsened condition or an actual flare up of symptoms. One of the things that we're trying to get at it [sic] though is you've got a chronic bad back. In fact your doctor told you to limit yourself to sedentary work and you got a permanent disability award. A year later you're moving and you spend all Saturday lifting heavy stuff. The end of the day you're in pain. The next day or Monday you go to the doctor, he gives you some medication to control your pain and says you ought to rest a couple of days. Your condition - the doctor takes a look at it and says you just overdid it. You probably shouldn't have done that.

"In fact, let's say you don't miss any work at all. You're just in pain. That's probably a better example, because if the doctor tells you not to do something he'll probably say you have a worsened condition. You've had a flare-up, you overdid it. Did you have an actual worsening that requires reopening of the claim, the payment of time loss, the reevaluation of permanent disability, or was this just a flare up of symptoms. Physicians are used to being asked that question, but the courts have tended to say well, if you had - sometimes they've said in the past - well you had increased pain with activity. That's enough to be an aggravation. Or we're going to take another look at your earning capacity a year later and we think you've lost some earning capacity so that's an aggravation. This turns around and says no, look at the pathological condition or the psychiatric condition. Do the physicians say there's an actual worsening of the condition or is this waxing and waning of symptoms. The kind of stuff you would have anticipated.

"Mr. Keene: Waxing and waning came from the court decisions. It wasn't statutory language originally. We just took their language and put it in.

"Rep. Mannix: Like phases of the moon.

"Unidentified: That was a court wording, huh?

"Mr. Keene: One of their better efforts.

"Rep. Mannix: We're trying to get back to clarifying no. that wasn't meant to be an aggravation. The original bill did that. This amendment, based on the Department's recommendation, they wanted to start out with a positive description of worsened condition and then talk about what is exempted, so we've reworded it to meet their request.

"Sen. Leonard: And who makes that determination with this language - in other words a waxing and waning of the symptom or an aggravation of an earlier approved condition?

"Rep. Mannix: It's based on the weight of the medical evidence.

"Mr. Keene: The doctor.

"Sen. Leonard: The doctor makes that decision.

"Mr. Keene: The doctor makes the initial decision, gives his opinion about whether it's happened or not - to the insurer when they send the bills for payment and trigger the claim on behalf of the worker.

"Sen. Leonard: So the insurer is going to have more latitude now with claims that are submitted for aggravations of approved claims - there's no disputes that the person was originally injured. The insurer will have more latitude to deny payment.

"Rep. Mannix: Yes

"Mr. Keene: It draws a clearer line.

"Rep. Mannix: It draws a clearer line and the physician can be asked very specifically - doctor, is this a worsened condition or is this a flare-up of symptoms.

"Sen. Leonard: And doctors can tell you that? they can clearly say that is--

"Rep. Mannix: Well to be frank about it, the attending physician will tend to err on the side of caution and say well looking at this and evaluating this condition, yeah it's worse. Is it temporarily or permanently worse? That doesn't matter. If it's a worsened condition you'll get an aggravation. Then later you can look at whether it's permanent or temporary and reevaluating [sic] it. Oh they got better again, fine. They didn't get better, then you got some more permanent disability."

(Minutes of the Senate Labor and Government Operations Committee, Tape 49A, February 17, 1995).

During meetings of the House Committee on Labor, Representative Mannix continued to make a distinction between a worsening of symptoms and a worsening of the condition. See (Minutes of the House Committee on Labor, Tape 42A, March 3, 1995). In discussing ORS 656.214(7), Representative Mannix stated:

"This is designed to close the back door aggravation claims where you say even though I'm not worse, I've had more waxing and waning of symptoms than was contemplated. And we get into that. In the aggravation statute we get back to no, ask the doctor has your condition worsened. Condition. It's a code word. Worsened is a code word. Waxing and waning of symptoms is a code phrase, too, because a doctor can give us an opinion based on their medical history, their prior examinations, what they expected in terms of waxing and waning symptoms. And let's be frank about this. At some point somebody's symptoms will have increased so much that the doctor's going to come to the conclusion that there is actually a worsening of the condition. Let the doctor say so. But let's not say that there are any other assumptions that somehow meant to having just the waxing and waning of symptoms reported that meant you have an aggravation. Ask the doctor the question about the aggravation." Id.

Representative Mannix was then asked whether ORS 656.214(7) would be more appropriately placed in ORS 656.273. He stated:

> "Well that's where I think that moving this over to the section dealing with ORS 656.273 the aggravation statute might be appropriate because this is really intended to take the subjectivity out of the question of aggravation. Aggravation ought to be a pathological worsening and the doctor can tell you whether or not there's been a pathological worsening. It shouldn't be well gee this person's had symptom swings and we're trying to nail down that point. Waxing and waning of symptoms does not mean that the person has had an aggravation. So maybe it's best to put this language in there. Because then it's less subjective. What we've got is some objective standards and we're saying this subjectivity stuff doesn't rate an aggravation claim." (Minutes of the House Committee on Labor, Tape 41B, March 3, 1995)

While some of Representative Mannix's comments seem to indicate that a pathological worsening of the underlying condition is required to establish an "actual worsening," other comments acknowledge that a symptomatic flare-up could constitute an "actual worsening" under certain circumstances, i.e., if the flare-up were greater than anticipated by the prior permanent disability award. See (Minutes of the House Committee on Labor, Tape 42A, March 3, 1995). These other comments are consistent with ORS 656.273(8), which was not amended by SB 369, and provides that where a worker has received a permanent disability award, an aggravation is established if it is shown "that the worsening is more than a waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." Moreover, amended ORS 656.273(1) does not employ the term "pathological worsening" but rather uses the term "actual worsening."

Based on the aforementioned legislative history, we reach the following conclusions with regard to what constitutes an "actual worsening" under amended ORS 656.273(1). A pathological worsening of the underlying condition is sufficient to establish an actual worsening. In addition, a symptomatic worsening of the condition, that is greater than anticipated by the prior award of permanent disability, is also sufficient to establish an actual worsening.

We may remand a case that 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 Helen M. Callandar, 47 Van Natta 626 (1995) (case remanded to ALJ because record devoid of evidence regarding new "actual worsening" standard under amended ORS 656.273(1)); 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, before our prior order became final, amended ORS 656.273(1)'s "actual worsening" standard went into effect. Inasmuch as claimant's claim was classified as nondisabling, she has not received a prior award of permanent disability. Moreover, other than evidence that claimant sustained a symptomatic worsening in 1992 and 1993 which resulted in a reduction of work hours, the record is devoid of either documentary or testimonial evidence regarding whether claimant sustained an "actual worsening" in either 1992 or 1993. In light of the fact that claimant has not received a prior award of permanent disability and given the parties' lack of opportunity to generate medical evidence regarding whether claimant's symptomatic worsening constitutes an "actual worsening" of her condition, 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 prior to our order becoming final, 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 her 1989 neck and shoulder claim.

Accordingly, on reconsideration, the ALJ's order dated November 23, 1994, as republished November 28, 1994, is affirmed in part and vacated in part. We affirm that portion of the ALJ's order which declined to reclassify claimant's claim. We vacate that portion of the ALJ's order which set aside the self-insured employer's aggravation denial and remand this matter to ALJ Daughtry for further proceedings in which each party will be permitted to present evidence regarding the compensability of claimant's 1992 and 1993 aggravation claim. 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 regarding the aggravation issue.

IT IS SO ORDERED.

**Member Hall specially concurring.**

I agree with the majority's interpretation of amended ORS 656.273(1) and the decision to remand this matter for the submission of further evidence. However, I write to express my concerns about the retroactive application of this provision.

The majority declares, without reservations or limitations, that amended ORS 656.273(1) is to be applied retroactively. There may be, however, cases in which retroactive application would be in error. For example, if the parties had previously agreed, by stipulation, that a worker's permanent disability award did not contemplate future waxing and waning, I believe that retroactive application of ORS 656.214(7) and amended ORS 656.273(1) would violate the Contracts Clause of Article I, section 21, of the Oregon Constitution as it would impair the rights and obligations of a contract between the injured worker and the employer or insurer.

While this issue is not present in this case, I write separately to register my concern with the majority's blanket statement regarding the retroactive application of the amended law.

---

December 15, 1995 Cite as 47 Van Natta 2378 (1995)

In the Matter of the Compensation of
**MARTIN L. MOYNAHAN, Claimant**
Own Motion No. 95-0472M
OWN MOTION ORDER OF ABATEMENT

Claimant requests reconsideration of our September 29, 1995 Own Motion Order, as reconsidered on November 16, 1995, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force when his condition worsened requiring surgery. With his request for reconsideration, claimant submits evidence regarding the work force issue.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The insurer 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
**BARBARA COOPER-TOWNSEND, Claimant**
WCB Case No. 94-07087
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) declined to award unscheduled permanent disability for a bilateral shoulder condition; and (2) decreased claimant's scheduled permanent disability for loss of use or function of claimant's left arm from 8 percent (15.36 degrees), as awarded by an Order on Reconsideration, to 5 percent (9.6 degrees) . The self-insured employer cross-requests review, contending that claimant's disability award should be reduced to zero. In addition, the employer requests that this case be consolidated with WCB Case No. 94-11262. On review, the issues are extent of permanent disability (scheduled and unscheduled) and motion to consolidate. We modify in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last two paragraphs and the "Findings of Ultimate Fact."

## CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we discuss the employer's request that this case be consolidated with WCB Case No. 94-11262, which concerns the effect of a written partial denial and claimant's claim for vocational services. Barbara Cooper-Townsend, 47 Van Natta 2381 (1995).

At the hearing in this case (WCB Case No. 94-07087), claimant specifically reserved "issues pertaining to penalties and fees in association with unreasonable resistance to the provision of compensation in the form of vocational assistance." (Tr. 3). The employer did not object to claimant's reservation. In his Opinion and Order, the ALJ stated that "[i]ssues relating to provision of vocational services, inter alia, were reserved and tried in case 94-11262." (O&O p.1).

With its brief, the employer seeks to consolidate our review of WCB Case No. 94-11262 with this case. Claimant objects to consolidation. After consideration of the parties' respective positions and particularly in light of the employer's prior failure to object to bifurcation of the issues at hearing, we deny the employer's motion to consolidate the two cases (see reasoning and ruling in WCB Case No. 94-11262). We proceed to address the extent issue.

Claimant has an accepted claim for mild bilateral carpal tunnel syndrome and wrist/forearm tendinitis. At hearing, she took the position that the employer had "de facto" denied a claim for a bilateral shoulder condition (resulting from the same work exposure) and sought to overturn that denial. The ALJ held that there had been no such "de facto" denial and that the real issue was extent of permanent disability, specifically, whether the disability claimed (scheduled and unscheduled) is work-related. We agree that the issue is extent of permanent disability.[1]

---

[1] In her opening brief, claimant argues that the ALJ erred in not considering claimant's myofascial pain syndrome "as an element of the extent of the permanent disability due to work-related compensable conditions. (Appellant's Br. p. 2). In her Appellant's Reply/Cross-Respondent's Brief, claimant further argues that we should conclude that there was a ("de facto") denial of a myofascial condition. (Appellant's Reply/Cross-Respondent's Brief p. 1). Even assuming that a "de facto" denial issue is properly raised and that such a denial existed at the time of hearing, we would not overturn it on this record. Instead, we would find that the myofascial diagnosis is merely another diagnosis for the compensable condition. Because we do not believe that the employer (by failing to respond to notice of this diagnosis) intended to "back-up" deny the accepted claim and since we agree with the ALJ that the real issue in this case is extent of disability, we conclude (as did the ALJ), that the alleged denial has no effect.

On review, claimant contends that the ALJ erred in not considering and rating all of her work-related disability. Specifically, she argues entitlement to an unscheduled award for bilateral shoulder myofascial pain syndrome and an additional scheduled award for loss of use or function of her right elbow. The employer contends that claimant should receive no permanent disability. Because the extent and location of claimant's work-related disability is disputed, the threshold issue is the scope of the compensable condition for purposes of rating permanent disability.

Unscheduled Disability

The ALJ stated that the compensable condition is "defined by the [employer's] acceptance of initial diagnoses of forearm tendinitis and carpal tunnel syndrome." (O&O p. 4). We do not agree that the extent of the compensable condition is necessarily "defined" by the language of the acceptance. Instead, where disputed, we believe that the extent of the compensable condition is essentially a medical question, to be resolved by persuasive medical evidence. See Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 1105 (1985), rev den 300 Or 546 (1986).

The ALJ acknowledged that claimant's myofascial shoulder problems were at one point viewed as an extension of her compensable upper extremity problems. Nonetheless, the ALJ further concluded that Dr. Morris' opinion that the shoulder condition is work-related is unpersuasive. We reach the same result, based on the following reasoning.

To begin, it is questionable whether Dr. Morris' "post-reconsideration" deposition can be considered under amended ORS 656.283(7). However, we need not decide whether that statute is applicable because we do not find Dr. Morris' opinion persuasive.

In his November 15, 1993 closing examination, Dr. Morris reported that claimant's objective signs had stabilized and that bilateral shoulder range of motion was full in all planes. (Ex. 8). Claimant had no significant trigger points, no neurologic deficits, and normal sensation, among other findings. (Ex. 8). Dr. Morris also noted claimant's permanent "inability to use the hands and arms in tasks of a repetitive nature." (Ex. 8). In a May 19, 1994 letter to claimant's counsel, Dr. Morris reported that with regard to claimant's "upper extremity repetitive use injury with chronic tendinitis and carpal tunnel syndrome tendencies, I believe this to be a permanent condition which precludes [claimant] from frequently engaging in repetitive lifting, pushing, pulling, grasping, manipulating, or above-shoulder work, as a component of her usual activities." (Ex. 15A). Finally, in his deposition, Dr. Morris testified that he had no reason to disagree with his prior statement that claimant had a chronic condition in her shoulder girdle area. (Ex. 21-37).

In his closing examination, Dr. Morris did not indicate that claimant had a chronic condition related to her shoulders and in fact reported full plane of motion. Yet, in his later report and deposition, Dr. Morris indicated that claimant had a chronic condition affecting her shoulders. Dr. Morris does not explain this inconsistency between his opinions and for this reason, we are not persuaded by his opinion. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Moreover, in his May 1994 letter, Dr. Morris does not adequately explain whether claimant's chronic condition relates to her forearms (for which we have herein affirmed a chronic condition award) or to her shoulders or both. Consequently, we agree with the ALJ that Dr. Morris' opinion is not sufficient to establish entitlement to an unscheduled permanent disability award for her shoulders.

Scheduled Disability

A December 13, 1993 Determination Order closed this claim and awarded claimant 5 percent scheduled permanent disability bilaterally for loss of use or function of her arms. Claimant requested reconsideration.

A June 10, 1994 Order on Reconsideration increased claimant's scheduled awards to 7 percent for the right arm and 8 percent for the left arm. Both parties contested the scheduled awards at hearing.

The ALJ reduced claimant's award for the left arm to 5 percent and increased the award for the right arm to 8 percent. In light of claimant's request that her scheduled awards be increased and the employer's request that the awards be reduced to zero, we next evaluate claimant's entitlement to permanent disability for loss of use or function of her arms. Based on the following reasoning, we reduce claimant's award.

We agree with the ALJ that claimant has proven entitlement to 5 percent impairment ratings for a chronic bilateral forearm condition which renders her unable to use her arms repetitively (see Exs. 8-2, 15A-2). OAR 436-35-010(6). In addition, we agree that claimant is entitled to a 1 percent rating for lost right wrist range of motion (extension), for a combined total of 6 percent scheduled permanent disability for loss of use or function of her right forearm. (Ex. 8). However, we further find that claimant has not established entitlement to additional ratings for either arm (including both wrists and elbows), because the medical evidence does not adequately relate any such loss of use or function to the work exposure. (See id.). Accordingly, claimant's 5 percent rating for her left forearm is converted to 4 percent of the left arm and her 6 percent rating for her right forearm is converted to 5 percent of the right arm. See OAR 436-35-090(1).

Finally, we acknowledge the employer's contention that claimant has no work-related disability because she did not testify credibly about her work history following the exposure at issue in this case. In this regard, the employer asserts that claimant misrepresented and minimized the fact that she did work during the year before hearing (over a year after she stopped working for the employer). However, we do not consider these misstatements so significant as to reject the unrebutted opinion of claimant's treating physician (which is supported by impairment findings), that claimant does have the above described work-related disability. See Weiland v. SAIF, 64 Or App 810 (1983).

ORDER

The ALJ's order dated January 27, 1995 is modified in part and affirmed in part. Claimant's scheduled permanent disability award for loss of use or function of her left arm is reduced from 5 percent (9.6 degrees) to 4 percent (7.68 degrees). Claimant's scheduled permanent disability award for loss of use or function of her right arm is reduced from 8 percent (15.36 degrees) to 5 percent (9.6 degrees). The remainder of the ALJ's order is affirmed.

---

December 21, 1995 Cite as 47 Van Natta 2381 (1995)

In the Matter of the Compensation of
**BARBARA COOPER-TOWNSEND, Claimant**
WCB Case No. 94-11262
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) upheld its partial denial of claimant's current upper extremity condition; and (2) affirmed a Director's order which directed the employer to process claimant's claim for vocational assistance. The employer requests that this case be consolidated with WCB Case No. 94-07087. On review, the issues are the effect of the denial (compensability), jurisdiction (vocational assistance), and motion to consolidate. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for his "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we address the employer's request that this case be consolidated with WCB Case No. 94-07087, a case involving the same claimant's claim for permanent partial disability (decided this date).

As noted in our order in WCB Case No. 94-07087 (Barbara Cooper-Townsend, 47 Van Natta 2379 (1995)), claimant specifically reserved "issues pertaining to penalties and fees in association with unreasonable resistance to the provision of compensation in the form of vocational assistance." (Tr. 3). The employer did not object. In his Opinion and Order in WCB Case No. 94-07087, the ALJ stated that "[i]ssues relating to provision of vocational services, inter alia, were reserved and tried in case 94-11262." (O&O p.1).

With its brief in the present case, the employer moves to consolidate the two cases. Claimant objects to consolidation.

As we have noted, the ALJ bifurcated the two cases at the beginning of the hearing in WCB Case No. 94-07087 without objection from the employer. Under these circumstances, we find that the ALJ did not abuse his discretion in refusing to consolidate the two cases. See OAR 438-06-065(2).

The employer would have us consolidate the cases on review, because it seeks to introduce evidence from the record in WCB Case No. 94-07087 to impeach claimant's credibility regarding her employment history after she stopped working for the employer. However, the employer has not explained, or introduced relevant evidence explaining, how claimant's failure to initially "tell the whole truth" (see O &O p. 3) at hearing is relevant to her then-existing and previously established compensable claim. Moreover, because we do not find claimant's history in this regard material or relevant,[1] consolidating the two records would not change the result in either case. Under these circumstances, we deny the employer's motion to consolidate. We proceed to address the denial and jurisdiction issues.

Effect of the Employer's November 16, 1994 Denial

The ALJ set aside the employer's November 16, 1994 partial denial of claimant's current condition (Ex. 39), reasoning that the denial was a "nullity" because there was no outstanding claim for compensation. We agree that the denial must be set aside, based on the following reasoning.

The employer specifically accepted only mild bilateral carpal tunnel syndrome and wrist forearm tendinitis. However, Dr. Morris, treating physician, prescribed treatment for claimant's upper extremities, including her shoulder girdle musculature, based on a right trigger point discovered in the right seratus posterior. (See Exs. 30, 31, 38-13-22). Dr. Morris also explained how claimant's upper extremity condition was related to work activities. (Id.) Based on the treating physician's diagnosis, opinion relating the diagnosis to employment, and treatment prescribed, we find that there was an existing claim for compensation when the November 16, 1994 written partial denial[2] issued. See ORS 656.005(6) (a claim is "a written request for compensation from a subject worker. . . ."); Calvin E. Bigelow, 45 Van Natta 1577 (1993). Under these circumstances, the employer was procedurally entitled to issue a "precautionary" denial, based on its apparent belief that claimant's then-current condition was not compensable. See Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989) (The employer is free to partially deny any condition which it reasonably believes could be a claim); compare Debra M. Sansburn, 47 Van Natta 1462 (1995) (Where no treating physician diagnosed condition or recommended treatment for it, no claim existed and denial was premature).

The employer argues that its denial should be upheld, based on examining physicians' opinion that claimant does not have objective findings of disability (see Ex. 35) and the above-described misrepresentations regarding claimant's work history. However, we do not find the employer's credibility argument persuasive, because there is no showing that claimant's work history since her exposure with this employer is material or relevant to the issues presented.[3] See Taylor v. Multnomah School District No. 1, 109 Or App 499, 501 (1991); Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984) (Even if claimant is not a credible witness, it does not necessarily follow that he did not prove his claim). Moreover, considering the treating physician's many opportunities to examine and evaluate claimant and his well-reasoned opinion (which explains claimant's objective findings), we find no persuasive reason to discount his conclusion that claimant's current condition results from her work exposure with the employer. (See Exs. 8, 20, 30, 31, 38). See Givens v. SAIF, 61 Or App 490, 494

---

[1] See note 3, infra.

[2] The denial notified claimant that the employer was "denying the current compensability of your claim in [sic] the grounds that you do not have a current condition of [sic] need for treatment that constitutes a compensable consequence of the injury/occupational disease for which this claim was filed. Please note that this is a partial denial only. . . ." (Ex. 39).

[3] Specifically, there is no evidence that such exposure contributed to claimant's condition or that consideration of claimant's approximately 79 hours of work for the subsequent employer would have impacted the treating doctor's opinion that claimant's work for the employer at bar caused her upper extremity problems.

(1983) (Treating physician's opinion regarding causation accorded greater weight than examining physician's opinion, based on treating physician's "firsthand exposure and knowledge of claimant's condition"). Accordingly, we agree with the ALJ's ultimate conclusion that the employer's denial of claimant's current condition must be set aside.

Jurisdiction (Vocational Assistance)

The ALJ affirmed the Director's September 7, 1994 order concerning claimant's claim for vocational assistance. However, since the June 7, 1995 amendments to Workers' Compensation Law, the Hearings Division lacks jurisdiction over vocational issues.

ORS 656.283(2) now provides only for Director review of vocational assistance disputes. Or Laws 1995, ch 332, § 34(2).

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 1387 (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.

Under the statute, when the Director issues an administrative order in a vocational assistance matter, "the order shall be subject to review only by the director."[4] Amended ORS 656.283(2)(c) (emphasis supplied). Under these circumstances, the ALJ's order purporting to uphold and enforce the Director's September 7, 1994 order concerning claimant's claim for vocational assistance must be vacated. See Ross M. Enyart, 47 Van Natta 1540 (1995).

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief and her attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 27, 1994 is vacated in part and affirmed in part. Those portions of the order affirming the Director's order concerning vocational services and awarding a related attorney fee are vacated. Claimant's request for hearing on the vocational services matter is dismissed. The remainder of the order is affirmed. For services on review regarding the compensability issue, claimant's counsel is awarded a $1,000 attorney fee, payable by the employer.

---

[4] 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). 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.

In the Matter of the Compensation of
**DARAL T. MORROW, Claimant**
WCB Case Nos. 94-10771 & 94-08852
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney
Scott Terrall & Associates, Defense Attorneys

On November 16, 1995, we abated our October 18, 1995 order in which we affirmed the Administrative Law Judge's (ALJ's) order that: (1) set aside Sedgwick James' denial of claimant's "new injury" claim for a low back condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. We took this action to consider Sedgwick James' motion for reconsideration. Having received claimant's and SAIF's responses to Sedgwick James' motion, we now proceed with our reconsideration.

Sedgwick James, as claims administrator for the self-insured employer, contends that we failed to address the law of either Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), or ORS 656.308(1). To begin, we note that Sedgwick James did not rely on Kearns in its brief on review.

In any event, Sedgwick James' reliance on Industrial Indemnity Co. v. Kearns, supra, is misplaced. Kearns created a rebuttable presumption that, in the context of successive accepted injuries involving the same body part, the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. Encompassed in the "Kearns presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. See id. at 587. The carrier with the last accepted injury can rebut the Kearns presumption by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. Id. at 588.

In Raymond H. Timmel, 47 Van Natta 31 (1995), we held that, where a claimant has several accepted claims for injuries involving the same body part, but not the same condition as that for which the claimant currently seeks compensation, Kearns remains valid law, notwithstanding the enactment of ORS 656.308(1).

In the present case, SAIF is the only carrier with an accepted claim. When only one accepted claim is involved, the Kearns presumption does not apply. See Lynnette D. Barnes, 44 Van Natta 993 (1992).

Sedgwick James also contends that we failed to address ORS 656.308(1). In our order, we said that, given our determination that the 1994 injury was the major contributing cause of claimant's condition, it was not necessary to address whether claimant's current low back condition was the "same condition" as the condition accepted by SAIF or a separate injury to the same body part. Although our order did not specifically address ORS 656.308(1), we said that, even if we assumed that claimant's condition was the "same condition" and ORS 656.308(1) applied, Sedgwick James was responsible because claimant sustained a "new compensable injury involving the same condition" in June 1994. See Antonio J. Lopez, 47 Van Natta 1304 (1995) (since the injury was the major contributing cause of the claimant's condition, the carrier was responsible regardless of the analysis adopted).

On reconsideration, we adhere to that reasoning and continue to adhere to our prior conclusion that claimant's June 1994 industrial injury was the major contributing cause of his current disability and need for treatment.

Accordingly, on reconsideration, as supplemented herein, we republish our October 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
**JOHN B. REYNOLDS, Claimant**
WCB Case Nos. 94-06295 & 94-06659
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Beers, Zimmerman, et al, Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

EBI Companies (EBI) requests review of that portion of Administrative Law Judge (ALJ) Howell's order which set aside its denial of claimant's current low back condition. Claimant cross-requests review of that portion of the ALJ's order that upheld the denials of Barrett Business Services (BBS) for the same condition. On review, the issues are compensability and responsibility.

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

Claimant sustained a compensable low back strain in December 1983. (See e.g., Ex. 87-1). The claim was accepted and processed by EBI. The claim was closed by a September 5, 1986 Determination Order awarding 15 percent unscheduled permanent disability, which was later increased to 25 percent disability. (Exs. 52, 68). Claimant continued to receive chiropractic treatment for his low back condition until 1987. Between 1987 and 1993, claimant received no medical treatment, but he experienced intermittent flare-ups of his low back symptoms.

In December 1993, claimant performed work for Barrett Business Services (BBS). He was leased to work for Ahlteen Medical for two weeks assembling dialysis machines. On December 11, 1993, while vacuuming at home, claimant experienced sudden and severe low back pain, for which he received treatment later that month. He was diagnosed with "low back strain," or "chronic low back pain with acute exacerbation." (Exs. 69, 72-2).

The ALJ held, relying on Beck v. James River Corp., 124 Or App 484 (1993), that claimant need only prove a material causal relationship between his current condition and need for treatment and his accepted 1983 injury. The ALJ reasoned that since claimant's 1983 claim is in Own Motion status, the only benefits available to claimant are medical services under ORS 656.245. We agree and offer the following supplementation.[1]

In Beck, the court held 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. 124 Or App 487. Subsequently, we explained that the Beck holding was limited to the situation where a worker seeks medical services for a condition that has already been accepted. Shirreline J. Bray-Lodwig, 47 Van Natta 1358, 1359, corrected 47 Van Natta 1436 (1995); Joseph R. Klinsky, 47 Van Natta 872, 873 (1995).

Here, claimant sought treatment in December 1993 for a low back strain. (Ex. 69). This is the same condition that was accepted as a result of claimant's compensable 1983 injury. (See e.g., Ex. 87). Moreover, Dr. Thompson, an orthopedist who treated claimant in December 1993, opined that, because claimant had had ongoing symptoms since 1983, the 1983 injury was the major contributing cause of claimant's current symptoms. (Ex. 72-2). We agree with the ALJ that Dr. Thompson's opinion is most persuasive. Therefore, we find that claimant sought treatment in 1993 for the same condition that was accepted as a result of the 1983 compensable injury. Accordingly, we conclude that the ALJ correctly applied the material contributing cause standard under Beck.

Moreover, subsequent to the ALJ's order in this case, the legislature enacted Senate Bill 369 which amended ORS 656.245, among other provisions. Since no exception is relevant to this case,

---

[1] Because the carriers issued formal denials of compensability of claimant's current low back condition, we retain jurisdiction to review this dispute even though it involves a claim for medical services. SB 369, § 25(6); Richard L. Wheeler, 47 Van Natta 2011 (1995).

amended ORS 656.245 applies. Or Laws 1995, ch 332, § 66 (SB 369, § 66); Volk v. America West Airlines, 135 Or App 565 (1995).[2]

Amended ORS 656.245(1)(a) now provides that medical services shall be provided "for conditions caused in material part by the injury," subject to the limitations of Section 3 of SB 369 and the limitations pertaining to consequential and combined conditions under ORS 656.005(7). SB 369, § 25(1)(a) (emphasis added). Section 3 pertains to medical services solely directed to a worker's preexisting condition. SB 369, § 3. This limitation does not apply in this case, since we find, relying on Dr. Thompson's opinion, that claimant's treatment is not directed to a preexisting condition. (See Ex. 75). Likewise, the limitations pertaining to consequential and combined conditions are not applicable here, since neither a consequential nor a combined condition is involved in the present claim. Accordingly, we conclude that under amended ORS 656.245(1)(a), the material contributing cause standard applies. Claimant's claim for medical treatment is compensable because his current condition and need for treatment is materially related to his compensable injury. Amended ORS 656.245(1)(a).

Because we affirm the ALJ's order upholding BBS' denials, we need not address the contention that claimant's claim was not timely filed against BBS.

Inasmuch as the compensation awarded to claimant has not been disallowed or reduced, 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 EBI's appeal is $500, payable by EBI Companies. In reaching this conclusion, we have particularly considered the time devoted to responding to EBI's contentions (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 13, 1995 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the EBI Companies.

---

[2] Claimant asserts in his brief on review that retroactive application of SB 369 is unconstitutional. Claimant did not further develop his constitutionality argument. We are not inclined to address constitutional arguments that are not adequately developed for our review. Preston E. Jones, 45 Van Natta 853 (1993); Ronald B. Olson, 44 Van Natta 100, 101 (1992). In any event, under either version of the statutory scheme, we would reach the same determination that EBI is responsible for the claim. Therefore, we would disagree with the contention that claimant's rights to benefits were violated by a retroactive application of the statutory amendments.

---



In the Matter of the Compensation of
**PATRICIA L. SERPA, Claimant**
WCB Case No. 93-10053
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order[1] that upheld the self-insured employer's denial of her claim for a current low back condition. Claimant requests that this matter be remanded to the ALJ for consideration of post-hearing medical reports. Alternatively, she requests that review of this matter be deferred until the resolution of pending litigation regarding subsequent claim denials. On review, the issues are remand, deferral and compensability.

---

[1] ALJ Crumme's first order in this matter was issued on August 23, 1994, and reconsidered on October 20, 1994. In the order, the ALJ set aside the employer's denial as being procedurally invalid. The employer appealed and, by Order on Review dated April 21, 1995, the Board remanded the matter to the ALJ for a determination of whether claimant's current low back condition is compensable on the merits. On remand, the ALJ issued a "Second Order on Reconsideration" dated June 2, 1995 which upheld the employer's denial on the merits. The June 2, 1995 order is the subject of this review.

We deny the motions for remand and deferral and, on the merits, adopt and affirm the ALJ's order with the following supplementation.

Remand

Claimant asserts that she underwent low back surgery by orthopedic surgeon Dr. Jenkins on February 6, 1995, and that a letter from Dr. Jenkins was received on June 8, 1995 indicating his belief that her accepted injuries were the major cause of her low back condition in and after September 1992. She therefore requests that the record be reopened for admission of Dr. Jenkins' operative reports, chart notes and letters of opinion as new evidence which was not previously available to her. We deny her request for the following reason.

Our review is limited to the record developed at hearing, and we have no authority to consider evidence not admitted in the record at hearing. ORS 656.295(5); Brown v. SAIF, 51 Or App 389, 393 (1981). However, 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). There must be a compelling reason 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).

"Post-hearing" surgical reports may provide a compelling basis for remand. For example, in Parmer v. Plaid Pantry #54, 76 Or App 405 (1985), the court held that the case must be remanded to the referee[2] for consideration of medical opinions generated following "post-hearing" surgery. The issue in that case was the compensability of proposed low back surgery. Medical opinions were offered by various doctors, only one of whom attributed the need for the proposed surgery to the accepted injury. However, the opinion was premised on the possibility that the accepted injury caused additional scarring at the site of previous surgery. Because the opinion was stated in terms of possibilities rather than probabilities, the medical evidence was deemed insufficient to establish compensability. Subsequent to the hearing and the issuance of the referee's order, the claimant underwent the disputed low back surgery, which was performed by the same doctor who gave the earlier opinion supporting compensability. In a letter opinion, the doctor stated that, based on what he discovered during the surgery, he believed the accepted injury caused increased scarring and the need for further medical care. The court concluded that, inasmuch as the "post-hearing" evidence filled in gaps which were found in the medical record, the claimant should have the opportunity to explore fully the medical opinions following surgery. Id. at 409.

In this case, we are not persuaded that the "post-hearing" surgery yielded any new findings or information which was not previously available. Previous physical examinations and diagnostic studies have already confirmed the presence of degenerative lumbar disc disease and sacralization of L5. (Exs. 60, 65, 80, 93, 97, 123). Claimant has not submitted a copy of Dr. Jenkins' opinion letter, nor does claimant explain what new information, if any, Dr. Jenkins relied on in reaching his opinion. Absent new information or findings, Dr. Jenkins' opinion is merely cumulative of the opinions already rendered by Drs. Long and Mawk in support of claimant's claim. Unlike Parmer, in this case, there is no basis for finding that the proffered evidence fills in any gaps in the medical record. Therefore, we do not find that the additional evidence is reasonably likely to affect the outcome of this case. Accordingly, we conclude the record in this case was sufficiently developed, and claimant's motion for remand is denied.

Deferral

Claimant also requests that this matter be deferred until the resolution of pending litigation regarding other denials of claimant's low back condition. (WCB Case Nos. 94-15187, 94-02044). Claimant asserts the issues in these cases are inextricably linked. We disagree.

While the compensability issues in these cases may be similar, we are not persuaded they are inextricably linked. A finding that issues are inextricably linked requires more than claimant's bald

---

[2] "Referee" was the former title for an ALJ.

assertion that that is the case. Here, claimant offers no explanation for her assertion. In addition, we note that it was claimant who successfully moved for bifurcation and deferral of WCB Case No. 94-02044, which concerned issues arising from an Order on Reconsideration, pending final resolution of this case. Under these circumstances, we deny claimant's motion for deferral.

Compensability

On review, claimant argues that the 1995 amendments to the Workers' Compensation Law should not apply retroactively to this case, because it would violate her due process rights under the United States Constitution and deprive her of a "remedy by due course of law" in violation of Article I, section 10 of the Oregon Constitution. Specifically, claimant argues that the new definition of "preexisting condition," which now expressly includes a congenital abnormality that predisposes the worker to disability or the need for treatment, (Or Laws 1995, ch 332, § 1 (SB 369, § 1)), should not be applied to her claim. Alternatively, should we conclude that SB 369 does apply to this case, claimant requests that this case be remanded to the ALJ for development of medical evidence under the new standard.

We need not decide if SB 369 applies retroactively to this case because we agree with the ALJ's finding that claimant's congenital and degenerative low back conditions were causes of claimant's disability and need for treatment, not merely predispositions. Therefore, the analysis and result in this case would be the same under either the former or amended version of the statutes. Accordingly, claimant's motion for remand on this basis is denied.

ORDER

The ALJ's order dated June 2, 1995 is affirmed.

---

December 22, 1995 Cite as 47 Van Natta 2388 (1995)

In the Matter of the Compensation of
**ROBERT GEDDES, Claimant**
WCB Case No. 94-10588
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that dismissed his request for hearing on the basis that the Hearings Division lacked jurisdiction over the matter. Claimant contends that, if the Hearings Division has jurisdiction, he is entitled to penalties and attorney fees for an allegedly unreasonable delay in paying the proceeds of a Claim Disposition Agreement (CDA). On review, the issues are jurisdiction and, if jurisdiction is established, penalties and attorney fees.

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

Claimant sustained a compensable injury in 1985. In 1994, the parties entered into a claim disposition agreement (CDA) that was approved by the Board. Claimant requested immediate payment of the CDA proceeds, which the insurer paid untimely. Claimant subsequently requested a hearing on the issue of a penalty for late payment of the CDA proceeds.

The ALJ dismissed claimant's request for hearing on the basis that, pursuant to former ORS 656.262(10)(a) (renumbered ORS 656.262(11)(a)),[1] the Hearings Division has no jurisdiction over proceedings in which penalties and penalty-related attorney fees are the only issue.

---

[1] This renumbering was effective June 7, 1995. Or Laws 1995, ch 332, §§ 28,66 (1995) (SB 369, §§ 28, 66). Accordingly, we apply the new number in this case.

Claimant contends that Albert A. Scott, 46 Van Natta 56 (1994), establishes that a penalty is appropriate as the result of the late payment of proceeds under a CDA, and that we have jurisdiction to determine the issue of a penalty for late payment of proceeds under a CDA. We disagree.

ORS 656.262(11)(a) provides in pertinent part:

> "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." (Emphasis added).

Here, the insurer paid the CDA proceeds prior to the request for hearing. Thus, the sole issue raised is a penalty and related attorney fee for the insurer's allegedly unreasonable delay in paying the proceeds of a CDA. Claimant raised no other issue or other acts of unreasonable conduct that would independently support awards of penalties or attorney fees. See Corona v. Pacific Resource Recycling, 125 Or App 47 (1993) (When a claimant raises a viable request for a penalty under former ORS 656.262(10)(a), and the unreasonable conduct that supports the penalty is the sole issue, the director has exclusive jurisdiction). See also Ronald A. Stock, 43 Van Natta 1889 (1991) (Board has jurisdiction where the hearing request raises a separate attorney fee as the sole issue or alleges different acts of unreasonable conduct which would support both an ORS 656.382(1) attorney fee and a penalty pursuant to former ORS 656.262(10)).

In Albert A. Scott, supra, the CDA proceeds were paid untimely prior to hearing. The sole issue before the ALJ (formerly referee) was assessment of penalties for the untimely payment. The ALJ concluded that no penalty could be assessed for an untimely payment of the amounts due under a CDA, on the basis that proceeds of a CDA were not "compensation." We concluded that CDA proceeds are "compensation" pursuant to the Workers' Compensation Law and found that the claimant was entitled to seek a penalty pursuant to former ORS 656.262(10)(a). We then proceeded to assess a penalty based on the CDA proceeds "then due" at the time the insurer untimely paid the remaining proceeds and denied an attorney fee under ORS 656.382(1) on the ground that the asserted factual basis for an attorney fee under ORS 656.382(1) was the same as the basis for the penalty awarded under ORS 656.262(10).

Because the sole issue before the ALJ was the assessment and payment of a penalty, our assertion of jurisdiction over the penalty issue in Scott is inconsistent with ORS 656.262(11)(a).[2]

---

[2] We disagree with the dissent's assertion that this Board retains jurisdiction over this case. First, claimant's hearing request sought a "penalty" for "late payment of CDA and TTD payments." Claimant's request did not raise "attorney fees" as an issue. Thus, the record does not support a conclusion that claimant sought an attorney fee under ORS 656.382(1). To the contrary, in written closing arguments to the ALJ, claimant expressly sought a 25 percent penalty based on the allegedly untimely paid CDA proceeds. Since ORS 656.382(1) pertains to carrier-paid attorney fees and ORS 656.262(11) refers to "an additional amount up to 25 percent of the amounts then due," it is apparent that claimant was only seeking a penalty assessment under ORS 656.262(11).

Moreover, although claimant's hearing request listed late TTD payments as an issue, it is apparent that his reference to late TTD installments was designed to establish an alleged pattern of late claim processing payments in support of his request for a 25 percent penalty based on the CDA payment. In other words, claimant was not seeking separate penalties for the allegedly untimely TTD payments; he was only asking for a penalty regarding the CDA payment. In any event, even if claimant was requesting several "penalties" (additional amounts not to exceed 25 percent of the amounts then due) under ORS 656.262(11), exclusive jurisdiction would rest with the Director because claimant did not also request an attorney fee under ORS 656.382(1).

Finally, even if we interpreted claimant's argument as raising a "382(1)" attorney fee issue, we would continue to hold that jurisdiction rests with the Director. As previously explained, claimant did not seek a penalty under ORS 656.262(11) based on the insurer's allegedly unreasonable failure to pay TTD. Instead, claimant limited her request to the insurer's alleged failure to timely pay CDA proceeds. Under such circumstances, the insurer's "acts" of misconduct pertain to one single omission; i.e., the insurer's alleged failure to pay claimant the proceeds from the CDA within 14 days of the date the CDA received Board approval. Since the act of misconduct asserted in support of the penalty under ORS 656.262(11) is identical to the misconduct asserted in support of the attorney fee under ORS 656.382(1), the sole issue is the entitlement to a penalty, for which the Director has exclusive jurisdiction. See Corona v. Pacific Resources Recycling, supra, pages 50-51, n. 1. In this regard, we acknowledge the dissent's attempt to distinguish the Corona holding on the ground that the basis for the "382(1)" attorney fee in Corona was not a failure to comply with a Board order. Nonetheless, in light of the court's clear and unequivocal pronouncement regarding jurisdiction over "same misconduct" disputes and until otherwise instructed, we consider it a more prudent path to hold that jurisdiction over matters such as this rest with the Director.

Consequently, to the extent that our decision in Scott regarding the penalty issue is inconsistent with the statute and the holdings in Corona v. Pacific Resource Recycling, supra, and Ronald A. Stock, supra, we disavow it.

We distinguish our decision in this case from that in Harry E. Forrester, 43 Van Natta 1480 (1991). In Forrester, we issued an order awarding the claimant temporary disability benefits. The employer requested judicial review and continued to withhold claimant's temporary disability benefits. Pursuant to the law that governed the matter at the time the employer requested judicial review, we concluded that, despite its request for judicial review, the employer was required to pay the temporary disability benefits and that its refusal to do so was unreasonable. We accordingly assessed a penalty against the employer pursuant to former ORS 656.262(10). In response to the insurer's argument that we lacked jurisdiction over the claimant's request for hearing, we concluded that, because the claimant sought enforcement of the Board's order (which, unlike the circumstances in this case, had not been satisfied by the carrier), the proceeding did not involve solely the assessment of a penalty within the meaning of former ORS 656.262(10)(a).

Consequently, consistent with the rationale expressed in Forrester, we continue to have jurisdiction of enforcement requests not satisfied by the carrier and the assessment of any penalties flowing therefrom. However, because the carrier's obligation in this case was fully satisfied prior to hearing, leaving the penalty and attorney fee issues only, we lack jurisdiction over this matter.

ORDER

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

**Board Chair Hall specially concurring.**

I write separately to express my agreement with Member Gunn's conclusion that this Board retains jurisdiction to address hearing requests seeking an attorney fee under ORS 656.382(1) for a carrier's refusal to pay compensation granted by an ALJ, Board, or court order. As explained by Member Gunn, since such requests are not requesting an "additional amount" as described by "this subsection [ORS 656.262(11)]," the Director does not have exclusive jurisdiction over such matters. In a case with different facts and pleadings, I would write to address the jurisdictional issues.

Notwithstanding my interpretation of this jurisdictional question, I agree with the majority's finding that claimant's counsel did not request a hearing seeking an attorney fee award under ORS 656.382(1). Inasmuch as claimant's request was solely limited to penalties under ORS 656.262(11), I concur with the majority's reasoning that exclusive authority over the issue rests with the Director.

**Board Member Gunn dissenting.**

I disagree with the majority's conclusion that this Board is without jurisdiction to decide this matter, and dissent for the following reason.

Former ORS 656.262(10) (now (11)) expressly provides that the Director retains "exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection." (Emphasis added). The "additional amount" described in subsection (11) pertains to claim processing violations; i.e., delays or refusals to pay compensation. In contrast, ORS 656.382(1) provides for an attorney fee if an insurer "refuses to pay compensation due under an order of an Administrative Law Judge, board or court...". If the "amount" (i.e., fee) is pursuant to ORS 656.382(1), it is obviously not pursuant to ORS 656.262(11) and, thus, not within the exclusive jurisdiction of the Director. Again, it is only an amount described in "this subsection" (ORS 656.262(11)) that is subject to the Director's exclusive jurisdiction.

Here, claimant requested a hearing contesting the insurer's failure to pay proceeds from a Board-approved CDA. Since a CDA must receive Board approval to become enforceable, the approved CDA constitutes a Board order. See ORS 656.236(1); OAR 438-09-020(3); OAR 438-09-028; OAR 438-09-030(4), (5). Moreover, because the CDA did not provide otherwise, payment of the proceeds was due no later than the 14th day after Board approval. OAR 436-60-145(8).

Consequently, in seeking a hearing, claimant was alleging a failure to timely pay the compensation due pursuant to the Board-approved CDA.[1] Inasmuch as claimant's hearing request did not pertain solely to a penalty amount under ORS 656.262(11), but involved noncompliance with a Board order under ORS 656.382(1), I submit that this Board retains jurisdiction to consider claimant's request for relief.[2]

In conclusion, I respectfully disagree with the majority's decision that this case calls into issue "solely" ORS 656.262(11). Simply stated, the issues in this case include noncompliance with a Board order. While there may be an issue under ORS 656.262(11) for untimely payment of temporary disability, there is a separate factual basis for a fee pursuant to ORS 656.382(1) for noncompliance with a Board order. Therefore, jurisdiction rests with the Board.

---

[1] Claimant also alleged a failure to timely pay temporary disability which from the correspondence and arguments of the parties appears to be separate and apart from the payment of compensation under the CDA.

[2] In reaching this conclusion, I recognize the court's holding in Corona that the same act of misconduct cannot support the assessment of both a penalty and attorney fee and, thus, the Director would have sole jurisdiction over such disputes. However, as explained above, I submit that there are separate acts of misconduct: (1) the insurer's failure to timely pay compensation granted by a Board order; and (2) the apparent failure to pay time loss. In other words, the Corona court was not presented with an alleged act of misconduct which involved noncompliance with a Board order. Since such a violation is expressly addressed in ORS 656.382(1), I submit that the ALJ and this Board are the appropriate forum to address the matter. Although admittedly not precisely addressed by the court, such reasoning is consistent with the court's holding in Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992), where a Board order assessing a penalty for a failure to timely comply with a prior Board order, but not an attorney fee under ORS 656.382(1), was affirmed.

---

December 22, 1995 Cite as 47 Van Natta 2391 (1995)

In the Matter of the Compensation of
**PATRICIA L. McVAY, Claimant**
WCB Case No. 94-15088
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) reduced claimant's scheduled permanent disability for the loss of use or function of the right arm from 19 percent (36.48 degrees), as awarded by an Order on Reconsideration, to 12 percent (23.04 degrees); and (2) reduced claimant's scheduled permanent disability for the loss of use or function of the left arm from 21 percent (40.32 degrees), as awarded by an Order on Reconsideration, to 14 percent (26.88 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for right and left arm conditions. A Notice of Closure awarded 7 percent scheduled permanent disability for the right arm and 10 percent scheduled permanent disability for the left arm. An Order on Reconsideration increased the awards to 19 percent for the right arm and 21 percent for the left arm.

The ALJ reduced the awards to 12 percent for the right arm and 14 percent for the left arm. In reaching this conclusion, the ALJ found that claimant had a loss of strength in her arms due to disuse, deconditioning, and a cumulative trauma disorder. Furthermore, unlike the Order on Reconsideration, the ALJ found that any impairment from the loss of strength did not entitle claimant to a rating under OAR 436-35-110(8)(a) (WCD Admin. Order 6-1992).

On review, claimant asserts that we should reinstate the Director's award. Alternatively, if we agree with the ALJ that claimant is not entitled to a value under OAR 436-35-110(8), claimant requests that we remand the claim to the Director for promulgation of a temporary rule to address the disability.

"Loss of strength" is rated "when the cause is a peripheral nerve injury" or "due to loss of muscle or disruption of the musculo tendonous unit." OAR 436-35-110(8), 436-35-110(8)(a). Here, claimant's treating orthopedic surgeon, Dr. Butters, provided his opinion in a letter drafted by claimant's attorney. He first indicated that claimant had "loss of strength" in her right and left arms as a result of the industrial injury. (Ex. 12-2). The letter further asked whether the loss of strength was caused by "peripheral nerve injury, disruption of the musculotendinous unit or other." Dr. Butters checked "other," adding "cumulative trauma disorder - disuse - deconditioning." (Id. at 3).

Based on such evidence, we are persuaded that claimant's loss of strength was not caused by peripheral nerve injury or disruption of the musculo tendonous unit. The evidence shows, however, a loss of muscle. Specifically, we understand Dr. Butters as indicating that claimant's cumulative trauma disorder resulted in disuse of the muscle, leading to loss of muscle and, ultimately, loss of strength.[1]

Thus, we agree with the Director that claimant is entitled to a 10 percent rating for each arm under OAR 436-35-110(8)(a). The parties do not dispute the following: for loss of range of motion of the forearm, claimant has 4 percent for the right arm and 3 percent for the left arm, OAR 436-35-080; for loss of range of motion of the elbow, claimant has 3 percent for the right arm and 7 percent for the left arm, OAR 436-35-100; finally, claimant is entitled to 5 percent for each arm for a chronic condition, OAR 436-35-010(6). Combining these values results in 19 percent for the right arm and 21 percent for the left arm.

Thus, we affirm the Order on Reconsideration's scheduled permanent disability award of 19 percent for the loss of use or function of the right arm and 21 percent for the loss of use or function of the left arm. Inasmuch as we have concluded that OAR 436-35-110(8)(a) applies to this case, claimant is not entitled to remand to the Director for promulgation of a temporary rule. ORS 656.726(3)(f)(C).

Because we have modified the ALJ's order which reduced claimant's scheduled permanent disability and reinstated the awards made by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is 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). 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 136 Or App (1995).

## ORDER

The ALJ's order dated April 7, 1995 is modified. In addition to the ALJ's award, claimant is awarded additional scheduled permanent disability of 7 percent (13.44 degrees), for a total of 19 percent (36.48 degrees), for the right arm and 7 percent (13.44 degrees), for a total of 21 percent (40.32 degrees), for the left arm. Claimant's attorney is awarded 25 percent of the additional compensation created by this order, not to exceed $3,800. In the event that all or any portion of the "increased" 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.

---

[1] Relying on Vena K. Mast, 46 Van Natta 34, 35, aff'd Mast v. Cardinal Services Inc., 132 Or App 108 (1994), the ALJ stated that disruption of the musculo tendonous unit "does not exist by virtue of deconditioning and disuse." In Mast, we found that a physician's opinion relating strength loss only to "general deconditioning" was not sufficient to entitle claimant to an award under OAR 436-35-110(8).

Our conclusion in Mast should not be interpreted as holding that deconditioning can never satisfy OAR 436-35-110(8)(a). Rather, our reasoning in Mast relates only to our analysis of the medical opinion in that case. Thus, we find nothing in Mast that prevents us from interpreting the medical opinion here as proving that a loss of muscle caused claimant's loss of strength.

In the Matter of the Compensation of
**CANDACE L. SPEARS, Claimant**
WCB Case Nos. 93-11798 & 93-11797
ORDER ON REVIEW
David C. Force, Claimant Attorney
Raymond Myers (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's occupational disease claim for a psychological condition; (2) assessed a penalty for an allegedly unreasonable denial: and (3) awarded a $30,000 attorney fee. On review, the issues are compensability, penalties, and attorney fees.

We adopt and affirm the ALJ's order, with the following supplementation regarding the penalty and modification of the ALJ's attorney fee award.

We agree with the ALJ that SAIF's denial was unreasonable. In reaching this conclusion, we acknowledge SAIF's reliance on Dr. Sargent's June 6, 1993 chartnote which mentions that claimant was being investigated by the police department. (Ex. 41-1). However, because the primary focus of the note is claimant's ongoing stress from previous work-related problems, we are not persuaded that SAIF had a legitimate doubt regarding its liability for this claim on this basis.

The ALJ awarded a $30,000 attorney fee for claimant's counsel's services at the hearing level, based on claimant's counsel's statement of services and consideration of the factors set out in OAR 438-15-010(4). SAIF challenges the award, contending that it is excessive.

In determining an appropriate fee for claimant's attorney's services at hearing, we consider the factors set forth in OAR 438-15-010(4). Those factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The file consists of 135 exhibits. The hearing consumed four days. The transcript totals 732 pages. Four witnesses, including claimant, testified on claimant's behalf, while six witnesses testified for the defense. Claimant's counsel presented extensive written closing arguments. Based on counsel's statement of services, approximately 250 hours were devoted to the case at the hearing level.[1] The statement does not differentiate between services devoted to the compensability issue from those directed at the penalty issue for an unreasonable denial.

Having considered the parties' respective positions on the attorney fee issue, we draw the following conclusions from the foregoing findings.

The value of the compensability issue is high, in that claimant has incurred substantial medical expense and extensive time loss from work.

The issue in dispute involved complex factual matters, considerably more complex than those compensability disputes that are generally presented at hearing and for Board resolution. The events which transpired at the hearing level (preparation for a hotly contested, lengthy hearing and closing arguments) were greater than those which normally arise when the Board confronts a compensability

---

[1] We note that "paralegal" time represents a cost incurred by an attorney in pursuing a matter on behalf of a party. When viewed in this context, such costs are not directly considered as fees paid to an attorney. See OAR 438-15-005(6); see also Tom Goodpaster, 46 Van Natta 936 (1994); Jeffery P. Keimig, 41 Van Natta 1486 (1986). Nonetheless, to the extent that reference to "paralegal" time represents hours of research and investigation subject to supervision of an attorney, such efforts have been considered in evaluating a reasonable attorney fee. Of course, in light of the indirect involvement of the attorney, such services are accorded less significance than efforts directly expended by the attorney. Finally, such "paralegal" services devoted to copying and word processing duties have not been considered in determining a reasonable attorney fee because such services constitute legal costs incurred by the attorney.

dispute, even one involving a claim for a mental disorder. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner, identifying the relevant factual and legal issues for our resolution. Finally, there was a decided risk that claimant's counsel's efforts might have gone uncompensated.

After considering the above factors and applying them to this case, we agree that claimant's counsel is entitled to a significant attorney fee award for services rendered at the hearings level regarding the compensability issue. However, we modify the ALJ's $30,000 attorney fee award. After considering the factors discussed above, we find that $23,500 is a reasonable fee for claimant's counsel's services at hearing regarding the compensability issue. In modifying the ALJ's attorney fee award, we have particularly taken into consideration claimant's counsel's paralegal expenses which are attributable to legal costs.

Furthermore, after considering the parties' respective positions and applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning 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 claimant's respondent's brief and claimant's attorney's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee for services on review concerning the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc, 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 18, 1995, as modified April 19, 1995, is modified in part and affirmed in part. In lieu of the ALJ's attorney fee for services at hearing, claimant's counsel is awarded a $23,500 attorney fee, payable by the SAIF Corporation. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded a $3,000 attorney fee, payable by SAIF.

---



In the Matter of the Compensation of
**THERESA J. STONE, Claimant**
WCB Case No. 95-01676
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Schultz's order that upheld the self-insured employer's denial of claimant's L5-S1 disc condition. On review, the issues are jurisdiction and compensability.

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

Subsequent to the ALJ's order, the legislature amended ORS 656.327(1) and added ORS 656.245(6), each of which requires review of medical services disputes by the Director, unless a claim for medical services is denied on the basis that the underlying claim is not compensable. Or Laws 1995, ch 332, §§ 25, 41, 66, and 69 (SB 369, §§ 25, 41, 66, and 69); Newell v. SAIF, 136 Or App 280 (1995); Walter L. Keeney, 47 Van Natta 1387, 1389, recon den 47 Van Natta 1525 (1995). Inasmuch as the employer has denied the compensability of claimant's underlying L5-S1 condition, we retain jurisdiction over this matter.

Turning to the merits, claimant's original claim was accepted for a lumbar strain only. This dispute concerns a later diagnosed L5-S1 disc condition. We first decide what standard applies to determine the compensability of the disputed condition. Claimant argues that because her claim is for a condition arising "directly out of her industrial exposure," she need only prove the compensability of her

condition by the material contributing cause standard. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We conclude, however, that the applicable statutes are either ORS 656.005(7)(a)(B) or ORS 656.802(1)(c).[1]

Claimant filed a claim for a low back condition which occurred as a result of lifting activity over a period of two to three weeks in July 1993. The claim was accepted as a disabling lumbar strain. The medical record demonstrates that there was no specific injurious event. We conclude, therefore, that claimant must establish the compensability of her L5-S1 disc condition by the major contributing cause standard applicable to occupational disease claims under ORS 656.802(1)(c). Alternatively, if analyzed under an "injury" theory, we agree with the ALJ's reasoning that the appropriate standard would remain "major contributing cause" under ORS 656.005(7)(a)(B) since the disc condition would constitute a combined/resultant condition.

After reviewing the record, we too are persuaded that claimant has failed to establish that either her work activities in general or her particular work exposure in July 1993 were the major contributing cause of her L5-S1 disc condition and need for treatment in November 1994. The ALJ's decision upholding the employer's denial is therefore affirmed.[2]

ORDER

The ALJ's order dated May 19, 1995 is affirmed.

---

[1] ORS 656.802(1)(c) was renumbered ORS 656.802(1)(a)(C). Or Law 1995, ch 332, § 56 (SB 369, § 56).

[2] Inasmuch as we have herein found that the L5-S1 disc condition is not compensable, we do not reach the employer's argument on review that the proposed surgery is not "reasonable and necessary." In any event, the Director now has exclusive jurisdiction over such medical services disputes. ORS 656.327(1); ORS 656.245(6); (SB 369, §§ 25, 41, 66, and 69); Newell v. SAIF, supra; Walter L. Keeney, supra.

---



In the Matter of the Compensation of
**KELLY O. SULLIVAN, Claimant**
WCB Case No. 93-02652
ORDER ON REMAND
Black, Chapman, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Sullivan v. Sears, Roebuck & Co., 136 Or App 302 (1995). This case has been remanded to us to for "reconsideration in light of ORS 656.273 as amended."

In our prior order, Kelly O. Sullivan, 46 Van Natta 2144 (1994), we dismissed claimant's request for hearing concerning his aggravation claim for lack of jurisdiction. In reaching our conclusion, we found that claimant had failed to perfect an aggravation claim prior to the expiration of his aggravation rights. Alternatively, we concluded that, even if claimant had perfected an aggravation claim prior to the expiration of his aggravation rights, he had not established that his compensable condition has worsened.

In the absence of a specific exception, the changes to the Workers' Compensation Law made by Senate Bill 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995). Here, our prior order was appealed and the case has been remanded to us from the court. Because our order has not become final, Senate Bill 369 is applicable.[1]

---

[1] On October 31, 1995, the Board granted the parties an opportunity to file supplemental briefs following the issuance of the court's judgment and record. The insurer has submitted a supplemental brief. However, claimant has not submitted a supplemental brief and the time for submitting such briefs has expired. Thus, we have proceeded with our reconsideration without benefit of further argument from claimant.

Assuming that the amendments to ORS 656.273(3) are retroactively applicable to this case, we find nothing in those amendments which would change our conclusion that claimant did not perfect an aggravation claim prior to the expiration of his aggravation rights. Moreover, there is an additional basis for our prior conclusion.

Subsequent to our prior order, the court issued its decision in SAIF v. Reddekopp, 137 Or App 102 (1995). In Reddekopp, supra, the court vacated the Board's order which had held that the claimant's aggravation had been perfected prior to the expiration of aggravation rights. The court held that the claimant's failure to appeal a prior Own Motion order, which had affirmed the closure of the claimant's Own Motion claim and found that the claimant's condition had worsened after the expiration of his aggravation rights, precluded the claimant from relitigating the question of whether the claimant's condition had worsened prior to the expiration of his aggravation rights. Id. at 107.

Here, as in Reddekopp, the Board reopened claimant's claim, pursuant to its Own Motion jurisdiction under ORS 656.278, by order dated January 27, 1993. By authorizing the payment of temporary disability benefits pursuant to ORS 656.278, the Board's Own Motion order necessarily determined that claimant's condition worsened subsequent to the expiration of his aggravation rights. The Board's January 27, 1993 Own Motion order was not appealed and became final. Consequently, claimant cannot now collaterally attack the Board's Own Motion decision and is precluded from asserting that his condition worsened prior to the expiration of his aggravation rights. Reddekopp, supra.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 4, 1994 order in its entirety.

IT IS SO ORDERED.

---

December 22, 1995 Cite as 47 Van Natta 2396 (1995)

In the Matter of the Compensation of
**BETTY S. TEE, Claimant**
WCB Case No. 88-11538
CORRECTED ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by the Board en banc.[1]

It has come to our attention that our prior Order on Reconsideration contained a clerical error. Specifically, our order contained an incorrect date of mailing of "November 20, 1995," whereas the order was actually mailed on December 20, 1995. To correct this oversight, we withdraw our prior order and replace it with the following order. The parties' rights of appeal shall begin to run from the date of this order.

The self-insured employer requested reconsideration of our May 25, 1995 Order on Review which affirmed Administrative Law Judge (ALJ) Hoguet's order granting claimant permanent total disability (PTD) benefits. Specifically, the employer requests that we reconsider our decision under the new statutory standards established by Senate Bill 369, which took effect on June 7, 1995. Or Laws 1995, ch 332 (SB 369). In order to allow claimant an opportunity to respond, we abated our order on June 21, 1995. We have received claimant's response and now proceed with our reconsideration.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for his finding that the part-time telemarketing job is not a gainful occupation. Instead, we find that the job is gainful employment.

---

[1] Board Chair Hall has recused himself from this case. OAR 438-11-023. Consequently, he has not participated in this matter.

## PROCEDURAL HISTORY

This matter was before the Board on remand from the Supreme Court. Tee v. Albertsons, Inc., 314 Or 633 (1992). The Supreme Court modified the Court of Appeals' decision, 107 Or App 638 (1991), which had affirmed our order, 42 Van Natta 540 (1990), that declined to grant claimant PTD because she could perform a telemarketing job and a hotel/motel inspectress job. Identifying the salient issue as the definition of the term "gainful occupation," the Supreme Court reasoned that the term relates to earnings a worker can obtain by working at a "suitable occupation." The Court held that the term "gainful occupation" means "profitable remuneration." The Court remanded for further consideration concerning whether "both the telemarketing job and the hotel/motel inspectress jobs were gainful and suitable employments for claimant."

On remand, we found that the record concerning whether the jobs in question represent employments for "profitable remuneration" was insufficiently developed for our review. Consequently, we remanded this matter to the ALJ for the parties' submission of additional evidence regarding the issue of whether the telemarketing and hotel/motel inspectress jobs constitute employments for profitable remuneration. 45 Van Natta 289 (1993).

On remand before the ALJ, the parties stipulated that the hotel/motel inspectress job is no longer at issue and that the sole focus is on the telemarketing job.[2] The parties further stipulated that, as of September 26, 1988 (i.e., claimant's effective PTD date under the ALJ's first Opinion and Order), claimant was able to work four to six hours per day and that telemarketing work was available as a suitable occupation, paying an hourly wage of about $4.75.[3] Thus, the parties framed the dispositive issue as whether, as of September 26, 1988, the part-time telemarketing job constituted employment for profitable remuneration.

Finding that part-time telemarketing work would not provide claimant with profitable remuneration, the ALJ concluded that such work was not a gainful occupation. Accordingly, the ALJ held that claimant was entitled to PTD benefits. The employer appealed.

## CONCLUSIONS OF LAW AND OPINION

In our May 25, 1995 Order on Review, we affirmed the ALJ's order. Applying a "net gain" analysis, we found that the anticipated expenses of claimant performing the part-time telemarketing job would exceed her anticipated income from the job. Because claimant would have realized no net income from the part-time telemarketing job, we concluded that the job was not employment for "profitable remuneration." Accordingly, we concluded that there was no gainful employment which claimant could regularly perform, and that she was therefore permanently and totally disabled under ORS 656.206.

Subsequent to our order, ORS 656.206(1)(a) was amended as follows:

> "Notwithstanding section 3 of this 1995 Act, 'permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a gainful occupation is one that pays wages equal to or greater than the state mandated hourly minimum wage. As used in this section, a suitable occupation is one [which] that the worker has the ability and the training or experience to perform, or an occupation [which] that the worker is able to perform after rehabilitation." SB 369, § 14.

---

[2] This stipulation was entered because neither party could find part-time hotel/motel inspectress jobs in sufficient quantity to constitute a suitable occupation for claimant. (Remand Hearing Tr. 2). Therefore, we do not consider that occupation in our review.

[3] This stipulation is consistent with the Board's previous finding, which claimant did not contest on judicial review, that she was employable without training as a telemarketer and that such work was available. Tee v. Albertsons, Inc., supra, 314 Or at 636.

Our first inquiry is whether the amended statute applies to this case. We conclude it does. Except as otherwise provided, SB 369 applies 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. Newell v. SAIF, 136 Or App 280 (1995). We abated our prior order before the time for appealing that order had expired. In addition, amended ORS 656.206 is not among the exceptions to that general rule. See SB 369, § 66 (enumerating exceptions to general retroactivity provision). Consequently, amended ORS 656.206 applies here. Therefore, we review this matter under the new definition of "gainful occupation."

"Gainful occupation" is now defined as an occupation "that pays wages equal to or greater than the state mandated hourly minimum wage." The "state mandated hourly minimum hourly wage" is set forth in ORS 653.025. Claimant argues that, under ORS 653.025, the applicable wage rate is $4.75. We disagree. The $4.75 wage rate applies "[f]or calendar years after December 31, 1990." ORS 653.025(3). In this case, however, claimant's permanent disability is being rated on the basis of conditions existing at the time of the September 1988 hearing. See Gettman v. SAIF, 289 Or 609, 614 (1980); Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). Therefore, we look to labor market conditions existing at the time of the September 1988 hearing to determine whether claimant was employable at a gainful occupation. In September 1988, the state mandated hourly minimum wage was $3.35. Former ORS 653.025(2) (Or Laws 1985, ch 161, § 1). Therefore, the dispositive issue is whether claimant was employable at an occupation that pays an hourly wage of $3.35 or more.

It is undisputed that in September 1988 the telemarketing jobs paid an hourly wage rate in excess of $3.35. Nevertheless, claimant argues that the telemarketing jobs are not "gainful" because she cannot work enough hours to realize any "gain" when work-related expenses are subtracted. Essentially, claimant argues that the "net gain" analysis we applied in our prior order should still be applied under the new definition of "gainful occupation." We disagree.

Based on our review of the statutory text and context, see PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993), we conclude that amended ORS 656.206(1)(a) is unambiguous. The definition of "gainful occupation" is precise; it is an occupation that pays at or above the minimum wage rate. There is no language in the definition which indicates that the legislature intended to have anticipated job-related expenses subtracted from anticipated income in the determination of "gainful" employment. Had the legislature intended to adopt the "net gain" analysis, it could have codified the Supreme Court's definition of "gainful" as "profitable remuneration." The fact that the legislature did not codify that definition, and instead, adopted a definition which is based on the minimum wage rate, persuades us that the legislature intended to overrule Tee v. Albertsons, Inc., supra, and Fred D. Justice, 47 Van Natta 634 (1995). Indeed, we conclude from the statutory text that the legislature adopted Justice Graber's dissenting opinion in Tee that a gainful occupation "is simply an occupation for which the worker receives a lawful wage." 314 Or at 644. Hence, the notion of "profit," upon which we based our "net gain" analysis, is no longer a consideration under amended ORS 656.206(1)(a).

Claimant argues that the legislature did not intend that any number of hours of work paid at minimum wage necessarily would constitute a gainful occupation. However, the number of work hours is not mentioned as a factor in the new definition of "gainful occupation." Because we may not read into a statute an additional requirement that is not there, see ORS 174.010, we do not find there is a minimum number of work hours required for an occupation to be "gainful" within the meaning of amended ORS 656.206(1)(a).[4]

Although we are not required to resort to legislative history, we find that our construction of amended ORS 656.206(1)(a) is supported by the legislative history of Senate Bill 369. In an informational hearing before the House Committee on Labor, Representative Mannix explained the intent behind the new definition of "gainful occupation":

---

[4] Gainful employment must also be available to claimant on a "regular" basis in order to avoid a PTD finding. See ORS 656.206(1)(a); Wiley v. SAIF, 77 Or App 486, 491, rev den 301 Or 77 (1986); cf. Lankford v. Commodore Corporation, 92 Or App 622, 625 (1988) (the claimant's failure to seek work as a respite care provider did not disqualify her from PTD status where the record does not demonstrate that such work was available on a regular basis). In this case, based on the testimony of claimant's vocational counselor, Ms. Gaffuri (Remand Hearing Tr. 123-27), we find that there were telemarketing jobs available on a regular, part-time (four to six hours per day) basis in September 1988. See Pournelle v. SAIF, 70 Or App 56, 60 (1984) (the ability to work on a permanent part-time basis is sufficient to avoid a PTD finding).

"[Rep. Mannix:] What is gainful in terms of occupation or employment? [Section 14 of SB 369] says if it's minimum wage, that's gainful. That is actually the standard that is currently in the administrative rules for workers' compensation, and it's been in those rules for some time. * * * * [H]ere we're trying to say, well, we're going to take what's in the administrative rules and just put it into statute so there's no question as to that definition. * * * * It's simply the intention to lock in what had been the administrative practice for some time as to the definition of gainful, because the courts are starting to play around with that and try to figure out what gainful means. And this says let's take the administrative rule and put it into statute so there won't be any question about what it means.

"[Chairman Watt:] Can . . . can you just expound on that? You say the courts are starting to play around with this. Give us an idea.

"[Rep. Mannix:] As soon as you see a Annabella decision which says 'Well, gee, it's not defined in statute' and if I recall there's a case which says that we need to be talking about--I'm not certain about the phrase--profitable remuneration or reasonable remuneration, they're trying to come up with some phraseology. You begin to wonder, the courts are starting to wonder about how to define this. Maybe it's the legislature's job to step in and say 'We already have a definition. It's in the rules. We're happy with it so let's put it in the statute.' Because sometimes there'll be an argument that the rule goes beyond the authority of the agency that provides the rule. And here we're trying to make it clear 'No, the rule...the rule's there and we're gonna put the rule into the statute.' That makes it clear to the court that that is the standard for gainful." Hearing, House Committee on Labor, March 3, 1995, Tape 41, Side A.

Representative Mannix's statements indicate that the new definition of "gainful employment" was intended to overturn the "profitable remuneration" definition formulated by the Supreme Court. His statements further indicate that the new definition was intended to reflect the same definition of "gainful occupation" which is in the administrative rules of the Department of Consumer and Business Services. The Department's administrative rules define "gainful occupation" as "those types of general occupations that are either full-time or part time in duration and pay wages equivalent to, or greater than, the state and federal mandated minimum hourly wage." OAR 436-30-055(1)(c) (Emphasis supplied). Hence, the legislative history supports our conclusion that the new definition of "gainful occupation" was intended to include either a full-time and part-time job which pays at or above the minimum hourly wage.

Finally, claimant raises constitutional challenges to the retroactive application of amended ORS 656.206(1)(a). She argues that retroactive application of the statute would deprive her of a property interest (PTD benefits) without due process, contrary to the U.S. Constitution. She also argues that retroactivity would deprive her of a "remedy by due course of law" which is guaranteed by Article I, section 10, of the Oregon Constitution. She reasons that, if amended ORS 656.206(1)(a) is applied retroactively, she would be deprived of PTD benefits without any notice, opportunity to present evidence, or a hearing before an impartial decision-maker. She also reasons that her private interest in PTD benefits outweighs any public interest served by retroactive application. We disagree.

Claimant does not indicate what, if any, additional evidence she wishes to submit under the new definition of "gainful occupation." Inasmuch as the parties have stipulated that the telemarketing jobs paid wages above the state mandated minimum rate, we conclude that the record is fully developed on the issue of whether the telemarketing jobs constituted a gainful occupation. Had we concluded otherwise, we would have remanded this case to the ALJ for further proceedings. See ORS 656.295(5). We find no reason to do so.

We also decline claimant's invitation to engage in policy judgments reserved for the legislature. The most important consideration in determining proper application of a legislative enactment is the legislature's intended application. Within constitutional limits, the legislature may impose any special considerations 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). We have previously held that the legislature clearly intended the 1995 amendments to apply retroactively to pending cases. See SB 369, § 66(1); Walter L. Keeney, 47 Van Natta 1387 (1995).

Furthermore, insofar as claimant is asserting that retroactive application of Senate Bill 369 violates the federal constitutional guarantee of substantive due process, we conclude that constitutional challenge fails. The "rational basis" standard of due process review is applied to constitutional challenges of retroactive social and economic legislation. See, e.g., In re Consolidated U.S. Atmosphere Testing Litigation, 820 F2d 982 (9th Cir 1987), cert den 485 US 905 (1988). Retroactive legislation will pass muster under the rational basis test if a legitimate legislative purpose is furthered by rational means. General Motors Corp. v. Romein, 112 S Ct 1105, 1112 (1992). Here, even by claimant's own admission, the public interest in Senate Bill 369 was workers' compensation premium reduction. We find that is a legitimate legislative purpose. We also find that the legislative implementation of stricter requirements for the receipt of benefits, and the retroactive application of those requirements to pending cases, were rational means for reducing workers' compensation premiums. Therefore, we conclude that retroactive application of Senate Bill 369 does not violate claimant's substantive due process rights.

Under amended ORS 656.206(1)(a), we find that in September 1988 claimant was regularly employable at a gainful and suitable occupation.[5] Accordingly, we reverse the ALJ's award of PTD benefits and reinstate the additional award of 25 percent unscheduled permanent partial disability award (which was granted by the Board's March 15, 1990 Order on Review).

## ORDER

The ALJ's order dated April 15, 1994 is reversed in part and affirmed in part. The ALJ's award of PTD benefits is reversed. In addition to the June 27, 1988 Determination Order award of 20 percent (64 degrees) unscheduled permanent disability, claimant is awarded 25 percent (80 degrees) unscheduled permanent disability, for a total award to date of 75 percent (240 degrees) unscheduled permanent disability for her 1984 injury. Claimant's attorney is awarded 25 percent of the additional compensation awarded by this order, not to exceed $3,800, payable directly to claimant's attorney. The employer is authorized to credit the attorney fee paid pursuant to the ALJ's order and prior Board order in this matter against the attorney fee awarded by this order. The remainder of the ALJ's order is affirmed.

---

[5] Senate Bill 369 also amended ORS 656.283(7), which now provides in pertinent 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." SB 369, § 34. Section 34 is not among the enumerated exceptions to retroactive application in Section 66 of Senate Bill 369. In this case, however, the Determination Order issued in 1988, long before the implementation of the mandatory reconsideration procedures in 1990. Therefore, we conclude that retroactive application of Section 34 to this case would produce an absurd and unjust result and would clearly be inconsistent with the purposes and policies of the workers' compensation law. See Rick A. Webb, 47 Van Natta 1550 (1995); Ida M. Walker, 43 Van Natta 1402 (1991). Therefore, we decline to retroactively apply amended ORS 656.283(7) to this case.

**Board Member Gunn dissenting.**

The majority is persuaded that the new definition of "gainful occupation" was intended to encompass any part-time or full-time job paying at or above the minimum hourly wage. Here, because part-time telemarketing jobs paid at least the minimum hourly wage in 1988, my colleagues find that those jobs constituted a "gainful occupation." I disagree and therefore, dissent.

During testimony before the House Labor Committee on Senate Bill 369, Representative Mannix was asked what effect the new definition of "gainful occupation" would have on this particular claimant. He was told that this claimant's anticipated expenses of accepting part-time work would have exceeded the income she earned from the job. Representative Mannix responded: "[I]t would seem to me to be unreasonable to say to somebody 'you have to spend more than you're gonna earn in order to get a job.'" He then added that other factors besides the "gainfulness" of claimant's proposed part-time job, such as the regularity and suitability of the job, must also be considered. When he was asked whether somebody like this claimant would still have the opportunity to receive PTD benefits, Representative Mannix answered: "The opportunity to establish a case would still be there." Hearing, House Committee on Labor, March 3, 1995, Tape 41, Side A.

I wholeheartedly concur with Representative Mannix that it is unreasonable to expect an injured worker to lose money accepting a part-time, minimum-wage job. The legislature has declared that an objective of workers' compensation 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). When viewed in the context of this statutory objective, Representative Mannix's comments can mean only one thing: A worker who is being paid at or above the minimum wage, yet realizes no net income (after deducting job-related expenses), is not being restored to an economically self-sufficient status and is therefore not employed at a "gainful occupation." Representative Mannix did not intend for any minimum-wage job to be deemed "gainful." If he had, there would be no "opportunity to establish a case." Hence, Representative Mannix's comments evidence an intent to have only those jobs which restore the worker to an economically self-sufficient status, i.e., net the worker some income, be deemed "gainful" occupations. Because the part-time telemarketing jobs would not have restored this claimant to an economically self-sufficient status, I conclude they were not "gainful."

Finally, as I noted in my dissenting opinion in Fred D. Justice, 47 Van Natta 634 (1995), we are trying to determine the gainfulness of a worker's employment when the employment is merely "proposed" rather than "actual." We are again dealing with a market abstraction which exists in the report and testimony of a vocational expert. The evidence consists of market surveys of potential employment that may have existed in 1988. We do not have an actual employer with a real job upon which we can determine actual expenses. Yet, despite the absence of a real job with actual expenses, the majority finds that claimant is employable at a gainful occupation. That, I believe, is contrary to substantial justice, and violates the purposes and policies of the Workers' Compensation Law. For these reasons, I dissent.

---

December 27, 1995 Cite as 47 Van Natta 2401 (1995)

In the Matter of the Compensation of
**LESLIE MOSSMAN (Deceased), Claimant**
WCB Case No. 95-01237
ORDER ON REVIEW
Peterson & Peterson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order which: (1) found that SAIF was precluded from contesting the compensability of the deceased worker's coronary disease which caused the decedent's death; and (2) awarded claimants widow death benefits. On review, the issue is death benefits. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

On May 23, 1969, claimant suffered a compensable myocardial infarction. A March 1971 Determination Order awarded unscheduled heart disability. (Ex. 2d). In January 1972, claimant had another myocardial infarction. (Ex. 2h). The claim was reopened and eventually closed with an additional unscheduled heart disability award. (Ex. 2m).

In 1985, SAIF denied claimant's current coronary artery disease. (Ex. 12a). By Stipulation and Order, SAIF agreed to pay for treatment and medication relating to claimant's compensable injury (myocardial infarction). (Ex. 13-2).

On December 1, 1992, claimant died of cardiac arrest. Claimant's widow requested benefits pursuant to ORS 656.204. SAIF denied the claim and claimant's widow requested a hearing.

The ALJ determined that claimant's widow was entitled to benefits under ORS 656.204. In so doing, the ALJ found that the prior Determination Order awards were, at least partially, based on claimant's noncompensable condition (coronary disease). As such, the ALJ concluded that SAIF was precluded from denying the compensability of claimant's noncompensable condition when it failed to contest the Determination Order which had granted permanent disability based on the coronary disease. Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) rev den, 320 Or 507 (1995).

Subsequent to the date of the ALJ's decision, the legislature enacted SB 369, which amended ORS 656.262(10) (formerly ORS 656.262(9)). Or Laws 1995, ch 332, § 28 (SB 369, §28). According to § 66(5)(b) of SB 369, ORS 656.262(10) applies retroactively to all claims "without regard to any previous order or closure." Under § 66(5)(a) of SB 369, the amendments to ORS chapter 656 apply only to those matters for which an order or decision has not become final on or before the effective date of the Act.[1]

Inasmuch as there has been no final order or decision in this case and because the statute does not alter procedural time limitations, amended ORS 656.262(10) applies retroactively. See Volk v. America West Airlines, 135 Or App 565 (1995); Cigna Insurance Co. v. McMasters, 135 Or App 583 (1995). Amended ORS 656.262(10) provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. 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." (Emphasis added).

Here, claimant's 1969 and 1972 myocardial infarctions were found to be compensable. Claimant received permanent disability benefits pursuant to two Determination Orders. SAIF did not formally accept claimant's underlying coronary disease. Based on the clear language of amended ORS 656.262(10), payment of a DO award "shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein * * *." According to § 66, the statute applies retroactively regardless of any previous order or closure. Therefore, SAIF is not precluded from denying claimant's coronary disease. Craig L. Hiatt, 47 Van Natta 2287 (1995) (Members Hall and Gunn dissenting).

Alternatively, claimant's widow asserts that SAIF accepted claimant's coronary disease when it accepted his myocardial infarction condition. Georgia Pacific v. Piwowar, 305 Or 494 (1988). We disagree.

A carrier's acceptance of a claim includes injuries or conditions specifically accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). However, where a carrier has accepted a symptom of a disease, it is deemed to have also accepted the underlying disease causing that symptom. Georgia Pacific v. Piwowar, supra.

Here, SAIF did not accept a symptom of a disease. Instead, it accepted claimant's myocardial infarctions (heart attack) which is a specific condition. See Emmert v. City of Klamath Falls, 135 Or App 209 (1995). In Emmert, the court concluded that the carrier did not accept a particular condition when it accepted the claimant's "chest pains" claim. Therefore, the court determined that the carrier did not limit its acceptance.

Here, although claimant submitted a claim for aggravation of his arteriosclerotic heart condition, SAIF specifically accepted claimant's myocardial infarction. (Ex. 2h; 2i). Accordingly, we conclude that SAIF's acceptance of claimant's myocardial infarctions limited its acceptance to that particular condition. Consequently, SAIF is not precluded from contesting the compensability of claimant's coronary disease.

---

[1] We note that claimant's contention that a Determination Order is a final order, which appears to exclude if from retroactive application under § 66(5)(a) of SB 369, the amendments to ORS chapter 656. However, ORS 656.262(10) specifically states that payment of benefits pursuant to a determination order shall not preclude a carrier from subsequently contesting the compensability of the condition rated therein.

We turn to a review of the merits of the claim. The ALJ found that claimant's myocardial infarctions were not a material or major cause of his death. Claimant's widow asserts that the material cause of claimant's death was his compensable myocardial infarctions.

SAIF was ordered to accept claimant's myocardial infarction. (Ex. 2). The medical reports of Drs. Wasenmiller, Kremkau, DeMots, as well as the attending physician, Dr. Freiermuth, support a finding that claimant's accepted condition combined with a noncompensable condition (coronary disease), to cause or prolong disability or a need for treatment. Thus, claimant's widow must prove that the compensable condition was the major contributing cause of claimant's death. See ORS 656.005(7)(a)(B); SAIF v. Batchelor, supra. Even though a work injury precipitates symptoms in a previously asymptomatic, preexisting condition, the work injury must still be the major contributing cause in order for the resultant condition to be compensable. See Dietz v. Ramuda, 130 Or App 397 (1994). Further, we normally give greater weight to the opinion of the treating physician absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Finally, 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 1986, Dr. Banner, medical examiner on behalf of SAIF, stated that claimant had several factors contributing to his current chest pains and coronary heart disease. These factors included a family history, obesity and smoking. (Ex. 7a-1). Dr. Banner could not opine as to whether claimant's initial heart attack was the cause of his then current condition.

Dr. Wasenmiller reviewed records on behalf of SAIF, in 1986. He stated that, prior to claimant's 1969 heart attack, claimant developed progressive coronary disease accelerated by multiple risk factors (i.e. smoking). (Ex. 10). Dr. Wasenmiller opined that claimant's 1969 heart attack was caused by his coronary disease. Dr. Wasenmiller noted that the heart attack had no effect on claimant's on-going coronary disease. He believed that claimant's risk factors would continue to progress claimant's heart disease.

In February 1992, Dr. Kremkau, examining physician, opined that claimant's myocardial infarctions were the major causes of his heart disease and need for medications. (Ex. 22). Dr. Kremkau did not present an opinion regarding the cause of claimant's death.

In May 1994, Dr. DeMots reviewed records for SAIF and opined that the cause of claimant's death was progression of his coronary disease. (Ex. 28). He stated that, after the 1969 and 1972 heart attacks, claimant's coronary disease progressed due to several risk factors (i.e. smoking, hypertension, lipid abnormalities and diabetes). Dr. DeMots explained that a myocardial infarction results in loss of heart muscle which forms a scar and affects the ability of the heart to function. If the heart is damaged enough by the myocardial infarction, Dr. DeMots stated that congestive heart failure results. However, noting that claimant died of cardiac arrhythmia caused by a "new" myocardial infarction, Dr. DeMots concluded that this new myocardial infarction was caused by the progression of claimant's coronary disease.

On July 13, 1994, Dr. Freiermuth stated that the major cause of claimant's death was coronary disease. (Ex. 29). He was of the opinion that claimant's 1969 and 1972 myocardial infarctions were the causes of claimant's heart disease. Therefore, Dr. Freiermuth believed that claimant's myocardial infarctions were the major contributing cause of his death. He based his opinion on a history of claimant giving up tobacco in 1967 prior to the first myocardial infarction. (Ex. 29).

We are not persuaded by Dr. Freiermuth's opinion because it is based on an inaccurate history. Miller v. Granite Construction Co., 28 Or App 473, 478 (1977). Specifically, Dr. Freiermuth believed that claimant had quit smoking in 1967 and had never resumed. However, Drs. Wasenmiller, DeMots and Banner reported that claimant was a user of tobacco. Further, because Drs. DeMots, Banner, and Wasenmiller identified the smoking of cigarettes as a risk factor which accelerates the progression of coronary heart disease, we find Dr. Freiermuth's inaccurate history significant. Additionally, we are not persuaded by the reports of Drs. Kremkau and Banner, as neither physician advanced an opinion on the cause of claimant's death.

Conversely, we find Dr. DeMots' opinion persuasive because it is well-reasoned and complete. Somers v. SAIF, supra. Dr. DeMots explained that claimant's heart attacks resulted in loss of heart muscle. He opined that the loss of heart muscle will cause congestive heart failure. However, claimant did not die of heart failure. According to Dr. DeMots, claimant died of another myocardial infarction which was caused by the progression of his coronary disease which in turn was caused by claimant's smoking, diabetes and hypertension. (Ex. 28-2). Therefore, we are not persuaded that the material/major contributing cause of claimant's death was his compensable condition. Consequently, claimant's widow is not entitled to survivor benefits.

ORDER

The ALJ's order dated May 17, 1995 is reversed. The ALJ's attorney fee award is reversed.

---

December 27, 1995 Cite as 47 Van Natta 2404 (1995)

In the Matter of the Compensation of
**DARLENE E. PARKS, Claimant**
WCB Case No. 91-14715
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Cummins, Goodman, et el, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order which: (1) upheld the self-insured employer's denial of her injury claim for temporomandibular joint (TMJ) syndrome; (2) determined that claimant's claim had not been prematurely closed by an April 15, 1991 Notice of Closure; (3) declined to grant claimant an award of permanent total disability; (4) increased claimant's award of unscheduled permanent disability in an Order on Reconsideration from zero to 15 percent (48 degrees); and (5) declined to award claimant temporary disability from November 6, 1989 through October 18, 1990. In her brief, claimant requests that we award an assessed attorney fee pursuant to ORS 656.386(1) for prevailing with respect to an alleged "de facto" denial of her visual dependence condition. On review, the issues are compensability, premature closure, unscheduled permanent disability, permanent total disability, temporary disability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

On January 2, 1989, a tarp handle struck claimant on the head, arms, back and shoulders while she was performing her duties as a truck driver. In September 1989, the employer orally agreed to accept claimant's neck, shoulder and back strains/sprains, as well as an inner ear disorder, benign paroxysmal positional vertigo (BPPV). (Ex. 20-5). Before reading or signing the written stipulation formally accepting the claim, claimant left Oregon for the East Coast to drive trucks for a Wisconsin trucking firm.

In September 1989, claimant continued to experience symptoms of her injury, including balance problems and vertigo. On September 29, 1989, while working in Maryland, claimant bumped her head on the door of her truck and experienced an onset of dizziness. Claimant's employer eventually flew claimant back to Oregon where she sought care from her attending chiropractor, Dr. Webb, and a otolaryngologist, Dr. Brown. Dr. Brown authorized temporary disability from October 12, 1989 to December 1, 1989. On her return to Oregon, claimant for the first time saw the written settlement stipulation accepting her January 1989 claim. Claimant signed the settlement document, which was approved by an ALJ on October 19, 1989. (Ex. 10BB).

The employer began paying temporary disability within 14 days of receipt of Dr. Browns' authorization, but terminated payment of interim time loss on October 18, 1989. (Ex. 14-4). On

November 6, 1989, the employer issued a denial of both compensability and responsibility pertaining to claimant's current condition. (Ex. 14-4).[1]

By order of October 18, 1990, ALJ Michael Johnson denied the employer's motion to set aside the October 1989 settlement stipulation and held that claimant's BPPV condition remained compensable in spite of the intervening out-of-state injury. (Ex. 20). Setting aside the employer's denial, the ALJ also determined that claimant's BPPV condition had lead to claimant becoming "visually dependent," a condition that was itself compensable. (Ex. 20-9). The employer appealed ALJ Johnson's order and stayed payment of temporary disability between November 6, 1989 and October 18, 1990 pursuant to former ORS 656.313.

The Board subsequently vacated the ALJ's order and remanded to the ALJ Johnson for the admission of new evidence. (Ex. 37). In October 1991, ALJ Johnson issued another order reaching the same conclusions made in his previous order. (Ex. 40). Although the ALJ did not specifically address the issue of temporary disability, the claim was remanded to the employer for processing and provision of appropriate benefits. ALJ Johnson's order was not appealed.

In the meantime, the claim was closed on April 15, 1991 by Notice of Closure, which awarded temporary disability from October 18, 1990 through December 21, 1990 and 17 percent unscheduled permanent disability for injury to claimant's neck and cranial nerves. (Ex. 32). Claimant requested reconsideration of the closure notice.

Dr. Grimm, a neurologist, wrote on May 11, 1991 that claimant's January 1991 injury produced her BPPV, but that her symptoms were in excess of what that condition would produce by itself. (Ex. 34-1). Dr. Grimm further concluded that the September 1991 incident in Maryland added "insult" to the January 1989 injury and produced a traumatic perilymph fistula (PLF) and either worsened or produced a secondary endolymphatic hydrops (EH) condition. (Ex. 34-2). Dr. Grimm emphasized that claimant had experienced new symptoms that could not be accounted for by her BPPV conditon. (Id.) Dr. Brown later opined on June 20, 1991 that claimant's disability after September 28, 1991 was caused in major part by the traumatically induced PLF and EH conditions. (Ex. 35).

In response to Dr. Grimm's reports, the employer denied the compensability of the PLF and EH conditions on the ground that they were unrelated to claimant's compensable January 1991 injury. (Ex. 36).

On July 31, 1991, an Order on Reconsideration was issued, which reduced claimant's permanent disability award to zero and awarded temporary disability from October 18, 1989 through November 5, 1989. (Ex. 38). Claimant was determined to be medically stationary on November 6, 1989. Both claimant and the employer requested hearings from the reconsideration order.

In September 1991, a hearing was held before ALJ Mongrain with regard to the compensability of the denied PLF and EH conditions. Also at issue were responsibility for claimant's compensable BPPV condition and claimant's entitlement to temporary disability from November 6, 1989 to October 18, 1990. By Opinion and Order of January 22, 1992, ALJ Mongrain found that the employer was still responsible for claimant's BPPV condition and that claimant's PLF and EH conditions were not compensable. The ALJ also declined to award temporary disability from November 6, 1989 through October 18, 1990. (Ex. 43). The ALJ reasoned that the employer was entitled to stay payment of temporary disability pending review of ALJ Johnson's October 18, 1990 order and, since that order was subsequently vacated by the Board, there was no duty to pay temporary disability pursuant to that order. ALJ Mongrain's order was affirmed by the Board on April 22, 1993. (Ex. 52).

In March 1993, Dr. Yanney, dentist and medical doctor, evaluated claimant's severe jaw pain. Claimant reported that she had been hit in the face by the tarp handle during the January 1991 incident of injury and had experienced an immediate onset of symptoms. Dr. Yanney diagnosed right traumatic temporomandibular joint dysfunction (TMJ), which he related to claimant's injury. (Ex. 53). The employer denied the TMJ condition on August 18, 1993. (Ex. 54).

---

[1] On February 9, 1990, ALJ Michael Johnson found that the employer had not shown good cause for terminating claimant's temporary disability and ordered it to pay temporary disability from October 18, 1990 to the date of the November 6, 1989 denial. (Ex. 14-9).

CONCLUSIONS OF LAW AND OPINION

At hearing, the issues were the compensability of claimant's TMJ condition, permanent total disability, unscheduled permanent disability, premature claim closure and temporary disability. The ALJ upheld the employer's denial of claimant's TMJ condition, reasoning that Dr. Yanney's opinion was not persuasive because it relied on an inaccurate history of a blow to the jaw and immediate onset of symptoms.

The ALJ then determined that the April 15, 1991 Notice of Closure was not prematurely issued. In reaching this conclusion, the ALJ found the opinion of an examining physician, Dr. Howell, who had opined that claimant was medically stationary prior to issuance of the April 1991 Notice of Closure, more persuasive than that of Dr. Shonerd, the attending physician for claimant's musculoskeletal conditions. Dr. Shonerd had not declared claimant medically stationary prior to claim closure.

With respect to claimant's contention that she was permanently and totally disabled, the ALJ concluded that the only limitation imposed on claimant as a result of her compensable injury was a prohibition of working at heights and on machinery and of lifting more than 30 pounds. The ALJ found that claimant was not permanently and totally disabled, reasoning that, to the extent that the vocational evidence indicated that she was, it relied on non-compensable conditions, such as the PLF and EH disorders. The ALJ then awarded 15 percent unscheduled permanent disability for the permanent residuals of the January 1989 injury.

Finally, the ALJ affirmed the award of temporary disability in the Order on Reconsideration and found that claimant was not entitled to temporary disability from November 6, 1989 through October 18, 1990. The ALJ reasoned that entitlement to temporary disability between November 6, 1989 and October 18, 1990 had already been litigated before ALJ Johnson in October 1989 and October 1990 and could not be relitigated. On reconsideration, the ALJ reduced claimant's temporary disability award in the Order on Reconsideration to zero, concluding that any temporary disability that claimant incurred was not due to her compensable injury.

On review, claimant alleges that her TMJ syndrome is compensable and that the April 15, 1991 Notice of Closure was prematurely issued. In the alternative, claimant contends that she is permanently and totally disabled and, if she is determined not to be, that she is entitled to an increased award of unscheduled permanent disability. Claimant also contends that the ALJ erred in refusing to award temporary disability from November 6, 1989 to October 18, 1990. Finally, claimant asserts that the employer denied her visual dependence condition "de facto," thereby entitling her to an award of attorney fees pursuant to ORS 656.386(1).

TMJ Syndrome

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

Premature Claim closure

It is claimant's burden to prove that her claim was prematurely closed by the April 15, 1991 Notice of Closure . Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 15, 1991 Notice of Closure, considering claimant's condition at the time of closure and not subsequent developments. 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).

Claimant does not contend that her vestibular condition was not medically stationary when her claim was closed. Claimant contends, however, that her musculoskeletal condition in the cervical and thoracic spine was not medically stationary when her claim was closed on April 15, 1991. Claimant asserts that the ALJ erred in relying on the medical opinion of the examining physician, Dr. Howell, instead of that of the attending physician for her musculoskeletal complaints, Dr. Shonerd. We disagree.

Dr. Howell concluded in his initial report, based on his December 21, 1990 medical examination, that claimant was medically stationary. Dr. Howell reasoned that, given claimant's extended course of treatment for her musculoskeletal complaints, her neck, trapezius and upper back soft tissue strains were medically stationary. Dr. Howell wrote that any resolution of claimant's conditions would have occurred by the time of his examination and that any beneficial effects of current treatment were short-lived. (Ex. 22-10).

Dr. Shonerd began his course of manipulative treatment in July 1990, some 18 months after the January 1989 injury. Dr. Shonerd responded to Dr. Howell's examination by noting that he had "very little to quibble with." (Ex. 23-1). However, Dr. Shonerd insisted that he was still providing curative treatment for claimant's thoracic and cervical strains and for myofascial "injury" in the right trapezius.

Dr. Shonerd explained that the type of sprain/strain that claimant experienced would typically resolve in the range of two to four months. However, when asked why it was taking so long for claimants' soft tissue injuries to heal, Dr. Shonerd replied that "it takes longer" in a case such as this where there was a great deal of scar tissue within the muscle fiber. (Ex. 25-26). However, Dr. Shonerd acknowledged that Dr. Howell had the expertise to detect improvement in claimant's condition within two months of his first examination by conducting a palpatory examination. (Ex. 25-27).

In March 1991, Dr. Howell reexamined claimant and could not detect any objective improvement in the areas of complaint over his initial examination in December 1990. (Ex. 29-5). Dr. Howell again reiterated his opinion that claimant was medically stationary considering the length of time since the original injury in 1989, the lack of change in objective abnormalities, and the fact that the benefits of self-treatment exceeded those claimant received after treatment with Dr. Shonerd.

While we generally give greater weight to the medical opinion of the attending physician, absent persuasive reasons to do otherwise, see Weiland v. SAIF, 64 Or App 810 (1983), we agree with the ALJ that Dr. Howell's opinion that claimant was medically stationary is more persuasive than Dr. Shonerd's. This is not only because we consider Dr. Howell's medical opinion to be better reasoned and more thorough than Dr. Shonerd's, but also because Dr. Shonerd agreed that Dr. Howell should have been able to detect improvement in claimant's condition, but Dr. Howell was unable to do so. Because of this and the length of time since claimant's injury, we are persuaded that claimant reached maximum medical improvement prior to claim closure. Thus, we agree with the ALJ that the April 15, 1991 Notice of Closure did not prematurely close the claim.

Permanent Total Disability

ORS 656.206(1)(a) provides that a claimant is permanently totally disabled if he or she is permanently incapacitated from "regularly performing work at a gainful and suitable occupation." In order to establish permanent total disability, 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 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).

Claimant contends that she is entitled to permanent total disability (PTD) 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 or her 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 or she 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, she is willing to work. SAIF v. Stephen, 308 Or 41 (1989).

Here, claimant asserts that she is permanently and totally disabled because she is unable to regularly perform work in a hypothetically normal labor market. See Harris v. SAIF, 292 Or 683 (1982). Claimant emphasizes Dr. Brown's comment that she will require significant amounts of time loss at whatever job she attempts to perform (Ex. 45-2), as well as the concession by the employer's vocational expert, Ms. Ridley-Hartgrave, that significant time loss would be a "hurdle" and would require a "very flexible" employer. (Trs. II-18, 19).

The employer responds that there is insufficient evidence that claimant is unable to sell her services in a hypothetically normal labor market and that, based on Dr. Grimm's opinion, claimant has not proven permanent and total disability due to her compensable conditions, as opposed to her non-compensable PLF and EH conditions that arose post-injury. See Searles v. Johnstone Cement, 101 Or App 589 (1990). We agree with the employer that claimant is not permanently and totally disabled.

First, there is no medical evidence that claimant is permanently and totally disabled. Although Dr. Shonerd restricted claimant to lifting no more than 15 pounds, the only work restrictions that have been imposed by Dr. Brown and Dr. Howell on claimant are that she avoid working at heights and on machinery and that she limit her lifting to 30 pounds.

The only expert to testify with respect to claimant's vocational status was Ms. Ridley-Hartgrave. She opined that, based on an eligibility examination, claimant did not have a substantial handicap to employment. (Tr. II-5). Ms. Ridley-Hartgrave further testified that claimant was not permanently and totally disabled. (Id.) at 8. Ms. Ridley-Hartgrave emphasized that claimant has a college degree, a real estate license and 16 years administrative experience and would qualify for employment with independent social service agencies and for employment with temporary employment agencies. (Id.) at 4-7.

Although Ms. Ridley-Hartgrave conceded that, based on Dr. Brown's statement that claimant may require significant time loss, an employer would have to be "very flexible," that concession alone does not satisfy claimant's burden of proof. Considering the totality of Ms. Ridley-Hartgrave's unrebutted testimony that claimant is not permanently and totally disabled, we are not persuaded that claimant is unable to regularly sell her services in a hypothetically normal labor market, as claimant contends.[2]

Second, even if the vocational evidence established claimant's permanent total disability status, we would find, alternatively, that claimant has failed to prove that her disability was due to her compensable BPPV and musculoskeletal injuries. We agree with the ALJ that Dr. Grimm was the only physician to segregate the symptoms resulting from the compensable BPPV condition and those resulting from the noncompensable PLF and EH conditions. (Ex. 34). Dr. Grimm opined that the major portion of claimant's disability results from the noncompensable conditions. (Ex. 35).

We are mindful that Dr. Brown believes that the only definitive diagnosis for claimant's inner ear disorder is BPPV. Ordinarily we would defer to the opinion of the attending physician. Weiland v. SAIF, supra. However, in this case, we find persuasive reasons to do otherwise.

Dr. Brown admitted that "it is impossible to be more specific" about what portion of claimant's disability is due to her BPPV condition. (Ex.11E-2). In November, 1992, Dr. Brown conceded that claimant's symptoms were reminiscent of post-concussion syndrome than BPPV. (Ex. 45-1). Moreover, Dr. Brown never analyzed or discussed Dr. Grimm's opinion that the PLF and EH conditions were the major contributing cause of claimant's disability.

---

[2] Effective June 7, 1995, Senate Bill 369 amended ORS 656.283(7) to provide that evidence on an issue regarding a Notice of Closure or Determination Order that was not submitted at the reconsideration is not admissible at hearing. SB 369, 68th Leg., Reg. Sess., Section 34 (June 7, 1995). Pursuant to Section 66(1) of that Act, amended ORS 656.283(7) is to be applied retroactively to claims pending on or after the Act's effective date. We need not determine the affect of the amended statute on the admissibility of "post-reconsideration" medical evidence from Dr. Brown and Ms. Ridley-Hartgrave. Even if we were to limit our consideration to the "reconsideration record," or, alternatively, if we were to consider the entire record, we would still conclude that claimant has not established that she is permanently and totally disabled. See Duane B. Onstott, 47 Van Natta 1429 (1995).

Accordingly, we agree with the ALJ that, even if claimant were permanently and totally disabled based on the vocational evidence, claimant has failed to prove that this disability is due to her compensable injury. Thus, we affirm the ALJ's decision to deny claimant permanent total disability status.

Permanent Partial Disability

The ALJ awarded claimant 15 percent unscheduled permanent disability. On review, claimant contends that she is entitled to an award of 68 percent unscheduled permanent disability. While we agree that claimant is entitled to an increased unscheduled award, we do not agree with claimant's calculation.

We begin our analysis by determining the applicable standards. The claim was closed on April 15, 1991. The ALJ applied the temporary rules in WCD Admin. Order 93-052, which applied to all ratings of permanent disability made after June 17, 1993. See Erma J. Jones, 45 Van Natta 2274 (1993). However, those temporary rules expired on December 14, 1993, after the September 1993 hearing took place. In place of the temporary rules, the Director adopted permanent rules set forth in WCD Admin. Order 93-056.

The permanent rules do not apply to all ratings. Rather, they apply 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). 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 438-35-003(2).

Claimant became medically stationary on December 21, 1990 and her claim was closed by Notice of Closure on April 15, 1991. Since claimant became medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268, the applicable "standards" are those in effect at the time of the April 15, 1991 Notice of Closure. OAR 438-10-010(2); OAR 436-35-003(2); WCD Admin. Order 2-1991 (effective April 1, 1991). See Cornell D. Garrett, 46 Van Natta 340 (1994), aff'd mem Garrett v. Still Water Corporation, 130 Or App 679 (1994); Michelle Cadigan, 46 Van Natta 307 (1994).

A determination of unscheduled permanent disability under the applicable standards is made by determining the appropriate values assigned by the standards to the worker's age, education, adaptability and impairment. The education value is obtained by adding the values for formal education, skills and, in certain circumstances, for the lack of a license or certificate related to employment. Former OAR 436-35-300(6). Once determined, the values for age and education are added. The sum is then multiplied by the appropriate adaptability value. The product of those two values is then added to the impairment value and yields the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

Former OAR 436-35-290(2) provides for the assignment of a value of 1 for age if claimant is 40 years of age or more and has not been released to, or returned to, regular work or work requiring greater strength than the job at injury. For all other workers, a value of 0 shall be given. Because claimant (52 years of age at the time of claim closure) is over 40 years of age and has not been able to successfully return to regular work, the appropriate value for claimant's age is 1. Former OAR 436-35-290(2).

Formal Education

Claimant has more than a high school education. Accordingly, the appropriate value for this factor is 0. Former OAR 436-35-300(3)(a).

Skills

Assignment of a skills value under former OAR 436-35-300(4) depends upon the jobs the worker performed during the 10 years preceding the "time of determination." The "time of determination" is the mailing date of the Determination Order or Notice of Closure. Former OAR 436-35-005(12).

In this case, the "time of determination" is April 15, 1991, the date the Notice of Closure was issued. Based upon claimant's job performance, the job title describing the job providing the highest SVP number during the 10 years prior to the time of determination was Truck Driver (DOT # 905.663.014). That job title is assigned an SVP number of 4. Therefore, claimant is entitled to a skills value of 3. Former OAR 436-35-300(4)(e). Claimant's total education value is 4, the sum of the values for formal education and skills. Former OAR 436-35-300(6).

Adaptability

The adaptability factor is based on a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum residual functional capacity at the time of determination. Former OAR 436-35-310(1). The adaptability value is obtained from the matrix of values at former OAR 436-35-310(3). Former OAR 436-35-310(1) and (2).

Here, at the time of determination, claimant had not been released to or returned to regular work and did not have the residual functional capacity (RFC) for regular work. Therefore, the adaptability factor is determined by a comparison of the strength demands of the worker's job at the time of injury with the worker's maximum RFC at the time of determination. Former OAR 436-35-310(1). The worker's maximum RFC is the greatest capacity evidenced by: (1) the attending physician's release; or (2) a preponderance of medical opinion; or (3) the strength of any job at which a worker has returned to work at the time of determination. Former OAR 436-35-270(3)(d)(A)-(C).

At the time of closure, Dr. Howell had released claimant to modified work with no lifting over 30 pounds. (Ex. 5-4, 16).[3] We agree with the ALJ that this is the most persuasive medical evidence regarding claimant's RFC at the time of determination. Thus, we find that claimant's RFC is in the light/medium category. Former OAR 436-35-270(3)(h); 436-35-310(3). Comparing claimant's at-injury job strength of medium capacity to her RFC of medium/light capacity results in an adaptability factor of 2. Former OAR 436-35-310(3).

Impairment

The ALJ calculated claimant's impairment as 9 based on chronic conditions limiting repetitive use of her upper back and head. Neither party contests these impairment values. Claimant contends that she is entitled to an additional 23 percent impairment for cranial nerve damage pursuant to OAR 436-35-390(7)(a)(b), citing Dr. Yanney's "post-reconsideration order" medical opinion that claimant has cranial nerve impairment due to the compensable injury. Claimant notes that the April 15, 1991 Notice of Closure awarded permanent impairment for this condition and contends that the employer cannot now argue that this impairment is unrelated to the compensable injury.

Under the rationale expressed in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), a carrier is generally precluded from denying compensability of a condition for which permanent disability was awarded. However, Messmer is not applicable here because the April 15, 1991 Notice of Closure is on appeal in this case and is, therefore, not "final." Moreover, the award of permanent disability for claimant's cranial nerve impairment was eliminated by the Order on Reconsideration. Thus, we conclude that the employer is not precluded by Messmer from denying the compensability of claimant's cranial nerve impairment.[4]

---

[3] Claimant contends that Dr. Howell's opinion cannot be considered on the issue of adaptability because he is not claimant's attending physician. Citing Koitzsch v. Liberty Northwest, 125 Or App 666 (1994), claimant asserts the impairment findings of an examining physician cannot be considered in evaluating the adaptability factor. We disagree. The administrative rules concerning adaptability clearly allow that factor to be determined on the basis of a "preponderance" of medical evidence, as well as on the basis of the attending physician's opinion. This includes consideration of medical opinions apart from that of the attending physician. Moreover, the calculation of adaptability is a process separate from determining permanent impairment. See Deborah A. Johnston, 47 Van Natta 1949 (1995). Therefore, we consider Dr. Howell's opinion in determining claimant's adaptability factor.

[4] Effective June 7, 1995, Senate Bill 369 amended former ORS 656.262(9) (renumbered ORS 656.262(10)) to provide that payment of permanent disability shall not preclude an employer from subsequently contesting the compensability of the condition rated in the Notice of Closure. Or Laws 1995, ch 332, § 28 (SB 369, § 28). According to § 66(5)(b) of SB 369, ORS 656.262(10) applies retroactively to all claims "without regard to any previous order or closure." However, given our finding that Messmer is inapposite, we need not determine the affect of amended ORS 656.262(10) on the Messmer rationale. But See Craig L. Hiatt, 47 Van Natta 2287 (1995).

We agree with the employer that Dr. Yanney's medical opinion that claimant's cranial nerve condition is related to the January 1989 injury does not satisfy claimant's burden of proving that her cranial nerve impairment is due to her compensable injury. Dr. Yanney testified that the mechanism of claimant's injury as she described it to him was consistent with her cranial nerve damage. (Ex. 57-44). However, we agree for the reasons cited by the ALJ that the history claimant provided Dr. Yanney regarding the location of the blow to her head is inaccurate and unreliable. Therefore, we find Dr. Yanney's opinion unpersuasive because it relies on an inaccurate and unreliable history.[5] See Somers v. SAIF, 77 Or App 259 (1986). Thus, we reject claimant's contention that she is entitled to permanent impairment for her cranial nerve disorder. Therefore, we adopt the ALJ's finding that claimant's impairment value is 9.

Calculation of Unscheduled Permanent Disability

Having determined each of the values necessary under the standards, claimant's unscheduled permanent disability may be calculated. The sum of the value (1) for claimant's age and the value (3) for claimant's education is 4. The product of that value and the value (2) for claimant's adaptability is 8. The sum of that product and the value (9) for claimant's impairment is 17. That value represents claimant's unscheduled permanent disability. Former OAR 436-35-280.

Temporary Disability

The ALJ eliminated claimant's award of temporary disability in the Order on Reconsideration, as well as denied claimant's request for temporary disability from November 6, 1989 (the date of the original denial of compensability) to October 18, 1990 (the date of ALJ Johnson's initial order on the compensability issue). The ALJ reasoned that the medical evidence did not establish that claimant's temporary disability was related to the compensable injury and that the issue of claimant's entitlement to temporary disability from November 6, 1989 to October 18, 1990 had already been litigated before ALJ Johnson in October 1990 and October 1991.

It is true that ALJ Mongrain's January 22, 1992 order, which was affirmed by the Board, held that the employer had no duty to pay temporary disability from November 6, 1989 to October 18, 1990 pursuant to ALJ Johnson's October 18, 1990 order, which was vacated. It is also true that ALJ Johnson's subsequent October 1991 order did not specifically address the issue of temporary disability. However, ALJ Johnson's October 1991 order remanded the claim to the employer for provision of worker's compensation benefits, which would include the provision of temporary disability. (Ex. 40-12). In light of such circumstances, we conclude that claimant is not now precluded from asserting entitlement to temporary disability for the period in dispute.

However, since we have determined that Dr. Grimm's opinion is more persuasive than Dr. Brown's with respect to the issue of whether claimant's disability is due to the compensable injury, we agree with the ALJ's conclusion that claimant has failed to prove that her temporary disability is due to her compensable January 1989 injury. Accordingly, we find that she is not entitled to the temporary disability she seeks.

Attorney fees

Claimant contends that she is entitled to an attorney fee for setting aside a "de facto" denial of her visual dependence condition. We reject claimant's request. Claimant never raised the issue of "de facto" denial of her visual dependence condition at hearing. (Tr. I-2). Because of this, we do not address this issue raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).[6]

---

[5] Given our finding that "post-reconsideration order" evidence from Dr. Yanney is unpersuasive, we need not determine the effect of amended ORS 656.283(7) on consideration of this evidence. See Duane B. Onstott, supra.

[6] Claimant argues that the ALJ adopted the position of the employer that claimant's visual dependence condition was not compensable in making his determinations with respect to permanent and temporary disability. Claimant asserts that the employer is precluded by the doctrine of issue preclusion as applied in Drews v. EBI Companies, 310 Or 134 (1990), from relitigating the finding in ALJ Johnson's October 1991 order that her visual dependence condition is compensable. We agree with the employer that claimant misconstrues the ALJ's order. The ALJ's findings are premised on the fact that claimant suffers from noncompensable conditions, such as her PLF and EH disorders, which she had alleged in previous litigation were the result of her January 1989 injury, but which ALJ Mongrain determined to be noncompensable.

ORDER

The ALJ's order dated October 12, 1993, as reconsidered on September 15, 1994, is affirmed in part and modified in part. That portion of the order which increased claimant's award of unscheduled permanent disability from zero to 15 percent is modified. In addition to the ALJ's award of 15 percent (48 degrees) unscheduled permanent disability, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, for a total award of 17 percent (54.4 degrees). Claimant's counsel is awarded an approved attorney fee of 25 percent of the increased compensation created by this order, payable directly by the employer to claimant's attorney. However, the total "out-of-compensation" attorney fee granted by the ALJ's order and this order shall not exceed $3,800. The remainder of the ALJ's order is affirmed.

---



In the Matter of the Compensation of
**RONALD L. SWAN, SR., Claimant**
WCB Case Nos. 94-14101 & 94-06147
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
G. Joseph Gorciak III, Defense Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Commercial Carriers, Inc. (Commercial) requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) awarded an attorney fee for its alleged compensability denial; and (2) assessed penalties for its allegedly unreasonable compensability denial. Farmers Insurance Group, on behalf of Convoy Company (Farmers/Convoy), cross-requests review of those portions of the order that: (1) awarded an attorney fee for its alleged compensability denials; and (2) assessed penalties for its allegedly unreasonable compensability denials. In its brief, Commercial contends that the ALJ erred in declining to admit a letter into evidence. On review, the issues are evidence, attorney fees and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. On page 3, after the third full paragraph, we insert the following:

> "On January 10, 1994, ALJ Hoguet concluded that claimant's March 1979 compensable injury and subsequent surgeries were the major contributing cause of his current left knee condition and need for treatment. (Ex. 2). The Board adopted and affirmed the ALJ's order. (Ex. 13)."

On page 3, we change the seventh full paragraph to read: "On April 4, 1994, Commercial issued a disclaimer and denial of responsibility for claimant's right shoulder injury. Ex. 5."

CONCLUSIONS OF LAW AND OPINION

We briefly recap claimant's injuries. Claimant suffered a left knee injury in March 1979, while working for Convoy (Farmers' insured). Claimant was awarded 35 percent scheduled permanent disability. Claimant's left knee condition worsened in 1992. Claimant's March 1979 compensable injury was determined to be the major contributing cause of his left knee condition.

On December 14, 1993, claimant fell and injured his right shoulder while working for Commercial's insured. Claimant was diagnosed with a right rotator cuff tear.

The ALJ found that claimant's compensable left knee condition with Farmers/Convoy was not a material contributing cause of claimant's right shoulder injury. Rather, the ALJ concluded that Commercial was responsible for claimant's right shoulder injury. The ALJ determined that both carriers had denied compensability of the claim and assessed attorney fees against both carriers. The ALJ also assessed penalties against both carriers, finding that they had issued unreasonable denials of compensability.

Evidence

After the hearing, Commercial submitted a copy of its November 29, 1994 letter that requested issuance of a "307" order. Commercial contends that the ALJ erred in declining to admit the letter into evidence. The ALJ treated the submission as a request to reopen the record and declined to admit it on the basis that it was cumulative of what was already in the record.

We need not address Commercial's evidentiary argument because, even if it is well-taken, the proffered letter would not affect the outcome of this case. Therefore, we need not consider whether the ALJ abused his discretion by excluding the letter. See Fred W. Hodgen, 47 Van Natta 413 (1995); Larry D. Poor, 46 Van Natta 2451 (1994).

Retroactivity of Amended ORS 656.386(1)

After the ALJ's order, the legislature enacted Senate Bill 369. Under amended ORS 656.386(1), a claimant's attorney is entitled to an attorney fee in cases involving denied claims where a claimant prevails finally in a hearing. 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." Or Laws 1995, ch 332, § 43 (SB 369, § 43).

Except as provided otherwise, Senate Bill 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, 569 (1995). Because amended ORS 656.386(1) is not among the exceptions to this general rule, the amended version of the statute applies here. See Guillermo Rivera, 47 Van Natta 996, on recon 47 Van Natta 1723 (1995).

Commercial's Denial

Commercial contends that the ALJ erred by construing its denial as one of compensability. On April 4, 1994, Commercial advised claimant that Farmers/Convoy could be responsible for the claim. In addition, Commercial's letter said:

> "The medical evidence shows that your right shoulder complaints are due to your March 6, 1979 condition and not due to your current work activities. Therefore, we must respectfully deny responsibility of your current shoulder condition.
>
> "As we do agree that your right shoulder condition is compensable, we will be requesting the designation of a paying agent pursuant to ORS 656.307." (Ex. 5).

The ALJ found that, because Commercial provided claimant with the notice that the claim was denied and provided notice of hearing rights in accordance with OAR 438-05-053, its letter constituted a denial of compensability. We disagree.

In Ray L. Bennett, 47 Van Natta 866 (1995), one of the carriers had issued a denial that stated, in part: "After review of the investigation material available, it appears that your condition is compensable; however, responsibility may rest with one of the employers identified above. Therefore, this letter represents a denial of responsibility for your current condition." In addition, the carrier's denial indicated that a paying agent had been requested.

Relying on James D. Lollar, 47 Van Natta 740 (1995), and James McGougan, 46 Van Natta 1639 (1994), we concluded that the carrier's denial in Bennett did not raise an issue of compensability. We found that the carrier's responsibility denial clearly and unambiguously conceded that the claim was compensable and indicated that responsibility was the only issue. Although the carrier's denial contained "notice of hearing" provisions and stated that it was a denial of the claim for benefits, we did not construe the denial to extend to compensability, given the express language conceding compensability and denying only responsibility.

We reach the same conclusion in this case. In its denial, Commercial agreed that claimant's right shoulder condition was compensable and notified claimant that it would be requesting the designation of a paying agent pursuant to ORS 656.307. Notwithstanding the inclusion of "notice of hearing" provisions, we do not construe Commercial's denial to extend to compensability, in light of the express language conceding compensability and denying only responsibility. See Ray L. Bennett, supra; James D. Lollar, supra; James McGougan, supra.

We conclude that the responsibility denial issued by Commercial did not raise an issue of compensability. Furthermore, we find that Commercial did not refuse to pay on the ground that the condition was not compensable. See amended ORS 656.386(1). We also find that Commercial did not refuse to pay on the ground that the claim did not "give rise to an entitlement to any compensation." See id. Therefore, claimant's claim for benefits with Commercial does not constitute a "denied claim" pursuant to amended ORS 656.386(1). Accordingly, we reverse that portion of the ALJ's order that found Commercial responsible for the payment of an assessed fee.[1]

The ALJ's assessment of a penalty-related attorney fee was based on Commercial's unreasonable denial of compensability. In light of our conclusion that Commercial did not deny compensability of claimant's condition, we also reverse the ALJ's assessment of penalties against Commercial.

Farmers/Convoy's Denial

Farmers/Convoy argues that the ALJ erred by construing its letters as denials of compensability. On September 27, 1994, Farmers/Convoy advised claimant that Commercial could be responsible for his right shoulder injury. (Ex. 12). On November 10, 1994, Farmers/Convoy acknowledged that claimant was seeking treatment for a right rotator cuff tear that was allegedly related to his left knee claim with Farmers/Convoy. (Ex. 16). The November 10, 1994 letter also stated:

> "After reviewing the information in your file, we are unable to accept responsibility for rotator cuff tear for the following reasons:
>
> "1) There was not a timely filing of the claim, 2) the right shoulder condition is not a compensable consequential condition of the left knee condition / claim and 3) the current right shoulder condition is not related to the left knee condition." (Ex. 16).

On November 16, 1994, Farmers/Convoy issued an amended denial, notifying claimant that his claim was under the Board's Own Motion jurisdiction. (Ex. 18). The denial also stated that "We are also denying responsibility for any and all claims you may be making for medical benefits for the right rotator cuff tear under this claim." (Id.)

On November 23, 1994, Farmers/Convoy issued an amended denial/disclaimer, which incorporated the terms of its September 27, 1994 disclaimer and the denials dated November 10, 1994 and November 16, 1994. (Ex. 19). The letter stated that it was recommending that the Board deny reopening and said that it believed "your right shoulder and rotator problem are the responsibility" of Commercial. The letter also repeated that it was "also denying responsibility for any and all claims you may be making for medical benefits for the right rotator cuff tear under this claim." (Id.)

The Department of Consumer and Business Services (DCBS) refused to issue a "307" order on the basis that Farmers/Convoy had "indicated responsibility is not the only issue stating that the worker failed to timely file a claim as required under ORS 656.308." (Ex. 21).

The ALJ found that Farmers/Convoy had denied compensability on November 10, 1994 and November 16, 1994, and had disclaimed responsibility for and compensability of claimant's right shoulder condition on November 23, 1994.

---

[1] In light of our conclusion that claimant is not entitled to an attorney fee payable by Commercial, we do not address Commercial's alternative argument that the amount of the fee should be reduced.

Farmers/Convoy argues that, under amended ORS 656.386(1), it did not contend that claimant's shoulder claim was not compensable or otherwise did not give rise to entitlement to any compensation. According to Farmers/Convoy, it has contended all along that it was not the responsible insurer and that claimant did not file the claim on a timely basis. Farmers/Convoy asserts that its November 10, 1994 denial (Ex. 16) challenged the claim on an untimely filing allegation, but did not challenge the work relationship of the right shoulder condition. Farmers/Convoy acknowledges, however, that it contended that the right shoulder condition did not constitute a compensable consequential condition of the left knee condition.

In Angela M. Stratis, 46 Van Natta 816 (1994), a denial from one of the carriers stated that information indicated that the claimant's accepted condition was no longer the major contributing cause for her current need for treatment and the carrier provided a list of potential responsible employers. Furthermore, the letter stated that it had not requested a paying agent pursuant to ORS 656.307. The letter included the notice required for disclaimers of responsibility and denials of compensation. We found that the letter contested causation and, therefore, denied compensability as well as responsibility.

In David J. Rowe, 46 Van Natta 1150 (1994), the carriers' denials expressly denied that the claimant's current condition was related, in major part, to the claimant's work activities at the carrier's insureds. In addition, the titles of the carrier's denials indicated that the carrier intended to disclaim responsibility and to deny claimant's claim. We concluded that, read as a whole, the denials could mean only that the carrier intended to deny the compensability of, as well as responsibility for, the claimant's current condition.

In the present case, Farmers/Convoy's November 10, 1994 denial, which was incorporated into the November 23, 1994 amended denial/disclaimer, stated that Farmers/Convoy was "unable to accept responsibility for the rotator cuff tear" because the "right shoulder condition is not a compensable consequential condition of the left knee condition / claim" and the "current right shoulder condition is not related to the left knee condition." (Ex. 16). Farmers/Convoy also indicated that there was not a timely filing of the claim.

We conclude that Farmers/Convoy's denials contested causation and, therefore, denied compensability as well as responsibility. See Angela M. Stratis, supra; David J. Rowe, supra. By contesting causation, Farmers/Convoy's denials refused to pay on the express ground that the shoulder condition was not compensable. See amended ORS 656.386(1). Furthermore, Farmers/Convoy's denial on the ground that claimant did not file a timely claim constituted a refusal to pay on the express ground that the shoulder condition "otherwise did not give rise to an entitlement to any compensation." See amended ORS 656.386(1); see also SAIF v. Bates, 94 Or App 666 (1989) (by asserting that the claim was not filed timely, the carrier put compensability as well as responsibility in issue). Therefore, claimant's right shoulder condition constitutes a "denied claim" under amended ORS 656.386(1). Since the ALJ found that claimant right shoulder condition was compensable, claimant's attorney "prevailed finally" in a hearing and claimant is entitled to a reasonable attorney fee.[2]

The Board's policy has been 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. Julie M. Baldie, 47 Van Natta 2249 (1995); 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, supra (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).

Here, we have concluded that the responsible carrier, Commercial, denied only responsibility for the claim and did not deny compensability. Although Farmers/Convoy was not determined to be responsible for claimant's shoulder condition, we find that it is responsible for the attorney fee award

---

[2] Farmers/Convoy asserts that, under amended ORS 656.262(7), it was arguably required to issue a written notice of denial of a claim for a new medical condition, i.e., the shoulder condition. Or Laws 1995, ch 332, § 28 (SB 369, § 28). Since amended ORS 656.262(7) was not effective when Farmers/Convoy issued its denials, we are not persuaded that it provides a sufficient justification for Farmers/Convoy's compensability denials. Moreover, amended ORS 656.262(7) does not require a carrier to deny compensability of a new medical condition. Under amended ORS 656.262(7) and ORS 656.308(2)(a), a carrier may choose to deny only responsibility for a claimant's new medical condition.

under ORS 656.386(1) because it created the need for claimant to establish the compensability of his claim. See Julie M. Baldie, supra; Raymond H. Timmel, 47 Van Natta 31 (1995).

Claimant's attorney is entitled to an assessed fee for services at hearing regarding 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 fee for claimant's attorney's services at hearing regarding the compensability issue is $1,600, payable by Farmers/Convoy. 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.

In addition, claimant's attorney is entitled to an assessed fee at hearing for active and meaningful participation in prevailing against Commercial's responsibility denial. ORS 656.308(2)(d).[3] 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 concerning the responsibility denial is $1,000, payable by Commercial. 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.

Penalties For Farmers/Convoy's Allegedly Unreasonable Compensability Denials

The ALJ found that there was no evidence to support either carrier's denials of compensability, although there was some reason to question responsibility based on early reports. The ALJ found both carrier's compensability denials were unreasonable. Farmers/Convoy argues that it was not unreasonable for it to resist payment of services for a "clearly unrelated" 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).

At the time Farmers/Convoy issued its denials, it had reports that indicated that claimant's shoulder injury was not related to his accepted left knee condition. On May 5, 1994, Dr. Switlyk reported that claimant's rotator cuff tear was due to his December 1993 work injury. (Ex. 8). On October 7, 1994, Dr. Switlyk agreed that claimant's left knee condition was not the major contributing cause of his right shoulder condition. (Ex. 12B). In light of Dr. Switlyk's reports, we conclude that Farmers/Convoy had a legitimate doubt as to its liability. Consequently, its denial was not unreasonable. We reverse the ALJ's assessment of penalties against Farmers/Convoy.

Claimant is not entitled to an attorney fee for services on review concerning the attorney fee and penalty issues in this case. See 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)

---

[3] ORS 656.308(2)(d) provides:

"Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances." Or Laws 1995, ch 332, § 37(2)(d) (SB 369, § 37(2)(d)).

Since ORS 656.308(2)(d) provides that a claimant is entitled to an attorney fee "[n]otwithstanding ORS 656.382(2), 656.386 and 656.388," we conclude that an attorney fee awarded pursuant to ORS 656.308(2)(d) is separate from, and in addition to, an attorney fee awarded for finally prevailing over a compensability denial under ORS 656.386(1). See Julie M. Baldie, supra.

ORDER

The ALJ's order dated March 17, 1995 is affirmed in part and reversed in part. Those portions of the order that awarded claimant assessed penalties, payable by Commercial and by Farmers/Convoy, are reversed. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded $1,600 for services at hearing on the compensability issue, payable by Farmers/Convoy. Claimant's attorney is also awarded $1,000 for services at hearing on the responsibility issue, payable by Commercial. The remainder of the ALJ's order is affirmed.

---



In the Matter of the Compensation of
**OPAL L. WHELCHEL, Claimant**
WCB Case No. 93-10237
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that " (1) affirmed an Order on Reconsideration finding claimant medically stationary on November 6, 1992; and (2) awarded claimant 11 percent scheduled permanent disability for loss of use or function of the left arm, whereas the Order on Reconsideration awarded claimant 6 percent scheduled permanent disability. The insurer cross-requests review of that portion of the ALJ's order that increased claimant's scheduled permanent disability award to 11 percent. On review, the issues are medically stationary date and extent of scheduled disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for fact number 6, with the following clarification.

The Order on Reconsideration issued on August 9, 1993, rather than on August 9, 1983.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

The Order on Reconsideration found claimant medically stationary on November 6, 1992. The ALJ affirmed. On review, claimant contends that we should defer to Dr. Layman, her attending physician, and find her medically stationary on January 22, 1993.

"Medically stationary means that no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). It is claimant's burden to establish that she was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Co., 84 Or App 622, 625 (1987).

Dr. Layman performed an ulnar nerve release on claimant's left elbow in December 1991. Because of persistent symptoms, Dr. Layman proposed anterior transposition of the left ulnar nerve. Dr. Button, hand surgeon, examined claimant at the request of the insurer in July 1992. Dr. Button opined that claimant's continuing symptoms are on a psychological rather than an organic basis. He advised against the proposed surgery.

Dr. Parvaresh, psychiatrist, examined claimant at the request of the insurer in September 1992. Dr. Parvaresh diagnosed a somatization disorder, and opined that additional surgery would not improve claimant's primarily psychogenic symptoms. Drs. Layman and Button concurred.

Dr. Farris, orthopedic surgeon, examined claimant on behalf of the insurer on November 6, 1992. Opining that claimant would not benefit from left ulnar nerve transposition surgery, given her nonanatomical findings, Dr. Farris declared claimant medically stationary. Dr. Button concurred.

Dr. Layman responded that both physiological and psychological factors are contributing to claimant's symptoms, but now opines that transposition surgery would only provide claimant "some" relief. Dr. Layman neither agreed nor disagreed with Dr. Farris' medically stationary statement. Dr. Layman did not perform additional surgery on claimant. Rather, on January 22, 1993, Dr. Layman performed a closing examination and declared claimant medically stationary.

When there is a conflict as to the date upon which a worker became medically stationary, the medically stationary date is the earliest date established by the preponderance of the medical evidence. OAR 436-30-035(4); see OAR 435-30-035(2). The preponderance of the medical opinions establishes that claimant was medically stationary on November 6, 1992. Moreover, Dr. Layman does not contradict Dr. Farris' finding that claimant was medically stationary on the earlier November 6, 1992 date as well. Accordingly, we affirm that portion of the ALJ's order that affirmed the November 6, 1992 medically stationary date.

Extent of Scheduled Disability

A February 3, 1993 Determination Order awarded claimant 3 percent scheduled permanent disability. Claimant requested reconsideration, disagreeing with her attending physician's impairment rating. Dr. Stanford performed a medical arbiter's examination on July 21, 1993. Finding claimant's muscle strength testing and sensory loss testing invalid, the Appellate Unit allowed no value for either. However, based on additional lost range of motion, an August 9, 1993 Order on Reconsideration increased claimant's scheduled disability award to 6 percent.

Claimant requested a hearing, alleging entitlement to values for a chronic condition, loss of muscle strength, and sensory loss. The ALJ found claimant entitled to an additional value for sensory loss, and increased her scheduled disability award to 11 percent.

On review, claimant renews her argument that she is entitled to an award of 19 percent scheduled permanent disability, based on additional values for a chronic condition and loss of muscle strength. The insurer challenges the increased award based on a value for sensory loss.

Claimant became medically stationary after July 1, 1990, and made a request for reconsideration pursuant to ORS 656.268. Therefore, the applicable standards are those in effect on the date of the February 3, 1993 Determination Order. Those standards are provided in WCD Admin. Order 6-1992.

Chronic Condition

Claimant contends that the ALJ erred in declining to award her 5 percent scheduled permanent disability for a chronic and permanent condition limiting repetitive use of the left arm. Claimant relies upon the July 21, 1993 report of medical arbiter Stanford, specifically his comment:

> "I would place [claimant] in the medium work category. This indicates that because of her chronic and permanent medical condition, arising out of the accepted claim, she would not be able to go past that amount, at least on a regular basis."

OAR 436-35-010(6) 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). None of the medical opinions state or imply that claimant's compensable ulnar nerve palsy limits repetitive use of her right arm.

Dr. Stanford concluded that claimant should not do more than medium work on a regular basis. Dr. Stanford's recommendation that claimant avoid heavy work does not imply that claimant has lost (or partially lost) her ability to use her left arm repetitively. See David A. Kamp, 46 Van Natta 389, 390 (1994) (work limitations were imposed to avoid likelihood of reinjury; no other medical evidence established that claimant had partially lost his ability to use his neck and right shoulder repetitively); Kathleen L. Hofrichter, 45 Van Natta 2368, 2369 (1993), aff'd mem Hofrichter v. Hazelwood Farms Bakeries, 129 Or App 304 (1994) (physician's recommendation that claimant avoid certain motions at work in order to prevent an increase in symptoms was insufficient to establish permanent and chronic impairment of the back); Rae L. Holzapfel, 45 Van Natta 1748 (1993) (physicians' recommendation that claimant avoid repetitive strenuous work with her hands in order to prevent an increase in symptoms was insufficient to establish a permanent and chronic impairment of the wrists).

On this record, we are not persuaded that claimant is unable to repetitively use her left arm due to a chronic and permanent medical condition. OAR 436-35-010(6); Donald E. Lowry, supra. Accordingly, we conclude that claimant has failed to satisfy her burden of proof. Inasmuch as the evidence is insufficient to establish a permanent and chronic impairment of claimant's left arm, the ALJ did not err in declining to award claimant a value for a chronic and permanent condition limiting repetitive use of the left arm.

Loss of Grip Strength

On review, claimant also challenges the ALJ's finding that she is not entitled to a value for loss of grip strength. The insurer argues that claimant's loss of grip strength is not attributable to her compensable injury.

Scheduled partial disability is determined by rating the permanent loss of use or function of a body part due to an on-the-job injury. ORS 656.214(1)(b) and (2); OAR 436-35-010(2). Physical disability ratings shall be established on the basis of medical evidence supported by objective findings by the attending physician, or by other medical providers if concurred in by the attending physician, or by the medical arbiter. ORS 656.245 (3)(b)(B) and 656.268(7).

Dr. Layman reported that claimant's muscle strength in her arms was symmetrical at "5/5" on December 15, 1992. Subsequently, on January 22, 1993, Dr. Layman reported that claimant demonstrated decreased grip strength on the left. In March 1993, Dr. Layman quantified claimant's left grip strength as "4/5" and assigned causation to an ulnar nerve injury.

Dr. Layman is the only physician that has examined claimant who attributes her grip strength loss to an anatomical condition due to the compensable injury. However, Dr. Layman does not address claimant's symptoms in light of her diagnosed somatization disorder. This omission becomes particularly glaring when compared with the findings and persuasive opinion offered by the medical arbiter, Dr. Stanford.

Dr. Stanford performed an arbiter's examination on July 21, 1993. In his report, he commented that:

> "In the left upper extremity there was almost global give way of all muscles from the elbow to, and including, the intrinsic muscle of the hand and a grip strength of only 15 pounds limited by pain.
>
> "Because of the measurements of her upper extremities, which are normal, I cannot rate any true weakness here. The global give way would go along with Dr Parvaresh's diagnosis and there certainly is not evidence of true weakness.
>
> " * * *
>
> "It was felt that the give way of her left upper extremity was not on an anatomic basis. I could not detect any true ulnar nerve weakness in the sense that she had no atrophy that could be discerned."

Based on those comments, we find that claimant's loss of grip strength is not due to her compensable injury, but rather to her noncompensable psychological disorder. Inasmuch as Dr. Stanford's opinion is the most thorough and complete analysis of claimant's grip strength, we give Dr. Stanford's report the greatest weight. See Somers v. SAIF, 77 Or App 259 (1986).

On this evidence, we find that claimant's loss of strength is due only to pain and giveway weakness. In light of Dr. Stanford's conclusions, claimant has failed to prove by a preponderance of the evidence that she is entitled to an award of permanent disability for loss of grip strength. ORS 656.266; see OAR 436-35-110(8) (loss of strength is rated when the cause is a peripheral nerve injury, loss of muscle or disruption of the musculotendonous unit).

Sensory Loss

The insurer argues that claimant is not entitled to an award of permanent disability for sensory loss, as the loss is not due to claimant's compensable injury. We agree.

Dr. Layman performed a closing examination on January 22, 1993. He reported that claimant "had no useful two-point discrimination throughout the entire length of her left ring and small fingers, with protective sensibility only." Impliedly, Dr. Layman attributed claimant's sensory loss to the compensable injury. However, Dr. Layman did not address Dr. Button or Dr. Farris' earlier reports explaining that claimant's two-point discrimination represented functional overlay, rather than anatomical loss.

We find that Dr. Stanford's opinion is the most persuasive concerning claimant's sensory loss. Medical arbiter Stanford reported that claimant:

> "states that she feels no pinprick over the entire long, ring and fifth fingers . . . . She says she has no two point discrimination because she cannot feel any pressure whatsoever. This sensory loss does not go hand in hand with the rest of her neurological examination."

Based on Dr. Stanford's persuasive medical opinion, we find that claimant is not entitled to an award for the loss of sensation. Although various medical examiners recorded that claimant reported decreased sensation, with the exception of Dr. Layman, all questioned the validity of this finding, instead attributing claimant's loss to her psychological disorder. We conclude, therefore, that the preponderance of the medical evidence establishes that claimant's sensory loss is not due to her compensable ulnar nerve injury. Accordingly, claimant is not entitled to an award for the loss of sensation. ORS 656.214(1)(b) and (2); OAR 436-35-010(2).

Accordingly, we reverse that portion of the ALJ's order that increased claimant's scheduled permanent disability from 6 percent to 11 percent. The Order on Reconsideration award of 6 percent scheduled permanent disability for loss of use or function of the left arm is reinstated.

ORDER

The ALJ's order dated December 27, 1993 is affirmed in part and reversed in part. That portion of the order that increased claimant's scheduled permanent disability award to 11 percent is reversed. The Order on Reconsideration is reinstated and affirmed in its entirety. The out-of-compensation fee awarded claimant's attorney by the ALJ is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
**JUAN A. HERNANDEZ, Claimant**
WCB Case No. 94-04741
ORDER DENYING MOTION TO DISMISS
David O. Horne, Defense Attorney

Claimant, pro se, has requested Board review of Administrative Law Judge (ALJ) Podnar's November 9, 1995 Opinion and Order. Contending that claimant's request was untimely filed, the insurer has moved the Board for an order dismissing the request for review. The motion is denied.

## FINDINGS OF FACT

The ALJ's Opinion and Order issued on November 9, 1995. On Monday, December 11, 1995, the Board received claimant's December 7, 1995 pro se request for review of the ALJ's order. The request did not indicate whether a copy of the request had been mailed to the employer, the insurer, or their attorney. The envelope in which claimant's request was contained carried a postmark date of December 7, 1995.

A computer-generated acknowledgment of claimant's December 7, 1995 request for review was mailed by the Board on December 12, 1995.

On December 12, 1995, the insurer directed a letter to the Board. Noting that "[i]t appeared the [request] was sent directly to us and that the Board did not receive a copy," and "that the letter is dated December 7, 1995 and was not received in our office until December 11, 1995," the insurer asked that "[claimant's] request for review be denied as he failed to properly and timely make that request to the Board." With a copy of claimant's December 7, 1995 letter, the insurer forwarded to the Board a copy of the envelope postmarked December 7, 1995, in which the copy of claimant's request was contained.

## CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance v. King, 63 Or App 847, 852 (1983).

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(20). In the absence of prejudice to a party, timely service of a request for review on an employer's insurer is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975); Franklin Jefferson, 42 Van Natta 509 (1990).

Here, the 30th day after the ALJ's November 9, 1995 order was December 9, 1995, a Saturday. Therefore, the final day to perfect a timely appeal was Monday, December 11, 1995, the first business day following the expiration of the 30-day period. See Anita L. Clifton, 43 Van Natta 1921 (1991). Inasmuch as claimant's request for review was received by the Board on December 11, 1995, it was timely filed. See ORS 656.289(3); 656.295(2); OAR 438-05-046(l)(a).

We further conclude that claimant provided timely notice of his appeal to the insurer. Based on the insurer's acknowledgment of receipt of claimant's December 7, 1995 request on December 11, 1995 and the accompanying envelope postmarked December 7, 1995, we are persuaded that a copy of claimant's request for review was mailed to the insurer prior to expiration of the aforementioned 30-day period. Harold E. Smith, 47 Van Natta 703 (1995). Inasmuch as no contention has been made that the employer has been prejudiced by apparently not receiving actual notice of claimant's request for review, we conclude that claimant's timely service on the insurer is adequate compliance with ORS 656.295(2). See Franklin Jefferson, supra. In reaching this conclusion, we emphasize that the insurer's receipt of a

copy of claimant's appeal is not determinative; instead, the pivotal issue is when a copy of the request was mailed to the insurer. Judy W. Louie, 47 Van Natta 383 (1995); Daryl M. Britzius, 43 Van Natta 1269 (1991); Danny R. Akers, 39 Van Natta 732, on recon 39 Van Natta 813 (1987). Consequently,, we retain appellate jurisdiction to consider claimant's appeal. See ORS 656.295(2); Harold E. Smith, supra; Judy W. Louie, supra.

Accordingly, the insurer's motion to dismiss is denied. A hearing transcript has been ordered. Upon its receipt, copies will be distributed to the parties and a briefing schedule will be implemented. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
**JERRY SIMMONS, Claimant**
Own Motion No. 92-0581M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Heiling, Dodge, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's November 13, 1995 Notice of Closure which closed his claim with an award of temporary disability compensation from December 17, 1992 through May 31, 1994 and from May 15, 1995 through November 6, 1995. SAIF declared claimant medically stationary as of November 6, 1995. Claimant contends that he is entitled to additional benefits because he was not medically stationary when his claim was closed. In addition, claimant requests a penalty for SAIF's allegedly unreasonable claims processing. For the reasons discussed below, we find the claim prematurely closed and deny the request for penalties.

Premature Closure

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at the date of closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the November 13, 1995 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(l); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). However, we may consider post-closure medical reports regarding the question of whether claimant was medically stationary at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence.

On August 18, 1995, Dr. Uhle, treating surgeon, requested authorization for surgical exploration of claimant's compensable right inguinal hernia condition. SAIF authorized this requested surgery. On November 3, 1995, SAIF's claims adjuster asked Dr. Uhle about the status of the authorized surgery and claimant's condition. Specifically, the claims examiner asked, in part, whether the authorized surgery had been scheduled and whether claimant's condition was medically stationary if he decided not to proceed with the surgery. By letter dated November 6, 1995, Dr. Uhle responded that the requested surgery had not been scheduled because claimant did not wish to proceed at this time due to ongoing back problems and the fact that claimant had applied for total disability under Social Security. Dr. Uhle opined that claimant "is medically stationary at this time and hopefully will remain so until he decides to proceed with the exploration." In addition, Dr. Uhle requested that the request for authorization for claimant's right inguinal exploration "be kept open until after January 4, 1996[,] at which time [claimant's] Social Security status will be completed." Based on Dr. Uhle's November 6, 1995 letter, SAIF closed claimant's claim on November 13, 1995, declaring claimant medically stationary as of November 6, 1995.

Subsequently, claimant decided to proceed with the hernia surgery, which Dr. Uhle performed on December 14, 1995. On December 26, 1995, Dr. Uhle opined that:

> "[w]ith the hindsight of having done the surgery on December 14, 1995, and discovering the re-occurring hernia from [an] earlier SAIF surgery, and the foreign body from [the] earlier SAIF surgery, [claimant] was not capable of returning to work and was in need of curative treatment when seen in October and November, 1995 and thereafter. [Claimant's] need for surgery on December 14, 1995 was the direct result of his 1983 injury with SAIF and its sequela. He is expected to be off work for about another two months and cannot return to heavy lifting when again medically stationary."

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find no such reasons. Dr. Uhle persuasively explained his change of opinion regarding his earlier declaration that claimant was medically stationary as being based on his findings during the December 14, 1995 surgery. Furthermore,

we find that Dr. Uhle's December 26, 1995 opinion relates back to claimant's medically stationary status at claim closure. Scheuning v. J.R. Simplot & Co., supra. Relying on Dr. Uhle's December 26, 1995 opinion,, we find that claimant was not medically stationary on November 13, 1995, when his claim was closed by SAIF.

Therefore, we set aside SAIF's November 13, 1995 Notice of Closure and direct it to resume payment of temporary disability compensation commencing on November 6, 1995.[1] When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

Claimant's attorney is allowed an out-of-compensation 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.

Penalties

Claimant argues that he is entitled to a "25% penalty on unpaid time loss until it is restored." (Letter from claimant's attorney dated December 19, 1995). Claimant argues that the basis for this penalty is SAIF's allegedly unreasonable claims processing in closing his claim on November 13, 1995. We disagree.

The standard for determining unreasonable resistance to the 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) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). 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 employer at the time of the carrier's action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

Here, Dr. Uhle's November 6, 1995 letter establishes that the reason for the postponement of claimant's hernia surgery was claimant's decision not to proceed with that surgery until the status of his Social Security claim was determined.

In addition, in those cases where a claimant's medically stationary status is contingent upon undergoing recommended surgery, we have held that a claim is not prematurely closed if the claimant refuses the surgery. See Stephen L. Gilcher, 43 Van Natta 319, 320 (1991); Karen T. Mariels, 44 Van Natta 2452, 2453 (1992). Here, claimant initially refused to proceed with the authorized surgery pending the outcome of his Social Security claim.

On this record, we do not find that SAIF was unreasonable in issuing the November 13, 1995 Notice of Closure based on Dr. Uhle's November 6, 1995 letter. In this regard, we conclude that, at the time of SAIF's closure, it had legitimate doubt as to its continuing liability for temporary disability payments because the medical evidence indicated that claimant's compensable condition was medically stationary. Thus, we find that claimant is not entitled to a penalty regarding SAIF's claim closure.

IT IS SO ORDERED.

---

[1] We note that SAIF has recommended reopening claimant's claim as of the date of the December 14, 1995 surgery. However, given our decision that the claim was prematurely closed, that recommendation is moot.

## WORKERS' COMPENSATION CASES

Decided in the Oregon Court of Appeals: Page

Cite as 136 Or App 550 (1995) September 13, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Floyd B. Talley, Jr., Claimant.

WEYERHAEUSER COMPANY, *Petitioner,*
v.
Floyd B. TALLEY, Jr., Menashe Paperboard, SAIF Corporation, Menashe Corporation, and Employers Insurance of Wausau, *Respondents.*
(WCB 93-08692, 93-06477, 93-07900; CA A86143)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 21, 1995.
John M. Pitcher argued the cause and filed the brief for petitioner.
Ralph E. Wiser III argued the cause for respondent Floyd B. Talley, Jr. With him on the brief was Bennett & Hartman.
David 0. Horne argued the cause and filed the brief for respondent Employers Insurance of Wausau.
Steven R. Cotton, Special Assistant Attorney General, argued the cause for respondents SAIF Corporation, Menashe Paperboard and Menashe Corporation. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Sohcitor General.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Reversed and remanded for reconsideration. Request for sanctions denied.

---

**136 Or App 552>** Employer seeks review of a Workers' Compensation Board order that held that claimant's hearing loss was compensable. Claimant seeks sanctions against employer for filing a frivolous request for review. ORS 656.390. We reverse the Board's order and deny the request for sanctions.

Claimant has worked in employer's paper mill since 1963. Until 1981, the mill was owned by Menashe Corporation. In 1981, employer purchased the mill, and claimant continued to work there. At the mill, he was exposed to loud noise. In 1971, claimant's hearing was tested. The test showed normal hearing in his right ear and an 11 percent hearing loss in his left ear. His hearing was next tested in 1979. That test showed a 3.8 percent hearing loss in the right ear and a 20 percent loss in the left ear. In January 1992, claimant sought treatment for the hearing loss. In 1993, he was examined by Dr. Hodgson, an otolaryngologist. Hodgson noted that the hearing loss in claimant's right ear had slightly progressed since 1979 over and above what would be expected from the natural aging process alone, and that the hearing in claimant's left ear had remained stable since 1979.

Claimant filed a workers'compensation claim, which employer denied. Claimant sought a hearing, and the referee concluded that the hearing loss was compensable as an occupational disease that was caused in major part by occupational noise exposure. See ORS 656.802.[1] The Board adopted and affirmed the referee's order with supplementation. It said:

> "We rely on Dr. Hodgson's opinion regarding causation * * *. Accordingly, based on Dr. Hodgson's opinion, we agree with the Referee that claimant has established that his 30-year noise exposure at work was the major contributing cause of his bflateral hearing loss."

Employer seeks review. We affirm without discussion its challenge to the Board's determination that the claim is not time barred. Employer also assigns error to the Board's conclusion that the claim is compensable. It argues that the Board misread Hodgson's opinion. According to employer, Hodgson's report,

---

[1] The 1995 amendments to ORS 656.802 do not affect this case. Or Laws 1995, ch 332, § 56.

**136 Or App 552>** on which the Board relied, does not support the finding that work was the major contributing cause of claimant's hearing loss over 30 years. Claimant responds that there is substantial evidence in the record to support the Board's finding.

Four experts provided evidence of causation in this case. The referee discussed each expert's testimony. The Board, however, relied exclusively on Hodgson's opinion in reaching its conclusion. We agree with employer that the Board misread Hodgson's opinion. In his initial letter report, Hodgson said that " [t]he type of hearing loss seen in this case is quite typical of that due to excessive noise exposure." He noted that claimant had been exposed to noise at work as well as to noise while engaged in his hobby of shooting guns. He concluded that the hearing loss suffered between 1971 and 1979 was due to occupational noise exposure. He then said:

> "When comparing his activities of shooting guns throughout his entire lifetime with his work-related activities of full-time work for thirty years in a paper mill, then in my view, the work-related noise exposure represents more than 51% of [claimant's] total lifetime noise exposure.
>
> "It is my opinion,. that the major contributing factor in this gentleman's hearing loss is occupational noise exposure."

Later, however, Hodgson clarified his opinion. In a May 26, 1993, letter, as corrected by a June 11, 1993, letter, he said:

> "To state my opinions more clearly, * * * I feel that [claimant] clearly had an increase in hearing loss between 1971 and 1979 in both ears directly related to occupational noise exposure. However I do not see clear evidence of occupational hearing loss from 1979 to the present time. Although there has been a slight progression of hearing loss in the right ear since 1979, I can not conclusively determine whether this is related to the natural effects of aging or other factors, including the possibility of occupational damage. However overall I feel that [claimant's] hearing loss since 1979 can not be determined to be occupationally related based on reasonable medical probability.
>
> "In addition there has not been any hearing loss noted between 1981 and 1993 that can be attributed to occupational factors on a more probable than not basis."

**136 Or App 554>** Further, in response to a written question from claimant's attorney, Hodgson responded:

> "Industrial noise exposure was the major contributing factor to the worsening of hearing loss between 1971 and 1979. 1 am unable to determine the major contributing factor of hearing loss before 1971 and after 1979 to a reasonable medical probability."

Based on those statements, it is apparent that Hodgson's opinion is that hearing loss between 1971 and 1979 of 9 percent in the left ear and 3.8 percent in the right ear was caused by occupational exposure, but that he cannot determine whether hearing loss before or after that period was caused by occupational exposure. It appears that the Board misread Hodgson's reports, because it concluded that they established that claimant's "30-year noise exposure at work was the major contributing cause of his bilateral hearing loss." That finding is not supported by a proper reading of all of Hodgson's reports. There was, however, other evidence in the record, on which the referee relied, that could support the Board's finding of compensability. Accordingly, we remand for reconsideration. *See Skochenko v. Weyerhaeuser Co.*, 118 Or App 241, 846 P2d 1212 (1993); *Asten-Hill Co. v. Armstrong*, 100 Or App 559, 787 P2d 890 (1990)[2].

---

[2] Claimant argues that, because Hodgson's opinions support a finding that workwas themajorcontributingeauseof his hearingloss between 1971 and 1979, he has established the compensability of his claim for hearing loss, and that employer's arguments go to the extent of disability rather than to compensability. The Board did not find that work was the major contributing cause of claimant's hearing loss between 1971 and 1979; it found that claimant's hearing loss was caused in major part by his 30-year noise exposure at work. Thus, the issue of whether the claim might be compensable because part of claimant's hearing loss was caused by work is not raised by the Board's order, and we express no opinion about that.

Because of our disposition of employer's assignment of error challenging compensability, we need not address its assignment regarding responsibility. We deny claimant's request for sanctions under ORS 656.390.

Reversed and remanded for reconsideration. Request for sanctions denied.

---

Cite as 136 Or App 612 (1995) September 13, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Therese L. Petkovich, Claimant.

Therese L. PETKOVICH, *Petitioner,*
v.
SAFEWAY STORES, INC., *Respondent.*
(93-07299; CA A84646)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 25, 1995.

Linda C. Love argued the cause for petitioner. With her on the brief were Craine & Love and Edward J. Harri.

Kenneth L. Kleinsmith argued the cause for respondent. On the brief were Meyers, Radler, Replogle & Bohy and David J. Lefkowitz.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

---

**136 Or App 613>** Claimant seeks judicial review of an order of the Workers' Compensation Board that reduced her award of unscheduled permanent partial disability. The statutes pertinent to that review have been amended by Oregon Laws 1995, chapter 332 (SB 369). The changes to the Workers' Compensation Law made by SB 369 generally apply to cases pending before this court on the effective date of the act, which was June 7, 1995. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). Because ORS 656.726(3)(f)(D) may affect the outcome of this case, we remand for reconsideration in the light of the new law.

Reversed and remanded for reconsideration.

---

Cite as 137 Or App 95 (1995) September 27, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Order Denying Further Reconsideration of Ramira U. Guardado, Claimant.

Ramira U. GUARDADO, *Petitioner,*
v.
J. R. SIMPLOT COMPANY, *Respondent,*
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, *Intervenor.*
(H93-045; CA A83592)

Judicial Review from Department of Consumer and Business Services.

Argued and submitted April 18, 1995.

Robert Wollheim argued the cause for petitioner. With him on the brief were Welch, Bruun, Green & Wollheim, and J. David Kryger and Emmons, Kropp, Kryger.

Kenneth L. Kleinsmith argued the cause for respondent. With him on the brief was Meyers, Radler, Replogle & Bohy.

Stephen L. Madkour, Assistant Attorney General, argued the cause for intervenor. 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.

Reversed and remanded.

Riggs, P. J., dissenting.

---

**137 Or App 97>** Claimant seeks review of an order of the Director of the Department of Consumer and Business Services, contending that the Director erred in refusing to allow her to file a request for reconsideration of a determination order of the Workers' Compensation Division. We reverse.

The facts are not disputed. Claimant was compensably injured in August 1991. Her claim was closed by determination order on October 14, 1992. On October 22, 1992, employer filed a request for reconsideration. That request challenged the impairment findings and both scheduled and unscheduled partial disability ratings. Employer sent copies of the request to claimant and to her attorney. The Appellate Review Unit also sent claimant a notice that employer had filed a request for reconsideration.

On December 16, 1992, claimant was examined by a medical arbiter. On January 14, 1993, the Appellate Review Unit issued an order on reconsideration affirming the determination order in all respects.

On March 18, 1993, claimant submitted a request for reconsideration of the October 14, 1992, determination order, contesting the rating of claimant's scheduled and unscheduled permanent partial disability. On April 5, claimant submitted a supplemental request for reconsideration, contesting the failure to award unscheduled permanent total disability. On May 25, 1993, the Appellate Review Unit issued an order denying claimant's request for reconsideration, on the ground that "the reconsideration process has been completed for this closure" and that it therefore lacked jurisdiction under ORS 656.268. The director's hearings officer affirmed the Appellate Review Unit's order.

Claimant assigns error to the denial of her request for reconsideration. She argues that nothing in ORS 656.268 or the relevant administrative rule, OAR 436-30-050(l), limits her right to request reconsideration merely because employer exercised its right to request reconsideration before she did. She maintains that, under the statute and rule, either party has the right to request reconsideration and that, as long as the request was made within 180 days of the mailing **<137 Or App 97/98>** of the determination order, she was not barred from requesting reconsideration. Employer responds that claimant was given notice that employer had requested reconsideration and that she was advised of her right to correct misinformation in the record or to submit additional medical evidence. According to employer, claimant was not denied her right to request reconsideration; she simply "did not act timely to exercise her rights."

ORS 656.268(5) (1993) provides, in part:

> "If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order. At the reconsideration proceeding, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure."

ORS 656.268(5) does not secify the time period within which a party must request reconsideration. However, ORS 656.268(6)(b) (1993) provides:

> "If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 180 days after copies of notice of closure or the determination order are mailed, whichever is applicable. The time from the request for reconsideration until the reconsideration is made shall not be counted in any limitation on the time allowed for the request for hearing."

Because a request for reconsideration of a determination order tolls the limitation on the time allowed for hearing, the effect of the two statutes is to require that a request for reconsideration be filed within 180 days from the mailing of the determination order.[1] The purpose of reconsideration is **<137 Or App 98/99>** "to provide a less formalized level of review of a determination order at the department level, in an attempt to reduce the number of hearings and appeals." *Duncan v. Liberty Northwest Insurance,* 133 Or App 605, 894 P2d 477 (1995). The Appellate Review Unit of the Workers' Compensation Division is responsible for processing requests for reconsideration of determination orders. OAR 436-30-050(j).[2]

In this case, claimant submitted her requests for reconsideration within 180 days of the mailing of the determination order. If claimant had been the only party to request reconsideration in this case, her request on March 18, 1993, and her supplemental request on April 5, 1993, clearly would have been timely. The issue is the effect, if any, on claimant's reconsideration rights of employer's request for reconsideration on October 22, 1992. Resolution of the issue is a matter of statutory construction. We begin with the text and context of the statute. *PGE v. Bureau of Labor and Industries,* 317 Or 606, 610, 859 P2d 1143 (1993).

The text of ORS 656.268(5) is clear: A party that objects to a determination order must request reconsideration of the order. If a party fails to raise an issue on reconsideration, it is foreclosed from objecting to the determination order for the first dime at hearing. ORS 656.268(5); *Duncan,* 133 Or App at 611. The statute does not state that there can be only one request for reconsideration. Neither does it state that if one party requests reconsideration, any other party must raise its objections to the determination order at that time or be precluded from doing so subsequently, even if its request is made within the 180-day period. ORS 656.268(5) also provides that at the reconsideration proceeding "the worker or the insurer or self-insured employer *may* correct information in the record." (Emphasis supplied.) That language is permissive: it allows a party not seeking reconsideration to raise issues before the Appellate Review Unit, but does not require that party to do so or state that failure to do so will preclude the party from making an **<137 Or App 99/100>** otherwise timely

---

[1] Oregon Laws 1995, chapter 332, section 30, amended ORS 656.268. ORS 656.268(5)(b) now provides that "the request for reconsideration must be made within 60 days of the date of the determination order." That amendment is not applicable to this case. Section 66(6) of the Act provides that the 1995 amendments

> "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."

There are no other changes to ORS 656.168 that affect the outcome of this case at this juncture.

[2] OAR 436-30-050(l) closely mirrors the language of the 1993 version of ORS 656.268(5). It provides:

> "A Determination Order shall be reconsidered by the Appellate Unit upon receipt by the Department of a written request for reconsideration by the worker, the worker's representative, the insurer or the self-insured employer."

request for reconsideration. In order to affirm the department's interpretation of the statute and its rule, we would be required to read into the statute words that are not there. We are prohibited from doing so. ORS 174.010.

The context of ORS 656.268(5) reinforces the clear language of the statute. ORS 656.270, for example, provides that a determination order shall contain

> "a notice in capital letters and boldfaced type that informs the parties of the proper manner in which to proceed if they are dissatisfied with the determination or closure. The notice shall include information on the rights and duties of the parties to obtain reconsideration and hearing on the determination * * *."

Like ORS 656.268(5), nothing in the notice provision of ORS 656.270 states that a party will be informed that its rights regarding reconsideration within the 180-day period are affected if another party requests reconsideration first.

Neither the text nor context of ORS 656.268(5) supports the contention that claimant failed to timely request reconsideration of the determination order. The dissent's desire for administrative simplicity is no justification for reading into the statute a requirement that the statute does not contain. Because claimant's request was filed within the 180 days allowed by statute, the director erred in concluding that it lacked jurisdiction under ORS 656.268.

Reversed and remanded.

**RIGGS, P. J.,** dissenting.

I disagree with the majority's holding that claimant is entitled to a second reconsideration of the determination order closing her claim. Claimant was notified of employer's request for reconsideration and given an opportunity to participate in the reconsideration process by submitting additional medical evidence. She was examined by a medical arbiter. The Appellate Review Unit issued its order on reconsideration affirming the determination order in all respects, and that put the case on track for the next level of review, a hearing. The order on reconsideration superseded the determination order. At a hearing, the referee would have reviewed the order on reconsideration, not the original determination **<137 Or App 100/101>** order. Once the determination order had been reconsidered, a subsequent request for reconsideration of the same determination order was misdirected. I cannot accept the majority's view that the legislature intended that each party is entitled to a separate reconsideration of the same determination order.

My view that there is intended to be only one reconsideration process is supported by the text and context of the statute. At the relevant time, ORS 656.268(5) provided that,

> "[a]t the reconsideration proceeding, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of closure."

The opportunity to participate in the reconsideration process is bilateral. Even a party not seeking reconsideration is entitled to raise issues before the Appellate Review Unit. It approaches absurdity to provide, on the one hand, that all parties may participate in a single reconsideration process, but to permit, on the other hand, that each party seek reconsideration separately. This is especially true in the light of the legislature's apparent objective in providing reconsideration at all: the simplification of the review process. Multiple reconsiderations would only complicate, not simplify, that process. For example, when multiple orders on reconsideration have been issued on multiple requests for reconsideration, which of the many orders must the referee review if a request for hearing is filed?

For the reasons expressed, I think that the majority is wrong, and I therefore dissent.

Cite as 137 Or App 102 (1995) September 27, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Daniel C. Reddekopp, Claimant.

SAIF CORPORATION and Coastway Construction Company, Inc., *Petitioners,*
v.
Daniel C. REDDEKOPP, *Respondent.*
(92-14452; CA A85411)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 24, 1995.
Julene M. Quinn, Assistant Attorney General, argued the cause for petitioners. On the brief were Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General.
Jeff J. Carter argued the cause for respondent. On the brief were David W. Hittle and Burt, Swanson, Lathen, Alexander, McCann & Smith.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Board order vacated; referee's order reinstated.

---

**137 Or App 104>** SAIF seeks review of an order of the Workers' Compensation Board holding that claimant is entitled to a hearing on his claim for aggravation of a compensable injury. Because we agree with SAIF that the Board lacked jurisdiction to consider the claim, we vacate the Board's order and reinstate the referee's order. This case has a complex procedural history. In August 1983, claimant suffered a compensable back injury. The claim was ultimately closed by a 1987 determination order that awarded 35 percent permanent partial disability. Claimant sought a hearing and received an award of permanent total disability (PTD), pursuant to a referee's order. SAIF appealed the referee's order to the Board.

In 1989, claimant began receiving treatment for a cervical condition. On April 18, 1989, his neurological surgeon, Dr. Collada, requested authorization for surgery. On May 5, 1989, SAIF partially denied the cervical condition. At that time, a referee had determined that claimant was permanently and totally disabled, although SAIF had appealed that determination to the Board. Claimant's claim for the cervical condition was thus characterized as a claim for medical benefits under ORS 656.245, and the sole disputed issue was whether the cervical condition was related to the 1983 compensable injury. The referee expressly found claimant not credible and upheld SAIF's denial of the claim. The Board affirmed the referee's order. We reversed and remanded the case to the Board on the ground that the Board had considered medical evidence that was not properly in the record. In an order on remand, the Board ultimately set aside SAIF's denial and upheld the compensability of the surgery, finding that the compensable low back condition was a material contributing cause of the cervical condition and need for surgery. In the meantime, on June 18, 1990, the Board reversed the referee's order awarding benefits for permanent and total disability and reinstated the 1987 determination order.

Pursuant to the Board's order on remand, holding that the surgery was compensable, SAIF sought to reopen the claim for payment of temporary total disability (TTD), *effective retroactively to the date of the surgery, December 13, 1989,* thereby placing the reopening outside claimant's aggravation **<137 Or 104/105>** period, which had expired on May 4, 1989, and within the Board's own motion jurisdiction. On June 11, 1992, on its own motion, the Board authorized reopening of the claim and the payment of TTD. On June 12, 1992, SAIF issued a notice of closure under the Board's own motion procedures.

On August 7, 1992, claimant filed an objection to the closure of the claim on the Board's own motion, contending that the matter should have been processed as an aggravation claim. On October 7, 1992, the Board issued an own motion order reviewing SAIF's closure of the claim and refusing to reconsider its own motion

order of June 11, 1992, on the ground that claimant had not timely requested reconsideration of the order pursuant to OAR 438-12-065(2). In the alternative, the Board said that, were it to consider the merits of the aggravation claim, it would find that claimant's condition had not worsened before the expiration of his aggravation rights and that claimant's claim was properly within the Board's own motion jurisdiction.

Claimant requested a hearing on November 4, 1992, challenging the "de facto" denial of his aggravation claim. The referee dismissed the request for hearing for lack of jurisdiction, on the ground that the Board's own motion order was binding and conclusive. The Board, sitting with different members, reversed the referee. It found that claimant had perfected his aggravation claim before his aggravation rights had expired under ORS 656.273, and remanded the case for a hearing. On review, SAIF contends that the Board's own motion orders precluded claimant's aggravation claim.

If claimant's claim is processed as an aggravation claim, he is entitled to a full hearing as well as all of the substantive benefits under the Workers' Compensation Law, including medical treatment, TTD, vocational rehabilitation and additional permanent disability, if appropriate. If his condition worsened after the expiration of the aggravation period, the matter must be considered by the Board on its own motion, without a hearing, and the only benefits available to claimant are for medical treatment and TTD from the date of hospitalization until the condition becomes medically stationary. There is no entitlement to additional permanent disability. Generally, a claimant may seek review of a Board's own motion order only if the order diminishes or terminates a **<137 Or App 105/106>** former award. We have held, however, that the Board's determination that it has own motion jurisdiction is subject to judicial review. *Miltenberger v. Howard's Plumbing,* 93 Or App 475, 477, 762 P2d 1057 (1988).

In its order of October 7, 1992, the Board expressly found that claimant's aggravation rights had expired and that it had own motion jurisdiction. Claimant did not seek review of that determination. Accordingly, the Board's order became final, with the force and effect of a judgment. Contrary to claimant's contention, even assuming that the Board was wrong as a factual matter when it found that his condition had not worsened during the aggravation period, that does not render the Board's order void. A judgment is void only when the tribunal rendering it had no jurisdiction over the parties or the subject matter. *Dolph v. Barney,* 5 Or 191, 211 (1874), *aff'd* 97 US 652 (1878). Subject matter jurisdiction depends on whether the tribunal had the authority to make an inquiry into the dispute. *SAIF v. Roles,* 111 Or App 597, 601, 826 P2d 1039, *rev den* 314 Or 391 (1992). ORS 656.278(1)[1] and

---

[1] ORS 656.278(l) provides:

"Except as provided in subsection (5) of this section, the power and jurisdiction of the board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker.'s condition becomes medically stationary, as determined by the board; or

"(b) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the board may authorize payment of medical benefits."

ORS 656.726(2)[2] implicitly authorize the **<137 Or App 106/107>** Board to determine whether it can exercise its own motion authority. To make that determination, the Board must decide when any alleged worsening of a claimant's condition occurred and whether the claimant's aggravation rights have expired.

We conclude that the Board has subject matter jurisdiction to determine whether a claim comes within its own motion jurisdiction. Although we could have considered a petition challenging the Board's determination that it had own motion jurisdiction, *Miltenberger,* 93 Or App at 477, no such petition was filed in this case, and the Board's order determining that it had own motion jurisdiction became final and is not subject to collateral attack. Additionally, the Board's order precludes relitigation of the issue that it expressly decided; namely, that claimant's condition did not worsen before the expiration of his aggravation rights. *Drews v. EBI Companies,* 310 Or 134, 140, 795 P2d 531 (1990). The Board erred in overturning its own decision.

Board order vacated; referee's order reinstated.

---

[2] ORS 656.726(2) provides:

"The board hereby is charged with the administration and the responsibility for the Hearings Division and for reviewing appealed orders of referees in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction under this chapter and providing such policy advice as the director may request, and providing such other review functions as may be prescribed by law. To that end any of its members or assistants authorized thereto by the members shall have power to:

"(a) Hold sessions at any place within the state.

"(b) Administer oaths.

"(c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony before any hearing under ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter.

"(d) Generally provide for the taking of testimony and for the recording of proceedings."

---

Cite as 137 Or App 146 (1995) September 27, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Melvin L. Shroy, Claimant.

SAFEWAY STORES, INC., *Petitioner,*

v.

Melvin L. SHROY, *Respondent.*

(93-07329, 93-02639; CA A85509)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 27, 1995.

Kenneth L. Kleinsmith argued the cause for petitioner. With him on the brief was Meyers, Radler, Replogle & Bohy.

Robert G. Dolton argued the cause and filed the brief for respondent.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

---

**137 Or App 147>** Employer seeks review of an order of the Workers' Compensation Board holding that a medical arbiter's report constitutes an aggravation claim under ORS 656.273 and that claimant has established a compensable worsening.

ORS 656.273(3) has been amended by Oregon Laws 1995, chapter 332, section 21. Because the amended version of the statute is applicable here, we remand for reconsideration in the light of the new law. *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995).

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Sherry A. Young, Claimant.

Sherry A. YOUNG, *Petitioner,*
v.
SAIF CORPORATION and Sunnyside Care Center, *Respondents.*
(WCB 91-12999; CA A82555)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 19, 1995.

Michael D. Callahan argued the cause for petitioner. With him on the brief was Callahan and Stevens.

David L. Runner, 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 Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

WARREN, P. J.

Reversed and remanded for reconsideration.

---

**137 Or App 195>** Claimant seeks review of an order of the Workers' Compensation Board. We reverse and remand.

Claimant requested authorization for low back surgery. SAIF, her employer's insurer, referred the request to the director of the Department of Consumer and Business Services for approval. The director concluded that the requested surgery was inappropriate. Claimant requested a hearing on the director's order. The referee held that the surgery was appropriate and awarded claimant an attorney fee under ORS 656.386(l) for prevailing on the issue. SAIF requested Board review of the referee's order. While that review was pending, the director issued a second order, in which he held that the proposed surgery was appropriate and ordered SAIF to provide reimbursement for the surgery. That order was not appealed.

The Board then vacated the referee's order concerning the first request for surgery. It concluded that the medical services dispute was moot, because the director had subsequently found the surgery to be appropriate and had ordered SAIF to pay for it. The Board further held that, even if the medical services dispute was not moot, and even if it were to determine that the original request for surgery should have been granted, it would nonetheless deny an award of attorney fees under ORS 656.386(l).

Claimant seeks review. She challenges the Board's determination that the medical services dispute is moot, as well as the denial of her request for attorney fees under ORS 656.386(l). At thisjuncture it is apparent that the only "live" issue in this case is claimant's entitlement to attorney fees under ORS 656.386(l). A Board determination that the original request for surgery should have been approved could no longer affect claimant's ability to obtain surgery; that has been resolved by the second director's order.

ORS 656.386(l) was amended by the 1995 legislature. Or Laws 1995, ch 332, § 43. The amendments took effect on June 7, 1995, and apply to cases pending before this court on that date. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). Accordingly, we remand for the Board to reconsider attorney fees in light of the 1995 amendments.

Reversed and remanded for reconsideration.

Cite as 137 Or App 368 (1995) October 25, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Estate of Robbie Wayne Worthen, Decedent.
Dorothy WORTHEN, Personal Representative of the Estate of Robbie Wayne Worthen, Decedent,
*Respondent*
v.
LUMBERMEN'S UNDERWRITING ALLIANCE, INC., *Appellant.*
(91-CV-0516)

In the Matter of the Estate of Robbie Wayne Worthen, Decedent.
Dorothy WORTHEN, Personal Representative of the Estate of Robbie Wayne Worthen, Decedent,
*Respondent,*
v.
NAVISTAR INTERNATIONAL TRANSPORTATION CORPORATION,
Northwest International Trucks and D-9 Construction, Inc., *Defendants,*
and LUMBERMEN'S UNDERWRITING ALLIANCE, INC., *Appellant.*
(91-CV-0596; CA A84846)

Appeal from Circuit Court, Coos County. Robert F. Walberg, Judge.
Submitted on record and briefs April 18, 1995.
**137 Or App 369>** Kenneth L. Kleinsmith and Meyers, Radler, Replogle & Bohy filed the briefs for appellant.
G. Jefferson Campbell, Jr., filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

---

**137 Or App 371>** Lumbermen's Underwriting Alliance, Inc. (Lumbermen's), appeals from an order issued by a probate court. The order distributes the recovery obtained in a wrongful death action brought by a decedent's personal representative, who is also a workers' compensation claimant.[1] We affirm.

The decedent was killed in a logging truck accident that arose out of and in the course of his employment with an insured of Lumbermen's. The decedent's surviving spouse (plaintiff), filed a workers' compensation claim that was accepted by Lumbermen's, and she began to receive benefits. Plaintiff was appointed personal representative of the decedent's estate and she elected to seek recovery against the third parties who allegedly caused the fatal injury: D-9 Construction, Inc. (D-9), Northwest International Trucks (Northwest) and Navistar International Transportation Corporation (Navistar).[2] Plaintiff filed a wrongful death action against D-9, Northwest and Navistar on behalf of herself and the decedent's three surviving adult children.[3] She provided notice of the claim to Lumbermen's as required by ORS 656.593(j).[4] The action resulted in a pretrial settlement with D-9 for $15,000 and a judgment against Navistar for $42,343.64.[5]

---

[1] The order was issued by the circuit court that presided over the wrongful death action, sitting in its capacity as a probate court.

[2] Oregon's workers' compensation laws permit a worker or worker's beneficiary to pursue recovery for injury or death against a negligent third party. ORS 656.154; ORS 656.578.

[3] The decedent's children are not workers' compensation beneficiaries. ORS 656.005(2), (5); ORS 656.204.

[4] If a claimant elects to proceed against a third party for damages, ORS 656.580(2) grants the paying agency a "lien" against the cause of action. *Toole v. EBI Companies,* 314 Or 102,105-06,838 P2d 60 (1992). This arrangement shifts the cost of compensating the claimant to the wrongdoer and provides "both the paying agency and the [claimant] some benefit from the third-party claim recovery." *SAIF v. Parker,* 61 Or App 47,53,656 P2d 335 (1982). A "paying agency" is defined by ORS 656.576 as "the self-insured employer or insurer paying benefits to the worker or beneficiaries." The parties do not dispute that Lumbermen's qualifies as a paying agency under that definition.

[5] The claims against Northwest were dismissed with prejudice.

A dispute arose between plaintiff and Lumbermen's over the distribution of the total recovery ($57,343.64) **<137 Or App 371\372>** obtained in the wrongful death action. Both parties petitioned the Workers' Compensation Board (Board) for resolution of their dispute. The Board issued a third-party distribution order in which it determined that Lumbermen's was entitled to a "just and proper" share of the D-9 settlement proceeds, in the amount of $6,115.45, and that it was not entitled to a share of the damages awarded in the Navistar judgment. ORS 656.593(l), (3).[6]

After the Board issued its' order, plaintiff filed a motion in the probate court requesting distribution of the recovery from the wrongful death action. Applying ORS 30.030,[7] the court ordered that the entire recovery be allocated to pay the costs, expenses and fees incurred in prosecuting the wrongful death claim, which "far exceeded the amount of the total recoveries." *See* ORS 30.030 (2). As a result, there were no funds remaining to distribute to the decedent's beneficiaries, including plaintiff. The court further concluded:

> "[T]here is and will be no distribution from the Estate of Robbie Plaintiff to [plaintiff], as the surviving spouse of the decedent, from the wrongful death action recoveries against which a paying agency lien under ORS 656.580(2) might otherwise be applied in favor of Lumbermen's Underwriting Alliance, Inc., the workers' compensation insurer of decedent's employer."

On appeal, Lumbermen's challenges the court's distribution of the wrongful death recovery, arguing that the court **<137 Or App 372\373>** lacked statutory authority to abrogate the Board's award of a just and proper share of the settlement proceeds. Lumbermen's specifically contends that, because the wrongful death claim was brought by a workers' compensation claimant as a third-party action, the court must distribute the recovery in a manner consistent with the Board's third-party distribution order. We disagree.

Two statutory provisions affect the distribution of the recovery obtained in this wrongful death action. The first, ORS 30.030, directs the personal representative to distribute the damages obtained from a settlement of or judgment in a wrongful death action in a specified manner. The second, ORS 656.593, applies because the claim was brought as a third-party action by a workers' compensation claimant. That provision determines, *inter alia,* how the damages obtained by a workers' compensation claimant in a third party action are to be allocated between the claimant and the paying agency that has been granted a lien against the cause of action pursuant to ORS 656.580(2).[8] The parties' dispute here centers on the order in which those two provisions are to be applied.

---

[6] The Board's third-party distribution order is the subject of a separate appeal. *See Worthen* v. *Lumbermen's Underwriting (A83303),* 137 Or App 434, ___ P2d ___ (1995).

[7] ORS 30.030 provides, in part:

"(1) Upon settlement of a claim, or recovery of judgment in an action, for damages for wrongful death, * * * the amount of damages so accepted or recovered *shall be distributed in the manner prescribed by this section.*

"(2) The personal representative shall make payment or reimbursement for costs, expenses and fees incurred in prosecution or enforcement of the claim, action or judgment.

"(4) If under ORS 30.040 or 30.050 or by agreement of the beneficiaries a portion of the damages so accepted or recovered is apportioned to a beneficiary as recovery for loss described in ORS 30.020(2)(d), the personal representative shall distribute that portion to the beneficiary.

"(5) The remainder of the damages accepted or recovered shall be distributed to the beneficiaries * * *." (Emphasis supplied.)

[8] A paying agency's lien is qualified by ORS 656.593, which ultimately controls the amount that a paying agency may recover from a third-party action. In the event that a claimant recovers damages, the paying agency is entitled to an "amount equal to any compensation benefits paid and 'the present value of its reasonably to be expected future expenditures.' " *Estate of Troy Vance v. Williams,* 84 Or App 616, 619, 734 P2d 1372 (1987) (quoting ORS 656.593(l)(c)). If, on the other hand, a claimant *settles* the third party action, the paying agency is authorized to accept a "just and proper" share of the settlement proceeds. ORS 656.593(3); *Vance,* 84 Or App at 619-20. That amount is either less than or equal to "the amount of the lien to which it would be entitled if the claim had not been settled. " *Id.* If the parties dispute what constitutes a "just and proper" share of a settlement, the Board resolves such conflicts. ORS 656.593(3).

A wrongful death action that is brought as a third-party action by, or on behalf of, a workers' compensation claimant is not necessarily exclusive to that claimant. The action may also involve dependents of the decedent who do not qualify as workers' compensation beneficiaries.[9] See ORS 30.020 (listing wrongful death beneficiaries); ORS **<137 Or App 373/374>** 656.005(2)(defining workers' compensation beneficiary). In instances where a group of wrongful death beneficiaries includes both workers' compensation claimants and nonclaimants, we have held that, although ORS 656.580(2) grants the paying agency "a lien against the cause of action," the lien attaches only to that portion of the recovery *distributed to a workers' compensation* claimant, not to the total amount obtained in the cause of action. *Scarino v. SAIF, 91* Or App 350, 755 P2d 139, *rev* den 306 Or 660 (1988). Accordingly, the recovery first must be allocated among the wrongful death beneficiaries pursuant to ORS 30.030. Once a claimant, standing as a wrongful death beneficiary, receives his or her portion of the recovery, ORS 656.593 dictates how much of that claimant's share will be distributed to the paying agency.

Like *Scarino,* this wrongful death action involves a workers' compensation claimant and three nonclaimants. Therefore, we begin by applying ORS 30.030 to the recovery. According to the prioritization scheme set forth in that statute, the costs, fees and expenses incurred in pursuing the wrongful death claim must be paid first. ORS 30.030(2)[10] Here, the costs, fees and expenses exceed the amount of the total recovery. As a result, none of the wrongful death beneficiaries, including plaintiff, receive any part of the settlement or damages. Under the rule enunciated in *Scarino,* Lumbermen's lien against the third-party action would be reimbursed out of the portion of the total recovery allocated to plaintiff, the workers' compensation claimant.[11] However, because plaintiff did not receive any share of the recovery, Lumbermen's lien is effectively extinguished. The probate court did not err in concluding similarly.

Lumbermen's contention that *Liberty Northwest v. Golden,* 116 Or App 64, 840 P2d 1362 (1992), *rev* den 315 Or 442 (1993), controls the outcome of this case is incorrect. In *Golden,* we recognized an exception to *Scarino*, holding that when a third-party wrongful death action involves workers' compensation claimants *exclusively,* the paying agency's lien **<137 Or App 374/375>** attaches to the entire amount of the recovery distributed to the group, even though one or more of the individual claimants may not receive a share of the recovery.[12] 116 Or App at 68. We distinguished *Scarino* because there were no nonclaimants represented in the wrongful death action. Id. That is not the situation here. The group of wrongful death beneficiaries in this case involves both claimants and nonclaimants; therefore, the exception we stated in *Golden* does not apply.

In applying ORS 30.030, the probate court was required to distribute the recovery in a manner consistent with the statute, and was not affected by the Board's determination that Lumbermen's was entitled to an amount representing a "just and proper" share of the D-9 settlement.

Affirmed.

---

[9] In *Liberty Northwest v. Golden,* 116 Or App 64, 67, 840 P2d 1362 (1992), *rev* den 315 Or 442 (1993), we noted:

> "The beneficiaries of a wrongful death action, ORS 30.020, are not the same as beneficiaries under the Workers' Compensation Act. ORS 656.204. "

[10] *See* n 7, *supra.*

[11] We use the term "lien" to refer generally to the interest that the paying agency has in the third-party claim. *See* ORS 656.580(2).

[12] The settlement obtained in the wrongful death action in *Golden* was distributed to two of the three claimants only. Nevertheless, we held that the paying agency could recover the claim costs attributed to all three claimants. *Golden,* 116 Or App at 68. Had we followed the rule in *Scarino,* the paying agency would have been able to recover only the claim costs attributed to the two claimants who actually received a share of the settlement.

Cite as 137 Or App 413 (1995) October 25, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Thomas R. Yon, Jr., Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and Sturdi-Craft, Inc., *Petitioners,*

v.

Thomas R. YON, Jr., *Respondent.*

(94-01229; CA A86186)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 21, 1995.
David 0. Wilson argued the cause and filed the briefs for petitioners.
James L. Edmunson argued the cause for respondent. With him on the brief was Christine Jensen.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Reversed and remanded with instructions to vacate referee's order and dismiss request for hearing.

---

**137 Or App 415>** This is a medical services dispute in which employer seeks review of a Workers' Compensation Board order affirming the referee's finding that surgical treatment for claimant's accepted right-hand injury is compensable. Employer argues that the director of the Department of Consumer and Business Services now has exclusive jurisdiction to review proposed medical treatment. We conclude that the Board lacked jurisdiction.

In deciding that it had authority to consider this medical services dispute, the Board relied on our opinion in *Meyers v. Darigold, Inc.*, 123 Or App 217, 861 P2d 352 (1993), *rev* den 320 Or 453 (1994). In *Meyers,* we held that the relevant statutory provisions give the injured worker a choice in a medical services dispute whether to seek review by the director pursuant to ORS 656.327, or to seek a hearing with the Board. Before oral argument in this court, the legislature amended ORS 656.245, ORS 656.327 and ORS 656.704 regarding jurisdiction over medical services disputes. Or Laws 1995, ch 332, §§ 25, 41 and 50. The 1995 amendments became effective on June 7, 1995. Or Laws 1995, ch 332, § 69. Subsection 6 was added to ORS 656.245 and provides that:

> "(6) 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 review by the director [of the Department of Consumer and Business Services] 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." 1995 Or Laws, ch 332, § 25.

The amendments to ORS 656.327 eliminated the language that in *Meyers* we had interpreted as giving an injured worker a choice about whether the director would review a medical services dispute. As amended, ORS 656.327 now specifies that:

> "(1)(a) 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 **<137 Or App 415/416>** 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." 1995 Or Laws, ch 332, § 41. (Emphasis supplied.)

For purposes of determining the respective authority of the director and the Board to conduct hearings or other proceedings, ORS 656.704 was amended to state that the phrase "matters concerning a claim"

> *"do[es] 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." 1995 Or Laws, ch 332, § 50. (Emphasis supplied.)

With certain exceptions not relevant here, the amendments are intended to apply retroactively to "all claims * existing * * * on or after the effective date of this Act * * Or Laws 1995, ch 332, § 66. In *Volk v. America West Airlines,* 135 Or App 565, 572-73, 899 P2d 746 (1995), we held that

> "the legislature's intent in subsection (5)(a) of section 66 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."

In *Newell v. SAIF,* 136 Or App 280, ___ P2d ___ (1995), and *SAIF v. Bowen,* 136 Or App 222, 901 P2d 925 (1995), we held that, by virtue of the amendments, the Board lacked jurisdiction to consider the appropriateness of *proposed* medical treatment. The parties have provided us with supplemental briefs on the effects of the amendments. We write to address contentions that were not raised by or considered in *Newell* and *Bowen.*

Claimant contends that the amendments deny him "due process of state law under the Fourteenth Amendment to the United States Constitution." He makes no specific argument about how due process has been violated, but argues that we

> "should not uphold *any* application of substantive statutory amendments that limit or diminish a party's *ability* to obtain a remedy under the terms of law that existed when a claim for **<137 Or App 416/417>** statutory benefits was brought, heard and decided below." (Emphasis claimant's.)

Employer responds that there is no constitutional impediment preventing the legislature from applying its laws retroactively. *Whipple v. Howser,* 291 Or 475, 632 P2d 782 (1981).

On the facts of this case, we agree with employer. The Supreme Court has already rejected an argument similar to claimant's. In *State ex rel Huntington v. Sulmonetti,* 276 Or 967, 557 P2d 641 (1976), a mandamus proceeding, the claimant's first claim for compensation was denied because it had not been timely filed under the statute then in existence. Five years later, the claimant filed the identical claim. Before it was adjudicated, the legislature amended the statute to extend the filing period and make it retroactive, so that the claimant's second claim would have been timely. The employer argued that retroactive application of the amendments should be barred on the ground of *res judicata* and because they violated substantive due process and the separation of powers provision of Article III, section 1, of the Oregon Constitution. The court disagreed, on the, ground that workers' compensation claims "are part of an exclusively legislative plan." Id. at 972. It observed:

> "If the legislature wants to provide for the refiring or retrial of claims previously created and litigated in accordance with legislative direction because it feels that the claimants did not have a fair opportunity to do so under prior law, it is the legislature's business * * *." *Id.*

The court's rationale in *Huntington* is all the more persuasive here, because there is no issue of *res judicata.* The amendments to ORS 656.245, ORS 656.327 and ORS 656.704 do not deprive claimant of any rights that had vested by virtue of a final determination in his case. The amendments have eliminated claimant's choice to have his medical services dispute resolved by the Board, but they do not deny him of an opportunity to have his claim for medical services reviewed. If claimant is dissatisfied with the director's determination about surgical treatment for his right-hand injury, he may request a contested case hearing and may seek review of that order in the Court of Appeals. ORS 656.327(2).

Reversed and remanded with instructions to vacate referee's order and dismiss request for hearing.

Cite as 137 Or App 497 (1995) November 8, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of George 0. Hamlin, Claimant.

George 0. HAMLIN, *Petitioner,*
v.
SALEM AREA TRANSIT and SAIF Corporation, *Respondents.*
(93-02757; CA A83907)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 21, 1094.
Max Rae argued the cause and filed the brief for petitioner.
Steve R. Cotton, 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 Warren, Presiding Judge, and Edmonds and Armstrong,* Judges.
ARMSTRONG, J.
Affirmed.
* Armstrong, J., *vice* Landau, J.

---

**137 Or App 499>** Claimant seeks judicial review of an order of the Workers' Compensation Board that increased claimant's permanent partial disability (PPD) award based on a finding that claimant has the capacity to perform work in the "medium/light" category. He contends that there is not substantial evidence in the record to support that finding. We review for substantial evidence, ORS 183.482(8)(c), and affirm.

Claimant has been employed as a city bus driver for the past ten years. In 1985, claimant suffered a compensable injury to his neck and mid-back when the bus he was driving was rear ended. At that time, the Board awarded claimant 10 percent PPD. Following the injury, claimant returned to work driving buses, some equipped with power steering and others equipped with manual steering. In April 1992, he suffered an aggravation of his condition. Claimant's treating physician, Dr. Rohwer, determined that the condition was exacerbated by the musculoskeletal strain caused by driving buses that lack power steering.

On June 8, 1992, Rohwer released claimant to return to modified work, with the limitation that he drive only buses equipped with power steering. Claimant's aggravation claim was closed without any increase in PPD. He sought reconsideration and then a hearing on the denial of his claim for increased PPD. Ultimately, claimant appealed to the Board, arguing that his award of PPD should be increased by 8 percent to a total of 18 percent, because he was no longer able to perform the full range of work as a bus driver. The Board increased claimant's PPD award to 13 percent. Claimant sought judicial review.

The administrative rules that provide for PPD have changed over the years.[1] At the time of claimant's determination order, one of the factors that affected a PPD award was a claimant's "adaptability," which was determined by comparing the claimant's original physical capacity to work, measured in terms of strength, with the claimant's remaining **<137 Or App 499/500>** capacity to do so after injury. OAR 436-35-270(2). A claimant's remaining capacity was called residual functional capacity (RFC). OAR 436-35-310. Adaptability was measured by comparing the "strength" of the claimant's job prior to injury with the "strength" of the job the claimant was performing or was able to perform

---

[1] The parties agree that claimant's adaptability should be rated pursuant to the versions of OAR 436-35-270 and OAR 436-35-310 that are found in WCD Administrative Order 6-1992, effective March 13, 1992. All of our citations to those rules refer to the March 1992 version of them.

post-injury.[2] OAR 436-35-310(3)(d). The strength of a particular occupation was classified as "sedentary..... light," "medium," "heavy" or "very heavy." *Id.;* OAR 436-35-270(3)(g).

The parties do not dispute that the strength rating for claimant's job as a bus driver, before modification, is medium. See U.S. Department of Labor, 2 *Dictionary of Occupational Titles §* 913.463-010, at 926 (4th ed 1991). That rating then must be compared with claimant's maximum RFC at the time of the determination order to determine his adaptability score. OAR 436-35-310(l).

The debate here is whether claimant's maximum RFC as evidenced either by Rohwer's release, or the job to which claimant returned, should be light or medium/light. *See* OAR 436-35-270(3)(d). The Board found:

> "Claimant's attending physician released him to his job as a bus driver, which has a strength value of 'medium.' The only limitation identified by his attending physician was a permanent restriction to operating only buses with power steering. We interpret the attending physician's release as a release to work in the medium' strength category, but with a restriction that prevents claimant from performing the full range of requirements of his 'medium' strength job as [a] bus driver. Accordingly, pursuant to former OAR 436-35-310(3), we conclude that claimant's RFC is 'medium/light,' based on his attending physician's release."

On judicial review, claimant argues that substantial evidence does not support a finding that he retains the RFC for medium/light work. He argues that the evidence shows **<137 Or App 500\501>** that he is able to work only in the light category. We review the Board's findings for substantial evidence in the record. ORS 183.482(8)(c).

We begin by examining the capacity evidenced by Rohwer's release. The release did not contain any specific activity or weight restrictions that track with the limitations in the definitions of "light" or "medium" work. *See* OAR 436-35-270(3)(g)(B) & (C). It allowed claimant to return to work at a medium-strength job, that of a bus driver, with the limitation that he drive only buses with power steering. Aside from that one limitation, claimant was released to perform all the other duties associated with his medium-strength job.

OAR 436-35-310(3) provided that, if a worker had the RFC to do "more than the requirements of one category of RFC, but not the full range of requirements for the next higher category," the classification established between the two categories was used. Thus, the Board could find that claimant could perform more than the requirements of the light category of RFC, but not the full range of requirements for the medium category, and rank claimant's RFC as medium/light. Because we conclude that Rohwer's release provides substantial evidence that claimant could perform a medium/light strength job, we do not address the strength of the job to which claimant returned. See OAR 436-35270(3)(d).

In summary, there is substantial evidence to support the Board's finding that claimant has the RFC to do medium/ light work. Hence, the Board did not err in its PPD award to claimant.

Claimant further argues that we should order that his PPD award be paid at the increased rates mandated by Senate Bill 369, which was enacted by the 1995 Oregon Legislature. See Or Laws 1995, ch 332, §§ 17, 66. At this point, the Board's order provides only that SAIF must pay claimant an additional award of three percent (9.6 degrees) PPD. The rate at which that award must be paid is not now properly before this court, and we express no opinion on it.

Affirmed.

---

[2] A worker's maximum RFC was defined to be:

"the *greatest* capacity evidenced by:

"(A) The attending physician's release; or

"(C) The strength of any job at which a worker has 'returned to work' at the time of determination."

OAR 436-35-270(3)(d) (emphasis supplied).

Cite as 137 Or App 506 (1995) November 8, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON OCCUPATIONAL SAFETY AND HEALTH DIVISION, *Petitioner,*
v.
FALL CREEK LOGGING CO., *Respondent.*
(SH-92352: CA A84785)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 19, 1995.

Jas. Adams, Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Elliott Cummins argued the cause for respondent. With him on the brief were George W. Goodman and Cummins, Goodman, Fish & Peterson, P.C.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

ARMSTRONG, J.

Reversed and remanded for reconsideration.

---

**137 Or App 508>** The Oregon Occupational Safety and Health Division (OSHD) seeks review of a referee's order that dismissed a citation issued to Fall Creek Logging Co. OSHD issued the citation for an alleged failure by a log-truck driver to wear a hard-hat, as required by OAR 437-06-045(2). OSHD based the citation on information that it had obtained in an inspection of Fall Creek that was undertaken to determine the cause of a fatal accident. OSHD asserts that the referee erroneously dismissed the citation on the ground that it was issued for a condition that was unrelated to the accident that triggered the inspection. We review for errors of law, ORS 183.482(8)(a), and reverse.

Neither party disputes the referee's findings:

> "On May 1, 1992, at approximately 7:20 a.m., [employer] was [engaged] in logging activities at a site near Grande Ronde, Oregon. At that time and place, Nolan J. 'Shorty' Curl was receiving a load of pulp logs onto his log truck. The shovel operator was moving a saw log, which was not intended to be a part of the truck load, from the landing on the right side of the truck to the log deck on the left side of the truck. As the log approached the truck, the shovel operator observed Mr. Curl standing by the left side of the truck adjacent to the rear stakes, in the intended path of the saw log. The shovel operator raised the log to allow it to clear the truck. As the log [rose], it hit a guy line and was knocked loose from the heel plate. The log fell and struck Mr. Curl in the upper back and neck, killing him. Mr. Curl was not wearing an approved hard hat.
>
> "[Employer] had been comprehensively inspected by [OSHD] on March 23, 1992, and had been cited for several alleged violations, including a violation of OAR 437-06045(2).[1] That citation was not appealed. At approximately 10:30 a.m. on May 1, 1992, Sam Drill, Safety Compliance Officer (SCO), arrived at the logging site and began an accident investigation. * * * As a result of SCO Drill's investigation, [employer] was cited for an alleged repeat violation of OAR 437-06-045(2).
>
> **137 Or App 509>** "The result of the accident, Mr. Curl's death, would have occurred whether or not Mr. Curl had been wearing an. approved hard hat."

---

[1] OAR 437-06-045(2) provides, in relevant part:

> "Employees engaged in logging activities or working in areas where there is possible danger of head injury from impact or from falling or flying objects, shall wear an approved hard hat * * *."

On those facts, the referee concluded:

> "The issue is whether, in the context of an accident investigation conducted within 12 months of a comprehensive inspection, the inspection permits citation for alleged violations in no way related to the cause of the accident or its result. I conclude that it does not. OAR 437-01-015[(35)](f)."[2]

OSHD asserts that the referee erred as a matter of law in holding that OSHD may not issue a citation for a violation that it discovers in the course of an accident investigation if the violation is not related to the cause of the accident. OSHD argues that it may issue a citation for any violation discovered while conducting a lawful accident inspection, regardless of whether the violation is a cause of the accident. Employer asserts that, if the scope of the investigation is limited to determining the cause of the accident, the authority to issue citations should be limited to violations that caused the accident. We hold that OSHD's authority to issue citations in the context of an accident investigation is not limited to violations that caused the accident.

OSHD's authority to issue citations is set forth in ORS 654.071(l):

> **137 Or App 510>** "If the director or an authorized representative of the director has reason to believe, after inspection or investigation of a 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 employee 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 statute authorizes a citation whenever the inspector has reason to believe that the employer has violated any regulation. Nowhere does the statute state that the inspector's authority to issue citations is limited to violations that are related to the inspection-triggering event. Likewise, the administrative rules place no such restriction on the inspector's authority to issue citations. OAR 437-01205(l) provides: "If the Division concludes from the review of an inspection report that a rule or order was violated, a citation will be issued to the employer * * *."

Employer concedes that OSHD properly obtained the evidence on which it based its citation for the hard-hat violation.[3] Employer asserts, however, that although OSHD had authority to gather the evidence, it did not have authority to issue a citation based on that evidence. In support of that assertion, employer argues that, in the context of an accident investigation, when OSHD cites an employer for a nonaccident-related violation,

---

[2] OAR 437-01-015(35) defines the inspections relevant to this case as follows:

> "**Inspection** - An official examination of a place of employment by [a] Compliance Officer to determine if an employer is in compliance with the Act. An inspection may be classified as:
>
> "(a) **Routine inspection** - An inspection of a place of employment which is made based principally on that place of employment's record of workers' compensation claims or Standard Industrial Classification and number of employees.
>
> "* * * * *
>
> "(f) **Accident investigation** - An inspection made to determine the cause of an accident[.]"

OAR 431-01-057(4) limits complete routine inspections of any fixed place of employment to one inspection every 12 months, absent circumstances that are not present in this case. The parties do not discuss whether the place of employment in this case was a fixed place of employment that is subject to the 12-month limit on routine inspections in OAR 431-01-057(4). See OAR 431-01-015(30). Because of the basis of our decision, we need not decide that question.

[3] The SCO learned that Curl was not wearing a hard-hat through questioning witnesses about the accident. The shovel operator told the SCO that he became aware of Curl's location when he saw Curl's baseball cap. The SCO used that information to issue the hard-hat citation.

OSHD is, in effect, going beyond the scope of the accident investigation. At that point, employer argues, OSHD must obtain either the employer's consent or an appropriate, additional inspection warrant, not for evidence-gathering purposes, but in order to issue a valid citation.[4]

**137 Or App 511>** Employer's argument wrongly equates the scope of OSHD's authority to inspect, or to obtain evidence, with the scope of its authority to issue citations. OSHD's authority to issue citation's is distinct from its authority to inspect. *Compare* ORS 654.071(l) *with* ORS 654.067(3) *and* ORS 654.206(l).

OSHD may inspect an employer's premises with the employer's consent or with a valid inspection warrant. ORS 654.067(3). OSHD may obtain an inspection warrant based on cause, ORS 654.206(l), and

> "[c]ause shall be deemed to exist if reasonable legislative or administrative standards for conducting a routine, periodic or area inspection are satisfied with respect to the particular place of employment, or there is probable cause to believe that a condition of nonconformity with a safety or health statute, ordinance, regulation, rule, standard or order exists with respect to the particular place of employment, or an investigation is reasonably believed to be necessary in order to determine or verify the cause of an employee's death, injury or illness."

ORS 654.206(2). A warrant to perform an accident investigation gives OSHD the authority to inspect an employer to determine the cause of an accident. ORS 654.067(3); ORS 654.206(2); OAR 437-01-015(35)(f). In contrast, although OSHD's evidence-gathering authority is limited by the purpose for which the inspection is authorized, its authority to issue citations is not. That is because ORS 654.071(l) authorizes OSHD, on completion of an inspection, to issue a citation for any violation believed to exist. Therefore, OSHD's authority to issue citations is not linked to, or limited by, the type of inspection being performed.[5]

Under ORS 654.071(l), on completing its accident investigation, OSHD properly cited employer for the alleged hard-hat violation. Because OSHD lawfully obtained the **<137 Or App 511/512>** evidence on which it based the citation, the referee erred in dismissing the citation.

Reversed and remanded for reconsideration.

---

[4] Employer does not specify what additional warrant OSHD should be required to obtain before it may issue a citation for a violation discovered in the course of conducting a valid accident investigation. In this case, OSHD did not go beyond the scope of the accident investigation to obtain the evidence underlying the alleged hard-hat violation. Because OSHD did not need additional evidence-gathering authority, there is no basis to require an additional warrant.

[5] Employer cites *Marshall* v. *Barlow's, Inc.*, 436 US 307, 323, 98 S Ct 1816, 56 L Ed 2d 305 (1978), in support of the assertion that OSHD needed an additional warrant or employer's consent to issue the citation. Employer's argument finds no support in that case, which addressed the reasonableness of warrantless administrative searches under the Fourth Amendment to the United States Constitution. That case did not address the agency's authority to issue citations pursuant to a properly conducted inspection.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wayne L. Duval, Claimant.

CABAX MILLS, INC. and Argonaut Insurance Company, *Petitioners,*
v.
Wayne L. DUVAL, *Respondent.*
(93-06091; CA A86718)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 2, 1995.

Craig A. Staples argued the cause for petitioners. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C.

Thomas M. Cary argued the cause for respondent. With him on the brief was Coons, Cole, Cary & Wing, P.C.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

---

**137 Or App 526>** Employer seeks judicial review of an order of the Workers' Compensation Board holding that employer's failure to contest a previous determination order precluded it from contesting the compensability of claimant's knee condition. The statutes pertinent to this review have been amended by Oregon Laws 1995, chapter 332. The amended versions of the statutes are applicable to this case, and the changes may affect the Board's analysis or result. Accordingly, we remand for reconsideration in light of the new law. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995).

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Benjamin G. Santos, Claimant.

Benjamin G. SANTOS, *Petitioner,*
v.
. CARYALL TRANSPORT and SAIF Corporation, *Respondents.*
(92-05344; CA A85510)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 28, 1995.
Donald M. Hooton argued the cause and filed the brief for petitioner.
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 Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
PER CURIAM
Reversed and remanded for reconsideration.

---

**137 Or App 528>** Claimant seeks judicial review of an order of the Workers' Compensation Board that denied an award of temporary partial disability for the period after which he became medically stationary. The statutes pertinent to that review have been amended by Oregon Laws 1995, chapter 332 (SB 369). The changes to the Workers' Compensation Law made by SB 369 generally apply to cases pending before this court on the effective date of the act, which was June 7, 1995. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). Because the 1995 amendments to ORS sections 656.262(4), 656.268(l), (2) and (3) may affect the outcome of this case, we remand for reconsideration in the light of the new law.

Reversed and remanded for reconsideration.

Cite as 137 Or App 598 (1995) November 15, 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)

Judicial Review from Workers' Compensation Board.

On respondent's motion for reconsideration filed September 22, 1995. Opinion filed September 6, 1995. 136 Or App 222, 901 P2d 925.

James L. Edmunson and Malagon, Moore, Johnson & Jensen, for motion.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

DEITS, P. J.

Reconsideration allowed; opinion modified; remanded to Board for reconsideration.

---

**137 Or App 600>** Claimant moves for reconsideration of our decision in *SAIF v. Bowen,* 136 Or App 222, 901 P2d 925 (1995). He argues that our disposition of the case, remanding to the Board with instructions to dismiss, is in error. We allow the motion to reconsider.

Claimant asserts that our statement in the opinion that "The issue in this case is whether the Workers' Compensation Board had jurisdiction to determine the appropriateness of proposed medical treatment for claimant" is in error. *Id.* at 224. Our statement of the issue was correct as far as it went. However, claimant is correct that there is a remaining question before the Board concerning this issue that we did not identify and that has not been directly resolved. That question is whether, under these circumstances, the Director's exclusive authority to determine whether treatment is "appropriate" includes the authority to decide whether the condition requiring treatment is causally related to the compensable injury or whether the Board has jurisdiction to consider that question. Accordingly, our conclusion that the Board lacked jurisdiction was premature, and our remand to the Board should not have been with instructions to dismiss. Rather, the remand should be for reconsideration.

Reconsideration allowed; opinion modified; remanded to Board for reconsideration.

---

Cite as 138 Or App 1 (1995) November 22, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Kathy McCALL, *Appellant,*
v.
DYNIC USA CORPORATION and Kathy Hogan, *Respondents.*
(C93-0334CV; CA A84907)

Appeal from Circuit Court, Washington County.
Hollie M. Pihl, Judge.
Argued and submitted October 2, 1995.
Kevin L. Cathcart argued the cause for appellant. With him on the briefs was Clayton H. Morrison. Scott G. Seidman argued the cause for respondents. With him on the brief were Zachary W.L. Wright and Tonkon, Torp, Galen, Marmaduke & Booth.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Affirmed.

---

**138 Or App 3>** Plaintiff appeals a summary judgment for defendants[1] in this employment discrimination case. She argues that the trial court erred in applying issue preclusion to the reason for her discharge from employment. We affirm.

Defendants are entitled to summary judgment if they have shown that there are no genuine issues of material fact and that they are entitled to judgment as a matter of law. ORCP 47 C.[2]

According to the record on summary judgment, plaintiff worked for employer for approximately four and one half years. In November 1992, plaintiff filed a workers' compensation claim for an injured right middle finger. Employer began paying temporary disability. On March 14, 1993, plaintiff's physician released her to return to modified work at tasks that allowed her to use only her uninjured hand. The first morning she returned to her job, she was given a copy of the modified job analysis. Plaintiff began working, but began having problems with the machine that she was operating. She began using her injured hand to perform the job, which caused her pain. She called her physician, who in turn called employer and said that plaintiff had called him complaining about adverse working conditions.

Plaintiff's supervisor, defendant Hogan, talked to plaintiff about her ability to perform one-handed work. Hogan then asked plaintiff whether she was refusing to do the job. Plaintiff was not given an opportunity to explain, and her employment was terminated.

Employer then terminated plaintiff's temporary disability benefits. Plaintiff sought a hearing before the Workers' Compensation Hearings Division. The issue in that case was whether employer had properly terminated benefits pursuant to ORS 656.268(3)(c). At that time, the statute provided:

> **138 Or App 4>** "Temporary total disability benefits shall continue until whichever of the following events first occurs:
>
> " * * * * *
>
> "(c) 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] Defendants are plaintiff's former employer, Dynic USA Corporation (employer), and Hogan, one of employer's supervisors.

[2] ORCP 47C was amended by the 1995 legislature. Or Laws 1995, ch ___, § ___. This case involves only a question of law and the changes do not affect the determination of this case.

At the hearing, there was no dispute that plaintiff's attending physician had provided a written release for plaintiff to return to work or that employer had made a written offer of modified work and that plaintiff had returned to work. The dispute was over whether plaintiff had failed to begin the modified employment. Plaintiff's position was that she was "ready, willing and able to work within her physician's written release" but was precluded from doing so because she was wrongfully terminated. Employer's position was that plaintiff was terminated because she refused to continue working within her physician's restrictions.

The referee agreed with employer, finding that plaintiff "was terminated for refusing to work within her restrictions." On appeal, the Workers' Compensation Board (Board) agreed with the referee, who had upheld employer's termination of plaintiff's temporary disability benefits.

Plaintiff then filed this action under ORS 659.121(l), claiming that defendants had engaged in an unlawful employment practice by terminating her employment because she had filed a workers' compensation claim, in violation of ORS 659.410.[3] Defendants denied plaintiff's claim and filed a motion for summary judgment. They argued that the Board's determination in the workers' compensation case, that plaintiff was terminated for refusing to work within her physician's restrictions, precludes plaintiff from showing in this case that the termination was for a different, unlawful **<138 Or App 4/5>** purpose, i.e., discrimination for using the workers' compensation system. The trial court agreed and granted defendants' motion for summary judgment.

Plaintiff assigns error to the order granting summary judgment. She asserts that the trial court erred in applying issue preclusion in this case. Defendants respond that the trial court correctly applied issue preclusion, and that the trial court therefore correctly determined that defendants were entitled to judgment as a matter of law.

Issue preclusion applies to preclude relitigation of an issue or fact when that issue or fact has been determined by a "valid and final determination in a prior proceeding." *Nelson* v. *Emerald People's Utility Dist.*, 318 Or 99, 103, 862 P2d 1293 (1993); *see Chavez v. Boise Cascade Corporation,* 307 Or 632, 634-35, 772 P2d 409 (1989) (giving preclusive effect in employment discrimination case to determination of fact in workers' compensation case). There are five requirements for application of issue preclusion:

> "1. The issue in the two proceedings is identical.
>
> "2. The issue was actually litigated and was essential to a final decision on the merits in the prior proceeding.
>
> "3. The party sought to be precluded has had a full and fair opportunity to be heard on that issue.
>
> "4. The party sought to be precluded was a party or was in privity with a party to the prior proceeding.
>
> "5. The prior proceeding was the type of proceeding to which this court will give preclusive effect." *Nelson,* 318 Or at 104 (citations omitted).

Plaintiff challenges each requirement except the fourth; she concedes that she was a party to the workers' compensation dispute. We reject her arguments relating to the third and fifth requirements without discussion.

---

[3] ORS 659.410(l) provides:

> "It is unlawful employment practice for an employer to discriminate against any worker with respect to hire or tenure or any term or condition of employment because the worker has applied for benefits or invoked or utilized the procedures provided for in ORS chapter 656 * * *."

Plaintiff alleged two other claims as well. Both of those claims were dismissed and are not at issue in this appeal.

Plaintiff first argues that the issue decided by the Board was not identical to the issue to be decided in this case. She asserts that the only issue before the Board was "whether the employer was authorized to terminate benefits under ORS 656.268(3)(c). " According to plaintiff, under that statute, the only factual determinations to be made by the Board are: " 1) Did a physician give [plaintiff] a release for **<138 Or App 5/6>** modified employment; 2) was the modified employment offered in writing to [plaintiff], and 3) did [plaintiff] fail to begin the modified employment?" She argues that the factual determinations were completely different under the employment discrimination claim. Under ORS 656.410(1), she has to prove: " 1) Did defendants discriminate against [plaintiff] by terminating her employment because she exercised her rights under the workers' compensation statutes, and 2) did defendants otherwise discriminate against [plaintiff] in the terms and conditions of her employment because she exercised her rights under the workers' compensation statutes?"

Defendants respond that the issue in this case, whether claimant was fired because she made use of the workers' compensation system or whether she was fired for a different, nondiscriminatory reason, is the same issue that the Board decided. We agree with defendants.

The legal issue in the workers' compensation case was whether employer properly terminated temporary disability benefits. However, because of plaintiff's argument to the referee and the Board, the dispositive factual question in that case was whether plaintiff was terminated for refusing to perform work within her restrictions or whether her employer wrongfully terminated her. In order for the Board to find that plaintiff was terminated for refusing to perform work within her restrictions, and therefore that she had failed to return to modified work, it necessarily had to reject plaintiff's argument that the reason that she had failed to return to modified work was that she was wrongfully fired. That is the identical factual question that must be determined in this discrimination case.

Plaintiff also asserts that a different factual question is presented in this action, because the Board did not make any findings about whether defendants had discriminated against her in-the terms and conditions of her employment before she was terminated. We need not address that argument, because plaintiff did not plead a claim that defendants discriminated in the terms and conditions of her employment *before* she was terminated, nor did she raise the issue in her response to defendants' motion for summary judgment.[4] **<138 Or App 6/7>** Accordingly, it was not preserved for our review. See ORAP 5.45.

Plaintiff also argues that the determination that she was terminated for refusing to work within her restrictions was not necessary to the Board's decision. As we explained above, because of the way plaintiff framed the issues in the workers' compensation case, the Board necessarily had to decide whether she had failed to return to modified work because she was wrongfully terminated or whether the reason was that she was terminated for refusing to perform her job. The factual determination was necessary to the Board's decision.

Plaintiff argues, nonetheless, that, even if the Board determined that she was terminated because she refused to perform work within her restrictions, defendant was not entitled to summary judgment because "a jury could determine that defendant's proffered reason for termination was pre-textual." She asserts that the Board did not consider whether defendant had potential mixed motives "because such consideration was not allowed by the [workers' compensation] statute nor was it necessary to the determination of whether [plaintiff] failed to begin modified work authorized by her physician."

Plaintiff's argument seems to be that, even if the Board's determination conclusively establishes that she was terminated for refusing to perform work within her physician's restrictions, she nonetheless can prevail on her discrimination claim if she can demonstrate that a different motive, discrimination for her exercise of her workers' compensation rights, was a substantial factor in her termination. *See Seitz v. Albina Human Resources*

---

[4] In her response to defendant's motion for summary judgment, plaintiff argued that "[t]he issue in plaintiff's workers' compensation discrimination claim is whether the reason given for her termination was pretextual and whether defendant Dynic had a pattern and practice, which it applied to plaintiff, of discriminating against employees who had filed worker's compensation claims." It is clear from plaintiff's later argument in that response that she viewed evidence of a pattern and practice as showing that "the reason for her termination was pretextual." There is no indication that she intended to argue that she had an independent claim for pretermination discrimination.

*Center, 100* Or App 665, 675, 788 P2d 1004 (1990). We disagree. In a mixed-motive discrimination case, a plaintiff can prevail despite an employer's legitimate reason for termination, if the plaintiff **<138 Or App 7/8>** can show that he or she "would not have been fired but for the unlawful, discriminatory motive of the employer." *Vaughn v. Pacific Northwest Bell Telephone,* 289 Or 73, 92, 611 P2d 281 (1980). Plaintiff's argument fails for the same reason the plaintiff's argument failed in *Callan v. Confed. of Oreg. Sch.* Adm., 79 Or App 73, 717 P2d 1252 (1986). In that case, the plaintiff argued that the burden shifting mechanism that applies in federal employment discrimination cases applies to Oregon discrimination cases as well. *See McDonnell Douglas Corp. v. Green,* 411 US 792, 93 S Ct 1817, 36 L Ed 2d 668 (1973). We noted that, in *City of Portland v. Bureau of Labor and Ind.,* 298 Or 104, 690 P2d 475 (1984), the Supreme Court rejected that burden shifting in actions for employment discrimination under Oregon law. *Callan,* 79 Or App at 76. We noted, however,

> "[e]ven assuming that the principle of proof plaintiff derives from the federal mixed motive cases is applicable to actions under ORS 659.121, this is not a mixed motive case; it is a case in which one party alleged discrimination and the other responded that there was *no* discriminatory actuation. Plaintiff does not explain how this can be regarded as a mixed motive case, beyond the bare assertion in her opening brief that she proceeded on that theory as well as on the theory that defendant's denial and its evidence of nondiscriminatory motivation were pretextual. In any event, whatever plaintiff's theories may be, the pleadings and the evidence present a simple either-or question * * *." *Id.* at 78.

The same reasoning applies in this case. Plaintiff alleged that she was discharged from her employment because she had "[made] known to defendant her intention to utilize the procedures provided under the workers' compensation statutes * * *." Defendants denied that allegation. This is a simple "either-or" case, in which there is no allegation or defense of mixed motive. The trial court did not err in concluding that, because plaintiff is precluded from relitigating the reason for her discharge from employment, defendants were entitled to summary judgment.

Affirmed.

Cite as 138 Or App 9 (1995) November 22, 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, *Petitioners,*
v.
SPECTRUM MOTORWERKS, INC., Spectrum Motorwerks, Ltd., and SAIF Corporation, *Respondents.*
(WCB 91-17385, 91-10418; CA A80582)

In Banc*
Judicial Review from Workers' Compensation Board.
Argued and submitted August 18, 1994; resubmitted in banc May 3, 1995.
On respondent SAIF Corporation's motion for reconsideration filed July 5, 1995, and on respondent Spectrum Motorwerks, Inc.'s motion for reconsideration filed on July 6, 1995. 135 Or App 67, 897 P2d 335.
Michael 0. Whitty, Assistant Attorney General, for motion for SAIF Corporation, as insurer for Spectrum Motorwerks, Inc.
Vera Langer for motion for SAIF Corporation on behalf of Spectrum Motorwerks, Ltd.
RIGGS, J.
Reconsideration allowed; opinion modified and adhered to as modified.
Edmonds, J., dissenting.
* Landau, J., not participating.

---

**138 Or App 11>** SAIF Corporation, on behalf of Spectrum Motorwerks, Ltd. (SML), a noncomplying employer, moves for reconsideration of our opinion. 135 Or App 67, 897 P2d 335 (1995). SAIF Corporation, as insurer for Spectrum Motorwerks, Inc. (SMI), also seeks reconsideration. We allow both motions.

Claimant has had several employments as an auto mechanic, many of which were outside of Oregon. Claimant's most recent employments were in Oregon, beginning in 1984. In 1990, while working for SML, claimant suffered symptoms and sought treatment for what was later determined to be mesothelioma. Claimant settled with each of his Oregon employers except SML and SMI. In our first opinion, we held that controlling precedent with regard to the last injurious exposure rule required the conclusion that the last employer with conditions of a kind that could have caused claimant's mesothelioma be assigned responsibility for the claim, even if that specific employment could not have been the actual cause of the condition. We remanded the case to the Board for a determination as to whether employment conditions at either SML or SMI were of the type that could have caused claimant's condition.

In its motion for reconsideration on behalf of SML, the noncomplying employer, SAIF notes that in our opinion we referred to the "long-standing policy that the Workers' Compensation Act is to be liberally construed for the benefit of the worker." On June 7, 1995, the legislature amended ORS 656.012 by adding subsection (3):

> "In 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."

SAIF contends that this amendment effectively repeals the policy of liberal construction of workers' compensation laws for the benefit of the worker, and requires that the statutes be construed as favoring neither the worker nor the employer. On that basis, SAIF asks us to reconsider our decision.

As our first opinion explains, 135 Or App at 70, our holding in this case was required by controlling precedent. **<138 Or App 11/12>** Our reference to the rule of liberal construction was in the context of our response to the dissent's decision to disregard that precedent. It was not the rationale for our holding.

Assuming, without deciding, that the amendment of ORS 656.012(3) could effect a substantive change in the way that the workers' compensation laws are to be interpreted, that change has no effect on our decision, which is already based on an impartial and balanced interpretation of the law.

As the workers' compensation insurer for SMI, SAIF contends that our opinion mistakenly remands the case to the Board for consideration of whether SMI is responsible for claimant's condition when, in fact, as we noted in a footnote to our opinion, 135 Or App at 69 n 2, claimant was a partner in SMI who had not elected workers' compensation coverage and, hence, was exempt from coverage under ORS 656.027(8). We agree with SAIF that, because claimant was not a subject worker while he was a partner at SMI, he cannot establish a compensable claim arising from his employment at SMI. We mistakenly remanded the case to the Board for a determination whether conditions at SML or SMI could have caused claimant's illness. We allow reconsideration and correct our opinion to remand the case to the Board for a determination as to whether conditions at SML could have caused claimant's illness.

Reconsideration allowed; opinion modified and adhered to as modified.

**EDMONDS, J.**, dissenting.

I dissent for the reasons previously stated in my dissenting opinion in this case at 135 Or App 67, 897 P2d 335 (1995).

De Muniz, J., joins in this dissent.

Cite as 138 Or App 29 (1995) November 22, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Complying Status of Doris Mitchell, Employer,
and In the Matter of the Compensation of Michael D. Blevins, Claimant.

Michael D. BLEVINS, *Petitioner,*
v.
Doris MITCHELL; SAIF Corporation; and Department of Consumer and Business Services, *Respondents.*
(92-03349 and 92-04677; CA A85779)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 21, 1995.
Anita C. Smith argued the cause for petitioner. With her on the brief was Estell and Bewley.
E. Jay Perry argued the cause and filed the brief for respondent Doris Mitchell.
Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and Michael 0. Whitty, Special Assistant Attorney General, waived appearance for respondent SAIF Corporation.
Stephanie Striffler, Assistant Attorney General, argued the cause for respondent Department of Consumer and Business Services. With her on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

---

**138 Or App 31>** Claimant seeks review of an order of the Workers' Compensation Board that denied him benefits for injuries that he sustained while working on a house that he had been employed to remodel. Claimant asserts that the board erred as a matter of law in holding that he was exempt from workers'compensation coverage under ORS chapter 656. We review the board's order for errors of law, ORS 183.482(8)(a), and affirm.

Under ORS 656.027, all workers are subject to the workers' compensation laws in ORS chapter 656, unless excluded as a nonsubject worker. A nonsubject worker is defined to include a

> "worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker."

ORS 656.027(2). In this case, the board found that the house on which claimant was working was his employer's "private home," as that term is used in ORS 656.027(2). It therefore held that claimant was not subject to workers' compensation coverage. [1]

The parties do not dispute the board's findings. Claimant suffered an injury while remodeling a house owned by employer. Employer had repossessed the house in 1985 when a purchaser defaulted on a land-sale contract. The house remained vacant between 1985 and 1991, by which time the house had become unhabitable. In late 1990 or early 1991, a person named Holloway approached employer and offered to make repairs to the house in exchange for living in it. Employer and Holloway agreed that Holloway would remodel the house as an offset against "rent" of $300 per month. Employer had not planned to rent the house before being approached by Holloway.

---

[1] The board also found that claimant was not an independent contractor; employer does not contend otherwise.

Employer told Holloway that she intended to live in the house after it was remodeled. Towards that end, she purchased homeowner's insurance and changed the address on her driver's license to that of the house. The agreement **<138 Or App 31/32>** between Holloway and employer advanced her goal of living in the house, by discouraging vandalism, which had plagued the house while it stood vacant, and by furthering its remodeling.

Holloway began living in the house in March 1991. In August 1991, employer wrote Holloway a letter demanding the August rent; she subsequently evicted him. Claimant, whom employer also had hired to do remodeling on the house, suffered an injury there on September 7, 1991.

Claimant asserts that he is a subject worker and that the board erred in concluding that employer's house was a private home. In *Fincham v.* Wendt, 59 Or App 416, 651 P2d *159, rev den* 294 Or 149 (1982), we addressed the "householder" exemption in ORS 656.027(2) for people who employ workers to perform services on private homes. We held in *Fincham* that a worker engaged in remodeling an outbuilding on a "hobby farm" was subject to workers' compensation coverage, because the outbuilding was used for commercial purposes. Id. at 423.

In so doing, we explained that the householder exemption is premised on the principle that workers'compensation insurance is intended to spread to consumers of goods and services the cost of workplace injuries, by making the cost of the insurance a cost that can be reflected in the price of those goods and services. Id. at 422 (citing *Woody v. Waibel,* 276 Or 189, 194, 554 P2d 492 (1976)). For the principle to work as intended, the employer who is required to obtain that insurance must be someone whose covered employees are producing goods or services for a market. Otherwise, the cost of the insurance will be borne by the employer and not by consumers, because there will be no consumers to whom the cost of insurance can be passed. Under that regime, a householder who employs people to work on her home is not someone who is required to obtain workers' compensation insurance for those employees, because she is not a producer of goods or services. Rather, she is a consumer of goods and services who will not be able to pass the cost of workers' compensation insurance for her employees to others. *See. e.g., id.* at 422-23; Arthur Larson, *The Law of Workmen's Compensation* § 50.25 (1991).

**138 Or App 33>** Applying those principles to this case, we hold that the board did not err in concluding that employer's house was a private home and that the householder exemption in ORS 656.027(2) applies to claimant. Employer entered into the transaction with Holloway not to produce income, but to obtain remodeling services so that she could live in the house and caretaking services to protect the house against vandalism. She did not try to rent the house before being approached by Holloway, and she did not do so after evicting him. Notwithstanding her arrangement with Holloway, the house did not enter the stream of commerce and did not lose its character as a private home.[2]

In summary, employer was not using her house to produce income. She was having it remodeled in order to live in it. On those facts, the board did not err in concluding that employer's house was a private home for purposes of ORS 656.027(2).

Affirmed.

---

[2] Claimant also cites *Caddy v. SAIF, 110* Or App 353, 822 P2d 156 (1991), for the proposition that a homeowner must live in the house at the time of the injury in order for the householder exemption to apply. Claimant's reliance on that case is misplaced. In *Caddy,* we held that the householder exemption was inapplicable, not because the employer did not live in the house, but because the claimant was building a new house, an activity not listed in ORS 656.027(2). Id. at 357. In the present case, claimant was remodeling an existing house, an activity listed in ORS 656.027(2). Therefore, the reasoning in *Caddy* supports the conclusion that the householder exemption applies on the facts of this case.

Cite as 138 Or App 269 (1995) December 13, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ana J. Calles, Claimant.

SAIF CORPORATION and Los Chiles, Inc., *Petitioners*
v.
Ana J. CALLES, *Respondent.*
(93-07622; CA A86199)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 23, 1995.
Julene M. Quinn argued the cause for petitioners. On the brief were Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General.
Donald M. Hooton argued the cause for respondent. With him on the brief was Schneider, Hooton.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Reversed and remanded.

---

**138 Or App 271>** Employer and SAIF seek review of an order of the Workers' Compensation Board awarding claimant attorney fees pursuant to ORS 656.382(l) for employer's unreasonable resistance to the payment of compensation through the issuance of a premature notice of ineligibility for vocational assistance. Because of the legislature's amendment of the pertinent statutes, we conclude that the case must be remanded to the Board for further proceedings.

ORS 656.382(1) was amended by Oregon Laws 1995, chapter 332, section 42b. As amended, the statute expressly excludes from the Board's authority the power to award attorney fees under that section in a case involving a dispute over vocational assistance benefits heard by the director. In a separate provision, section 42(d)(5), the legislature provided:

> "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. "

Under section 50 of the bill, ORS 656.704(3) was amended to provide that disputes arising under ORS 656.340, regarding vocational benefits, are within the exclusive jurisdiction of the director. As we held in *Volk v. American West Airlines,* 135 Or App 565, 899 P2d 746 (1995), the amendments are applicable to all cases pending in litigation or on appeal. Accordingly, we reverse and remand this case to the Board for reconsideration in the light of the amendments.

Reversed and remanded.

---

Cite as 138 Or App 298 (1995) December 13, 1995

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gayle J. Williams, Claimant.

SAIF CORPORATION and Southcoast Lumber Co., *Petitioners*
v.
Gayle J. WILLIAMS, *Respondent.*
(91-10443; CA A76540)

On remand from the Oregon Supreme Court, *SAIF v. Williams*, 321 Or 559, 901 P2d 246 (1995).
Judicial Review from Workers' Compensation Board.
Submitted on remand October 24, 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.
James L. Edmunson argued the cause for respondent. With him on the briefs was Malagon, Moore, Johnson & Jensen.
Before Riggs, Presiding Judge, and Richardson, Chief Judge, and Leeson, Judge.
PER CURIAM
Remanded for reconsideration.

---

In *SAIF v.* Williams, 133 Or App 766, 893 P2d 577 (1995), on remand from the Supreme Court for reconsideration in the light of *SAIF v. Allen,* 320 Or 192, 881 P2d 773 (1994), we held that claimant was entitled to an attorney fee under ORS 656.386(l). SAIF sought review and the Supreme Court has again remanded, 321 Or 559, 901 P2d 246 (1995), this time for reconsideration in the light of ORS 656.386(l), as amended by Oregon Laws 1995, chapter 332, section 43.

Because the 1995 amendments may affect the outcome of this case, we remand to the Workers' Compensation Board for reconsideration in the light of the new law. *Santos v. Caryall Transport,* 137 Or App 527, ___ P2d ___ (1995).

Remanded for reconsideration.

# INDEX CONTENTS

Volume 47



Throughout the Index, page numbers in **Bold** refer to Court Cases.

# OVERVIEW OF SUBJECT INDEX

**AOE/COE (ARISING OUT OF & IN THE COURSE OF EMPLOYMENT)**

See also: ACCIDENTAL INJURIES; COVERAGE QUESTIONS; DENIAL OF CLAIMS; MEDICAL CAUSATION

"Arising out of" and "in the course of" analysis, 318,347,801,938,959,1046,1060,**1187**,1365,1419, 1425,1531,1941,2092,2160,2318,2340

Assault or aggressor defense, 338,626,707,807,1349,2254,2261,2323

Bunkhouse rule, 1307

Burden of proof, 1556

Going & coming rule

Dual purpose trip, 1027,1419

Employer's conveyance rule, 959

*** Bold Page = Court Case ***

"Happy" employee injury, 2160

Horseplay, 1046,1531,**1792**

Idiopathic or unexplained fall, 1645,1666,2088

Illegal activity, 2316

Increased risk or hazard, 347,712,801,1645

Lunch break injury, 801,1046

Misconduct involving method of performing work, 473

Parking lot rule, 405,938,1425,**1818**

Personal comfort, 1307

Personal mission, **1187**,**1205**,1350,1365,1941

Pre-employment try-out issue, 969

Prohibited activity, 41,154,473,494,1969,2318

Recreational or social activity, 1307,1556

Rescue doctrine, 2340

Risk of employment requirement, 318,394,801,2092,2160

Traveling employee, 318,**1205**,2092

**AGGRAVATION CLAIM (PROCEDURAL)**

Five-year rights, calculation of

CDA as first closure, 459

Filing v. worsening, 1999

Occupational disease: "date of injury", 1293

Vs. Own Motion claim, 2343,2395

"Worsening" issue, 1999

Worsening, timing of, **497**,2237

Notice of

*Prima facie* claim, 64

Under SB 369

Retroactivity, 1550

What constitutes, 64,447

Validity of, when claim in open status, 986

**AGGRAVATION (ACCEPTED CLAIM)**

See also: DENIAL OF CLAIMS; MEDICAL CAUSATION; TOTAL TEMPORARY DISABILITY

Burden of proof

Consequential condition, 169,177

Elements of proof: causation & worsening, 64,177,232,2004

Generally, 8,277

Material vs. major causation, 94,100,169,177,276,1550,2004,2348

Scheduled injury, 8,100,232

Worsening: medical and legal, 64

Factors considered

Earning capacity

No prior award, 829

Not decreased, 64,216,223

Proposed surgery, 64

Increased loss of use or function issue, 232

**ATTORNEY FEES** (continued)
Fee affirmed, awarded or increased
Assessed fee for hearing or rescission of denial
Appeal for Director's order (medical services issue), 24,71
De facto denial, 226,253,283,311,313,463,**530**,884,894,1509,2152
Denial rescinded before hearing
Compensability/responsibility issues, 2062
De facto denial, 59,**493**,1723
Fee affirmed, 2077,2332
Medical services issue, 936,**1170**,**1193**
Employer's request: closure set aside, 1475
Extraordinary fee, 347,463,1050
Fee affirmed, 45,94,139,226,667,742,944,986,1063,1509,1723,1921
Fee awarded, 105
Fee increased, 1010
Fee not increased, 128,139,280,730,1610
"Instrumental in obtaining compensation" discussed, 2062
Medical services issue (entitlement), 59,211,377,411
Minimal fee affirmed, 271
PPD not reduced; offset allowed, 667
PPD not reduced on part of award, 1466
Board review
Carrier request, compensation not reduced, 627,996,1085,1104,1509,2138
Carrier's reconsideration request, 163,361,886
Extraordinary fee, 1050
Minimal fee, 18
PPD: part of award affirmed (employer's request for review), 769
Referee's order reversed: fee for hearing and review, 749
Court of Appeals, on remand from, 1,311,463,725,891,967,1112,1499,1563,2068,2354
Former attorney's fee, 1044
Noncomplying employer case, 1498
PPD not reduced, generally, 1524,1638
Supreme Court, on remand from, 89,255,268
Unreasonable conduct
Fee awarded or affirmed, 258,311,313,332,463,2263
Own Motion case, 1367
Fee out of, and not in addition to, compensation
Court of Appeals, on remand from, PPD issue, 1570
Determination Order set aside, 462,790
Future PPD
Fee agreement issue, **1214**
Fee not awarded, 616
Method of recovery of fee, 22,1035,1085,**1209**,**1776**,2018,2352,2391
Not allowed: no authority for, 1413
Order on Reconsideration (DCBS)
DCBS authority to set fee, 2207
Maximum fee issue, 2207
Own Motion case, 1367,14446,1469
PPD, 1638
Premature closure issue, 1085
Reclassification issue, 364,848,1316
Subjectivity issue, 364
"Substantive" vs. "actual increase" in PPD, 22
TTD issue, 281,**1209**,1499,2018
Two attorneys, 1496

*** Bold Page = Court Case ***

**BENEFICIARIES & DEPENDENTS**
Discussed or defined, 46,414
Invalid dependent child issue, 718
Personal representative as, 46
PPD issue, 414,1059
Sister/dependent, 1059

*** Bold Page = Court Case ***

**BOARD'S OWN MOTION** See OWN MOTION RELIEF

**CLAIMS DISPOSITION AGREEMENTS** See SETTLEMENTS & STIPULATIONS

**CLAIMS FILING**
Filing
What constitutes
Billing as, 1712
Doctor's report as
Examining vs. attending physician, 1462
Form 827, 391
Form 829, 243
Generally, 114,2038
Treatment request vs. observation, 153
Generally, **1139**,1380
Notice of "claim", 1380
Symptoms vs. condition, 238
Late filing issue
Employer knowledge, 40,923,1663
Employer prejudice issue, 182,845,923,1595,1663,1919
Responsibility case, **1781**

**CLAIMS PROCESSING**
See also: DETERMINATION ORDER/NOTICE OF CLOSURE; OWN MOTION RELIEF; TEMPORARY TOTAL DISABILITY

Acceptance
Condition part of another diagnosis, 760
Form 1502 as, 454,707
Includes condition from prior injury, 887
Initial litigation not final, 826
Multiple diagnoses, same condition, 945
No specific acceptance, 763,945,2085
Notice of Acceptance, 760
Notice of: injury vs. occupational disease, 2091
One of several conditions encompassed in claim, 909
Overbroad denial set aside, 826
Payment of compensation as, **541**
Payment of medical services as, 734
Payment of PPD as, 420,734,1486,2085,2287,2401,2404
Scope of
Claim vs. condition, 1765,2068
Condition not in existence when claim accepted, 177,1423
Condition part of another diagnosis, 760
For PPD rating, 2379
Generally, 734
Includes condition from prior injury, 887
Initial litigation not final, 826
Multiple diagnoses, 226,2068
Multiple diagnoses, same condition, 945
No contemporary records, 2209
Notice of Acceptance, 760

**COVERAGE QUESTIONS**

- Noncomplying employer issue: Timeliness, objection to claim acceptance, 1969
- Nonsubject employer issue
  - Prime vs. subcontractor: who provides coverage, 234
  - Right to control test, 486
- Nonsubject worker issue
  - Burden of proof, 347
  - Corporate officer issue, 1176,1326,1368
  - Dual capacity doctrine, 1002,1176,1640
  - Householder exemption issue, **2455**
  - Independent contractor issue, 48,1368,**1774**,2082
  - "Nature of the work" test, 2082
  - Out-of-state worker issue, 123
  - Partner, 1312,1640,**2453**
  - Personal election, 1640
  - Relative-nature-of-the-work test, 48
  - Right-to-control test, 39,48,2082
  - Sole proprietor, 48
  - Temporary workplace issue, 364
  - Unpaid trainee
    - College program, 2168
    - Non-college supervised, 898
  - Volunteer vs. worker, 347
- Premium audit issue
  - Taxi "shift-lease" operators, **1163**

*** Bold Page = Court Case ***

**CREDIBILITY ISSUES**

- ALJ's opinion
  - Agreed with, based on *de novo* review, 670,819,1552,1614,1666
  - Deferred to
    - Demeanor, attitude, appearance, 129,289,460,723,819,1347,1605,1608,1614,1967, 1977,2092
    - Unreliable witness, 1061
  - None given; Board decides, 689,998,1360
  - Not deferred to
    - Demeanor, 2005
    - Demeanor vs. inconsistencies in record, 2261
    - Demeanor vs. substance of testimony, 2183,2272
    - Generally consistent testimony, evidence, 1716,2138
    - Inconsistencies, 438,723,1647,1963
- Board's role, 129,2261,2277
- Cultural sensitivity, 1967
- Embellishment, 1020
- Failure to call corroborating witness, 670,1647
- Financial interest in outcome, 447
- Inconsistent statements
  - Collateral matters, 129,1552
  - Generally, 447,1020,1360,1647,2092

**CRIME VICTIM ACT**

- Claim compensable
  - In part, 895
  - Victim's conduct contributes to injuries, 297
- Claim not compensable
  - Failure to cooperate with police, 793,798
  - Injuries due to victim's wrongful act, 877
- "Compensable crime" discussed, 793,798
- Department of Justice withdraws its order, 12
- Remand for additional evidence, 1322,2339
- Standard of review, 793,798

**DENIAL OF CLAIMS** (continued)
Scope of
Aggravation: "condition" denied, 1299
Aggravation and occupational disease issues, **528**
Amendment at hearing, 689,742,807,1662
Amendment vs. separate denial, 1637
Compensability vs. responsibility, 740,866,2313,2412
Course & scope vs. medical causation, 1307
Current condition, 2243
Current condition vs. back-up, 1973
Express condition, 2243
Medical services
Vs. aggravation, 103
Vs. preexisting condition, 872
Overbroad, set aside in part, 1333
Portion set aside by Referee, 131
Set aside in part, affirmed in part, 710,2263
Validity challenged, 1938
Withdrawn claim, 1933

*** Bold Page = Court Case ***

**DEPARTMENT OF CONSUMER & BUSINESS SERVICES**

**DEPENDENTS See BENEFICIARIES & DEPENDENTS**

**DETERMINATION ORDER/NOTICE OF CLOSURE**
See also: MEDICALLY STATIONARY; OWN MOTION RELIEF
Administrative closure, 1028,1921,2214,2223
Medically stationary issue
"Accepted" vs. "compensable" conditions; litigation not final, 1926
All compensable conditions considered issue, 322,1069,1085,1921,1926,1994
Attending physician issue, 1949
Changed opinions, 1529
Conflicting dates, 2417
Date of closure vs. post-closure changes, 121,1110,**1746**,2185,2301
Due to injury requirement, 1529,2330
Failure to return for closing exam, 1546
Further evaluation needed, 2330
Further improvement speculative, 2185
Further treatment recommended, 2132
Gaps in treatment, 1502
Improvement anticipated with treatment, 1082,1089
Improvement in functional ability, 121
"Material improvement" discussed, **1746**
Medically stationary date vs. date of closure, 1574
No further improvement expected, 978,1323,**1746**
No medical opinion says stationary, 790
Non-MCO attending physician, 1465
Non-stationary again before closure, 761
Post-closure reports, 978,1028,1617,2132,2301
Prediction of future problems, 35
Preponderance of medical opinion, 1994,2404
Presumption of stationary status
Notice requirement, 2214
Projection of future medically stationary date, 2132,2300
Psychological condition, 1502
Surgery postponed, 219
Who determines, 2074,2300,2301

*** Bold Page = Court Case ***

**JURISDICTION** (continued)
- Board v. D.C.B.S.
  - Classification: disabling vs. nondisabling, 395,672,908,979,1513,1659
  - Inmate injury case, 2182
  - Medical treatment or fees issue
    - Attending physician: non-MCO vs. MCO, 1612,1692,1712
    - Attorney fee, 1936
    - Change of attending physician, 423,510,1612
    - Compensability, 1995,2011,2024,2394
    - Delay in payment of bills, 2052
    - Generally, SB 369, 1525,1571,1612,1625,1690,1692,1704,1712
    - Home health care, 1571
    - Inappropriate, excessive, etc., 283,313,328,427,809,1387,1560,1690,1704,1715,2071, 2103,2121
    - Interpreter, liaison services, 1936
    - MCO issue
      - Attending physician issue, 2165
      - Generally, 2165
      - Proposed surgery or treatment, 193,293,324,377,379,399,411,861,988,1577, 1625,2202,2334
    - Palliative care
      - Disapproved, noncompensable, **556,560**
      - Vs. curative treatment, 54,1580
    - Penalty issue, 1580,1581,2052,2103,2337
    - Proposed surgery or treatment, 107,193,255,311,463,628,1581,1612,1692,**1745, 1795,1802**,2156,**2439**
    - Reimbursement for mileage, treatment, prescriptions, 423
    - Surgery (performed), 632
    - Three-doctor limitation, 272
    - Travel expenses, 891,1043,1971,2155
  - Noncomplying employer's time to protest claim acceptance, 1060
  - Order on Reconsideration of D.O. or Notice of Closure
    - Aggravation between Notice of Closure, Order on Reconsideration, 986
    - "Closure" of claim, 1089
    - Penalty for 25% increase in PPD over NOC
      - 20% PPD issue, 1410
      - Timeliness of appeal of Reconsideration Order, 28
    - Reconsideration of reconsideration, 119
    - Reinstated, 986
    - TTD
      - Substantive vs. procedural: original jurisdiction, 1301,1643
  - Penalty issue
    - Generally, 59,253,377,411,443
    - Late payment, CDA, 2388
  - Temporary total disability
    - Entitlement, 295,1091
  - Vocational assistance
    - Attorney fees, **2457**
    - Generally, 1540,1651,1946,2127,2301,2381
    - Own Motion case, 2307
    - Penalties and fees, 2278
- Department of Consumer & Business Services (D.C.B.S.)
  - Authority to appoint arbiter where none requested (PPD case), 189
  - Authority to reduce award on reconsideration, 2192
  - Multiple requests for reconsideration (of closure), **2429**
  - Premature reconsideration request (closure case) issue, 1085
- D.C.B.S. vs. Circuit Court
  - Civil ORICO case, medical fee issue, **1731**

**MEDICAL CAUSATION** (continued)
Direct & natural consequences
Burden of proof, 809
Insufficient medical evidence, 809
Physical therapy causes new condition, 614
Use of crutches not proven cause of new condition, 775

*** Bold Page = Court Case ***

**MEDICAL OPINION**
Analysis v. conclusory opinion
Conclusory opinion
Check-the-box response, 52,87,177,303,373,2249
Check-the-box response based on full record, 1988
Lacks persuasive analysis, 265,712,750,829,934,981,1007,1307,1353,1423,1434, 1457,1562,1628,1942,1955,1965,1974,2149,2249
Unexplained conclusion, 52,88,147,153,208,261,289,361,363,385,389,438,447,451, 617,656,663,727,742,829,887,1489,1585,1667,1692,1960,2005,2008,2030,2101, 2110,2272,2348
Persuasive analysis
Attorney's wording, doctor concurs, 244,454,727
Generally, 353,385,727,1040,1052,1117,1423,1527,1554,1618,1692,1960,1965,2097, 2173,2348,2367,2401,2404
Rebuts contrary conclusion, 255
Without examination of claimant, 1307
Based on
"A" major vs. "the" major cause, 819,905,1667
Assumption unsupported by record, 275,2367
Bias, 447
"But for" analysis, 905,2105
Changed opinion based on new information, 137,1304
Changed opinion explained, **2426**
Changed opinion not explained, 681,884,1506,1716,1924,2030,2036,2110
Complete, accurate history, 137,147,244,258,275,681,924,926,929,992,1010,1014,1052,1396, 1527,1548,1552,1692,1726,1977,2110,2138,2247
Consideration of contrary opinion, 258
Credible claimant, 819,884,1614
Diagnoses, varied, 2040
Elimination of other causes, 904,1769
Exam
Long after critical time, 887
Long before critical time, 1618
Vs. file review, 852
Exams, treatment before, after key event, 238,389,806,1024,1667
Expert analysis vs. obversation, 1307
Expertise, greater/lesser, 123,208,353,617,658,663,712,879,926,934,1111,1547,1562,1581, 1673,1720,1916,1988,2040,2328,2367
Etiology unexplained, 1654,2401
Failure to consider all possible factors, 663,750,795,806,819,887,970,1347,1377,1423, 1455,1489,1562,1628,1692,2136,2328
Failure to explain how work exposure caused condition, 1353
General information vs. specific to claimant, 244,451,727,868,2178
History inconsistent with medical record, 921,1604,1624,2005,2128
Inaccurate history, 438,454,656,727,828,868,926,934,953,961,981,998,1007,1102,1304,1339, 1358,1360,1377,1482,1489,1554,1604,1605,1608,1624,1692,1772,1955,2005,2070,2156,2277, 2291,2401,2402
Incomplete history or records, 315,326,343,689,795,861,887,981,1014,1323,1347,1495,1585, 1680,2136,2247,2249,2272
Inconsistencies, 177,315,890,921,1373,1455,1620,2110,2173,2379
Law of the case, 113,1628,2030
Long-term treatment, 88,879,1323

**MEDICAL SERVICES** (continued)
- Chiropractic treatment
  - Reasonableness issue, 685,829
- Counseling services, 311
- Define or discussed, 2257

*** Bold Page = Court Case ***

- Director's order
  - Standard of review, 158,685
  - Supported by substantial evidence, 24,158,685
  - Without authority, 193,754,861
- Home health care, 313,752,932
- Notice of eligible providers, 423
- Pain Center treatment, 988
- Palliative care
  - Constitutional argument premature, 54
  - Defined or discussed, 54
  - Vs. curative treatment, 54
- Penalty
  - Conduct reasonable, 411,628,754,803,891
  - Conduct unreasonable, 423,886
- "Physician"; who qualifies, 311
- Report, cost of: litigation vs.treatment, 2103
- Surgery
  - Performed: reasonable & necessary issue, 628,749
  - Processing claim for, 803
  - Proposed: reasonable & necessary issue, 107,193,255,379,754,763,861
- Swim therapy, 311
- Travel expenses, relocated worker, 891
- Vehicle with automatic transmission, 328

**MEDICALLY STATIONARY**
- See also: DETERMINATION ORDER/NOTICE OF CLOSURE; OWN MOTION
- Defined or discussed, 208

**NONCOMPLYING EMPLOYER** See COVERAGE QUESTIONS; DENIAL OF CLAIMS

**NONSUBJECT/SUBJECT WORKERS** See COVERAGE QUESTIONS

**O.S.H.A** See SAFETY VIOLATIONS

**OCCUPATIONAL DISEASE CLAIMS (FILING)**
- Timeliness
  - Filing issue, 822,845,1614

**OCCUPATIONAL DISEASE CLAIMS (PROCESSING)**
- See also: FIREFIGHTERS; PSYCHOLOGICAL CONDITION CLAIMS; SUCCESSIVE EMPLOYMENT EXPOSURES
- Burden of proof
  - Generally, 13,123,186,326,726,1411,1533,1585,1587,2110,2173
  - Material vs. major cause, 1421,2124
  - Medical services requirement, 2257
  - Necessity of medical evidence, 2183
  - Precipitating vs. major cause, 1528,1587
  - Preexisting condition
    - "Combining", 2025,2220
    - Generally, 248,501,2025
    - Pathological worsening, 126,623,698,732,819,884,909,1968
    - "Predisposition" discussed, 933,1421,2090,2178
    - Previous accepted claim, 497,2220
    - Previous denied claim, 501,1603
    - Vs. predisposition, 975

**OCCUPATIONAL DISEASE, CONDITION OR INJURY** (continued)



*** Bold Page = Court Case ***

*** Bold Page = Court Case ***

**PERMANENT PARTIAL DISABILITY (UNSCHEDULED)**



*** Bold Page = Court Case ***

**PSYCHOLOGICAL CONDITION CLAIMS** (continued)
Occupational disease claim (continued) *** Bold Page = Court Case ***
Claim not compensable
Cessation of employment, **1809**
Compensable, noncompensable stressors not distinguished, 221
Current condition not related to accepted occupational disease claim, 1014
Insufficient medical evidence, 110,221,1417,1434,1605,1608,1955,2077,2196
Major cause of worsening not established, **497**
Medical evidence not "clear and convincing", 1620
No treatment, 110
Preexisting condition not worsened, 1434
Reasonable disciplinary or corrective action, 143,221,397,2196
Stressor generally inherent, 143,179,859,1714,**1738**,1955,2196
Stressors not real & objective, 143,919,1417,1605,2015
Traumatic incident, **1738**
Federal law interplay with Oregon statutes, 1955
Occupational disease vs. injury, **1738**
Physical condition, stress caused, 110,127,143,1111
Relationship to physical injury claim
Burden of proof
Generally, 215,1654,2316
Medical vs. lay testimony, 1654
Claim compensable
Diagnosis varies, 2040
Injury, not claims processing, causes condition, 620
Major cause test met, 663,1437,1965,2040,2316
Claim not compensable
Insufficient medical evidence, 215,1654,2101
Major cause test not met, 289

**REMAND**
By Board
Motion for, allowed
Evidence unobtainable with due diligence, 324,1330,1952
Record improperly, insufficiently or incompletely developed, 1065
To allow hearsay statements, 2113,2253
To determine good cause, late appealed denial, 2113,2253
To develop record on new legal standard, 2283
Motion for, denied
Case not insufficiently, improperly developed, 379,481,988,1513,1955,2137,2171, 2241,2348
Court's interpretation of statute new, 1686
Evidence available with due diligence, 257,282,353,463,481,863,1344,1372,1383, 1549,1605,1949,1984,2033,2101,2310
For arbiter's exam (PPD issue), 83,119
For DCBS rulemaking, 174
Irrelevant evidence, 1608,1652
Issue raised first during closing argument, 1619
Moot issue, 45,71,2209
New information not likely to affect outcome, 71,463,861,1341,1372,1383,1549, 1605,1643,1662,1692,1984,2101,2386
No compelling reason for, 2119
Post-hearing surgical report, 2386
Proffered evidence admissible by administrative notice, 1619
Proffered evidence without authority, 463
Waiver of entitlement to new hearing, 1659
Presiding Referee's role, 1065,1659
To consider
Undisclosed, unoffered evidence, 319

**REQUEST FOR HEARING (FILING)** (continued)

Late filing issue (continued)

Denial, Good cause issue (continued) *** Bold Page = Court Case ***

Generally, 457
Lack of due diligence, 913,1072
Learning disability, 460
Misleading statement, carrier's representative, 2253
Negligence of attorney, 955
Pursuit of claim in another state, 391,789
Receipt of interim compensation, 391

Failure to notify attending physician, 460
Notice of denial issue, 457
Sufficiency of Request for Hearing, 1363

Noncomplying employer contests acceptance, 1060
Order on Reconsideration (D.O. or N.O.C.)

Generally, 28,309,481,1592
Mailing vs. receipt, 481
Necessity for cross-request for reconsideration, **1171**

Premature issue

De facto denial, 1521
Generally, 1004

**REQUEST FOR HEARING (PRACTICE & PROCEDURE)**

Consolidation of cases challenged, 1605,1608
Deferred

Compensable aggravation before Order on Reconsideration issued, 986

Dismissal, Order of

Affirmed

Attorney requests; claimant (unrepresented) appeals, 687,2003,2199
CDA final: all issues resolved, 304,2171
Claimant requests, later appeals, 2171
Unjustified delay of hearing, 1408

Set aside

"Failure to appear" issue: corporation without an attorney, 816
Failure to appear, request for postponement, 10
Failure to attend IME, 1313,1506
Late-retained counsel fired before hearing, 273
No justiciable controversy, 1589
"Unjustified delay" issue, 1313,1589
With prejudice, no basis for, 1594

With, without prejudice, 1594

Issue

Alternative theory of compensability, 924
Defense theory vs. claimant's burden of proof, 970
Denial, scope of, 172,**528**,1299,1470
D.O. or Notice of Closure

Issue not raised in reconsideration process, 1,1953

New injury claim raised at hearing, 287
Not raised, ALJ shouldn't decide, 747,1607,1677,1938
Objection to: when to make, 852
Procedural defect, 114,287,1938
Raised at hearing, 745,852,924,1459
Raised during hearing, **528**
Raised first in closing argument, 1588,1619,2112
Raised in pleadings, 1984,2191
Waiver of, discussed, 826,**1180**,1938,2191

Motion to Dismiss

Denied

Claimant's; to allow immediate refiling, 1316
Written denial not appealed; de facto denial appealed, 975

**REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE)** (continued)

Deferral, Request for, 2386
Consolidation: related cases pending review, 1085,2290,2379,2381
Issue
- Compensability theory not raised at hearing, 351,2115
- Evidentiary; no objection at hearing, 1295
- Jurisdiction, subject matter, 2119
- Moot, 2336
- No formal cross-request for review, 2033,2146

*** Bold Page = Court Case ***

- Not raised at hearing
  - ADA argument, 2124,2313
  - Constitutional argument, 2124
  - Jurisdictional, considered on review, 754,2119
  - Not considered on review, 6,83,174,238,287,616,878,1044,1060,1103,1307,1416, 1470,1653,1933,1938,1973,2115,2119,2219,2257,2291,2404
- Not raised by parties on review, 1481
- Raised at hearing, 96,253
- Raised at hearing, not raised by Request for Review, 1929,2272
- Raised first in closing argument, 2112
- Raised first on reconsideration (Board), **504**
- Raised pre-hearing, not preserved, 2306

Motion to Stay Appeal pending Court of Appeals decision, 1518
Motion to Strike Brief
- Allowed
  - Cross Appellant's brief: no cross appeal, 2033
  - In part: reference to documents not in evidence, 2033
  - Untimely filed, 253
- Not allowed
  - Extension for reply brief allowed, 848
  - Issue not raised by cross-request for review, 2033,2313
  - No appellant's brief; reply brief allowed, 20
  - No effect on resolution of case, 1297
  - No new issue raised, 91
  - No prejudice to other party, 115
  - Opposing party's reply brief considered instead, 1110
  - References to federal law irrelevant, 1683

Oral argument
- Request for, denied, 473,2160

Reconsideration request
- Clarify part of denial reversed, 436
- Objection to: no respondent's brief filed, 335
- Scope of Board's reversal of denial, 871
- Unrepresented claimant, 2334
- Untimely, 1097
- Withdrawn: claim DCA'd, 684

Scope of review, 2033
Supplemental authority
- Allowed, 1365
- Vs. argument, 1365

Surreply brief, 1628

**REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE & PROCEDURE)**

Issue not raised below not considered, **539,1163**,2231
Issue raised at hearing is considered, **544**
Order on Reconsideration/Petition for Judicial Review, 1064
Petition for Judicial Review/Request for Reconsideration, 789
Scope of review, **1764, 1767**

**SETTLEMENTS & STIPULATIONS** (continued)
Claims Disposition Agreement (continued)
Order approving (continued)
Disputes relating to CDA resolved, 706
"Existing disputes" resolution withdrawn, 706
Lump sum award issue, 997
No attorney for insurer, 870,954,1105
No NCE signature, 217,609,1107
Offset issue corrected, 2190
Overpayment waived, not part of consideration, 38,1544
Penalty and fee issues in future not resolved, 1074
Release of "conditions" vs. "claims", 901,1093,1098,1449
Right to appeal reserved (preferred worker eligibility), 55
Summary page inconsistent with body of CDA, 1105
Third party lien; proceeds as part of, 858
Two claims submitted as one, 1068
Waiver, 30-day period, 1062,1095,1105,2135
Order disapproving
30-day cooling-off period, waiver of "irrevocable", 2054
Assignment of proceeds to third party, 2061
Both parties request, 1539
Claim processing dispute: attempt to resolve, 472
Claim processing function, attempt to perform, 1537
Claimant's request (indirect), 914
Claimant's signature required, 81,214
Employer request, new law applied, 1321
No information on occupations actually worked, 865
Offset under federal statute, 2060
"Party" defined or discussed, 260
Penalty, late payment issue, 2388
Reconsideration request
Allowed: "existing disputes" resolution withdrawn, 691
Denied: untimely, 1636
Referred for hearing
Intentional misrepresentation, material fact issue, 485
Set aside, Motion to, 2171
Disputed Claim Settlement
Attorney fee for prior counsel, 977
Board members vs. Referee signature lines, 688
Date of settlement requirement, 688
Enforcement issue, 300
Extraordinary fee, 1543
Providers
All must be accounted for, 33,977
Payment in excess of 40%, 1925
Provision for payment to without listing, 1925
Reemployment, reinstatement rights waived, 977
Stipulated agreement
Interpretation, 1100
Not enforceable without order approving, 718

*** Bold Page = Court Case ***

**SUBJECT WORKERS** See COVERAGE QUESTIONS

**TEMPORARY TOTAL DISABILITY** (continued)
- Entitlement (continued)
  - Litigation order (appealed), 1082,2016
  - Litigation order (final against carrier), 332,1082,1502,2016
  - Notice of Closure not challenged, 1568
  - Own Motion case, 1496
  - Retroactive authorization, 2359
  - Substantive vs. procedural, 35,174,295,332,610,947,1091,1293,1383,1394,1496,1575,1596, 1643,2359
  - "To the present" defined or discussed, 991
  - Two claims, 2138
  - Withdrawal from labor force issue
    - Pursuit of grievance re job termination, 976
    - Time to determine, 776
- Interim compensation
  - Aggravation claim
    - Attending physician issue, 1499
    - Claim "form" requirement, 2285
    - Inclusive dates, 2285
    - Requirements for, generally, 2285
  - Original claim
    - "Attending physician" authorization issue, 1692,1703
    - Classification as nondisabling; role of, 1513
    - Defined or discussed, 1956
    - Inclusive dates, 1956,2313
    - "Leave work" requirement, 672,981,1956,2313
    - Medical verification requirement, 672
    - Nondisabling claim, classification not timely appealed, 672
    - Notice of Claim: knowledge imputed to employer, 351
    - Notice of Closure set aside, litigation order enforced, 332
    - Return to work, same fluctuating hours, 1513
    - Temporary partial disability, 1468
- Penalty issue
  - Failure to pay
    - Conduct reasonable
      - Appealed litigation order, 1383,2363
      - Legitimate doubt, 2313
      - No attending physician authorization, 1509
      - Termination issue, 335,2313
      - Withdrawal from work force issue, 776
    - Conduct unreasonable
      - Calculation of TPD, 403,1596
      - Employer knowledge attributable to carrier, 617
      - Failure to pay
        - Interim compensation, 1692,1703,1956
        - TTD authorized, 2359
        - TTD pursuant to D.O., 1575
      - Interim compensation, 981
      - No 2nd penalty, 332
      - Payments incorrect, 1044
      - Pending appeal, 1089
      - Rate of TTD, 617,1310,2018
      - Termination of TTD, 96,1643,1670,1984,2138,2229
- Rate
  - Bonus, 1310
  - Per diem, 2028
  - Extended gap issue, 6,77,430,431
  - Hourly rate, varying wage, 733
  - Lodging costs, 2028

*** Bold Page = Court Case ***

## CITATIONS TO CASES IN VAN NATTA'S

## ADMINISTRATIVE RULE CITATIONS

---

LARSON CITATIONS

1A Larson, WCL,
28.00 5-441 (1995)
2340

1A Larson, WCL,
28.11 5-446 (1995)
2340

1A Larson, WCL
28.22 5-457 (1995)
2340

1A Larson, WCL,
28.22 5-420, -421
2340

1A Larson, WCL,
28.24 5-432 (1985)
2340

1B Larson, WCL,
44.33(a) at 8-107
(1993)
486

1B Larson, WCL,
45.00 at 8-193 (1995)
2082

1B Larson, WCL,
45.32(c) at 8-255
(1995)
2082

1B Larson, WCL,
45.32(c) at 8-237
(1995)
2082

1B Larson, WCL
46.00 (1993)
1368

2A Larson, WCL,
68.13 (1994)
**1144**

4 Larson, WCL,95.21
1748

4 Larson, WCL,
95.24 at 17-173 (1984)
**1748**

---

OREGON RULES OF CIVIL PROCEDURE CITATIONS

Rule
Page(s)

ORCP 21
1589,**1731**

ORCP 21A(8)
**1144**,1589

ORCP 21A(9)
**553**

ORCP 21D
1589

ORCP 47
1589

ORCP 47C
**2449**

ORCP 67B
**1144**

ORCP 71B
391,955,1938

ORCP 71B(1)
460,1072

---

OREGON EVIDENCE CODE CITATIONS

Code
Page(s)

OEC 403
723

OEC 404(3)
723

---

* Appealed to Courts (through 11/30/95)