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

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

JULY-SEPTEMBER 1996

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Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review and claimant cross-requests review of that portion of Administrative Law Judge (ALJ) Davis' order that increased claimant's scheduled permanent disability award for loss of use or function of the right leg from zero percent, as awarded by the Order on Reconsideration, to 11 percent (16.5 degrees). On review, the issue is extent of scheduled permanent disability.

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

In addition to the reasons given by the ALJ for relying on the March 14, 1995 closing examination of Dr. Hendricks, M.D., as concurred in by Dr. Camp, claimant's attending physician, rather than the medical arbiter's examination, we find that Dr. Hendricks' evaluation of claimant's motor strength was more complete and thorough. (Ex. 8-3).

The ALJ relied on the March 14, 1995 closing examination in determining that claimant had no loss of plantar sensation in the right foot. (Exs. 8, 9). As the ALJ found, sensory loss in the foot is ratable only when it is found on the plantar surface. OAR 436-35-200(1). Therefore, the ALJ awarded no impairment for any sensory loss in claimant's right foot.

On review, claimant argues that we should rely on Dr. Hendricks' earlier closing examination, which was conducted on September 14, 1993, to award a 5 percent impairment for partial loss of plantar sensation in the right foot. (Ex. 6). However, unlike the March 14, 1995 closing examination, there is no indication that Dr. Camp concurred with the September 14, 1993 closing examination. Relevant impairment findings include the findings of the attending physician at the time of claim closure or any findings with which he or she concurred, as well as the findings of the medical arbiter when one is appointed. Roseburg Forrest Products v. Owen, 129 Or App 442 (1994). Because Dr. Camp did not concur with Dr. Hendricks' September 14, 1993 closing examination findings, we may not consider those findings in determining impairment.

SAIF requested review and we have found that claimant's compensation should not be reduced. Therefore, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by 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 January 16, 1995 (sic), as amended on January 30, 1996, is affirmed. For services on review, claimant's attorney is awarded $750, payable by the SAIF Corporation.

In the Matter of the Compensation of
PAMELA VINYARD, Claimant
Own Motion No. 96-0297M
OWN MOTION ORDER
Malagon, et al, Claimant Attorneys

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable hernia injury. Claimant's aggravation rights expired on July 25, 1990. The insurer recommends that we deny authorization of temporary disability compensation, contending that claimant's physician did "not post-date time loss authorization for more than a fourteen-day period."

However, in its recommendation, the insurer agreed that: (1) claimant's compensable condition worsened requiring surgery or hospitalization; (2) the current condition is causally related to the accepted condition; (3) it is responsible for claimant's current condition; (4) surgery or hospitalization is reasonable and necessary for the compensable injury; and (5) claimant was in the work force at the time of disability.

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

On January 9, 1996, Dr. Wilhite, claimant's treating surgeon, performed an excision of the abdominal wall mass/seroma; reapproximation of abdominal wall and limited panniculectomy. We are persuaded that claimant's compensable injury has worsened requiring surgery.

The insurer cites "current rules" which require that an attending physician document in writing that time loss from work was being authorized, and that the documentation occur within 14 days of the actual recommendation. See ORS 656.262(4)(f). However, under ORS 656.278(1), the Board may, upon its own motion, modify, change or terminate former findings, orders or awards if in its opinion such action is justified. Thus, when a claimant makes a claim for aggravation after claimant's aggravation rights have expired, the Board, under its Own Motion authority, has exclusive jurisdiction to authorize the reopening of a claim under ORS 656.278 and OAR Chapter 438, Division 012 of the Board's rules. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Moreover, the 14-day limitation concerning retroactive time loss authorization pursuant to ORS 656.262(4)(f) pertains to temporary disability payable under ORS 656.268. Since any temporary disability authorized in this case flows from ORS 656.278(1), the "14-day limitation" of ORS 656.262(4)(f) is not applicable.

Here, OAR 438-012-0035 provides that:

> "(1) The Board shall order the payment of temporary disability compensation from the date the claimant is actually hospitalized or undergoes outpatient surgery in those cases where:
>
> "(a) The own motion claim for temporary disability if filed after the aggravation rights have expired;
>
> "(b) There is a worsening of a compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization; and
>
> "(c) The claimant was in the work force at the time of the worsening of the compensable injury."

Our rules further state that the insurer shall make the first payment of temporary disability compensation within 14 days from the date of an order of the Board reopening the claim, and that temporary disability compensation shall be paid until: (1) the claim is closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement is submitted to the Board pursuant to ORS 656.236(1), unless the claim disposition agreement provides for the continued payment of temporary disability compensation; or (3) termination of such benefits is authorized by the terms of ORS 656.268.

Finally, under OAR 438-012-0020(3), an insurer is deemed to have notice of an own motion claim for temporary disability benefits when one of the following documents is submitted to the insurer by or on behalf of the claimant after the expiration of aggravation rights: (1) a written request for temporary disability compensation or claim reopening; or (2) any document that reasonably notifies the insurer that the claimant's compensable injury requires surgery or hospitalization. In an April 9, 1996 letter, claimant's attorney, on behalf of claimant, notified the insurer that claimant "remained in the work force at the time of her most recent surgery," and submitted a copy of claimant's Schedule C, Form 1040 in support of that position.

Here, the record establishes that claimant meets all of the requirements set forth above. In addition, the insurer agrees that this is the case. Furthermore, the Board's rules do not limit the time within which a claimant may request own motion relief. Finally, we have sole own motion jurisdiction to review claimant's 1984 injury claim for the purposes of authorizing temporary disability compensation when claimant qualifies for claim reopening under our rules. Therefore, we have the statutory authority to authorize the reopening of the claim for the payment of temporary disability compensation beginning the date of surgery, notwithstanding the attending physician's allegedly belated submission of "authorization for time loss" under an inapplicable statute (ORS 656.262(4)(f)). Miltenberger v. Howard's Plumbing, supra; Martin L. Moynahan, 47 Van Natta 2238 (1995) on recon 48 Van Natta 103 (1996); Mary K. Karppinen 46, Van Natta 678 (1994); Mark D. Fuller, 46 Van Natta 63 (1994).

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning January 9, 1996, the date claimant was hospitalized for the surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

July 3, 1996 Cite as 48 Van Natta 1443 (1996)

In the Matter of the Compensation of
WARREN N. BOWEN, Claimant
WCB Case No. 91-15616
SECOND ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

On May 16, 1996, we abated our April 17, 1996 Order on Remand, in which we found that we retained jurisdiction under ORS 656.245(6) to resolve a dispute regarding the causal relationship between claimant's compensable right foot injury and a proposed weight-loss program. We took this action to consider the SAIF Corporation's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

In our first Order on Remand, we rejected SAIF's argument that we lacked jurisdiction under ORS 656.245(6) because there was no dispute regarding the compensability of an "underlying claim." We reasoned that the "underlying claim" was either a "consequential " or a "combined" condition (claimant's weight gain). After conducting our review of the record, we concluded that claimant's compensable right foot injury was the major contributing cause of his need for a weight-loss program to treat his compensable injury. Accordingly, we concluded that the ALJ properly set aside that portion of SAIF's denial based on lack of causation. Citing Lynda Zeller, 47 Van Natta 1581 (1995), however, we emphasized that the Board was without authority to address the propriety of the proposed medical treatment, which is an issue within the province of the Director.

In its motion to reconsider, SAIF first contends that it is fundamentally unfair to decide the issue of the compensability of claimant's weight gain because the issue was never litigated by the parties. We disagree with SAIF's contention.

As noted in our previous order, the ALJ specifically mentioned SAIF's argument that claimant must prove that the "resultant condition" is caused in major part by claimant's compensable injury. Although SAIF cites portions of the transcript to support its assertion that claimant's weight gain was not at issue, we are persuaded that compensability of an "underlying claim" was raised in light of the ALJ's recitation of SAIF's argument.[1] Moreover, neither on Board review of the ALJ's order nor at any level of this appeal (until its motion for reconsideration), has SAIF contested the ALJ's statement that it was contending that claimant's accepted foot injury was not the major contributing cause of the "resultant condition."

SAIF next contends that, even assuming that compensability was raised as an issue, we lack jurisdiction to determine whether the weight-loss program is related to the compensable condition. Once again, we disagree with SAIF's assertion.

As previously noted, SAIF contended that claimant must prove that the "resultant condition" was caused in major part by claimant's injury. We see no reason to depart from our prior conclusion that the dispute concerned the compensability of an "underlying claim." Moreover, we have consistently ruled that we retain jurisdiction over a medical treatment dispute where the issue concerns whether treatment for a worker's condition was causally related to the compensable injury. See Michael L. Wofford, 48 Van Natta 1087 (1996) (citing Arthur R. Morris, 48 Van Natta 349 (1996)); Richard L. Wheeler, 47 Van Natta 2011 (1995). Inasmuch as the record establishes, and SAIF does not dispute our finding, that claimant's compensable injury is the major contributing cause of claimant's need for treatment for the "combined" or "consequential" condition, the proposed medical treatment (weight loss program) is compensable.[2]

Finally, SAIF contends that we erroneously awarded an attorney fee because there is no "denied claim" within the meaning of ORS 656.386(1). We disagree.

Inasmuch as SAIF disputed (at hearing and in its denial) the causal relationship between the proposed weight-loss program for claimant's "combined" condition and his compensable injury, we conclude that SAIF refused to pay a claim for compensation on the "express ground" that the injury or condition for which compensation was sought was not compensable or otherwise did not give rise to an entitlement to compensation. ORS 656.386(1). Accordingly, we decline to disturb our prior attorney fee award.

Claimant's attorney is entitled to an attorney fee for services on reconsideration. After considering the factors recited in OAR 438-015-0010(4), we find that a reasonable attorney fee for such services is $500, to be paid by SAIF. In particular, we have considered the time devoted to the compensability issue (as represented by claimant's response), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 17, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

---

[1] Although SAIF's "resultant condition" argument does not appear in the recorded transcript, closing arguments were not recorded.

[2] We once more emphasize that our determination is limited to causation, not the propriety of the proposed medical treatment. Lynda J. Zeller, supra.

In the Matter of the Compensation of
WILLIAM K. BOWLER, Claimant
WCB Case No. 95-00645
ORDER ON REVIEW
Swanson, et al, Claimant Attorneys
Bailey & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) McCullough's order which assessed a penalty for its allegedly unreasonable claim processing. Claimant "cross-requests" review, alleging that the insurer's request for review was frivolous or was filed in bad faith or for the purpose of harassment. ORS 656.390(1). On review, the issues are penalties and sanctions for "frivolous" appeal. We reverse the ALJ's penalty assessment and decline to sanction the insurer for appealing the ALJ's order.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the last paragraph, which finds that the insurer's denial was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable right knee injury on August 5, 1994. Claimant subsequently developed left knee symptoms which resulted in the insurer's May 10, 1995 denial of claimant's left knee condition.

The ALJ determined that claimant's left knee condition was compensable, reasoning that the medical evidence established that the left knee condition was either a direct result of claimant's accident or a secondary consequence of claimant's injury. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). The ALJ also awarded a 25 percent penalty under ORS 656.262(11), finding that, even if the insurer's denial of claimant's left knee condition was not unreasonable when issued in May 1995, continuation of the denial became unreasonable after claimant submitted a medical report from claimant's attending physician, Dr. Stanley, at the October 24, 1995 hearing. See Brown v. Argonaut Insurance Company, 93 Or App 588, 592 (1988) (continuation of denial in the light of new medical evidence becomes unreasonable if the new evidence destroys any legitimate doubt about liability).

On review, the insurer contends that the ALJ incorrectly assessed a penalty for unreasonable denial. It asserts that its denial was reasonable when issued on May 10, 1995, and that continuation of the denial after claimant's submission of Dr. Stanley's October 20, 1995 concurrence report was likewise not unreasonable. We agree.

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." Amended ORS 656.262(11)(a) (formerly numbered 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. International Paper Co. v. Huntley, 106 Or App 107 (1991). Moreover, even after a carrier reasonably denies a claim, continuation of that denial may become unreasonable if new medical evidence destroys any legitimate doubt about liability. Brown v. Argonaut Ins. Co., supra.

Claimant compensably injured his right knee on August 5, 1994 while performing his duties as a core feeder. Claimant did not report left knee symptoms until over two months after the August 5, 1994 accident. (Ex. 15). The medical reports available at the time of the May 10, 1995 denial indicated that claimant had preexisting degenerative changes in the left knee. (Exs. 16A, 17-1, 18).

Dr. Stanley provided the only medical evidence prior to the insurer's May 10, 1995 denial that addressed the causal relationship between claimant's August 1994 injury and his left knee condition. On March 8, 1995, Dr. Stanley opined that claimant's "left knee is based on an aggravation of a pre-existing condition." (Ex. 17-2). While indicating that claimant had tears of his left medial and lateral menisci which were consistent with a recent injury, Dr. Stanley also acknowledged that he did not have documentation that claimant injured his left knee in August 1994. Dr. Stanley stated that he would have to get a more accurate history regarding the August injury in order to decide whether claimant injured his left knee at that time. (Ex. 17-1).

On March 27, 1995, Dr. Stanley opined that claimant's left medial and lateral meniscus tears were "new injuries" and that claimant's new injury "would definitely be related" to claimant's accident in August 1994. (Ex. 18-1).

Although claimant contends that the insurer's May 1995 denial was unreasonable in light of Dr. Stanley's medical reports, we conclude otherwise. Given the delayed onset of claimant's left knee symptoms, and the presence of preexisting degenerative changes in claimant's left knee, we find that Dr. Stanley's "pre-denial" medical reports did not render the insurer's denial unreasonable when issued. Dr. Stanley conceded in his March 8, 1995 report that he needed additional information regarding claimant's injury. Although Dr. Stanley's subsequent report on March 27, 1995 was more definitive, he provided no reasoning to support his conclusion that claimant sustained a "new injury." See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical opinion). Accordingly, we find that the insurer's May 10, 1995 denial was not unreasonable when issued.

The insurer, however, has a continuing obligation to reassess the propriety of its denial in light of "post-denial" medical evidence. Brown v. Argonaut Insurance Company, supra. The ALJ reasoned that, even if the insurer's denial was reasonable when issued, its receipt of Dr. Stanley's October 20, 1995 concurrence report at the October 24, 1995 hearing rendered continuation of the denial unreasonable. For the following reasons, we disagree with that conclusion.

In his October 1995 concurrence letter, Dr. Stanley agreed that claimant's August 1994 injury was the major contributing cause of claimant's left knee condition. (Ex. 23). Dr. Stanley agreed that the "tears" in claimant's left knee looked new and that the stresses that claimant put on his left knee while recovering from surgery for his compensable right knee injury also supported his opinion that the August 1994 injury was the major contributing cause of his left knee condition. (Ex. 23).

While Dr. Stanley's concurrence report clarified his opinion on causation, the report was not submitted until the hearing. The insurer objected to admission of the report and was granted the opportunity to depose Dr. Stanley.[1] Considering the lack of persuasive medical evidence before the hearing supporting the compensability of the claim, as well as the timing of claimant's submission of Dr. Stanley's concurrence report, we do not find it unreasonable for the insurer to await the ALJ's review of the entire record (including the medical report submitted at hearing) and the ultimate decision regarding compensability. See Randy L. Carter, 48 Van Natta 1271 (1996) (carrier's continuation of denial not unreasonable in light of medical report submitted at hearing and "post-hearing" deposition).[2]

Accordingly, we conclude that the insurer's continuation of its compensability denial was not unreasonable under the circumstances presented in this case. Therefore, we reverse the ALJ's decision to assess a penalty.[3]

ORDER

The ALJ's order dated January 4, 1996 is reversed in part and affirmed in part. That portion which assessed a penalty for the insurer's allegedly unreasonable denial is reversed. The remainder of the ALJ's order is affirmed.

---

[1] The insurer later determined that it was unnecessary to depose Dr. Stanley.

[2] We emphasize, as we did in Carter, that a carrier should not ignore the Brown proscription against continuation of a denial when "post-denial" medical evidence destroys legitimate doubt regarding a carrier's liability. However, we do not find it unreasonable under the circumstances of this case for the insurer to have awaited the ALJ's ultimate decision regarding compensability when that determination necessarily involved an assessment of the persuasiveness of Dr. Stanley's medical opinion. See William K. Young, 47 Van Natta 740, 744 (1995) (uncontradicted medical opinion found unpersuasive); Edwin Bollinger, 33 Van Natta 559 (1981) (uncontradicted medical opinion need not be followed).

[3] In light of our conclusion, it follows that the insurer's appeal was not "frivolous." Therefore, we reject claimant's request for sanctions pursuant to ORS 656.390(1). We acknowledge claimant's assertion that the insurer's appeal was unreasonable because its request for review indicated that payment of compensation had been stayed pending review. However, if in fact the insurer is not paying compensation pending review, this is an issue to be resolved in separate proceedings. Cf. Gilbert T. Hale, 44 Van Natta 729 (1992) (pending appeal, a carrier's obligation to pay interest on stayed compensation is not ripe for adjudication).

In the Matter of the Compensation of
HOWARD W. COCKERAM, Claimant
WCB Case No. 95-12056
ORDER ON REVIEW (REMANDING)
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Member Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that dismissed his request for hearing concerning an Order on Reconsideration. On review, the issue is the propriety of the ALJ's dismissal order. We remand.

On November 1, 1995, claimant requested a hearing, raising the issues of premature claim closure and extent of unscheduled permanent disability. A day before the scheduled hearing, claimant withdrew his request for hearing. An Order of Dismissal issued on February 13, 1996. On February 16, 1996, claimant filed a request for reconsideration of the Order of Dismissal. Claimant subsequently submitted documents which originated after the date of the Order on Reconsideration.

On March 6, 1996, the ALJ denied claimant's request for reconsideration. The ALJ reasoned that the documents which had been submitted by claimant would not be admissible as they were not in the record at the time of reconsideration. Accordingly, relying on Joe R. Ray, 48 Van Natta 325 (1996), and amended ORS 656.283(7), the ALJ found that because the motion for reconsideration was premised on documents which would not be admissible, the motion must be denied.

On review, claimant argues that the evidence submitted to the ALJ should be admitted pursuant to ORS 656.268(4)(e), which permits medical arbiter reports at hearing, even if the report was not prepared in time for the reconsideration proceeding. Claimant also argues that, because the ALJ denied the motion to reconsider, claimant did not have an opportunity to request remand to the Department to consider newly discovered evidence.

The SAIF Corporation argues that the evidence submitted by claimant has not been shown to be reasonably likely to affect the outcome of the case. Consequently, SAIF requests that the ALJ's decision to deny reconsideration be affirmed.

Our review is limited to the record developed at the hearing level. In this case, because no hearing was convened and no evidence taken, we are unable to address the parties' specific contentions. See Homer Betancourt, 46 Van Natta 2399 (1994). Moreover, neither party had an opportunity to present evidence concerning the issue of whether claimant is presently entitled to a hearing on the merits of his hearing request. See Larry Bergquist, 45 Van Natta 2140 (1993); Ana R. Sanchez, 45 Van Natta 753 (1993).

In the present case, SAIF does not challenge claimant's right to request reconsideration of his earlier withdrawal of his request for hearing. Rather, SAIF argues that the proposed evidence submitted by claimant would not be admissible at hearing. Under the circumstances, we conclude that the proper procedure is for a hearing to be held, at which time the parties may submit evidence (testimonial and documentary). At that time, the ALJ shall rule on the evidence and develop the record for appeal.

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. Keinow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, for the reasons expressed above, we conclude that the record is not sufficiently developed to address the parties' contentions. Therefore, a compelling basis for remand exists.

Accordingly, we vacate the ALJ's order and remand this matter to ALJ Hazelett. The parties shall have the opportunity to clarify the issues for resolution, as well as present evidence regarding those issues for the ALJ's determination concerning the admissibility of such evidence. The ALJ shall have the discretion to proceed in any manner that will achieve substantial justice, and will insure a complete and accurate record of all exhibits, examination and/or testimony (whether admitted or excluded). Thereafter, the ALJ shall issue a final, appealable order.

ORDER

The ALJ's order dated February 13, 1996 is vacated. Claimant's request for hearing is reinstated. This matter is remanded to ALJ Hazelett for further proceedings consistent with this order.

In the Matter of the Compensation of
IGNACIO GARCIA, Claimant
WCB Case No. 95-00205
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) declined to admit Exhibit 45 (a report from claimant's out-of-state attending physician, Dr. Rodrigo) into the evidentiary record; (2) upheld the insurer's denial of claimant's claim for degenerative arthritis of the right knee; (3) upheld the insurer's "de facto" denials of chondromalacia of the right knee and total knee replacement surgery; and (4) found that claimant was not permanently and totally disabled. On review, the issues are evidence, compensability and permanent total disability.

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

Claimant seeks admission of Exhibit 45 into the record. Based on the following reasoning, we affirm the ALJ's evidentiary ruling.

The hearing in this matter was initially convened on March 28, 1995. The record was left open for the cross-examination of claimant's vocational expert and for x-rays to be provided to claimant's out-of-state attending physician, Dr. Rodrigo.

On April 4, 1995, the insurer sent claimant's knee x-rays to Dr. Rodrigo. The x-rays were held for a time by Dr. Rodrigo's office, and then returned to the insurer, apparently without the doctor seeing them.

On September 8, 1995, the insurer's attorney wrote to the ALJ, noting that the x-rays had been forwarded to Dr. Rodrigo, but that no report had ever been received from the doctor. The insurer's attorney requested that the record be closed since it did not appear that Dr. Rodrigo would be submitting a report. On October 27, 1995, a conference call was held between the ALJ, counsel for claimant and counsel for the insurer. As memorialized in his October 30, 1995 letter to the attorneys, the ALJ made the following ruling:

> "I have requested that the insurer remail the x-rays. I am requiring that any report from Dr. Rodrigo be in the possession of [claimant's attorney] within three weeks of the insurer's date of mailing or said report will not be admitted and the record will be closed at that time."

The x-rays were re-mailed by the insurer to Dr. Rodrigo on October 27, 1995. On November 7, 1995, claimant's attorney wrote to Dr. Rodrigo and explained that she needed Dr. Rodrigo's response concerning the x-rays by November 17, 1995. On November 28, 1995, claimant's attorney received a report dated November 20, 1995, from Dr. Rodrigo.

In a letter dated December 7, 1995, the ALJ wrote to the parties' attorneys. The ALJ made the following ruling concerning the admissibility of Dr. Rodrigo's November 20, 1995 report (Exhibit 45):

> "As you know, I ruled that [claimant's attorney] would need to have the report from the physician in her possession within three weeks of the insurer's remailing of the x-rays to Dr. Rodrigo. My ruling was prompted by the long delay in concluding this matter that resulted from Dr. Rodrigo's office's handling of the x-rays the first time they were mailed. I am not inclined to change my ruling.

"OAR 438-06-091(3) provides in relevant part that an administrative law judge may continue a hearing for further proceedings upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden to obtain and present final rebuttal evidence. Claimant has had since apparently April to come up with the report. (I realize there have been some extenuating circumstances). The report was provided to me in late November, beyond the time I established during our phone conference as memorialized in my letter of October 30, 1995.

"I will not admit or consider the report. If [claimant's attorney] wishes to have it placed in the file under an offer of proof, she may do so."

Administrative Law Judges 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). We review the ALJ's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). The ALJ is given broad discretion on determinations concerning the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1991) (the ALJ's decision to admit or exclude evidence is limited only by the consideration that the hearing as a whole achieve substantial justice).

Claimant contends that Dr. Rodrigo's lack of diligence should not be attributed to claimant. However, the record was left open for claimant to obtain Dr. Rodrigo's opinion regarding the x-rays. Claimant had from at least April 1995 to September 1995 to inquire of Dr. Rodrigo concerning the x-rays. There is no explanation concerning why claimant did not determine sooner that Dr. Rodrigo had not seen the x-rays forwarded to him by the insurer in April 1995. In addition, claimant was given a second opportunity by the ALJ to obtain Dr. Rodrigo's opinion.

Our review of the ALJ's evidentiary ruling is for abuse of discretion. Based on this record, we do not find that the ALJ abused his discretion in excluding Exhibit 45 from the record. Accordingly, we decline to reverse the ALJ's evidentiary ruling.

ORDER

The ALJ's order dated February 2, 1996 is affirmed.

In the Matter of the Compensation of
SUSAN G. EISCHEN, Claimant
WCB Case No. 95-09349
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer requests review of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denial of claimant's injury or occupational disease claim for a dermatitis condition; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

We do not find that the medical evidence relating claimant's dermatitis condition to work exposure is based solely on a temporal relationship between her symptoms and her exposure. Instead, we find that the persuasive medical evidence concerning causation is based on that relationship, the ruling out of other causes, and Dr. Cofield's diagnostic expertise. See Estella Velasquez, 47 Van Natta 1117 (1995); Elizabeth E. Heller, 45 Van Natta 272 (1993). Our conclusion that claimant's condition is work-related is further supported by the number of contemporaneous complaints by claimant's co-workers.

Claimant's attorney is entitled to an assessed fee for services on review concerning the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 13, 1995 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
DAVID J. GORDON, Claimant
WCB Case No. 93-04848
ORDER ON REVIEW (REMANDING)
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Johnstone's order which dismissed his request for hearing because of his failure to appear at hearing. On review, the issue is the propriety of the dismissal. We remand.

FINDINGS OF FACT

Claimant filed several requests for hearing in 1993. The matter was set for hearing on multiple occasions, but the scheduled hearings were postponed for various reasons.

On June 19, 1995, a hearing was scheduled, but was also postponed by the ALJ so that claimant could obtain counsel. The ALJ advised claimant that there would be no further postponements if he was unable to find counsel, and that, if unrepresented at the next hearing, he would have to proceed without counsel or have his hearing request dismissed.

The case was rescheduled for hearing on January 5, 1996. However, claimant did not appear in person or through an attorney when the hearing was convened. On January 30, 1996, the ALJ issued an Order dismissing claimant's hearing requests pursuant to OAR 438-006-0071(2), on the ground that claimant had abandoned his requests for hearing.

On February 28, 1996, claimant mailed a request for review that the Board received on March 1, 1996. Claimant requested that the Board "reschedule" his hearing, alleging that he had "missed" the January 1996 hearing because of major surgery on December 11, 1995. Claimant's request of review indicated that copies were mailed to the self-insured employer, its processing agent and employer's counsel.

CONCLUSIONS OF LAW AND OPINION

The employer initially moves to dismiss claimant's request for review on the ground that claimant failed to serve its attorney with a copy of the request for review as required by ORS 656.295(2). For the following reasons, we deny the employer's motion.

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).

Here, the employer does not contend that claimant's request for review was untimely, only that it was not properly served on its counsel. However, claimant's February 28, 1996 request for review indicates that a copy was mailed to the employer's counsel, as well as to the employer and its claims administrator. Although the employer asserts that its counsel never received a copy of claimant's request for review, receipt of a copy of a request for review is not determinative; instead, the pivotal issue is when a copy of the request was mailed. See Judy W. Louie, 47 Van Natta 383 (1995).

Based on claimant's representation in his timely February 28, 1996 request for review, and considering that there is no allegation that the employer or its processing agent were not served, we are persuaded that the employer received timely notice of claimant's request for Board review. See Chester Johnson, 40 Van Natta 336 (1988) (timely service of request for review on employer's claims processor sufficient to vest jurisdiction with Board). Consequently, we retain appellate jurisdiction to consider claimant's appeal. Having made this determination, we now consider claimant's request to reschedule his hearing.

An ALJ shall dismiss a request for hearing if claimant and his attorney fail to attend a scheduled hearing, unless extraordinary circumstances justify postponement or continuance of the hearing. OAR 438-006-0071(2). We have previously held that an ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. Olga G. Semeniuk, 46 Van Natta 152 (1994); Harold Harris, 44 Van Natta 468 (1992).

Here, in response to the ALJ's January 30, 1996 dismissal order, claimant submitted a letter requesting review of the ALJ's order, alleging that he had been unable to attend the scheduled hearing because of "major surgery." In light of these circumstances, we interpret claimant's correspondence as a motion for postponement of the scheduled hearing. Inasmuch as the ALJ did not have an opportunity, nor did he rule on the motion, this matter must be remanded to the ALJ for consideration of the motion. See Randy L. Nott, 48 Van Natta 1 (1996); Olga G. Semeniuk, supra.[1]

In determining that remand is appropriate, we emphasize, as we have in similar cases, that our decision should not be interpreted as a ruling on the substance of any of the representations contained in claimant's submission or a finding on whether postponement of the previously scheduled hearing is warranted. Rather, as we have previously explained, we take this action because we consider the ALJ to be the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Olga G. Semeniuk, supra.[2]

Accordingly, the ALJ's January 30, 1996 order is vacated. This matter is remanded to the Presiding ALJ for assignment to an ALJ to determine whether postponement of claimant's hearing request is justified. In making this determination, the assigned ALJ shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the ALJ finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ finds that a postponement is not justified, the ALJ shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

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[1] Citing Compton v. Weyerhaueser Co., 301 Or 641 (1986), the employer argues that this claim should not be remanded to the Hearings Division because there is no "compelling reason" to do so. However, the "compelling reason" to remand is the Board's often-stated policy that the ALJ is the most appropriate adjudicator to consider a claimant's explanation for failure to appear at hearing and to determine whether "postponement" is warranted. E.g., Randy L. Nott, supra. As explained in Nott and similar cases, to do otherwise could result in our making a determination of a motion for postponement on less than all the relevant facts.

[2] The employer may present its objections, if any, to claimant's motion for postponement of the hearing to the ALJ when this case is returned to the Hearings Division.

In the Matter of the Compensation of
GLENN E. HALL, Claimant
WCB Case No. 95-09843
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that found that claimant was not entitled to additional temporary disability benefits. On review, the issue is temporary disability.

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

Claimant, a mill worker, sustained a compensable left hand injury on February 7, 1995. As he was attempting to remove a piece of wood from behind the gear assembly drive of a "hog belt" machine, his hand got caught up in the machine's rollers. A few days later, claimant was terminated for committing an unsafe act and violating the company safety policy.

On June 5, 1995, claimant's treating physician released him for modified work, with restrictions on twisting of his left arm and wrist. Because the employer had a written policy of offering modified work to injured employers, and claimant would have received a modified job offer had he not been terminated for violating the company's safety policy, SAIF terminated claimant's temporary disability benefits pursuant to ORS 656.325(5)(b) and 656.212.

The ALJ found that the SAIF Corporation properly ceased claimant's temporary total disability benefits pursuant to ORS 656.325(5)(b). Specifically, the ALJ found that the employer had a written policy of offering modified work to injured workers, that claimant's attending physician approved employment in a modified job, and that, but for his termination for violating a work rule, claimant would have been offered a modified job at the same pay.

On review, claimant renews his constitutional challenges to the validity of ORS 656.325(5)(b). First, with regard to the Oregon Constitution, claimant argues that the statute violates the separation of powers doctrine (found in Article III, Section 1 and Article IV, Section 1), because it improperly delegates a legislative decision making function to private interested individuals, i.e., the employer.[1] We reject this challenge, particularly because we do not consider termination of employment to be a legislative or governmental function.

Under the Oregon Constitution, the power to make and declare laws is vested exclusively with the legislative assembly, subject only to the initiative and referendum powers reserved to the people. See Van Winkle v. Fred Meyer, Inc., 151 Or 455 (1935). Because Article IV, Section 1 entrusts the law-making power to the legislature, "it is clear that when an act leaves the legislative halls, it must be complete and not contemplate that some other department of our government or any agency will complete it. In other words, the legislature cannot delegate the power to determine what the law shall be." Foeller v. Housing Authority of Portland, 198 Or 205, 264 (1953).

ORS 656.325(5)(b) provides as follows:

> "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."

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[1] In support of this contention, claimant cites, among other cases, Corvallis Lodge No. 1411 v. OLCC, 67 Or App 15 (1984), where the court invalidated an OLCC rule because it failed to provide sufficient procedural safeguards to protect against arbitrary application of governmental power (approving liquor permits) delegated to private, interested individuals (those with Class A liquor licenses).

Contrary to claimant's contention, this provision does not delegate to employers or insurers any power to determine what the law shall be. See Foeller v. Housing Authority of Portland, supra. Rather, the statute is complete in itself and sets forth the specific standards governing payment of temporary disability when the claimant has been terminated for violating a work rule. While amended ORS 656.325(5)(b) applies only when there has been such a termination, an employer's decision to terminate a worker for violating a work rule is not an exercise of legislative power. To the extent the employer's conduct was unlawful or unjustified, the worker's remedy is a civil action under ORS Chapter 659.

In addition, relying on Carr v. SAIF, 65 Or App 110 (1983), claimant contends that ORS 656.325(5)(b) violates the federal Due Process Clause because it allows an employer to terminate temporary total disability benefits without notice and an opportunity to be heard.[2] In Carr, the Workers' Compensation Department terminated the claimant's temporary disability benefits after being advised by the carrier that the claimant failed to attend a scheduled medical examination. The court found that the claimant's right to continuing benefits was a property interest encompassed by the Fourteenth Amendment, and that claimant was entitled to notice and an opportunity to respond before the Department suspended his compensation pursuant to former ORS 656.325.

The determinative distinction between Carr and this case is that, in this case, there has been no governmental deprivation of benefits. As the Carr court explained:

> "A person's constitutionally significant property interest is protected by the Fourteenth Amendment against governmental rather than private infringement. Flagg Brothers, Inc. v. Brooks, 439 US 149, 156, 98 S Ct 1729, 56 L Ed 2d 195 (1978). The procedural protections of the Fourteenth Amendment apply if the government is overtly involved in a private deprivation of protected property rights. 439 US at 157."

Because it was the Department, a state agency, that decided whether the suspension was warranted, the Carr court recognized that the deprivation of benefits was "clearly governmental." 65 Or App at 118. The court found that the state, through the Department, could not lawfully deprive the claimant of benefits without due process of law.

Here, on the other hand, the decision to terminate claimant for committing an unsafe act and violating the company's safety policy (which ultimately led to the cessation of claimant's temporary total disability benefits under amended ORS 656.325(5)), was made by the employer, a private entity. We find no evidence that the government had any involvement (overt or otherwise) in the employer's managerial decision. In the absence of any state action, the procedural protections guaranteed by the Due Process Clause are inapplicable to claimant's termination of employment or to the cessation of his temporary disability benefits.

Finally, we note that claimant does not contest SAIF's calculation of his temporary partial disability benefits as zero. Having considered and rejected claimant's constitutional challenges to amended ORS 656.325(5)(a), we agree with the ALJ that claimant is not entitled to additional temporary disability benefits.

ORDER

The ALJ's order dated December 18, 1995 is affirmed.

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[2] Claimant argues that amended ORS 656.325(5)(b) "allows the employer to effectively terminate TTD upon a summary termination of claimant, without notice." Again, we note that the statute sets forth specific requirements for ceasing temporary total disability payments "if the worker has been terminated for violation of work rules or other disciplinary reasons." The statute does not govern the reasonableness of the employer's work rules or the propriety of the worker's termination, as those issues are not within the purview of the workers' compensation laws. Rather, as noted above, unlawful employment practices are governed by other laws, including the provisions of ORS Chapter 659.

In the Matter of the Compensation of
PATSY G. HARPER, Claimant
WCB Case No. 95-12275
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that found that the insurer correctly calculated claimant's temporary total disability rate. On review, the issue is the rate of temporary total disability (TTD).

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

To begin, the insurer argues that ORS 656.210, rather than OAR 436-60-025(5)(a), applies to this case because claimant was regularly employed and paid on a daily basis. The insurer contends that claimant was not an "on call" employee because she was not called in to work any extra shifts. We disagree.

First, we note that the ALJ indicated that the parties had agreed that, because claimant was paid hourly, her weekly wage must be determined pursuant to OAR 436-60-025(5)(a).[1] Thus, it appears that the insurer did not raise the argument regarding ORS 656.210 at hearing. We are not inclined to consider the insurer's argument because the insurer failed to adequately raise the issue before the ALJ. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Nevertheless, we agree with the ALJ that OAR 436-60-025(5)(a), rather than ORS 656.210, applies to this case. ORS 656.210(2)(c) provides:

> "As used in this subsection, 'regularly employed' means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the Director of the Department of Consumer and Business Services, by rule, may prescribe methods for establishing the worker's weekly wage."

If claimant was "regularly employed" pursuant to ORS 656.210(2)(c), and was also paid on other than a daily or weekly wage basis, benefits shall be calculated under the Director's rules, rather than ORS 656.210. ORS 656.210(2)(c); Lowry v. DuLog, Inc., 99 Or App 459 (1989), rev den 310 Or 70 (1990).

Here, claimant's work status was changed effective July 28, 1995 to "part time on call." (Ex. A-1-2). The portion of claimant's "801" form filled out by the employer indicated that, at the time of the August 17, 1995 injury, claimant was scheduled to work from 8:00 a.m. to 4:30 p.m. on Thursday and Friday of each week, 8 hours per day, and her hourly wage at the time of injury was $4.75 per hour. (Ex. 1). Claimant's supervisor testified that claimant was "on call" and eligible for additional work if a housekeeper was needed, although claimant was not required to remain available for such work. (Tr. 24-26). Between July 28, 1995 and her August 17, 1995 injury, claimant did not work any "on call" shifts. (Tr. 20, 24).

Under OAR 436-60-005(10) (WCD Admin. Order 94-055), "'[e]mployment on call' means sporadic, unscheduled employment at the call of an employer without recourse if the worker is unavailable." Based on that definition, we conclude that, at the time of her injury, claimant was employed "on call." Since claimant was employed "on call," her remuneration was not based "solely" upon daily or weekly wages pursuant to ORS 656.210(2)(a), and, therefore, benefits must be calculated under the Director's rules. Although the insurer focuses on the fact that claimant did not actually work "on call" between the date her employment status changed and the date of injury, the issue is whether claimant was employed on call. OAR 436-60-025(5)(a) (WCD Admin. Order 94-055) provides that "[f]or workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist." (Emphasis added). We conclude that the ALJ properly applied OAR 436-60-025(5)(a), rather than ORS 656.210, to calculate claimant's temporary disability rate. See ORS 656.210(2)(c); Lowry v. DuLog, Inc., supra.

[1] Although the ALJ cited to OAR 436-60-020(5)(a), it is clear from the order that the ALJ was referring to 436-60-025(5)(a).

Claimant argues that the ALJ erroneously interpreted OAR 436-60-025(5)(a) and she asserts that there was no change in the amount or method of the wage earning agreement during the 52 week period before the injury. According to claimant, her time loss should be computed by using the "actual weeks of employment with the employer at injury up to the previous 52 weeks."

OAR 436-60-025(5)(a) provides:

> "For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist and where there has been no change in the amount or method of the wage earning agreement, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. Where there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury. For workers employed less than four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker." (Emphasis added).

The question in this case is whether there has been a "change in the amount or method of the wage earning agreement during the previous 52-week period." According to claimant, since her pay at $4.75 per hour did not change during her employment, there was no change in the "amount" of her pay. Claimant also asserts that the "method of the wage earning agreement" has not changed. Claimant relies on her supervisor's testimony agreeing that there had been no change in the method in which claimant was paid. (Tr. 22).

We disagree with claimant's narrow interpretation of OAR 436-60-025(5)(a). Claimant confuses the "rate" of pay with the "amount" of pay. OAR 436-60-025(5)(a) clearly refers to the "amount" of the wage earning agreement, not the "rate" of the wage earning agreement. Although claimant's rate of pay was $4.75 per hour, the amount of her wages was calculated based on the rate of pay and the number of hours she worked. We agree with the ALJ that, for workers paid an hourly wage, the amount of earnings depends upon both the hourly wage rate and the number of hours worked. We also agree that a change in the "wage earning agreement" may involve a change in the hourly rate, a change in the hours to be worked, or both.

Here, the wage earning agreement between claimant and the employer changed several times during claimant's employment. The last such change occurred effective July 28, 1995, when claimant's work status was changed to "part time on call." (Ex. A-1-2). The wage earning agreement at the time of injury provided for claimant to work eight hours a day, two days a week, at the rate of $4.75 per hour. (Ex. 1). Thus, claimant's wage earning agreement was changed in the "amount," in that claimant's number of hours was reduced, and it was changed in the "method," in that claimant worked "part time on call." OAR 436-60-025(5)(a) provides that, when a change in the amount or method of the wage earning agreement occurs, a weekly wage is determined based upon the actual weeks under the wage earning agreement at time of injury. We agree with the ALJ that the insurer correctly computed claimant's TTD rate.

ORDER

The ALJ's order dated February 12, 1996 is affirmed.

Board Chair Hall dissenting.

Because I disagree with the majority's interpretation of OAR 436-60-025(5)(a), I respectfully dissent.

The question in this case is whether there has been a "change in the amount or method of the wage earning agreement during the previous 52-week period." OAR 436-60-025(5)(a) (WCD Admin. Order 94-055). Under the rule, irregular nature of the work is assumed; indeed, the whole scheme centers around variables. Nevertheless, as long as the "amount" and "method" of the "wage earning

agreement" remain the same, it makes sense to use the worker's "average weekly earnings" for the "52 weeks prior to the date of injury" to determine the worker's disability benefits. In other words, as long as the "amount" (rate of pay) and the "method" (e.g., hourly, piece work, commission) remain the same, there is no risk of mixing "apples and oranges" in calculating a worker's average weekly wage.

In contrast, an accurate average weekly wage could not be determined if we attempted to "average" wages from hourly work with wages from commission work, or similarly, if we attempted to "average" work paid at $4.75 per hour one week with work paid at $6.50 per hour another week. For that reason, OAR 436-60-025(5)(a) provides, in part:

> "Where there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury."

It is, therefore, from the text and context of OAR 436-60-025(5)(a) that I conclude that the change in "amount" and "method" of the wage earning agreement refers to "rate" and "method." After all, given the irregular nature of the work in these cases, all such cases would constitute a "change in the wage earning agreement" when only the number of hours has changed. Furthermore, it must not be overlooked that OAR 436-60-025(5)(a) addresses changes in the "amount or method of the wage earning agreement," not changes in the amount of earnings themselves (as the majority interprets the rule). There must be a change in the "agreement" between employer and employee as to the "amount or method" of payment before the alternative basis for calculating average weekly wage is applied. Again, the text and context of OAR 436-60-025(5)(a) supports this interpretation.

I agree with claimant that there was no change in the "amount" of her pay because her pay at $4.75 per hour did not change during her employment. I also agree that the "method" of the wage earning agreement has not changed. Since there was no change in the amount or method of the wage earning agreement during the 52 week period before the injury, claimant's time loss should be computed by using the "worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury." OAR 436-60-025(5)(a). Because the majority concludes otherwise, I respectfully dissent.

In the Matter of the Compensation of
JACQUELINE M. JONES, Claimant
WCB Case No. 95-11338
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Johnstone's order that set aside its denial of claimant's injury claim for a bilateral carpal tunnel syndrome (CTS) condition. On review, the issue is compensability.

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

The insurer contends on review that claimant has failed to prove that her CTS is related to her injury under either ORS 656.005(7)(a) or ORS 656.005(7)(a)(A) and that Dr. Woods' opinions on causation are not persuasive. We disagree.

Our first task is to determine which provisions of the Workers' Compensation Law are applicable. Dibrito v. SAIF, 319 Or 244, 248 (1994); Daniel S. Field, 47 Van Natta 1457 (1995). The material contributing cause standard applies where a condition or need for treatment is caused by the industrial accident. If the condition or need for treatment is caused in turn by the compensable injury, the major contributing cause test applies. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). After our review of the record, we agree that the ALJ correctly found that there is nothing in the medical record to indicate that claimant's CTS condition was other than a direct result of the work-related motor vehicle accident itself. Accordingly, claimant must prove that the motor vehicle accident was a material contributing cause of her bilateral CTS. ORS 656.005(7)(a); Gasperino, supra.

Because of the length of time between the accident and claimant's seeking treatment for her carpal tunnel injury, the causation issue is a complex medical question. Resolution of the issue, therefore, requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Moreover, we do not give greater weight to the opinion of the treating physician, because resolution of the causation issue in this case involves expert analysis rather than expert external observation. Allie v. SAIF, 79 Or App 284 (1986). Where, as here, there is a dispute between medical experts, we give more weight to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986).

We find that only Dr. Woods' opinion meets both criteria and accordingly give his testimony the greatest weight. We give little weight to the opinion of Dr. Edmonds and Dr. Marble, because it is based on incomplete facts and analysis. The doctors state that, because there were no clinical findings of CTS at the time of their August 8, 1995 examination, they were unable to diagnose that condition. (Ex. 22-5). As noted by Dr. Woods, the doctors failed to discuss claimant's history of dysesthesias with wrist pain awakening her at night, positive nerve conduction studies, which support a diagnosis of CTS, and claimant's positive response to splinting, which confirms the diagnosis. Moreover, Dr. Edmonds and Dr. Marble's history of claimant's symptoms developing a month after the accident, which is the sole reason upon which they base their opinion that claimant's CTS could not have been caused by the motor vehicle accident, is inaccurate. (Compare Exs. 9-1, 9-4, 22-3, Tr. 14, 22).

Claimant reported the circumstances of the accident and the onset of her symptoms to Dr. Woods. These circumstances were verified by the contemporary medical records and claimant's testimony at hearing. (See Exs. 1-1, 9-1, 9-4, 15, 24-2, Tr. 7, 9, 14, 15, 22, 24, 26). Dr. Woods supported his opinion that the motor vehicle accident was the cause of claimant's CTS condition by the history of her bracing herself against the steering wheel just prior to the impact and her history of wrist pain and her hands falling asleep and awakening her at night dating from the accident, as well as the mildness of the neurophysiologic abnormalities. (See Ex. 22). Based on Dr. Woods' persuasive opinion, we conclude that claimant's bilateral 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 9, 1996 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, to be paid by the insurer.

July 3, 1996 Cite as 48 Van Natta 1457 (1996)

In the Matter of the Compensation of
ANDREW D. KIRKPATRICK, Claimant
WCB Case No. 95-00554
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that set aside its denial of claimant's aggravation claim for a cervical condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on July 20, 1993 when he jolted his neck while jumping off a bulldozer during the course of his work. The insurer accepted claimant's claim as a disabling C5-6 disc herniation with radiculopathy. Claimant underwent surgery for his compensable condition in October 1993. On January 13, 1994, claimant's then-attending physician declared him medically stationary and released him to regular work with the restriction that he not operate a crane for long periods of time due to inability to extend his neck. (Exs. 11; 13). On March 3, 1994, the claim was closed by a Determination Order which awarded 16 percent unscheduled permanent disability.

Claimant filed an aggravation claim, through his attorney, in late September 1994. The insurer denied the aggravation claim on December 15, 1994. On December 26, 1994, claimant's current attending physician, Dr. Boespflug, indicated that claimant was disabled from performing his regular work as a heavy equipment operator. Claimant requested a hearing from the insurer's aggravation denial.

The ALJ found that claimant had sustained an actual, pathological worsening of his compensable condition. On this basis, the ALJ set aside the insurer's aggravation denial. We reverse.

Subsequent to the date of the ALJ's order, we issued our decision in Carmen C. Neill, 47 Van Natta 2371 (1995). In Neill, we examined the interrelationship between amended ORS 656.273(1) and 656.214(7) and concluded that an "actual worsening" under amended ORS 656.273(1) was established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the condition greater than that anticipated by the prior award of permanent disability.

There are three medical opinions regarding whether claimant's compensable condition has worsened. Drs. Barth and Bald examined claimant on behalf of the insurer. These physicians found normal biceps function of 5/5. They found no evidence that claimant's condition had materially worsened since claim closure. The physicians noted increased subjective complaints of pain in the neck and posterior shoulder region and a slight increase limitation of cervical mobility. However, the doctors concluded that, if anything, claimant's neurological examination had improved since his strength in the right upper extremity had returned to normal and his sensory examination was minimally compromised.

Dr. Hacker, a consulting neurologist, concurred with the report of Drs. Barth and Bald. Dr. Hacker found claimant medically stationary on June 2, 1995 and released him, with Dr. Boespflug's agreement, to modified work as of June 5, 1995. Dr. Hacker suggested that claimant be released to work capacities in the light range. Dr. Boespflug concurred with Dr. Hacker's medically stationary finding and modified work release.

Claimant's current attending physician, Dr. Boespflug, noted that his examinations differed from that of Drs. Bald and Barth to the extent that in serial tests he found a right biceps strength of 4/5. Dr. Boespflug also noted that Dr. Hacker had also found right biceps weakness. Dr. Boespflug opined that claimant had suffered a worsening of his condition. As support for his conclusion, Dr. Boespflug noted his findings of 4/5 biceps weakness. Dr. Boespflug further noted that claimant was currently unable to perform his regular duty work as a heavy equipment operator.

In addition to the above-noted medical opinions, EMG studies by Dr. Mundall showed minimal changes of membrane instability in the right C5-6 innervated biceps muscle. Dr. Mundall indicated that the changes might reflect a very slight denervating process of unknown age.

Based on Dr. Boespflug's opinion and the EMG studies, the ALJ concluded that claimant's condition had pathologically worsened. We disagree. Neither Dr. Boespflug, nor any other physician, has described claimant's right biceps weakness, his mild denervation of unknown age, or any other findings as a "pathological worsening" of his condition. Moreover, "questionable" weakness of the right biceps had previously been noted by Dr. Bergquist in August and September 1993, prior to claim closure. (Exs. 6-2; 7). Given the presence of right biceps weakness earlier in the claim and the fact that no physician addressed whether or not the biceps weakness or the denervation of unknown age represented a pathological worsening of the compensable condition, we are unable to conclude that a pathological worsening occurred.

Because the medical evidence is insufficient to establish a pathological worsening, the question is whether claimant had a symptomatic worsening which was greater than that anticipated by the prior award of 16 percent unscheduled permanent disability. Carmen C. Neill, supra.

Dr. Boespflug has opined that claimant's biceps weakness represents a worsening of his compensable condition. The Board generally defers to the conclusions of a treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). For the following reasons, we do not defer to the opinion of Dr. Boespflug. First, Dr. Boespflug did not treat claimant for the initial compensable injury and only began treating claimant in July 1994 after the March 1994 claim closure. Thus, he is not in any better position than the other physicians to compare claimant's condition at the time of closure to his condition at the time of the alleged worsening. See Kienows Food Stores v. Lyster, 79 Or App 416 (1986). In addition, we find Dr. Boespflug's conclusion that the biceps weakness constitutes a worsening to be conclusory and lacking in explanation and analysis. Moe v. Ceiling Systems, 44 Or App 429 (1980). This is especially true in light of the fact that, pursuant to Dr. Bergquist's chart notes, claimant had some "questionable" biceps weakness prior to closure. Finally, although Dr. Boespflug indicated on December 26, 1994 that claimant was disabled from performing his regular work as a heavy equipment operator, there is some evidence that claimant had attempted work involving heavy equipment operation at the time of closure and was physically unable to perform that work. (Ex. 16, pages 1-2).

In contrast to Dr. Boespflug's flawed opinion, we consider the opinion of Drs. Barth and Bald to be well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259, 263 (1986) (when medical experts disagree, we rely on those medical opinions which are both well-reasoned and based on complete information). In addition, the opinion of Drs. Barth and Bald is supported by Dr. Hacker, a consulting neurologist.

Based on these persuasive opinions, we find that claimant's compensable condition has not sustained a symptomatic worsening that is greater than that contemplated by the prior permanent disability award. Thus, claimant failed to prove a compensable aggravation.

ORDER

The ALJ's order dated December 4, 1995 is reversed. The insurer's denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

July 3, 1996 Cite as 48 Van Natta 1459 (1996)

In the Matter of the Compensation of
CHRISTI L. McCORKLE, Claimant
Own Motion No. 95-0353M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Pozzi, et al, Claimant Attorneys

Claimant requests review of the self-insured employer's April 3, 1996 Notice of Closure which closed her claim with an award of temporary disability compensation from June 27, 1995 through December 4, 1995. The employer declared claimant medically stationary as of December 4, 1995. Claimant contends that she is entitled to additional benefits as she was not medically stationary on April 3, 1996, when her claim was closed. In addition, claimant requests "that a penalty be assessed on backdue amounts" commencing the date the employer terminated benefits (December 4, 1995). The issues in this case are: (1) premature closure; and (2) penalty for unreasonable claims processing.

FINDINGS OF FACT

On August 3, 1995, we issued our Own Motion Order authorizing the reopening of claimant's 1985 injury claim for the payment of temporary disability compensation commencing the date claimant underwent surgery. The employer closed claimant's claim on November 28, 1995, declaring claimant medically stationary on November 6, 1995, and awarding temporary disability compensation from June 27, 1995 through November 6, 1995. Claimant appealed the claim closure, and, on March 14, 1996, we found that the employer's closure was premature. Christi McCorkle, 48 Van Natta 840 (1996).

On April 3, 1996, the employer issued a "proposed" Notice of Closure, and requested reconsideration of our March 14, 1996 order. On April 10, 1996, we abated our prior order to allow claimant sufficient time to consider the employer's motion.

On April 11, 1996, claimant requested that we not reconsider our March 14, 1996 order, and asked us to review the employer's "proposed" April 3, 1996 Notice of Closure. In a May 7, 1996 order, we republished our March 14, 1996 order and found that the April 3, 1996 Notice of Closure was a new, separate document, and that it awarded claimant increased compensation, declared a new medically stationary date and "reclosed" the claim. In that order, we granted claimant's request for review of the employer's new April 3, 1996 Notice of Closure, and allowed the parties an opportunity to further develop the record by submitting evidence and argument regarding the appropriateness of the employer's April 3, 1996 closure.

Claimant has submitted evidence and argument to support her position that the employer's closure was premature. In addition, claimant requested that temporary disability compensation be reinstated and that a penalty be assessed on "back-due amounts." The employer was given 14 days from the date of claimant's submission to respond to claimant's evidence and argument. No further evidence or argument has been received from the employer. Therefore, we will proceed with our review of the record.

CONCLUSIONS OF LAW AND OPINION

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 she was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 3, 1996 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

The employer contends that its April 3, 1996 closure was proper. However, the record establishes that claimant was not medically stationary when the employer closed her claim.

On January 25, 1996, Dr. Carpenter noted that there was a "slight" effusion present in claimant's knee. Dr. Carpenter prescribed medication and advised claimant that, if she had no improvement in two weeks, she should return for followup.

On February 13, 1996, Dr. Carpenter noted that an effusion was present on claimant's right knee and that review of the x-rays "reveals degenerative changes." On that date, Dr. Carpenter injected claimant's right knee. In his February 13, 1996 chart note, Dr. Carpenter also noted that, should the injection not provide relief, "we would recommend a 2nd opinion and consultation before consideration of a joint replacement." In a March 7, 1996 chart note, Dr. Carpenter stated that:

> "[Claimant] was furnished with another injection into the knee and told that we would recommend again that she be scheduled for a 2nd opinion by the industrial carrier before joint replacement is considered."

In that chart note, Dr. Carpenter reported objective findings that "[t]here is an effusion present and tenderness over the medial joint line."

In an April 8, 1996 chart note, Dr. Carpenter noted that "[t]he carrier has not agreed to obtain a 2nd opinion and this will be required before we consider further surgical intervention." Dr. Carpenter recommended again that claimant seek a second opinion because she had swelling on a constant basis, and the injection given to her at the prior visit was of benefit for one week only. After reviewing Dr.

Carpenter's opinion, we find that it addressed claimant's condition at a time coinciding with the April 3, 1996 claim closure. Scheuning v. J.R. Simplot & Co., supra. Inasmuch as the record establishes that conservative treatment had become ineffective, we find Dr. Carpenter's recommendations that claimant seek a second opinion regarding surgery indicate that he recognized that her condition not medically stationary at that time.

Dr. Carpenter's opinions and observations establish that claimant's right knee condition was increasingly effused with fluid, and that the tenderness and crepitus around the knee had increased. Thus, although Dr. Carpenter has not spoken the "magic words" or used statutory language that claimant was not medically stationary at claim closure, the record establishes that claimant's knee condition was not medically stationary pursuant to ORS 656.005(17). 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, 417 (1986).

On the record, we are persuaded that claimant has established that she was not medically stationary on April 3, 1996, when the employer closed the claim.

Penalty

Claimant contends that she is entitled to a penalty on back-due amounts of temporary disability compensation. We agree.

In order to be entitled to a penalty on unpaid time loss, it must be determined that the employer unreasonably delayed or refused the payment of compensation. Under ORS 656.262(11)(a), if the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, the carrier is liable for an additional amount of 25 percent of the amounts "then due." 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); 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 its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 12, 126 n. 3 (1985).

Here, the employer issued its November 28, 1995 Notice of Closure, which awarded claimant temporary disability compensation from June 27, 1995 through November 6, 1995. Our March 14, 1996 order set aside that closure, and reopened claimant's claim. Pursuant to that order, it was the employer's duty to pay time loss on the "open" claim (unless claimant had satisfied one or more of the criteria set forth in ORS 656.268(3)), and to process that claim to closure pursuant to our March 14, 1996 order and own motion rules.

In response to our order, the employer paid claimant additional time loss from November 6, 1995 through December 4, 1995, and declared claimant medically stationary as of December 4, 1995. The employer categorized its April 3, 1996 Notice of Closure as a "proposed" closure and terminated temporary disability compensation on December 4, 1995. However, in our May 7, 1996 order, we found that the April 3, 1996 closure was a new closure which "reclosed" the claim. Therefore, no matter how the employer characterizes the situation, claimant's claim was not again closed until the issuance of the April 3, 1996 Notice of Closure.

Based on the medical evidence in the record, we have herein found that claimant was not medically stationary on April 3, 1996. Those same medical reports were available to the employer prior to claim closure. Thus, although Dr. Carpenter had declared claimant medically stationary on December 4, 1995, the employer should have considered Dr. Carpenter's subsequent medical reports to determine whether claimant's condition was medically stationary at the time of closure. Thus, the issue is whether the employer was reasonable in closing the claim on April 3, 1996 in light of Dr. Carpenter's then-existing opinions. Those opinions do not suggest that claimant's condition was medically stationary on April 3, 1996. Here, the employer does not offer any reasonable explanation for its failure consider those opinions. In the event that it did consider those opinions, and thus, was aware of the state claimant's right knee condition and "pending" surgery request, (based on its knowledge of Dr. Carpenter's repeated requests for a second opinion prior to surgery), it apparently ignored the evidence and closed the claim anyway. In any case, we conclude that the record establishes that the employer unreasonably closed the claim on April 3, 1996, disregarding any doubt of its liability prior to claim closure.

Finally, the employer issued what it termed as a "proposed" Notice of Closure. Nowhere in the statutes do we find such a procedure allowable nor do we find the creation of a such a procedure as this lawful. Therefore, we conclude that the employer unreasonably processed claimant's claim, and refused the payment of temporary disability compensation then due to claimant as awarded by our March 14, 1996 order. Consequently, a penalty is warranted.

ORDER

Accordingly, we set aside the employer's April 3, 1996 Notice of Closure as premature, and remand the claim to the employer for further processing in accordance with law. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-012-0055.

In addition, under ORS 656.262(11)(a), we are authorized to assess a 25 percent penalty of the amounts due by virtue of this order (from December 4, 1995 through the date of this order), payable in equal shares to claimant and her attorney.

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 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERTO ROCHA-BARRANCAS, Claimant
WCB Case No. 95-03895
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes, Christian, and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Schultz' order that awarded claimant temporary total disability (TTD) beginning with claimant's departure from an attending physician approved modified job. On review, the issue is temporary disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, the employer objects to claimant's submission of a transcript of the recorded closing arguments before the ALJ. There is no requirement that a closing arguments at hearing be recorded and/or transcribed. However, transcribed closing arguments obtained at a party's expense will be included in the record. See Albert W. Vanslyke, 42 Van Natta 2811 (1990), aff'd mem 108 Or App 493 (1991). Consequently, the closing argument transcript has been considered during our review.

We briefly summarize the relevant facts. Claimant had worked on and off for several years for Rain-Master Roofing Company (Rain-Master). In October 1994, Rain-Master had an agreement with Barrett Business Services (Barrett) whereby Barrett was the legal employer of Rain-Master's employees. Under this arrangement, Barrett hired Rain-Master employees and then leased them back to Rain-Master.

Claimant had been hired by the owner of Rain-Master (Ely) several times in the past. On October 11, 1994, claimant approached Ely to find out whether any jobs were available with Rain-

Master. Rain-Master needed more help at the time and claimant was sent out with one of Rain-Master's crews before the employment application process was complete.

On October 12, 1994, claimant was on a roofing job for Rain-Master. He fell at approximately 1:15 p.m. and severely fractured his right ankle. It was subsequently discovered that claimant's green card had expired and that he was working illegally. Claimant was admitted to the hospital on October 13, 1994 and underwent surgery for his right ankle fracture.

Claimant filed a workers' compensation claim with Barrett. The claim was accepted on December 7, 1994. In December 1994, claimant presented Ely with a modified work release from his physician. Ely provided claimant with light duty work. Claimant was not paid for his modified work and did not receive any workers' compensation benefits. After working for three weeks without pay, claimant quit working. Claimant subsequently filed a complaint with the Bureau of Labor and Industries (BOLI). Barrett ultimately paid claimant's wages for his modified work pursuant to a BOLI decision.

The parties stipulated that claimant had received no temporary disability benefits as a result of the October 12, 1994 injury.

Claimant requested a hearing seeking temporary disability and penalties and attorney fees.

The ALJ directed the employer to pay claimant TTD from the date of his injury until he was released by his physician to modified work. The ALJ further directed the employer to pay temporary partial disability (TPD) beginning after claimant's release to modified employment. The ALJ also assessed a penalty against the employer for its unreasonable failure to pay temporary disability. The employer does not object to these portions of the ALJ's order.

For the period of time after claimant left his modified work, the ALJ reasoned that, because of the employer's failure to pay claimant for his modified work, the modified job, in effect, no longer existed. Consequently, the ALJ concluded that claimant's TPD rate should be adjusted to the equivalent of the full TTD rate.

On review, the employer requests that we "modify the ALJ's Opinion and Order to the extent that it orders the self-insured employer to pay temporary total disability pursuant to ORS 656.325(5)(c), after claimant had been released to modified work."

ORS 656.325(5)(c) provides:

> "If the worker is a person present in the United States in violation of federal immigration laws, 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 whether or not such a job is available."

ORS 656.210 pertains to the payment of TTD and ORS 656.212 pertains to the payment of TPD. Based on the language of the ORS 656.325(5)(c), a carrier shall cease paying TTD and begin paying TPD when the attending physician of an illegal alien approves modified employment. Here, it is undisputed that claimant was an illegal alien. Likewise, it is uncontested that claimant's attending physician approved modified employment. Thus, we agree with the ALJ's conclusion that the employer was required to begin paying claimant TPD effective upon his release to modified employment.

We also hold that claimant was entitled to TPD for the period after he left his modified work. Based on the language of the statute, a carrier is required to begin paying TPD when the attending physician approves employment in a modified job. The statute is not dependent on the availability of a modified job.

Here, claimant's physician had approved his modified job, but claimant eventually quit when he was not paid for his modified work. Although such a decision is perfectly understandable, the applicable statute does not require the reinstatement of TTD so long as claimant remains capable of performing modified employment. Since there is no contention that claimant's attending physician re-authorized total disability, claimant remained entitled to TPD after his departure from the modified job.

Consequently, the carrier should have begun paying TPD when claimant's physician approved modified work and should have continued paying TPD even though the modified job ceased to exist, until such benefits could be legally terminated under ORS 656.268(3).[1]

ORDER

The ALJ's order dated November 17, 1995 is modified in part and affirmed in part. Those portions of the ALJ's order that awarded claimant the equivalent of TTD after claimant left his modified job, as well as an "out-of-compensation" attorney fee, are modified. Claimant is awarded TPD for the aforementioned period. Claimant's attorney's fee is modified accordingly. The remainder of the ALJ's order is affirmed.

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[1] In calculating claimant's TPD, his "at injury" wage would be compared with his "post-injury wage earnings"; i.e., the earnings that his employer subsequently paid him for his modified work (as a result of the BOLI decision). See ORS 656.212; OAR 436-060-0030(2).

Chair Hall specially concurring.

I concur with the majority's reasoning regarding the transformation from temporary total to temporary partial disability benefits as contingent on an attending physician's approval of an injured worker's employment in a modified job, rather than the availability of such a modified job. ORS 656.325(5)(c). However, in reaching this conclusion, I wish to emphasize that which we have not decided in this case. Since claimant has acknowledged his status as an illegal immigrant, it is unnecessary to decide which party has the burden of proving a claimant's illegal status or what is the precise meaning of "present in the United States in violation of federal immigration laws" as set forth in ORS 656.325(5)(c). Further, despite the majority's reference to OAR 436-060-0030(2), we are not deciding the actual calculation of claimant's TPD or the interpretation or application of OAR 436-060-0030(7). The answer to those questions must await a future case where the issues are ripe for resolution.

In the Matter of the Compensation of
BETH M. SAGESER, Claimant
WCB Case Nos. 94-12491 & 94-10958
ORDER ON REVIEW (REMANDING)
Rasmussen, et al, Claimant Attorneys
Employer Defense Counsel, Defense Attorney

Reviewed by Board Members Moller and Christian.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) adhered to the then-Presiding ALJ's interim order that denied the insurer's motion to reopen the record for a re-hearing because the ALJ who had convened the first hearing had withdrawn from the case; and (2) set aside the insurer's denial of claimant's injury claim for a right shoulder and upper back condition. On review, the issues are the ALJ's procedural ruling and compensability. We remand.

FINDINGS OF FACT

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

In September 1994, claimant, pro se, requested a hearing concerning the insurer's September 1, 1994 denial of her claim for a left upper back and left shoulder condition. She subsequently retained counsel and, in October 1994, filed a hearing request concerning the insurer's October 10, 1994 denial of her claim for a right upper back and right shoulder injury. Claimant also requested assessment of penalties and attorney fees relating to the October 10 denial. The matters (two separate injury claims) were consolidated for hearing.

The consolidated hearing was convened before ALJ Crumme in December 1994. Following receipt of testimony, the hearing was continued for depositions of Drs. Weller and Pugsley and closing arguments. Prior to closing arguments, in April 1995, ALJ Crumme advised the parties' attorneys that he was withdrawing from the case due to a conflict of interest. He asked the attorneys for their respective positions on whether a re-hearing should be granted or the case should proceed on the existing record. The insurer's attorney requested a re-hearing, while claimant's attorney requested the case proceed on the existing record. ALJ Crumme advised the attorneys of his understanding that a re-hearing would be granted if either party requested it.

The matter was transferred to the then-Presiding ALJ for assignment to a new ALJ. In June 1995, the parties' attorneys held a teleconference with the Presiding ALJ. At that time, the attorneys reiterated the positions they expressed to ALJ Crumme. The insurer's attorney moved for a re-hearing to allow a new ALJ to evaluate claimant's credibility, while claimant's attorney requested that the matter be transferred to a new ALJ for a decision based on the existing record. By Interim Order dated June 27, 1995, the Presiding ALJ denied the insurer's motion for a re-hearing, concluding that "credibility is not so significant an issue that an Administrative Law Judge assuming responsibility for the case would be at a disadvantage by not observing the witnesses personally." The matter was re-assigned to ALJ Nichols for a decision.

A transcript of the December 1994 hearing was prepared and provided to ALJ Nichols and the attorneys. The attorneys submitted written closing argument. The insurer argued that claimant was not credible and misrepresented the cause(s) of her conditions, while claimant argued that she had no motive to misrepresent the facts and that the medical record was consistent with her history. ALJ Nichols upheld the September 1, 1994 denial of the left upper back and left shoulder condition, and set aside the October 10, 1994 denial for the right upper back and right shoulder condition. The insurer requested Board review.

CONCLUSIONS OF LAW AND OPINION

The insurer requests that we remand this matter to the ALJ for a re-hearing to allow the ALJ to personally observe the witnesses, including claimant, and evaluate their credibility. For the following reasons, we grant the insurer's request.

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

We have previously declared that "[c]redibility is always potentially at issue in a compensability case." Jeffrey M. Fisher, 46 Van Natta 729, 730 (1994). Here, credibility is actually at issue. The insurer has specifically challenged claimant's credibility and the history upon which her doctors relied in rendering their opinions. Because this is a compensability case, and credibility has been raised as an actual issue, we conclude that substantial justice requires that the ALJ who issues the opinion and order in this case have the opportunity to observe claimant's (and the insurer's witness') demeanor. See ORS 656.283(7); OAR 438-007-0022; Melinda K. Wilson, 47 Van Natta 1065 (1995).

In reaching this conclusion, we have considered Dr. Weller's statement that her opinion regarding the causation of claimant's condition was based on the history claimant provided to her. (Ex. 19-18). Dr. Weller acknowledged that if claimant's history was inaccurate, Dr. Weller's causation opinion would also be inaccurate. (Ex. 19-19). Dr. Weller relied on claimant's history that she had no right upper back or right shoulder symptoms prior to lifting lead blocks at work on September 14, 1994. (Ex. 12). Dr. Weller initially was not aware that claimant was receiving chiropractic treatment in April and May 1994 for pain in the right upper back/shoulder area and for associated sleep disturbances. (Ex. 3-2). Dr. Weller was later advised of that history in her deposition. She indicated that if claimant had continued right upper back/shoulder pain and associated sleep disturbances from May 1994 through September 1994, when Dr. Weller first examined claimant, such symptoms would be consistent with myofascial pain syndrome, as opposed to an acute strain. (Ex. 19-11).

Thus, Dr. Weller's opinion that claimant suffered an acute right upper back/shoulder injury on September 14, 1994 rests in large part on claimant's history that she had no right upper back/shoulder pain prior to September 14, 1994. Inasmuch as the accuracy of claimant's history is largely dependent

on claimant's credibility, we conclude that claimant's credibility is a central issue in this compensability case. Under these circumstances, we conclude it was an abuse of discretion for the insurer's request for a re-hearing to have been denied. Because we find this a compelling reason for remand, and to assure that the parties will be afforded substantial justice, we remand this matter to ALJ Nichols for another hearing. See ORS 656.283(7); Melinda K. Wilson, supra.

Accordingly, we vacate ALJ Nichols' order dated November 27, 1995, as reconsidered on January 5, 1996. The matter is remanded to ALJ Nichols for further proceedings consistent with this order. The proceedings shall be conducted in any manner that the ALJ deems will achieve substantial justice. Thereafter, the ALJ will issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
FLORENCE G. SELVIDGE, Claimant
WCB Case No. 95-10876
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall, Christian and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the SAIF Corporation's denial of claimant's L4-5 disc herniation/protrusion and current disability. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We replace the first paragraph on page 3 with the following:

> "On December 23, 1994, Dr. Corrigan examined claimant and agreed with Dr. Feldstein's work limitations. (Ex. 31). Dr. Corrigan commented that claimant's left lateral disc herniation at L4-5 had been ascertained "by claim status" not to be related to the occupational injury of May 2, 1994. (Ex. 31-5). For that reason, Dr. Corrigan based claimant's work restrictions principally on her preexisting changes rather than the work injury. (Id.)
>
> "Dr. Corrigan performed a closing evaluation on January 23, 1995 and assigned no permanent impairment to the work injury. (Ex. 35). Dr. Corrigan reported that "[o]nce again," he based claimant's work restrictions on her preexisting conditions. (Id.) Dr. Corrigan commented that "as stated before the left lateral disc herniation was not considered to be due to her occupational injury but to the pre-existing condition that is the herniation on the left at L4-5." (Id.)

We do not adopt the second paragraph on page 3 and we do not adopt the findings of ultimate facts.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's May 1994 industrial injury combined with a preexisting condition, and, therefore, claimant had to prove that the industrial injury was the major contributing cause of the disability from the combined condition or the major contributing cause of the need for treatment of the combined condition. ORS 656.005(7)(a)(B). The ALJ concluded that the medical evidence was in equipoise and was not sufficient to meet claimant's burden of proof.

Claimant argues that her May 2, 1994 work injury was the major contributing cause of her L4-5 disc herniation/protusion and current disability. Claimant contends that we should defer to the opinions of her treating physician, Dr. Feldstein, as supported by Dr. Mandelblatt's opinion.

To begin, we address claimant's argument concerning her preexisting condition. Although claimant acknowledges that she had preexisting degenerative disc disease, she argues that Drs. Wilson and Arbeene incorrectly opined that she had a preexisting disc herniation.

SAIF relies on the report from Drs. Wilson and Arbeene, which found that claimant had preexisting degenerative disc disease and a disc herniation at L4-5. (Ex. 16). Drs. Wilson and Arbeene concluded that claimant's preexisting conditions were the major contributing cause of her current condition and need for treatment.

In contrast, Dr. Feldstein, claimant's treating physician, opined that claimant's preexisting condition was degenerative disc disease, not a herniation. (Ex. 42). Dr. Feldstein acknowledged that claimant's February 1991 lumbar CT scan revealed some bulging of the disks at L3-4 and L4-5, but there was no evidence of a herniated disk. (Id.)

Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reason not to defer to the opinion of Dr. Feldstein, claimant's treating physician. We are persuaded that claimant's preexisting condition consisted of disc bulging at L3-4 and L4-5 and degenerative disc disease.[1]

Dr. Feldstein concluded that claimant's May 2, 1994 work injury was the major contributing cause of the disc herniation at L4-5. (Ex. 42-1). Dr. Feldstein's opinion is consistent with Drs. Mandelblatt and Browning. On July 28, 1994, Dr. Browning reported that Dr. Mandelblatt had forwarded the report from Drs. Wilson and Arbeene to her with the note: "I briefly looked it over and knowing this patient, I disagree that her increased symptoms, May 1994, are just due to exacerbation of chronic condition and I do feel that she did something new in early May 1994." (Ex. 21). Dr. Browning concluded that there was a "definite worsening of [claimant's] underlying condition with persistent symptomatology above her baseline * * *." (Id.) Based on these medical opinions, claimant has established that the May 2, 1994 work injury was the major contributing cause of the disc herniation.

SAIF argues that Dr. Feldstein's opinion is not persuasive and it asserts that Dr. Feldstein appeared to concur with Dr. Corrigan's conclusion that the range of motion findings resulted from claimant's natural aging process. We disagree.

Dr. Corrigan examined claimant on December 23, 1994 at Dr. Feldstein's request. (Ex. 31). Dr. Corrigan did not recommend surgical intervention at that time and he agreed with Dr. Feldstein's work limitations for claimant. Dr. Corrigan commented:

> "Indeed, there is a left lateral disk herniation at L4-5, with some degree of left L4 radicular problems, but this appears to be improving and it has been ascertained, at least by claim status, that this is not definitely related to her occupational injury of May 2, 1994. I would base the work restrictions, therefore, principally on her pre-existing composite of changes rather than to the effects of the occupational injury per se." (Ex. 31-5; emphasis added).

Dr. Corrigan performed a closing evaluation on January 23, 1995. (Ex. 35). Dr. Corrigan reported that "[o]nce again," he would base claimant's work restrictions on her preexisting conditions. (Ex. 35-3). Dr. Corrigan commented that "as stated before the left lateral disc herniation was not considered to be due to her occupational injury but to the pre-existing condition that is the herniation on the left at L4-L5." (Id.)

Both of Dr. Corrigan's reports indicate that he was under the erroneous impression that claimant's disc herniation had been legally determined (i.e., "claim status") to be unrelated to the work injury. Dr. Corrigan apparently relied on that determination and did not actually explain his opinion of causation. Since Dr. Corrigan's comments were based on an erroneous factual premise, we afford his comments on causation little probative weight.

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[1] In light of our conclusion that claimant did not have a preexisting disc herniation at L4-5, we are not persuaded by the opinions of Drs. Wilson and Arbeene that claimant's major problem was preexisting degenerative disc disease and a disc herniation at L4-5. (Ex. 16).

For the same reason, and in light of Dr. Feldstein's opinion that claimant's injury was the major contributing cause of the disc herniation (Ex. 42), we are not persuaded by Dr. Feldstein's "concurrence" with Dr. Corrigan's conclusion that the range of motion findings resulted from claimant's natural aging process. SAIF wrote to Dr. Feldstein to ask if she agreed that the ranges of motion noted in Dr. Corrigan's examination were the result of claimant's natural aging process or the May 2, 1994 injury. Dr. Feldstein replied "yes." (Ex. 36-2). In a subsequent "check-the-box" letter, SAIF asked the same question and Dr. Feldstein checked "[n]atural aging process." (Ex. 39). Since Dr. Corrigan's comments were based on an erroneous factual premise, we assign little probative value to Dr. Feldstein's "concurrence" with Dr. Corrigan's report. Moreover, those reports did not address causation of claimant's disc herniation.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated January 22, 1996 is reversed in part and affirmed in part. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, payable by SAIF. The remainder of the ALJ's order is affirmed.

Board Member Haynes dissenting.

The majority concludes that claimant has established a compensable disc herniation claim. Because I believe the majority has misconstrued the medical evidence, I respectfully dissent.

Although the majority relies on the opinions of Drs. Feldstein, Mandelblatt and Browning to establish compensability, none of those physicians considered claimant's previous low back symptoms, including radicular pain, in rendering their opinions on causation. The majority erroneously defers to Dr. Feldstein's opinion and summarily dismisses the opinion of Drs. Wilson and Arbeene that claimant had a preexisting disc herniation at L4-5. Since Dr. Feldstein's opinion is conclusory and inconsistent, it is not persuasive and is certainly not entitled to any deference. The majority glosses over the problems with Dr. Feldstein's opinion by focusing instead on Dr. Corrigan's reports.

The medical record establishes that claimant had disc bulging at L4-5 and degenerative disc disease in February 1991. A lumbar spine CT scan was performed in February 1991 to "[r]ule out spinal stenosis in a patient who has pain and tingling with walking." (Ex. 1). The CT scan revealed "[a]t the L3-4 and to a greater extent at the L-4-5, there is a trefoil-shape of the spinal canal at the disc level due to very minimal circumferential bulging of the discs in addition to posterior facet ligamentous hypertrophy." (Id.) Moreover, "[a]ll levels reveal mild to moderate osteophytic degenerative changes of the posterior facets." (Id.)

Claimant testified that she suffered a back strain in early 1993 while gardening. (Tr. 7). Dr. Mandelblatt reported that claimant had pain radiating down her left leg and diagnosed left lumbar strain with sciatica. (Ex. 3). Dr. Mandelblatt prescribed physical therapy. An April 29, 1993 x-ray indicated that claimant had lumbar scoliosis. (Ex. 4). Claimant sought medical treatment again in October 1993 for right leg pain. (Ex. 5). Claimant was diagnosed with "chronic LS strain." (Ex. 5-4), and physical therapy was prescribed. (Ex. 6).

In early May 1994, claimant developed pain in her low back and left leg after lifting a carpet-cleaning machine up some stairs at work. Claimant was diagnosed with L-4 radiculopathy, resolving, secondary to a herniated nucleus pulposus at L4-5. (Ex. 13).

On July 14, 1994, Dr. Wilson, neurologist, and Dr. Arbeene, orthopedic surgeon, examined claimant and reported her previous back problems in April 1993 and October 1993. (Ex. 16-3). They

observed that "according to her records she has had a history of at least a year of back problems and in April 1993, had the history of lower back and left leg pain radiation that suggests that if she had a disc problem that the disc problem really started back in April 1993." (Ex. 16-6). They opined that claimant's "work exposure caused her to become symptomatic from a condition from which she had previously that was nonwork-related." (Ex. 16-7). They concluded that claimant's "major problem is a pre-existing condition with degenerative disc disease and a disc herniation at L4-5, left," and they believed that any need for treatment was due to claimant's preexisting condition and not to the May 1994 work injury. (Id.)

The majority erroneously relies on the opinions of Drs. Feldstein, Mandelblatt and Browning to establish compensability. Because the majority's reliance on Dr. Feldstein's opinion is the most egregious, I address that opinion first.

Dr. Feldstein examined claimant on June 24, 1994 and reported that "certainly degenerative joint disease and degenerative disk disease preceded this injury, but it does appear that the patient had an acute at least worsening of a herniation during this work-related injury." (Ex. 14). On December 15, 1995, Dr. Feldstein was asked whether claimant had a preexisting condition. She responded: "She does have a history of some degenerative disk disease. Her lumbar CT scan of 2/27/91 reveals some bulging of the disks at L3-4 and L4-5, but there was no evidence of herniated disk." (Ex. 42-1). Dr. Feldstein concluded that claimant's "work activities were the major contributing cause of the development of the disk herniation, which in this case was essentially a worsening of a preexisting condition." (Ex. 42-2).

I agree with the ALJ that Dr. Feldstein's opinion is not persuasive because it is inconsistent and conclusory. Although Dr. Feldstein initially opined that claimant "had an acute at least worsening of a herniation" during the work injury (Ex. 14), she subsequently reported that claimant's only preexisting condition was degenerative disc disease. (Ex. 42). Since Dr. Feldstein failed to explain her apparent change of opinion, it is not persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987). Moreover, there is no indication that Dr. Feldstein considered claimant's April 1993 or October 1993 low back symptoms, particularly the previous radicular pain, in rendering her decision. Although Dr. Feldstein said that there was no evidence of a herniated disk in 1991, she did not respond to Dr. Wilson's and Dr. Arbeene's assertion that claimant's disc problem actually started back in April 1993. Since Dr. Feldstein's opinion is poorly analyzed and fatally conclusory, the majority erred in relying on her opinion.

In addition, the majority's reliance on Dr. Browning's opinion is misplaced. Claimant was examined by Dr. Browning on July 28, 1994 for increased low back discomfort. (Ex. 20). On the same day, Dr. Browning wrote to SAIF, responding to a letter addressed to Dr. Mandelblatt. Dr. Browning reported that Dr. Mandelblatt had forwarded the report from Drs. Wilson and Arbeene to her with the note: "I briefly looked it over and knowing this patient, I disagree that her increased symptoms, May 1994, are just due to exacerbation of chronic condition and I do feel that she did something new in early May 1994." (Ex. 21). After examining claimant on one occasion, Dr. Browning concluded that there was a "definite worsening of [claimant's] underlying condition with persistent symptomatology above her baseline * * *." (Id.) As the ALJ noted, Dr. Browning's opinion is consistent with SAIF's acceptance of the claim as a symptomatic worsening of the preexisting L4-5 herniated disc.

Finally, the only evidence of Dr. Mandelblatt's opinion is a hearsay quote that appeared in Dr. Browning's July 28, 1994 letter. The ALJ properly discounted this "opinion" because it did not explain how claimant was injured or the contribution of the underlying condition. See Dietz v. Ramuda, 130 Or App 397 (1994) (determining the "major contributing cause" of an injury or disease involves evaluating the relative contribution of different causes and deciding which is the primary cause), rev dismissed 321 Or 416 (1995).

The majority concludes that claimant has established a compensable claim by conveniently ignoring much of the medical evidence and affording deference to Dr. Feldstein's opinion, despite the fact that her opinion is fatally conclusory. Because I cannot conclude that claimant has sustained her burden of proof on medical causation, I respectfully dissent.

In the Matter of the Compensation of
ALFRED STORMS, Claimant
WCB Case No. TP96001
THIRD PARTY DISTRIBUTION ORDER
Whitehead & Klosterman, Claimant Attorneys
Parks, Bauer & Sime, Defense Attorneys

Claimant has petitioned the Board for approval of a third party compromise. ORS 656.587. We approve the settlement.

FINDINGS OF FACT

On August 23, 1991, while working as a pizza delivery person, claimant was involved in an automobile accident which resulted in the death of a jogger. Claimant was immediately treated in the Emergency Room for "acute grief response to death involvement." Subsequently, claimant was diagnosed with post-traumatic stress disorder (PTSD) related to this automobile accident. The insurer eventually accepted claimant's claim for PTSD and claimant received treatment for PTSD through the time his claim was closed by Determination Order on August 15, 1994. To date, the insurer's lien totals $65,802.57, which includes medical costs of $48,057.49 and time loss benefits of $17,745.08.

In 1987, claimant was convicted of sexually molesting his third wife's nine year old grandson. As a result of this conviction, claimant spent one year "at a restitution center" and underwent five years of outpatient sexual offender treatment. He was diagnosed with pedophilia. During the time claimant was being treated for the compensable PTSD, he was also undergoing treatment for this pedophilia.

Claimant, through his legal counsel, filed a cause of action against a third party -- the driver of another car involved in the accident. The third party insurer ultimately offered $3,500 to settle the claim.

Claimant has agreed to settle the action for $3,500. Claimant contends that the psychological factors related to the conviction for sodomy and the subsequent treatment for pedophilia will be relevant in the upcoming jury trial, and the jury is likely to award claimant nothing once they find out about his past behavior and treatment for pedophilia.

The insurer has declined to approve the settlement. Contending that claimant has not established he would not prevail in his third party action, the insurer 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 $3,500 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).

The insurer 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 J. 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.[1] 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 the insurer would not recover full reimbursement of its entire lien is likewise not determinative. In the event that the $3,500 settlement is allocated in accordance with the statutory distributory scheme, the insurer stands to recover approximately $1,557.11, while its asserted lien amounts to $65,802.57.[2] In other words, the insurer would receive approximately 2.37 percent of its

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[1] We note that the insurer asserts that the proposed settlement is grossly unreasonable "in this case where the third party's negligence is so apparent." However, the record does not appear to support the insurer's evaluation of the third party's negligence. Claimant contends that the third party's car drifted into claimant's lane of traffic while claimant attempted to pass the third party's car, causing claimant's vehicle to leave the road and strike the jogger. However, the jogger's family sued claimant for wrongful death and that suit was settled. Considering these factors, a jury finding of significant contributory negligence on claimant's part would not be an unrealistic outcome. John C. Lappen, supra.

In addition, the medical evidence indicates that claimant did not report to all of his treating physicians his past psychological problems, including a psychiatric hospitalization for a nervous breakdown as a child, his severe developmental problems, including deprivation and physical and sexual abuse as a child, and his treatment for pedophilia. Moreover, Dr. Davies, clinical psychologist, and Dr. Goranson, psychiatrist, both of whom examined claimant on behalf of the insurer, opined that claimant's current psychiatric problems were related to preexisting conditions. Dr. Goranson opined that the major contributing cause for claimant's psychiatric disorder and need for treatment was claimant's developmental history, not the work-related automobile accident. Dr. Davies opined that claimant had no permanent psychiatric impairment due to the work incident. Given this medical record and the possibility of contributory negligence, a jury award in excess of the proposed settlement (particularly when one considers the accompanying additional litigation expenses) would be anything but certain.

[2] We reach this general estimate of the insurer's approximate recovery of $1,557.11 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 the insurer's concerns regarding its proportionate share of a $3,500 settlement. Assuming the absence of litigation expenses, a general distribution under ORS 656.593(1) would be as follows:

Settlement	$3,500.00
1/3 Attorney Fee	-1,165.50
Subtotal	$2,334.50
Claimant's 1/3 Share	-777.39
Remaining Balance (Insurer's Share)	$1,557.11

lien. We have 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 Douglas Scales, 47 Van Natta 2095 (1995); 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).

Here, we acknowledge that a recovery of only 2.37 percent of the lien is a small portion of the amount due the insurer. We also acknowledge that claimant's recovery is likewise minimal. However, on the facts of this case, after reviewing the parties' respective positions, as well as the record (particularly the evidence relating to claimant's conviction for sodomizing his nine year old step-grandson, the resulting psychological treatment for pedophilia, and claimant's contention that this evidence will likely result in no award from the jury if the matter proceeds to trial), 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
CHRIS L. THORNBURG, Claimant
WCB Case No. 95-05374
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

The self-insured employer requests reconsideration of our June 19, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that found that claimant had established the compensability of medical services for the osteochondral lesion of the right ankle. The employer contends that we erred in relying on the medical opinion of Dr. Donahoo to prove compensability. Specifically, the employer asserts that Dr. Donahoo's causation opinion relies on the "but for" analysis that was rejected in Alec E. Snyder, 47 Van Natta 838 (1995), and Cody L. Lambert, 48 Van Natta 115 (1996). We disagree.

In Alec E. Snyder, supra, we rejected the opinion of a physician who relied entirely on the facts that the claimant was asymptomatic for a year before the work incident and the claimant would not have needed treatment in the absence of the work incident. We concluded that the physician employed a "but for" analysis; that is, but for the work incident, the claimant would not have required treatment. We reasoned that the physician's analysis was essentially the same "precipitating cause" analysis that was rejected by the court in Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995). See also Cody L. Lambert, supra (the physician employed a "but for" analysis rather than weighing the relative contribution of the different causes for the claimant's symptoms).

We agree with the employer that 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 of claimant's current need for treatment. Dietz v. Ramuda, supra. We have reviewed the employer's contentions and, upon further consideration, continue to find that Dr. Donahoo's opinion is persuasive.

As noted in our original order, Dr. Donahoo was aware of claimant's preexisting ankle conditions. After discussing those conditions, Dr. Donahoo reported that, if claimant was "asymptomatic, as he states he was, and totally functional without symptoms, even though he had a pre-existing lesion and has now become non-functioning and symptomatic with documented synovitis (that is, objective evidence of inflammation), then the injury of December 12, 1992 would be the major contributing cause." (Ex. 15-10). In a later report, Dr. Donahoo further discussed claimant's preexisting conditions, particularly the osteochondral lesion. (Ex. 17). Dr. Donahoo indicated that the lesion might have been affected by the injury, in that the injury might have torn loose a small loose body or cartilage overlying the lesion. (Id.) Dr. Donahoo believed that whether or not the loose body was formed at the time of the work injury was primarily a question of claimant's history, i.e., whether claimant had previous complaints. (Id).

We find that Dr. Donahoo weighed the relative contribution of claimant's preexisting conditions against the contribution of the work incident in arriving at his conclusion as to the major contributing cause of claimant's need for treatment. See Dietz v. Ramuda, supra. We adhere to our previous conclusion that, based on Dr. Donahoo's reports, claimant's proposed surgery for the osteochondral lesion was "directed to medical conditions caused in major part by the injury." Amended ORS 656.245(1)(a).

Accordingly, we withdraw our June 19, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our June 19, 1996 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
CAMILLA R. BLANCO, Claimant
WCB Case No. 95-10109
ORDER OF ABATEMENT
Shelley K. Edling, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

The self-insured employer seeks reconsideration of our June 5, 1996 order that affirmed an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's occupational disease claim for a left leg condition. Specifically, the employer contends that: (1) this case should be remanded to the Hearings Division for further development of the record in light of Andrews v. Tektronix, Inc., 323 Or App 154 (1996); (2) the Board should review this case en banc; and (3) its denial should be reinstated and upheld.

In order to further consider the employer's contentions, we withdraw our June 5, 1996 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, this matter will be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
SANDRA K. BOWEN, Claimant
WCB Case No. 95-05983
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) awarded claimant additional temporary disability; and (2) assessed a penalty for the employer's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

In 1974 and 1983, claimant sustained nonwork-related right knee injuries; the first injury required surgery. In 1991, claimant sustained an injury while working for a California employer; she underwent surgery for that injury.

Pursuant to the parties' April 11, 1995 stipulation, the employer agreed to rescind its denial of claimant's September[1] 1994 bilateral knee injury claim. (Ex. 25-1). In return, claimant agreed that her hearing request contesting that denial could be "dismissed with prejudice to all claims and issues raised and [with] prejudice to all claims that could have been raised" on the date an ALJ approved the stipulation. (Id. at 2).

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

Concluding that the record established that an attending physician had authorized temporary disability from October 5, 1994 through March 5, 1995, and finding that the employer had been unwilling or unable to accommodate claimant's modified work release, the ALJ awarded temporary disability benefits for that period. The employer contends that, when the parties stipulated to the dismissal of claimant's hearing request regarding the employer's denial of claimant's September 1994 knee injury with prejudice to all issues then raised or raisable, claimant waived her right to challenge the employer's failure to pay temporary disability benefits from October 1994 to March 1995. We disagree.

If a stipulation contains language settling "all issues that were raised or raisable" at the time of settlement, the parties are barred from litigating a matter that was at issue, or of which they had notice, at the time of settlement. Safeway Stores, Inc. v. Seney, 124 Or App 450, 454 (1993); see Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994). The aforementioned rule is usually applied to bar a claimant from litigating matters that could have been negotiated before approval of a settlement agreement, however, the rule also applies to carriers. Therefore, if an agreement settles all issues "raised or raisable," both the carrier and the claimant are barred from litigating any matter that was at issue, or of which they had notice, at the time of settlement. Maria R. Fuentes, 48 Van Natta 110, 111 (1996); Daniel R. Loynes, 47 Van Natta 1075 (1995).

Here, the parties' stipulation purports to settles all claims and issues that were raised and all claims that were raisable. Claimant's benefits for her knee injury claim were at issue at the time of the stipulation. Because the stipulation settled all issues then raised or raisable, and because the employer agreed to rescind its denial of claimant's September 1994 knee injury claim, the agreement bars the employer from litigating its obligation to provide benefits for that claim. Maria R. Fuentes, supra.

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[1] Claimant injured her knee in September 1994; she filed a claim on October 13, 1994. (Ex. 8). The stipulation refers to the filing date. (Ex. 25-1).

Additionally, the stipulation provided that the employer accepted claimant's claim. Consequently, as a result of its acceptance, the employer was required to process the claim and determine whether benefits were due, and if so, the type and amount of benefits. ORS 656.262. However, in reaching this conclusion, we do not mean to imply that the stipulation is preclusive with respect to claimant's entitlement to temporary disability benefits. See Maria R. Fuentes, supra. Rather, that issue is resolved by the physicians' opinions and our interpretation of those opinions. Therefore, we next address the merits of claimant's claim.

On review, the employer argues that claimant's treating doctor was her family physician, Dr. Erdley, rather than Dr. Miller or Dr. DiPaola. Treating doctor status is a question of fact. See, e.g., Eduardo O'Campo, 48 Van Natta 432 (1996); Paula J. Gilman, 44 Van Natta 2539 (1992). Here, the record shows that, following her work injury, claimant treated with Dr. Miller, rather than Dr. Erdley, for her knee condition. Dr. Miller placed work restrictions on claimant and eventually referred her to Dr. Di Paola. Under the circumstances, we conclude that, for purposes of her bilateral knee injury, claimant's treating doctor was Dr. Miller.

The employer also contends that there is no causal relationship between the industrial injury and claimant's inability to continue working. However, the issue of a causal relationship was resolved pursuant to the parties' April 1995 stipulation, whereby the employer accepted claimant's claim. Furthermore, the medical evidence establishes that claimant's restrictions are due to the condition the employer accepted, i.e., a "symptomatic worsening of [claimant's] preexisting chondromalacia as a disabling injury." (Exs. 6, 24, 25-1).

Next, the employer argues that in a May 23, 1995 letter, Dr. Miller responded that he understood that he could not authorize time loss beyond the date that claimant sought treatment with Dr. DiPaola on October 5, 1994. (Ex. 29). We conclude that Dr. Miller's subsequent "belief" as expressed in his May 1995 letter is potentially relevant only to claimant's subsequent entitlement to substantive temporary total disability benefits following claim closure. Dr. Miller did not say that claimant was not subject to modified work. In other words, we find that Dr. Miller, claimant's treating doctor, released claimant to modified work and did not alter his release between October 1994 and March 1995. Consequently, we agree with the ALJ that claimant is entitled to temporary disability benefits for that time period.[2]

Finally, the employer argues that, even if Dr. Miller did release claimant to only modified work, ORS 656.252(2) requires continuing authorization from the treating doctor in 15 day increments, provided that the carrier makes such an authorization request. However, in this case, the employer did not ask the treating doctor for such authorization. Furthermore, we agree with the ALJ that the release in question was "prospective," rather than "retroactive." Accordingly, we do not find that ORS 656.262(4)(f), the statute which prohibits retroactive authorization more than 14 days prior to its issuance, applies in this case.

We therefore conclude that the ALJ correctly found that claimant was entitled to temporary disability benefits from October 5, 1994 through March 5, 1995.

Penalties

The ALJ found that claimant was entitled to a penalty for the employer's unreasonable failure to pay temporary disability benefits. We disagree.

The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the employer 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).

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[2] The ALJ also found that claimant did not continue to treat with Dr. Miller for financial reasons that were beyond claimant's control. ORS 656.262(4)(c) provides that temporary disability compensation is not due where the attending physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control. Consequently, we alternatively conclude that any lack of verification after claimant discontinued treatment with Drs. Miller and DiPaola was for reasons beyond claimant's control. Therefore, the statute does not provide a basis for the employer's failure to pay temporary disability benefits.

Here, the employer had obtained a report from Dr. Farris that claimant was medically stationary as of October 19, 1994. (Ex. 11-7). The employer also had Dr. DiPaola's April 4, 1995 concurrence letter which agreed with Dr. Farris' opinion. Finally, Dr. Miller had reported that he could not authorize disability benefits after Dr. DiPaola's exam. (Ex. 29).

Accordingly, we conclude that, in October 1994, and continuing through the date of hearing, the employer had legitimate doubt regarding its liability for claimant's temporary disability benefits, and consequently, its refusal to pay such benefits was not unreasonable. We therefore reverse the ALJ's penalty assessment.

Claimant's counsel is entitled to an assessed attorney fee for services on review concerning the issue of entitlement to temporary disability benefits. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on Board review regarding that issue is $900, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 26, 1995, as reconsidered November 1, 1995, is reversed in part and affirmed in part. That portion of the ALJ's order which awarded claimant a penalty is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $900, to be paid by the self-insured employer.

In the Matter of the Compensation of
MANUEL GARIBAY, Claimant
WCB Case No. 94-14940
ORDER ON REVIEW
Adams, Day, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the following changes.

In the second sentence of the third paragraph on page 2 of the Opinion and Order, we change "October 1994" to "November 1993." (Ex. 7). We also note that, although the Opinion and Order reflects that the ALJ admitted Exhibits 1 through 18 in evidence, Exhibit 15 subsequently was withdrawn by the employer. Thus, we have not considered Exhibit 15 on review.

CONCLUSIONS OF LAW AND OPINION

Since 1981, claimant has worked as a tree planter and harvester. In November 1993, claimant was diagnosed with CTS. At that time, his employer was Barrett Business Services.

The ALJ initially rejected the employer's argument that claimant's CTS qualified as a "preexisting condition" and concluded that claimant proved compensability. ORS 656.802(2). On reconsideration, however, the ALJ reversed his order. The ALJ found that, because claimant began working for the employer in 1991 and his CTS symptoms began in 1989, claimant's disease was a

"preexisting condition." ORS 656.005(24).[1] Concluding that the medical opinions were not persuasive in light of this finding, the ALJ upheld the employer's denial.

Claimant asserts that there is insufficient evidence to determine whether claimant's CTS preexisted his employment and, therefore, amended ORS 656.802(2)(b)[2] does not apply. Furthermore, claimant contends that retroactive application of ORS 656.802(2)(b) produces an absurd and unjust result and violates claimant's constitutional right to due process.

The medical evidence shows that the major contributing cause of claimant's CTS is his twelve year work history as a tree planter and harvester. (Exs. 14-2, 16, 18-21, 18-25). The record also is clear that the employer in this proceeding did not employ claimant throughout the twelve year period; the only evidence concerning this issue shows that claimant began working for the employer in 1991.[3] (Ex. 10). Because claimant joined only the employer, therefore, in order to prevail, he must show that employment conditions with the employer were the major contributing cause or worsening of his CTS. ORS 656.802(2)(a), 656.802(2)(b).

As discussed above, the medical evidence implicates only claimant's twelve-year work history as the cause of his occupational disease. There is no proof that claimant's "post-1991" work with the employer either caused or worsened his CTS. Thus, we conclude that claimant did not prove compensability. ORS 656.802(2)(a), 656.802(2)(b).

We turn to claimant's assertions concerning the application of ORS 656.802(2)(b). The statute was added effective June 7, 1995. It retroactively applies to this case. Or Laws 1995, ch 332, § 66(1); Volk v. America West Airlines, 135 Or App 565 (1995).

We first note that, because the record does not clarify the date of onset of claimant's CTS, it is difficult to determine whether the disease preexisted claimant's work with the employer. Assuming that the CTS is a "preexisting condition," we find no merit to claimant's arguments that application of the statute is absurd and unjust and denies claimant constitutionally guaranteed rights. Prior to the enactment of ORS 656.802(2)(b), claimant could prove compensability only with evidence that employment conditions pathologically worsened the underlying condition. Wheeler v. Boise Cascade, 298 Or 452, 457-58 (1985); Weller v. Union Carbide, 288 Or 27, 35 (1979). This standard of proof essentially is the same as that provided in ORS656.802(2)(b). But see Dan D. Cone, 47 Van Natta 2220 (1995) (worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease, not just the major contributing cause of the worsening). Consequently, we find that the result would not be different under the former version of the statute, and conclude that retroactive application of the present statute is neither absurd and unjust nor denies claimant of due process.

Finally, we respond to the dissent's application of the last injurious exposure rule and its conclusion that, under this analysis, the employer's denial should be set aside. First, the dissent mischaracterizes our order when it states that we have reached our conclusion based only on the fact that claimant joined only this employer. As described below, throughout the course of this case, claimant not only failed to join more employers but litigated his case based solely on the theory that he proved an occupational disease claim against only the employer.

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[1] ORS 656.005(24) 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, or that precedes a claim for worsening pursuant to ORS 656.273."

[2] 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."

[3] We find no merit to claimant's assertion that the ALJ erred in finding "Barrett Business Services to be the employer in this proceeding." The 801 Form and the Request for Hearing Form both refer to Barrett Business Services as the employer; we find this to be sufficient evidence that Barrett Business Services employed claimant. Furthermore, because claimant joined only Barrett Business Services, if indeed such entity was not the employer, our only option would be to dismiss the request for hearing. We note that claimant makes no such motion.

Claimant's request for hearing referred solely to the employer and checked "Compensability" as the issue to be litigated. At hearing, the ALJ stated that "the sole issue today is the compensability of an alleged bilateral carpal tunnel syndrome condition." (Tr. 7). Both attorneys agreed with the statement. (Id.) Consistent with this approach, the ALJ's Opinion and Order characterized the case as one for "occupational disease." The argument during reconsideration of the ALJ's initial order concerned the application of ORS 656.005(24) in the context of an occupational disease claim. This was the issue that continued to be advanced on Board review; that is, the parties disputed whether claimant had a "preexisting condition" for application of ORS 656.802(2)(b).

Thus, this case from the beginning has been litigated as an occupational disease claim under ORS 656.802. There has been no hint or suggestion from claimant at any time that he wished to invoke the last injurious exposure rule or proceed in any other manner than to prove an occupational disease claim against only the employer.[4]

We have no argument with the dissent's discussion that a claimant may seek to prove compensability by relying on an entire period of employment, even though every carrier providing coverage during that period is not joined or could not be held liable. Silveira v. Larch Enterprises, 133 Or App 292 (1995); Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994). Those court cases and Board decisions, however, employing such an analysis do so in the context of the claimant invoking, or expressly raising, the last injurious exposure rule. Id.; Charlene A. Dieringer, 48 Van Natta 20 (1996)[5]; Mary A. Kelley, 47 Van Natta 822 (1995). Such an approach is consistent with case law showing that claimants elect between proving actual causation against a single employer or carrier or, by invoking the last injurious exposure rule, establishing that an entire period of work conditions was the major contributing cause of the condition. Runft v. SAIF, 303 Or 493, 501-02 (1987); Bracke v. Baza'r, 293 Or 239, 247-48 (1982); Bennett v. Liberty Northwest Ins. Corp., supra.

Because the last injurious exposure rule was not raised, cited, or referenced at any time during this proceeding, we cannot agree with the dissent's argument that, on our own motion, we should decide the case on such a theory. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Instead, we have resolved the issue as it has been characterized and litigated by the parties. Based on claimant's theory of an occuational disease against the employer, the claim fails.

ORDER

The ALJ's order dated July 19, 1995, as reconsidered August 28, 1995, is affirmed.

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[4] Moreover, there was evidence before and during hearing giving claimant notice that he had worked for more than one employer. For instance, the 801 indicated that claimant had worked for the employer two and a half years (claimant worked as a tree harvester and planter for twelve years) and, during hearing, there was testimony that claimant worked for at least two different employers. Despite such information, claimant did not request a continuance or attempt to join other potentially liable employers; instead, claimant continued to assert an occupational disease claim only against the employer.

[5] We also disagree with the dissent's application of the holding in Charlene A. Dieringer, supra. There, we decided that, because the claimant could rely on different periods of employment to prove compensability, and there was no evidence that her occupational disease existed before those employments, there was no "preexisting condition" under ORS 656.005(24).

Here, unlike Dieringer, claimant has not pointed to all employers; instead, as explained above, claimant has asserted that he has a compensable occupational disease claim against the employer without invoking the last injurious exposure rule. Moreover, because this proceeding is limited to deciding only if claimant's period of employment with the employer caused his CTS, and the medical evidence suggests that the CTS began before such work, the CTS likely qualifies as a "preexisting condition" under ORS 656.005(24).

Board Chair Hall dissenting.

The majority concludes that, because claimant joined only the employer, in order to prevail, he must show that employment conditions with this one employer were the major contributing cause or worsening of his bilateral carpal tunnel syndrome (CTS). Because I disagree with the majority's analysis and conclusion, I respectfully dissent.

The majority says that claimant did not "invoke" the last injurious exposure rule. In my view, that is the wrong analysis. Rather, the issue is whether claimant elected to prove actual causation. In this case, an occupational disease claim based on years of employment activities, claimant did not elect to prove actual causation.

The last injurious exposure rule provides that where a worker proves that an occupational disease was caused by work conditions that existed when more than one employer or 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 last injurious exposure rule operates both as a rule of proof and as a means of assigning responsibility. Where a disease's major contributing cause is work related, the last injurious exposure "rule of proof" obviates the need for a claimant to prove compensability as against any particular employer and allows a condition to be found compensable if the claimant can show that the employment environment could have contributed to the condition. Inkley v. Forest Fiber Products Co., 288 Or 337, 345 (1980). The inequity of denying a disabled worker benefits under the statute because he or she mistakenly filed against the wrong employer influenced the adoption of the last injurious exposure rule. Id. at 343.

The last injurious exposure rule also operates as a rule for the assignment of responsibility by assigning full responsibility to the last employer at which the claimant could have been exposed to potentially causal conditions. Runft v. SAIF, 303 Or 493, 500 (1987). By assigning responsibility to an employer who can be identified without a determination of actual causation, the claimant is better protected from the risk of filing claims against the wrong employer. Id.

Here, claimant is relying on his employment in the tree planting business since 1981 to prove the compensability of his CTS. Claimant has referred to his entire 13 years of work or to work generally to prove compensability. Claimant testified that he had been employed with Chapparrall Reforestation from January 20, 1983 through 1994.[1] (Tr. 9, 10). Prior to that, claimant said he had been working for Northwest Green Tree since 1981. (Tr. 10). Claimant testified that, although the owners and the employees were the same, the company changed its name from Northwest Green Tree to Chapparrall Reforestation. (Tr. 11). Although claimant was aware that the company had changed its name, there is no indication that he was aware that he had been working for three different companies since 1981.

Furthermore, it is apparent from the medical records that claimant believed he had been working for the same company for 13 years. Dr. Nolan reported that claimant had worked for the "same company, which has had different names over the years, for 13 years, beginning work in January of 1981." (Ex. 14). Dr. Nolan agreed that claimant's work for the past thirteen years was compatible with the development of CTS. (Ex. 15). In a deposition, Dr. Gray referred to claimant's work at the same company over a 13 year period. (Exs. 18-20, -22). Claimant's attorney objected when the employer attempted to ask Dr. Gray questions about the worsening of the CTS condition since the involvement of Barrett Business Services. (Exs. 20-35 to 38).

Finally, claimant points out that the employer did not disclaim responsibility and notify him that he should file a claim with any other employers. See ORS 656.308. Under both the former and amended versions of ORS 656.308(2), a carrier who plans to dispute responsibility must notify a claimant that he or she may have a claim with any other potentially responsible employers or carriers. Based on claimant's "801" form, Barrett Business Services had notice that claimant's symptoms had originated before his employment with Barrett Business Services.[2] Thus, Barrett Business Services had notice that another employer could be involved in this dispute. Furthermore, Barrett had notice from the medical reports that claimant believed he had been working for the same company for 13 years.

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[1] Claimant's understanding of the dates of employment for the two companies was apparently incorrect. The owner of Chapparral Reforestation testified that claimant had worked with her father's company, Northwest Green Tree, for several years and then started working for Chapparral Reforestation in 1990. (Tr. 92).

[2] Claimant's "801" form indicated that he had experienced symptoms for at least 5 years, although the portion of the form filled out by Barrett Business Services indicated that claimant had been employed for 2 1/2 years. (Ex. 10). The form did not list a date of injury or occupational disease. On the form, the "employer's legal name" is listed as "Barrett Business Services, Inc." and the address is listed as "Chapparral Reforestation * * *." (Id.)

The last injurious exposure rule operates for the benefit of the interests of claimants, relieving them of the sometimes impossible task of proving which of multiple employers actually caused a work-related condition, Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994), thus relieving a claimant of the burden of proving medical causation as to any specific employer or insurer. Bracke v. Baza'r, 293 Or 239, 246 (1982). One purpose of the last injurious exposure rule of proof is to protect a claimant from the risk of filing claims against the wrong employer. See Runft v. SAIF, supra, 303 Or at 500; Inkley v. Forest Fiber Products Co., supra, 288 Or at 343. Based on the aforementioned evidence, it is apparent that claimant's occupational disease claim was based on his employment as a tree planter dating back to 1981. Under the facts in this case, I consider it appropriate to construe claimant's claim to be relying on the rule of proof aspect of the last injurious exposure rule. This is not a case in which the claimant has foregone the benefit of the rule and elected to prove actual causation. See Bracke v. Baza'r, supra, 293 Or at 250 n. 5.

This case also represents a situation where the defensive use of the last injurious exposure rule comes into play. See Bracke v. Baza'r, supra, 293 Or at 250. Barrett Business Services could have disclaimed responsibility and notified claimant that other employers could be responsible for the claim. Barrett has been aware from the outset of the occupational disease claim that claimant was basing his claim on his work activities beyond those performed with Barrett. By not allowing claimant to rely on the rule of proof aspect of the last injurious exposure rule, the majority rewards Barrett's actions in failing to comply with the responsibility disclaimer requirements.

The following cases illustrate how the last injurious exposure rule of proof operates, even when all of the potentially responsible carriers are not "joined" in the proceeding.

In determining whether an occupational disease is work-related, the rule of proof aspect of the last injurious exposure rule allows consideration of all employments, even those that could not ultimately be held responsible for the claim. Silveira v. Larch Enterprises, 133 Or App 297, 301 (1995); Bennett v. Liberty Northwest Ins. Corp., supra.

In Mary A. Kelley, 47 Van Natta 822 (1995), the carrier argued that the claimant could not use the last injurious exposure rule to establish the compensability of her claim because she did not join all of the former carriers. We rejected the carrier's argument. Relying on Silveira v. Larch Enterprises, supra, and Bennett v. Liberty Northwest Ins. Corp., supra, we reasoned that, if employment exposures for employers who had settled claims with claimants and exposures regarding "out-of-state" employment could be considered in applying the last injurious exposure rule to prove compensability of an occupational disease claim, employment conditions for "unjoined" carriers could also be considered. See also Beneficiaries of Strametz v. Spectrum Motorwerks, 135 Or App 67 (1995); Kristin Montgomery, 47 Van Natta 961 (1995).

Here, the ALJ found that claimant had worked for three employers, but only one employer was part of this case. Nevertheless, claimant may rely on all three employments to prove whether his CTS is work-related, even those that cannot ultimately be held responsible for the claim. See Silveira v. Larch Enterprises, supra; Bennett v. Liberty Northwest Ins. Corp., supra.

In Charlene A. Dieringer, 48 Van Natta 20 (1996), the ALJ found that the claimant's bilateral upper extremity condition was caused by her out-of-state employment that preexisted her employment with the employer. The ALJ reasoned that the claimant had to prove that employment conditions at the employer were the major contributing cause of the combined condition and pathological worsening of her condition.

In Dieringer, we concluded that, based on Silveira v. Larch Enterprises, supra, the claimant could rely on both her employments, even her out-of-state employment, for purposes of establishing that her condition was work-related. There was no evidence that the claimant's condition preexisted her employment with the out-of-state employer. We concluded that, since the claimant was relying on both her employments to prove compensability, there was no "preexisting condition." See ORS 656.005(24) (a "preexisting condition" is defined as a 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"). We reasoned that this was the initial claim for the claimant's bilateral upper extremity condition, and, therefore, there was no upper extremity condition that preexisted the initial onset of the claim.

I would reach the same result in this case. Here, claimant is relying on his employment in the tree planting business since 1981 to prove that his CTS is work-related. There is no evidence that claimant's CTS preexisted his employment in 1981 and claimant's claim is not based on the worsening or combining of a preexisting disease or condition. Therefore, there is no CTS condition that preexisted the initial onset of this claim. Thus, in order to establish the compensability, claimant must prove that his employment conditions at Northwest Green Tree, Chapparral Reforestation, and Barrett Business Services were the major contributing cause of his CTS condition. See ORS 656.802(2)(a).

Based on the medical evidence, claimant has met that standard of proof. Dr. Gray, claimant's treating physician, reported that claimant's work as a tree planter and harvester was the major contributing factor to his right CTS and to early CTS on the left. (Ex. 16). In a post-hearing deposition, Dr. Gray adhered to that opinion. (Exs. 18-21, 18-34, 18-36, 18-37). Dr. Gray had reviewed the videotape of claimant using an axe and chopping large pieces of wood. The videotape did not change Dr. Gray's opinion that claimant's work was the major contributing cause of his CTS. (Ex. 18-19, 18-20, 18-25). Dr. Gray's opinion is supported by that of Dr. Nolan, who reported that claimant's work for the past 13 years was "more than compatible" with the development of claimant's CTS.[3] (Ex. 14-2). Based on the medical reports, I would conclude that claimant's work activities, including his employment with Northwest Green Tree and Chapparral Reforestation were the major contributing cause of his CTS. Consequently, I would conclude that claimant's CTS is employment-related.

Moreover, I would conclude that Barrett Business Services is responsible for claimant's bilateral CTS condition.

No carrier had accepted claimant's CTS condition. Therefore, ORS 656.308(1) does not apply to assign responsibility. SAIF v. Yokum, 132 Or App 18 (1994). Instead, the last injurious exposure rule applies to assign responsibility, unless actual causation is proved with respect to a particular carrier.

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 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

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

Here, Dr. Gray testified that claimant first sought treatment for his bilateral CTS symptoms on November 24, 1993. (Ex. 18-7, 18-8). Claimant complained of tingling in the fingers of both hands which awakened him at night. (Exs. 7a, 11, 18-7). A nerve conduction study on January 5, 1994 showed moderate right median nerve compromise at the carpal tunnel. (Ex. 9). Based on Dr. Gray's reports, I would conclude that claimant first sought medical treatment for his bilateral CTS symptoms on November 24, 1993. At that time, claimant was employed by Barrett Business Services. Therefore, I would assign presumptive responsibility to Barrett Business Services.

Barrett Business Services can shift responsibility to a prior employer by showing that the prior employments were the sole cause of claimant's CTS, or that it was impossible for conditions while Barrett Business Services was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985).

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[3] Dr. Nolan commented that "[i]f there is a history of chopping firewood, that would certainly contribute to carpal tunnel syndrome, but unless it is shown that he does this very extensively (compared to his work), I would not consider this the major contributing cause." (Ex. 14-3). There is no evidence in the record that claimant's off-work wood chopping activities were extensive.

Barrett Business Services has not met that burden. Dr. Gray's reports indicate that claimant's employment as a tree planter and harvester, which included claimant's employment with Barrett Business Services, was the major contributing cause of claimant's CTS. (Exs. 16, 18-21, 18-25, 18-34, 18-37). Similarly, Dr. Nolan reported that claimant's work over the past 13 years was compatible with the development of CTS. (Ex. 14-2). Under the circumstances, I would conclude that Barrett Business Services has not satisfied the sole cause/impossibility standard.

For these reasons, I would reverse the ALJ's decision and set aside Barrett Business Services' denial of claimant's CTS claim. Because the majority concludes otherwise, I dissent.

In the Matter of the Compensation of
SHANNON E. JENKINS, Claimant
WCB Case No. 95-02338
ORDER ON REVIEW
Ernest Jenks, Claimant Attorney
Scheminske, Lyons, et al, Defense Attorneys

Reviewed by Board en banc.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its "de facto" denial of claimant's left knee/leg contusion claim; and (2) awarded an assessed attorney fee. In its brief, the employer contends that the ALJ had no jurisdiction to adjudicate the "de facto" denial because claimant did not file a valid request for hearing. On review, the issue is jurisdiction, and if the Hearings Division has jurisdiction, compensability and attorney fees. We vacate the ALJ's order and dismiss claimant's request for hearing without prejudice.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant injured her left leg on January 4, 1995 while working for the employer. The medical reports referred to claimant's condition as a contusion/abrasion of the left lower leg (Exs. 1, 1A), a slowly resolving hematoma and contusion of the left lower extremity (Ex. 4B), left leg contusion (Exs. 6A, 6B) and contusion of left knee and shin. (Ex. 9). Although the employer initially denied the claim on January 20, 1995, it subsequently accepted a "left knee laceration" on January 26, 1995. (Exs. 4, 6).

On February 9, 1995, claimant's attorney filed a request for hearing regarding the employer's January 20, 1995 denial. A hearing was scheduled for May 17, 1995.

On May 8, 1995, claimant filed a request for hearing on a "de facto denial of left knee 'contusion.'" The employer wrote to claimant's attorney on May 10, 1995, asking him to identify what claim he planned to allege was "de facto" denied. Claimant responded on May 12, 1995, repeating that the issue pertained to a "de facto" denial of a left knee contusion. Claimant's attorney explained that, when he filed the February 9, 1995 request for hearing, he had not yet received the employer's January 26, 1995 acceptance.

On May 17, 1995, a hearing was held on the "de facto" denial of the left knee/leg contusion. The record was left open for submission of a medical bill and a letter. (Tr. 30, 31). The employer wrote to claimant's attorney on the same day, asking for information about a medical bill that had allegedly not been paid.

On July 24, 1995, the employer wrote to the ALJ, stating that claimant's attorney had not produced any evidence to support claimant's contention that the employer had failed to pay medical bills. In addition, the employer argued that claimant's request for hearing should be dismissed pursuant to amended ORS 656.262(6) and (7), which had become effective on June 7, 1995 (subsequent to the May 17, 1995 hearing).

The ALJ closed the record on July 27, 1995. The ALJ denied the employer's motion to dismiss claimant's request for hearing, reasoning that claimant had complied with ORS 656.262(6)(d) in his May 8, 1995 supplemental request for hearing and May 12, 1995 letter to the employer's attorney. The ALJ concluded that the employer had refused to revise or clarify claimant's notice of acceptance. On the merits, the ALJ found that a contusion was separate from a laceration and should be accepted as a separate condition. The ALJ awarded an assessed attorney fee.

Retroactivity

The ALJ found that ORS 656.262(6)(d) applied retroactively to this case. Claimant contends that ORS 656.262(6)(d) does not apply retroactively because the statute pertains to procedural time limits. Claimant argues that the statute, if applied retroactively, would operate as a procedural extension.

Except as provided otherwise, the changes made to the Workers' Compensation law made by Senate Bill 369 apply 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, 569 (1995). Subsection (6) of section 66 of Senate Bill 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." Or Laws 1995, ch 332, § 66(6) (SB 369, § 66(6)).

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.

ORS 656.262(6)(d) provides that an injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance or that the notice is otherwise deficient, first must communicate in writing to the carrier the worker's objections to the notice. The carrier then has 30 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. The statute further provides that a worker who fails to comply with the communication requirements may not allege at any hearing or other proceeding on the claim a "de facto" denial of a condition based on information in the notice of acceptance from the carrier.

ORS 656.262(6)(d) imposes a new obligation on the part of the claimant to notify a carrier of objections to the notice of acceptance. The 30 day limit in which the carrier must respond to a claimant's objections relates to the new substantive provision. Since ORS 656.262(6)(d) is a new section added by Senate Bill 369, there were no previous procedural time limitations. Therefore, application of the new amendment will 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." Or Laws 1995, ch 332, § 66(6) (SB 369, § 66(6)). None of the other exceptions in section 66 applies in this case. Accordingly, we conclude that amended ORS 656.262(6)(d) applies to the present case.[1]

Validity of Claimant's Request for Hearing

The employer argues that the ALJ did not have jurisdiction to adjudicate the alleged "de facto" denial claim because claimant did not file a valid request for hearing. The employer contends that, even if claimant complied with the communication requirement of ORS 656.262(6)(d), her request for hearing was premature.

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[1] Claimant relies on Gerald A. Keipinger, 47 Van Natta 1509 (1995), to contend that ORS 656.262(6)(d) should not be applied retroactively. In Keipinger, we commented that the amendments to ORS 656.262(6)(d) "appear to pertain to procedural time limits" and "likely cannot be retroactively applied." 47 Van Natta at 1512. However, we did not resolve that question in Keipinger because, considering the employer's consistent opposition to the claimant's "sprain/strain" claim, we concluded that it would not be necessary to remand the case for compliance with the aforementioned procedural rules. Since we did not actually resolve the issue, claimant's reliance on our comment in Keipinger is misplaced because that comment was dicta.

In Guillermo Rivera, 47 Van Natta 1723 (1995), we found that the claimant's request for hearing alleging a "de facto" denial constituted a "communication in writing" to the employer of the claimant's objections to the notice of acceptance. Thus, we concluded that the claimant's hearing request satisfied amended ORS 656.262(6)(d).

Our decision in Rivera was made without benefit of the analysis required in PGE v. Bureau of Labor and Industries, 317 Or 606 (1993), and in the absence of a consideration of the legislative history supporting the statute. Thus, we find it appropriate to reexamine the statute. In construing ORS 656.262(6)(d), we begin with the text and context of the statute. PGE v. Bureau of Labor and Industries, supra. If those sources do not reveal legislative intent, we resort to legislative history and other extrinsic aids. Id. at 611.

ORS 656.262(6)(d) provides:

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

ORS 656.262(6)(d) manifests the legislature's intent that a worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or is otherwise deficient, "first must communicate in writing" to the carrier the worker's objections to the notice before the worker may allege a "de facto" denial of a condition at any hearing or other proceeding. After the worker's communication, the carrier then has 30 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. Taken together, that language requires that, after claim acceptance, a worker must first communicate the worker's objections to the notice to the carrier and allow the carrier 30 days to respond before a worker may allege a "de facto" denial of a condition at a hearing or other proceeding. It follows that the worker's objections to the notice of acceptance must also precede a request for hearing.

The context of ORS 656.262(6)(d) supports this construction. ORS 656.005(6) defines "claim" as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.283(1) provides, in part, that any party may at any time request a hearing on any matter concerning a claim. Taken together, a request for hearing pursuant to ORS 656.283(1) cannot also constitute a "claim" under ORS 656.005(6) since the request for a hearing must concern a claim.[2]

Thus, the text and context of ORS 656.262(6)(d) strongly suggest that the phrase requiring the worker to "first * * * communicate in writing" was intended to require a worker with an accepted claim to first request processing of any objections to the notice of acceptance and allow 30 days for a response before the worker requests a hearing and begins litigation. Nevertheless, the statute is arguably ambiguous in that there is no express requirement in the statute that the "communication in writing" must precede a request for hearing. Accordingly, we proceed to an examination of the legislative history.

ORS 656.262(6)(d) was amended by Senate Bill 369. Representative Mannix, a co-sponsor of the bill, testified that ORS 656.262(6)(d):

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[2] The dissent contends that ORS 656.262(6)(d) necessarily presumes that a claim has already been made and argues there is nothing in the language of ORS 656.262(6)(d) or the legislative history to indicate that a claimant makes a "claim" under ORS 656.262(6)(d). The dissent overlooks the statutory definition of a "claim." ORS 656.005(6) defines a "claim" as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." (Emphasis added). Thus, in the context of ORS 656.262(6)(d), a "claim" is a claimant's communication in writing to the carrier objecting to the notice of acceptance, i.e., a claimant's written request for compensation.

"Establishes a procedure to verify scope of acceptance. In 1990, as part of the reforms, we required employers and insurers to give a written statement to the worker, telling the worker what condition was accepted. We have now discovered a catch 22, when you tell the worker you have accepted the claim; you sent out that written notice, you describe the condition, the catch 22 is now the attorneys are saying, oh, implicitly, because you didn't list something else, you have denied that condition, even though you didn't issue a letter of denial; even though you paid the medical bills; even though you paid the time loss; you paid the permanent disability; somehow you have done a de facto denial, Latin for a denial as a matter of fact rather than a matter of law, and got you; you've done something wrong; you got caught.

"Well, wait a minute. This says, if you want to say that there is a condition that was properly part of the claim and it wasn't accepted, write a letter to the employer or insurer, tell them, hey, you overlooked this. They have 30 days to respond and if they don't provide you with clarification of acceptance, then you can challenge. * * *" Tape Recording, Senate Labor and Government Operations Committee, January 30, 1995, Tape 15B (emphasis added).

In subsequent testimony, Representative Mannix testified:

"We also have an important proviso with regard to the 1990 changes where we said insurers had to issue a notice of acceptance of a claim. That's the first time we specified it, and specify the conditions which are accepted. We wanted workers to have notice about what was covered. That was going fine until the last year or two when some attorneys started filing requests for hearing saying, ah, you missed a diagnosis. That's a de facto denial. I'm requesting a hearing; you denied my claim. And the insurer is saying, say what, oh gee, and sometimes they'll own up and say, yeah, gee we should have included that diagnosis. Well, let's go to hearing and let's award an attorney fee and maybe a penalty, going into litigation on this stuff. Or other times, no let's start talking about whether that diagnosis was included in the earlier diagnosis and you get into litigation back and forth. This says, wait a minute, send out this notice of acceptance and if the worker thinks something was left out, the worker should write a letter to the employer/insurer and say you left this out of my claim. Then they have 30 days to respond. And in most instances, in my opinion, they're going to respond by saying, oops, you're right, or let's clarify this, let's get to it. But that you don't just plop down and file a request for hearing. You have to go through this process to allow them an opportunity to correct the alleged error. And if they correct it, fine. If they don't, then you can litigate it. That is designed to, again, allow for a straightforward communication, where's the beef, try to get it clarified. If they refuse to clarify, then you can take it to hearing." Tape Recording, House Committee on Labor, March 6, 1995, Tape 46A (emphasis added).

Later in the hearing, Representative Mannix reiterated that the communication from the worker must precede the request for hearing:

"The employer/insurer pays the time loss, pays all the medical bills, pays the permanent disability award, and yet later on some attorney comes in and says, 'Aha, the diagnosis was lumbosacral strain and lower thoracic strain and your notice of acceptance only said lumbosacral strain. Therefore you, de facto, as a matter of fact, denied by thoracic strain... ' But wait a minute, didn't you get all your bills paid, didn't you get all your benefits. Doesn't matter. This is a denial because you didn't accept. That's what is happening lately. This says, screw it. No, if the benefits are not going to be paid, and they get a bill from a doctor for a condition, if they're not going to pay your time loss or your permanent disability, or they're not going to pay that medical bill, they're supposed to issue a denial and they still have to do that. The worker will get that denial letter and it says we won't pay. That will be the warning to the worker. Otherwise, if the worker does want to play doctor and gets his notice of acceptance and isn't too happy with it, there will now be an opportunity, and I'll be frank with you, this is designed to vector those attorneys and say, look, write a letter. They have to respond in 30 days. If there really is an issue about accepting something else, give them a chance to

respond rather than filing a request for hearing." Tape Recording, House Committee on Labor, March 6, 1995, Tape 46A (emphasis added).

In the same hearing, Representative Mannix said "we're saying don't turn it into litigation unless you write a letter. Give them a chance to clean it up." Tape Recording, House Committee on Labor, March 6, 1995, Tape 45B.

In sum, the history reveals the legislature's intent that the worker's "communication in writing" under ORS 656.262(6)(d) must precede the worker's request for hearing. The "communication in writing" requirement was intended to inform the carrier of claimant's objections to the notice of acceptance and allow the carrier to respond before there is any litigation. We construe ORS 656.262(6)(d) accordingly. To the extent that our holding in Guillermo Rivera, supra, is contrary to this construction, we disavow it.

We note that our reading of the statute comports with the express legislative objective of the Worker's Compensation Law to provide an administrative system "that reduces litigation and eliminates the adversary nature of the compensation proceedings to the greatest extent practicable." See ORS 656.012(2)(b). Further, we presume that the legislature, when creating ORS 656.262(6)(d), was not unmindful of the considerable administrative costs that follow receipt by the Board of a request for hearing.

Here, claimant only filed a request for hearing alleging a "de facto" denial. There is no evidence that claimant first communicated in writing her objections to the notice of acceptance before filing a request for hearing. Consequently, we conclude that claimant did not satisfy amended ORS 656.262(6)(d) and, thus, was precluded from alleging at hearing that the employer "de facto" denied a left knee contusion.

ORDER

The ALJ's order dated August 24, 1995, as reconsidered September 28, 1995, is vacated. Claimant's request for hearing on the "de facto" denial of a left knee contusion is dismissed without prejudice.

Board Chair Hall dissenting.

I agree with the majority that the legislature intended ORS 656.262(6)(d) to be applied retroactively in this case. I disagree, however, with the majority's interpretation of ORS 656.262(6)(d) and its decision to disavow Guillermo Rivera, 47 Van Natta 1723 (1995). For the following reasons, I respectfully dissent.

The issues in this case are what form of communication the legislature intended in ORS 656.262(6)(d) by requiring that the worker "first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice" and the timing of such written communication.

Form

ORS 656.262(6)(d) requires that a claimant "first must communicate in writing." There is nothing in the text or context of ORS 656.262(6)(d) to indicate that a particular form of written communication is required. In contrast, when specific forms are required, the statutes say so. For example, ORS 656.273(3) now provides that 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." In another example, ORS 656.262(6)(b) provides for particular requirements for a notice of acceptance. If the legislature had wanted to require a specific type or form of written communication in ORS 656.262(6)(d), it easily could have done so by including such a reference in the statute (especially since the amendments to ORS 656.262 and ORS 656.273 were in the same Senate bill). We may not read into a statute an additional requirement that is simply not there. ORS 174.010. Since the statute does not dictate the form of the written communication, the statutory requirement is satisfied as long as a claimant uses written communication. The majority errs in deciding that a "request for hearing," which is itself a form of written communication, cannot satisfy ORS 656.262(6)(d).

Even if we assume that the statutory language is ambiguous, the legislative history does not dictate a particular form for the worker's "communication in writing." Although Representative Mannix refers to a "letter" in the legislative history, he did not say that the only form of communication must be a letter. We are not at liberty to rewrite the statute so that it tracks with the legislature's unenacted intentions. Deluxe Cabinet Works v. Messmer, 140 Or App 548, 554 (1996). Moreover, the legislative history cited in the majority opinion is not persuasive because it refers only to the testimony of Representative Mannix. "[A]n examination of legislative history is most fraught with the potential for misconstruction, misattribution of the beliefs of a single legislator or witness to the body as a whole, or abuse in the form of 'padding the record' when the views of only a small number of persons on a narrow question can be found." Errand v. Cascade Steel Rolling Mills, Inc., 320 Or 509, 539 n.4 (1995) (Graber, J., dissenting).

Timing

I also disagree with the majority's conclusion that the text of ORS 656.262(6)(d) requires a worker's objections to the notice of acceptance to precede a request for hearing. The worker's objections have to precede the hearing itself, but not the request for hearing.

A worker who believes a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, "first must communicate in writing" the worker's objections to the notice. ORS 656.262(6)(d). The third sentence provides that a worker who has failed to comply with the "communication" requirements may not "allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance * * *." (Emphasis added). Having provided written notice, a claimant may allege a de facto denial at hearing.

On its face, the statute requires only written communication before alleging a de facto denial "at any hearing or other proceeding." In other words, the language "first must communicate" is in relation to the hearing-proceeding itself. The statute does not say that a claimant must object in writing before filing a request for hearing. Had the legislature intended to impose such a requirement, it could have done so. Again, we are not at liberty to read into a statute an additional requirement that simply is not there. ORS 174.010. Indeed, the final sentence of ORS 656.262(6)(d) provides that a worker may initiate objection to the notice of acceptance at any time. That provision supports the conclusion that a "communication in writing" does not have to precede a request for hearing.[1]

Jurisdiction

The majority concludes that claimant's written request for hearing cannot constitute the written communication required by ORS 656.262(6)(d), that claimant did not communicate in writing before the hearing, and thus orders claimant's request for hearing dismissed. Without saying so directly, the majority imposes a jurisdictional requirement not found in the statute. Without saying so directly, the majority has adopted the employer's reliance on Syphers v. K-W Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981). Reliance on Syphers is misplaced.

The employer argues that the ALJ did not have jurisdiction to adjudicate the alleged de facto denial claim because claimant did not file a valid request for hearing. Citing Syphers, the employer contends that, even if claimant complied with the communication requirement of ORS 656.262(6)(d), her request for hearing was premature. In Syphers v. K-W Logging, Inc., supra, the claimant requested a hearing on or about the same date his claim was filed. The court held that the claimant's request for hearing was premature and therefore ineffective. The court explained:

> "The statutory scheme does not reasonably permit a hearing on compensability of the claim prior to a timely acceptance or denial or prior to the expiration of the time in which the carrier may investigate and consider the claim without risking penalties." 51 Or App at 769.

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[1] If the carrier has not responded by the hearing date, and it has been less than 30 days, then a continuance may be in order (as is common with disclaimers under ORS 656.308); that does not, however, negate the fact that a claimant complied with the written communication before hearing.

Syphers v. K-W Logging, Inc., supra, is inapposite. Under ORS 656.262(6)(d), the subject is the scope of acceptance and a de facto denial. By definition, the 90 days to accept or deny a claim without risking penalties has already passed.[2]

Claimant's attorney initially filed a request for hearing on February 9, 1995 regarding the employer's January 20, 1995 denial. A hearing was scheduled for May 17, 1995. On May 8, 1995, claimant filed a request for hearing on a "de facto denial of left knee 'contusion.'" The employer wrote to claimant's attorney on May 10, 1995, asking him to identify what claim he planned to allege was "de facto" denied. Claimant responded on May 12, 1995, repeating that the issue pertained to a "de facto" denial of a left knee contusion. Claimant's attorney explained that, when he filed the February 9, 1995 request for hearing, he had not yet received the employer's January 26, 1995 acceptance. On May 17, 1995, a hearing was held on the "de facto" denial of the left knee/leg contusion. Thus, apart from claimant's May 8 hearing request, claimant also communicated in writing on May 12, before the hearing itself.

As of the May 17, 1995 hearing, the 30 day period for the employer to "revise the notice or to make other written clarification in response" to claimant's May 8, 1995 hearing request and claimant's May 12 letter had not expired. However, the fact that the 30 day time period had not expired was not jurisdictional. The jurisdictional requirement is that claimant communicate in writing before alleging a de facto denial as a part of a hearing or other proceeding. By writing on May 12 (if not by submitting the hearing request on May 8), claimant satisfied the jurisdictional requirement before the May 17 hearing. By statute, claimant could therefore allege at hearing the de facto denial. If the carrier wanted the balance of 30 days to revise the notice, the hearing could have been continued.[3] However, the hearing request itself was not invalid. The legislature did not amend the statute to preclude a claimant from filing a request for hearing under these circumstances.

For the foregoing reasons, I respectfully dissent.

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[2] The majority erroneously finds that the language of ORS 656.283(1) supports its construction of ORS 656.262(6)(d). The majority says that a request for hearing pursuant to ORS 656.283(1) cannot also constitute a "claim" under ORS 656.005(6) since the request for a hearing must concern a claim. Contrary to the majority's assertion, ORS 656.262(6)(d) has nothing to do with making a claim. There is nothing in the statute or legislative history to indicate that a claimant makes a "claim" under ORS 656.262(6)(d). Rather, ORS 656.262(6)(d) provides guidelines for a worker to clarify the scope of acceptance in a de facto denial situation. The statute necessarily presumes that a claim has already been made since there has been a notice of acceptance. ORS 656.262(6)(d) allows a claimant to object to the notice of acceptance and clarify its terms before alleging a de facto denial of the previously made claim.

Contrary to the majority's assertion, the dissent did not "overlook" the language of ORS 656.005(6). Although the majority refers to ORS 656.005(6), it fails to explain why the legislature chose to make the clear distinction between ORS 656.262(6)(d), which requires a claimant to "communicate in writing" the worker's objections to the notice [of acceptance]," and ORS 656.262(7)(a), which addresses claims for new medical conditions after acceptance. ORS 656.262(7)(a) requires written notice of such "claims" and allows the carrier 90 days to accept or deny such "claims." The 90 day time frame and the requirement for the carrier to issue a formal acceptance or denial under ORS 656.262(7)(a) is consistent with ORS 656.262(6)(a), which provides 90 days to accept or deny a "claim." ORS 656.262(6)(d) deals with clarifying the scope of acceptance of a claim that has already been made, whereas ORS 656.262(6)(a) and ORS 656.262(7)(a) deal with making initial or additional claims. Had the legislature intended to make the written communication under ORS 656.262(6)(d) a "claim," the legislature would have said so, as it did in ORS 656.262(6)(a) and ORS 656.262(7)(a), and it would have allowed the same 90 day period to accept or deny.

[3] ORS 656.283(4) requires hearings to be scheduled within 90 days of the request for hearing. Thus, the 30 days for the employer to revise/respond would typically fit well before the hearing is convened.

In the Matter of the Compensation of
ROBIN D. JONES, Claimant
WCB Case No. 95-11042
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that reduced claimant's award of scheduled permanent disability for loss of use or function of the left foot from 12 percent (16.2 degrees), as granted by an Order on Reconsideration, to zero. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except, in lieu of the ALJ's second finding of ultimate fact, we instead find:

As a result of her compensable injury, claimant has sustained a 12 percent (16.2 degrees) loss of use or function of the left foot.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable low back condition arising out of a January 1994 injury. The claim was closed by Determination Order on January 10, 1995, with no award of permanent disability. Claimant objected to the impairment findings of the treating physician, and a medical arbiter's examination was performed by Dr. Smith, orthopedic surgeon. Based on that examination, an Order on Reconsideration awarded claimant 22 percent unscheduled permanent disability and 12 percent scheduled permanent disability.

The insurer contested the award of scheduled permanent disability at hearing. Finding that the insurer had never accepted the L5-S1 disc condition or S1 nerve root injury that gave rise to claimant's left foot symptoms, the ALJ found no basis to support a scheduled award as a result of the accepted condition. The ALJ, therefore, eliminated the scheduled permanent disability award. This appeal by claimant followed.

On review, claimant argues that, because she has experienced radicular symptoms since the date of injury, and, on examination, shows weakness in a scheduled body part as a result of her compensable injury to an unscheduled area of the body, she has established entitlement to an award of scheduled permanent disability. The insurer responds that there can be no entitlement to a scheduled permanent disability award because claimant has failed to establish compensability of any scheduled body part. Based on the following reasoning, we find that claimant is entitled to the scheduled permanent disability award granted by the Order on Reconsideration.

To be entitled to permanent disability compensation for her left foot impairment, claimant must establish that the impairment is due to her compensable injury. ORS 656.214(2). Separate awards are required when an injury to an unscheduled portion of the body results in disability to both unscheduled and scheduled portions. Foster v. SAIF, 259 Or 86 (1971); Olds v. Superior Fast Freight, 36 Or App 673 (1978); William L. Fischbach, 48 Van Natta 1233 (1996). e.g., Alvena M. Peterson, 47 Van Natta 1331 (1995); Fred D. Justice, 47 Van Natta 634 (1995); Frances C. Johnson, 46 Van Natta 206 (1994). We conclude claimant has established scheduled permanent disability due to her compensable injury.[1]

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[1] On review, claimant contends she should prevail in light of ORS 656.268(16). That statute provides:

"Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

SB 369 (which added subsection (16) to ORS 656.268) went into effect in June 1995, prior to the December 1995 hearing in this case. Nonetheless, claimant did not raise this issue at hearing nor was it addressed by the ALJ. In any event, given our conclusion that claimant has left foot impairment as a result of her compensable low back injury (thus establishing entitlement to an award of scheduled permanent disability), it is unnecessary to consider the effect, if any, of ORS 656.268(16) on the outcome of this case.

The Medical Review Unit advised Dr. Smith to report "any objective permanent impairment resulting from the accepted condition only." (Ex. 22C, emphasis in original). The medical arbiter found that claimant has decreased sensation of the lateral area of the left foot, and 4/5 dorsiflexion of the left foot toes. Because the arbiter did not attribute the left foot findings to causes other than the compensable injury and, in fact, indicated that all the findings of impairment were the result of the accepted condition (see Ex 23-4), we conclude that Dr. Smith's impairment ratings relate to the work injury. See Kim E. Danboise, 47 Van Natta 2163, on recon 47 Van Natta 2281(1995).

Accordingly, we reverse the ALJ's order. We reinstate and affirm the Order on Reconsideration which awarded claimant 12 percent scheduled permanent disability for the loss of use or function of the left foot.

The insurer requested a hearing, seeking elimination of the Order on Reconsideration award of scheduled permanent disability. By this order, we have found that the permanent disability awarded by the Order on Reconsideration should not be disallowed or reduced. Under such circumstances, claimant is entitled to an attorney fee award under amended ORS 656.382(2) for successfully defending her scheduled award at hearing. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing is $1,500 to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Because we have reversed that portion of the ALJ's order which eliminated claimant's scheduled permanent disability award and have reinstated the scheduled award made by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is also entitled to an attorney fee in the amount of 25 percent of the increased compensation created by this order, not to exceed $3,800. See amended ORS 656.386(2); OAR 438-015-0055(1). In the event that a portion of the 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 (1994), 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 January 26, 1996 is reversed in part and affirmed in part. That portion of the order that reduced claimant's award of scheduled permanent disability from 12 percent (16.2 degrees) to zero is reversed. The September 22, 1995 Order on Reconsideration is reinstated and affirmed in its entirety, except, in accord with the insurer's concession at hearing, the scheduled permanent disability award shall be paid at the rate of $347.51 per degree, and the unscheduled permanent disability award shall be paid at the rate of $117.47 per degree. For services at hearing concerning the insurer's appeal of the scheduled permanent disability award, claimant's attorney is awarded an assessed attorney fee of $1,500, payable by the insurer. Claimant's counsel is also awarded an approved attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. In the event that a portion of this increased compensation has already been paid to claimant, claimant's attorney is authorized to seek recovery of the fee in the manner prescribed in Jane Volk, supra. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JERRY L. KOCHER, Claimant
WCB Case No. 95-11656
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's aggravation claim for his hearing loss condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had established an actual worsening of his hearing loss condition. The insurer contends that the ALJ substituted her own judgment for that of the medical experts by concluding, based on claimant's audiogram results, that claimant's hearing loss condition had actually worsened. The insurer further contends that the opinion of Dr. Hodgson persuasively establishes that there has been no worsening of claimant's hearing loss condition. Claimant relies on the opinion of Mr. Frink, an audiologist, and contends that his hearing loss has worsened since the last arrangement of compensation in October 1990.

Under amended ORS 656.273(1), "[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. An "actual worsening" is established by evidence of: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the condition that is greater than that anticipated by the prior award of permanent disability. Carmen C. Neill, 47 Van Natta 2371 (1995).

Claimant was evaluated by Dr. McMenomey of the Oregon Health Sciences University. Dr. McMenomey found some progression, primarily in the mid frequencies, of claimant's hearing loss. Dr. McMenomey did not provide specific decibel (dB) levels. Two other experts have addressed whether claimant's hearing loss condition has worsened.

Mr. Frink, an audiologist, compared claimant's test results from September 17, 1990, prior to the last arrangement of compensation, and October 27, 1994 and opined that claimant's hearing had significantly decreased since September 1990.

Claimant was also evaluated on behalf of the insurer by Dr. Hodgson, a physician specializing in otology and neuro-otology. Dr. Hodgson disagreed with Mr. Frink's conclusion and opined that there had not been any incremental change in claimant's hearing loss. Dr. Hodgson opined that the differences found by Mr. Frink were due to test, re-test variabilities.

Mr. Frink responded to Dr. Hodgson's report. Mr. Frink compared claimant's September 1990 test results to his October 1994 test results and opined that there had been a threshold shift in the hearing of the lower frequencies. Mr. Frink opined that the threshold shift in the lower frequencies between September 17, 1990 and October 27, 1994 was more than would be expected from test, re-test variability. Mr. Frink stated that the rule of thumb in audiological testing is a 5 dB variance, whereas claimant had a 10 to 20 dB variance. On this basis, Mr. Frink stood by his conclusion that claimant had had a significant change in his hearing in the past five years.

Dr. Hodgson responded to Mr. Frink's opinion. He stated:

> "Mr. Frink is correct in that the normal variation on test, re-test variability is 5 dB, However this is 5 dB in any direction and so a 10-15 dB change is required to determine any drop in hearing. In addition, it is common that audiograms done over time have variations depending on a variety of testing conditions. Therefore a true hearing loss

> must show a 10-20 dB variation as a sustained trend over time and not on any given test or two. I have again reviewed all of the audiograms available in [claimant's] file and feel that there is no sustained increase in hearing loss between January 1990 and November 1995, the time of my last evaluation. As mentioned in my previous report * * * the impairment ratings, which take into account the overall average hearing loss, did not change between 1990 and 1995. In fact, they are nearly identical. Again, this confirms my impression that there was no increase in hearing loss due to any cause between 1990 and 1995.
>
> "It has always been my position in doing industrial hearing loss claims to review sustained and definite increases in hearing loss over time. It is near universal that small fluctuations in the absolute values are obtained at any given test. In this case it is quite clear that no sustained increase in the hearing loss is seen over the time period in question." (Ex. 110).

When there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Here, we find the medical opinion of Dr. Hodgson to be better reasoned than that of Mr. Frink. In addition, we find Dr. Hodgson's opinion to be based on complete and accurate information. Based on Dr. Hodgson's persuasive opinion, we conclude that claimant has not established an actual worsening of his hearing loss condition since the last arrangement of compensation in 1990.[1]

ORDER

The ALJ's order dated February 12, 1996 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] Claimant argues that Dr. Hodgson's opinion is unpersuasive because he compares claimant's January 1990 hearing test to his 1995 hearing test. Claimant asserts that the September 1990 hearing test should be compared since it was closest in time to the last claim closure. In his January 1996 report, Dr. Hodgson indicated that he had again reviewed all of the audiograms available in claimant's file and found no sustained increase in hearing loss. Thus, we are persuaded that Dr. Hodgson took into account all of claimant's hearing tests and found no evidence of a worsening. Consequently, we disagree with claimant's assertion that Dr. Hodgson's opinion is unpersuasive.

In the Matter of the Compensation of
ANNIE M. NEUBERGER, Claimant
WCB Case No. 94-12337
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Meyers, Radler, 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) Herman's order that set aside its denial of claimant's aggravation claim for a neck condition. On review, the issue is aggravation. We reverse in part, and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts. Claimant compensably injured her neck in April 1990 while working for the employer. Her injury resulted in diskectomies and fusion at C5-6-7. A November 7, 1991 Order on Reconsideration awarded claimant 29 percent unscheduled permanent disability and affirmed an October 15, 1991 Determination Order's award of 5 percent scheduled permanent disability for each arm.

In May 1992, claimant became employed with SAIF's insured, where she was initially assigned light duty. Claimant's work duties increased, including long days, repetitive lifting with her arms and extending her neck backwards. In December 1993 and thereafter, claimant sought treatment from Dr. Sachdev for neck and shoulder pain. Dr. Sachdev diagnosed a cervical strain, prescribed physical therapy, and, in May 1994, took claimant off work. Claimant's condition improved only slightly with physical therapy. In July 1994, Dr. Sachdev referred claimant to Dr. Gerry, rehabilitation specialist, for chronic pain management.

On September 21, 1994, claimant filed a claim with the employer for a worsened neck condition. On October 3 and 10, 1994, the employer denied compensability of claimant's current condition, aggravation, and responsibility. (Exs. 58, 59).

On October 19, 1994, Dr. Sachdev referred claimant to Dr. Brett for evaluation. Dr. Brett compared 1994 neck films with those of 1991 and concluded that claimant's fusion had healed solidly with good alignment. On October 24, 1994, Dr. Sachdev limited claimant to part time work and a lifting limit of 10 pounds.

Aggravation

As a preliminary matter, we affirm and adopt that portion of the ALJ's opinion which found that claimant's current cervical condition is causally related to the 1990 work injury and concluded that the employer remains responsible for that condition.

The ALJ also found that claimant suffered increased symptoms resulting in diminished earning capacity while working for SAIF's insured.[1] The ALJ set aside the employer's denial of claimant's aggravation claim for a neck condition, finding that claimant's symptoms had become chronic, that her range of motion was reduced beyond that at the time of claim closure, and that claimant had demonstrated diminished earning capacity.

The employer contends that claimant has failed to establish that her accepted neck condition has "actually worsened" or that her worsening is more than a waxing and waning of symptoms contemplated by her previous permanent disability awards. We agree.

ORS 656.273(1) provides:

> "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."

In addition, ORS 656.214(7) 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."[2]

In Carmen C. Neill, 47 Van Natta 2371 (1995), we held that an "actual worsening" under ORS 656.273(1) is established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the condition that is greater than that anticipated by the prior award of permanent disability.

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[1] SAIF, as the insurer for Citadel, had been dismissed as a party to the claim.

[2] Except as provided otherwise, Senate Bill 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 ORS 656.273(1) and 656.214(7) are not among the exceptions to the general rule, See SB 369 § 66 (listing exceptions to general retroactivity provision), the current version of the statute now governs this matter.

In this case, we find insufficient evidence of either a pathological worsening of claimant's C5-6-7 neck condition or a symptomatic worsening greater than that anticipated by claimant's prior award of 29 percent unscheduled and 10 percent scheduled permanent disability for her April 10, 1990 compensable neck injury.

Three doctors provided opinions regarding claimant's current condition: Drs. Gerry, Sachdev and Brett. Dr. Gerry, who performed a rehabilitation consultation for Dr. Sachdev, claimant's treating physician, opined that claimant's current pain symptoms were due to a muscular strain brought about by the repetitive use of her arms and her sleep problems. He did not specifically relate claimant's current complaints to her accepted condition. (Ex. 55D-2).

Dr. Sachdev opined that claimant's C5-6-7 disc problem had not worsened. Instead, she opined that claimant was suffering from a new and separate muscle strain that resulted from her work at SAIF's insured. (Ex. 62A-1).

Dr. Brett, neurosurgeon, who treated claimant for her 1990 C5-6-7 disc condition and who examined her after her alleged worsening, found no objective evidence that claimant's compensable condition had worsened. Although he noted that claimant's cervical range of movement was slightly reduced to a residual of 10 degrees in extension, he also noted that such a reduction in range of movement was expected. He moreover opined that claimant remained medically stationary. (Ex. 58A-1).

Thus, none of the treating or examining doctors has indicated that claimant's underlying condition has pathologically worsened. Moreover, although Dr. Brett attributes claimant's current symptoms to the compensable condition, his opinion does not support claimant's burden to prove that the waxing and waning of her condition is greater than that contemplated by the prior permanent disability awards.

As noted above, ORS 656.214(7) 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." Claimant received 29 percent unscheduled and 10 percent scheduled permanent disability awards. Thus, future waxing and waning of her symptoms were contemplated. ORS 656.214(7); Paul Bilecki, 48 Van Natta 97 (1996). In order to establish an aggravation claim, claimant must prove that her waxing and waning is greater than that anticipated by the prior award.

Although the ALJ implicitly concluded that claimant is no longer capable of performing the work to which she was released subsequent to claim closure, claimant must nevertheless establish that her symptoms that resulted in loss of earning capacity are greater than those anticipated by the prior award. Dr. Brett's opinion does not indicate that claimant's symptoms are greater than the waxing and waning of her neck and arm conditions as contemplated by her prior permanent disability awards. Accordingly, we conclude that claimant has failed to carry her burden to prove that her compensable neck condition has "actually worsened."[3]

The ALJ awarded claimant a fee of $4,000 for her counsel's services at hearing for prevailing over a denied aggravation claim. Claimant is nevertheless statutorily entitled to an assessed fee on the compensability/current condition issue. See Frank P. Heaton, 44 Van Natta 2104 (1992). Accordingly, we reduce the fee awarded at hearing for prevailing solely on the compensability issue. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing on the compensability issue 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.

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[3] In reaching this conclusion, we note that the hearing was initially convened on June 7, 1995, the effective date of Senate Bill 369. When the hearing reconvened on June 20, 1995, the ALJ invited discussion on the changes in the law, which claimant declined. (Tr. 10). We have remanded for further development of the record in claims in which there is an issue regarding whether a symptomatic worsening constitutes an "actual worsening" under amended ORS 656.273(1). See,e.g., Carmen C. Neill, 47 Van Natta 2371 (1995). However, in this case, claimant expressed no need for further development of the record to address changes in the law. Under such circumstances, we find no compelling basis to remand. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Soilo C. Diaz, 48 Van Natta 371 n 2 (1996); James J. Lunski, 48 Van Natta 935 (1996).

ORDER

The ALJ's order dated August 17, 1995 is reversed in part and affirmed in part, and modified in part. That portion of the order that set aside the employer's denial of claimant's aggravation claim is reversed. The "aggravation" portion of the employer's denial is reinstated and upheld. That portion of the ALJ's order that set aside the current condition denial is affirmed. For services at hearing, claimant is awarded an assessed attorney fee of $2,500, in lieu of the ALJ's award of $4,000, payable by the self-insured employer.

July 9, 1996 Cite as 48 Van Natta 1495 (1996)

In the Matter of the Compensation of
SANDRA PICKETT, Claimant
WCB Case No. C601270
ORDER APPROVING CLAIM DISPOSITION AGREEMENT

Reviewed by Board Members Hall and Moller.

On April 29, 1996, 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, pro se, releases certain rights to future worker's compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On May 6, 1996, the Board wrote to the parties seeking additional information regarding claimant's present return to work status. On June 13, 1996, the Board received claimant's June 11, 1996, letter providing information regarding her current return to work status. In addition, claimant indicated that the self-insured employer's claim processing agent, Johnston and Culberson, was refusing to sign the addendum requested by the Board's May 6, 1996 letter until claimant signed a termination of employment agreement. Claimant's letter indicated that she had not agreed to, and did not wish to sign, the termination of employment agreement.

Thereafter, at the Board's request, Johnston and Culberson replied to claimant's letter. Specifically, Johnston and Culberson stated that the settlement offered to claimant was $20,000 in exchange for a CDA and a resignation and employment release. Johnston and Culberson further indicated that claimant had signed and returned the addendum to the CDA, but had not signed and returned the employment termination agreement.

Pursuant to ORS 656.236(1)(a), parties may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the Board may prescribe. We have previously held that only the rights and obligations under ORS Chapter 656 may be released by a claim disposition agreement. Karen A. Vearrier, 42 Van Natta 2071 (1990). In Vearrier, we disapproved a CDA that purported to release the claimant's rights to reemployment. We reasoned that we had no authority to approve a release of reemployment rights since the release of those rights pertained to a matter outside of Chapter 656.

ORS 656.236(1) provides that a disposition shall be approved, unless one of the following circumstances applies:

"(A) The Board finds the proposed disposition is unreasonable as a matter of law;

"(B) The Board finds the proposed disposition is the result of an intentional misrepresentation of material fact; or

"(C) Within 30 days of submitting the disposition for approval, the worker, the insurer or self-insured employer request the Board to disapprove the disposition."

Here, the CDA was submitted by the parties for approval on April 29, 1996. The CDA contains no provision regarding a termination of employment agreement. Inasmuch as the CDA submitted by

the parties contains no provision covering matters not within ORS Chapter 656, we do not find the document, as submitted, to be unreasonable as a matter of law.[1] In addition, neither party has requested, within the 30 day period since submission, that we disapprove the CDA. Finally, there is no allegation of an intentional misrepresentation of material fact. Under such circumstances, there is no statutory basis on which to disapprove the CDA. See ORS 656.236. Accordingly, we approve the parties' CDA.

IT IS SO ORDERED.

[1] OAR 438-009-0022(4)(d) requires the CDA to contain information regarding whether the worker has ever been able to return to the work force following the industrial injury or occupational disease. Here, the parties' CDA provides that claimant was released to modified work, but that the employer had no suitable work available. In other words, claimant has been released to modified work, but has not returned to the work force because no work was available. Inasmuch as the aforementioned provision satisfies the requirements of the applicable rule, we conclude that further supplementation of the parties' CDA is unnecessary. In reaching this conclusion, we note that, even if claimant's current return to work status had not improved, we would be unable to find the CDA, in which claimant releases certain rights to future non-medical worker's compensation benefits in return for $20,000, to be unreasonable as a matter of law. See ORS 656.236. Under such circumstances, we rescind our previous request for an addendum to the CDA.

In the Matter of the Compensation of
AARON D. PIERCE, Claimant
WCB Case Nos. 95-02185 & 94-13609
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall, Christian and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS) condition; and (2) upheld its denial of claimant's consequential right ulnar neuritis condition. On review, the issues are compensability. We reverse.

FINDINGS OF FACT

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

On May 12, 1990, claimant was standing on the back of a lathe when someone turned the lathe's belts on. Claimant fell, striking his right elbow on a sprocket.

We do not adopt the "Ultimate Findings of Fact."

We do not find that claimant's April 4, 1995 right ulnar translocation surgery was "for numbness and tingling in his right finger and marked degenerative changes in the elbow, with ulnar neuropathy." (Opinion and Order p.3). Instead, we find that the 1995 right elbow surgery was for chronic ulnar neuritis of the right elbow resulting from the May 1990 work injury. (See Ex. 42).

The ALJ found that claimant's work for the employer in the 1980's and 1990's did not require constant sustained flexion, extension, or pronation of the wrists or gripping or flexion of the fingers. (Opinion and Order p.3). Instead, we find that claimant performed largely repetitive hand intensive work activities for the employer for 30 years.

CONCLUSIONS OF LAW AND OPINION

Right CTS

The ALJ concluded that claimant failed to prove his occupational disease claim for a right CTS condition, because he found the opinion of Dr. Jewell, examining physician, more persuasive than that of Dr. Bert, treating physician. We disagree.

Claimant has performed a variety of jobs at the employer's mill for 30 years. He was off-bearer on the core belt, dry chain, and green chain. He operated the employer's four and eight foot lathes, chipper, pond boat, power saw, jack hammer, metal detector, and spreader. He was millwright/maintenance assistant, strip cutter helper, eight foot lathe spotter, and knife grinder.

Dr. Bert opined that claimant's repetitive hand-intensive work for the employer was the major contributing cause of claimant's right CTS condition. (Exs. 30, 40A, 41A).

Dr. Jewell provides the only evidence to the contrary. Having reviewed video tapes of a working dryer feeder, Dr. Jewell opined that claimant's activities for the employer did not involve the specific ergonomics associated with CTS. (Ex. 26). However, there is no evidence that Dr. Jewell actually considered or evaluated[1] the hand and wrist motions required by claimant's work other than dryer feeding.[2] Under these circumstances, we do not find Dr. Jewell's opinion that claimant's CTS is idiopathic particularly persuasive.

On the other hand, considering Dr. Bert's advantageous position as claimant's treating physician (and the absence of persuasive reasons to discount his opinion), we defer to his conclusion that claimant's 30-year work history with the employer is the major cause of his right CTS condition. See Givens v. SAIF, 61 Or App 490, 494 (1983) (The opinion of the treating doctor is entitled to greater weight because he has more firsthand exposure to and knowledge of claimant's condition). Accordingly, we conclude that claimant has carried his burden under ORS 656.802.

Right Ulnar Neuritis

The ALJ found that claimant failed to prove that his right elbow neuritis condition is a compensable consequence of his May 12, 1990 work injury. In reaching this conclusion, the ALJ again relied on the opinion of Dr. Jewell, examining physician, rather than that of Dr. Bert, treating surgeon. The ALJ reasoned that Dr. Bert's history was incomplete or inaccurate, because he was apparently unaware that claimant had suffered right elbow injury and symptoms prior to the May 1990 work injury.[3] Because Dr. Bert also failed to distinguish claimant's uninjured left elbow ulnar problems from those affecting his right elbow, the ALJ found Dr. Bert's opinion (that claimant's right ulnar neuritis condition is work related) unpersuasive.[4]

Claimant argues that his prior right elbow injuries and symptoms were never clinically significant; that they did not contribute to the claimed neuritis condition; and that the work injury alone caused his neuritis. He testified that he had right elbow injuries in 1966 or 1967 and in 1969 or 1970, but did not receive medical treatment or have time loss on either occasion. (Tr. 8-10; see Tr. 40-42). The latter injury was more painful than the former, but both resolved. Claimant was not aware that anything was wrong[5] with his right elbow, because it did not bother him for years. (Tr. 42).

After the 1990 injury, in contrast, claimant suffered continuing right elbow symptoms, including pain which woke him up at night. In 1993, Dr. Bert diagnosed post traumatic degenerative arthritis with some evidence of ulnar neuropathy in claimant's right elbow. (Ex. 5-3). Later, the diagnosis changed to chronic ulnar neuritis, for which Dr. Bert performed a translocation of claimant's right ulnar nerve on April 4, 1995. (The post-surgery diagnosis remained chronic ulnar neuritis.)

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[1] For example, although Dr. Jewell acknowledged claimant's history of cutting 25,000 to 30,000 pieces of veneer (3 foot by 2 inches) into smaller pieces (when working as a "strip cutter), the doctor did not explain how such work activities would or would not cause CTS. (Ex. 35-2).

[2] Nor is there evidence that claimant's CTS would only be caused by activities performed in the 1980's and 1990's (e.g., dryer feeding).

[3] See note 6, infra.

[4] Claimant does have left elbow degeneration similar to his right elbow degeneration. However, only the right elbow was injured in 1990 and only the right elbow subsequently required surgery. In our view, these circumstances support, rather than undermine, Dr. Bert's opinion that claimant's right elbow neuritis is a consequence of the 1990 work injury.

[5] Dr. Mann discovered an "old fracture of the radial head of claimant's right elbow, with some early osteoarthritis," while treating claimant for a serious left wrist injury in 1984. (Ex. 8). We note that claimant's right elbow degenerative condition was not compensable as of the employer's July 27, 1990 partial denial of that condition. (See Ex. 7).

Dr. Bert was aware of claimant's preexisting right elbow osteoarthritis and had a "hands on" opportunity to observe claimant's condition during surgery. Based on claimant's history and clinical presentation, Dr. Bert specifically opined that claimant's 1990 work injury, not his degenerative condition, was the major cause of the neuritis condition for which claimant required surgery. (Ex. 42). Considering his advantageous position as treating surgeon and his materially accurate history,[6] we find Dr. Bert's conclusions persuasive.[7] See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988); Givens v. SAIF, supra. Consequently, based on Dr. Bert's opinion, we conclude that claimant has carried his burden of proving that his right elbow neuritis condition is a compensable consequence of his May 12, 1990 work injury.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500 payable by the 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 issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated October 18, 1995, as reconsidered January 2, 1996, is reversed. The self-insured employer's denials are set aside and the claims are remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $4,500 attorney fee, payable by the self-insured employer.

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[6] We do not agree with the dissent's contention that Dr. Bert had an inaccurate history. The dissent argues that Dr. Bert was unaware of claimant's prior elbow injuries. However, on May 18, 1995, Dr. Bert reported in a chartnote that claimant amended his history and informed Dr. Bert about a 1984 wrist injury which resulted in loss of motion of the elbow. (Ex. 5, pg. 7). Consequently, when Dr. Bert reported in August 24, 1995 that claimant did not have a history of other injury (i.e., to his elbow), he had been advised by claimant about the 1984 wrist incident. We do not consider Dr. Bert's August 1995 report inaccurate or incomplete, merely because it does not consider the 1984 wrist injury to also include "injury" to claimant's elbow.

Furthermore, although it is not clear whether Dr. Bert was aware of claimant's elbow injuries sustained in the 1960's, we do not find such a factor to be dispositive. Over twenty years have passed since claimant's prior, relatively insignificant right elbow injuries. Moreover, in light of Dr. Bert's unique opportunity to directly observe claimant's right elbow condition (and the preexisting osteoarthritis) during surgery, we do not find that Dr. Bert's history regarding claimant's prior injuries was materially inaccurate. See Maria Gonzales, 46 Van Natta 466, 467 (1994) (A medical opinion is not unpersuasive due to an incomplete history, unless the omitted facts "have some bearing on the relevant issue.") (quoting Palmer v. SAIF, 78 Or App 1561 (1986)).

[7] Dr. Jewell provides the only evidence to the contrary. He opined that claimant's right elbow problems were probably not related to the 1990 injury, based largely on a belief that claimant had normal nerve conduction studies. (See Exs. 35-5, 43-2). However, considering Dr. Bert's explanation that claimant's ulnar neuritis is manifested clinically (rather than through conduction studies), we do not find Dr. Jewell's reasoning persuasive.

Board Member Moller concurring in part and dissenting in part.

The majority reverses the order of the ALJ which found that claimant failed to establish compensability of a right wrist carpal tunnel condition and a right ulnar neuritis condition. I agree with the majority that claimant has established compensability of his carpal tunnel condition. However, I dissent from that portion of majority's order which concludes that claimant has also established compensability of his ulnar condition.

Dr. Bert provides the only medical opinion supporting the claim for a right ulnar neuritis condition. Dr. Bert's opinion concerning causation of claimant's right ulnar condition consists solely of the following statement in a letter to claimant's attorney: "I do not feel the April 4, 1995 surgery for right ulnar neuritis was related to a degenerative condition in the elbow which pre-existed his 5-12-90 injury. I feel the major cause of his ulnar neuritis was, historically, the 1990 injury, as I have no history of any other injury." (Ex 42). As explained in the majority's opinion, the 1990 injury involved a blow to claimant's right elbow.

The conclusory nature of Dr. Bert's opinion is apparent. That reason alone would provide sufficient grounds to find the opinion unpersuasive. However, Dr. Bert's opinion suffers from an even more significant deficiency. What little reasoning Dr. Bert does offer is premised on the mistaken reasoning that claimant had "no history of any other injury" to his elbow. In fact, as early as 1984, claimant was found to have an "old" fracture of the radial head region of the elbow with early osteoarthritis. During that same year, Dr. Nathan reported that examination of the ulnar nerve proximally to each elbow was "slightly uncomfortable bilaterally." (Ex 1-1).

In addition, when Dr. Adams began treating claimant for his ulnar condition in August 1990, he reported that claimant "has had problems in that right elbow before. In 1984 Dr. Mann diagnosed an old fracture of the radial head with some early osteoarthritis. The patient has not been able to fully extend the elbow since." (Ex 8-1). Dr. Adams noted that claimant not only had osteoarthritis in the radial head, but that he also had osteoarthritis in the olecranon humeral joint as well. (Id.). Similarly, in 1990, Dr. Bufton noted that claimant "actually describes problems with the right elbow as far back as 1984." (Ex 11-1).

Further, claimant testified to two separate injuries to his right elbow occurring between 1966 and 1970. The first injury involved a fall of ten to twelve feet with claimant landing " on my arm, you know, elbows, and this was the elbow that I hurt too." (Tr. 9). The second injury involved a blow to claimant's right elbow which resulted in "a couple of months" of light duty work. (tr. 8-9). It is these injuries, rather than claimant's 1984 injury to his wrist, that Dr. Bert fails to consider. The significance of claimant's 1984 injury is that treatment for that injury disclosed a fracture which, at that time, was already characterized as "old" and also the disclosed the existence of early osteoarthritis.

By contrast, when Dr. Bert commenced treating claimant in October 1992, his treatment was directed to claimant's low back only. (Ex 15). Dr. Bert did not begin focusing attention on claimant's elbow until November 1993. (Ex 5-3). In April 1995, Dr. Bert performed right ulnar surgery in the form of translocation of the right ulnar nerve. One month later, in May 1995, Dr. Bert authored a chart note stating: "[Claimant] amends the history of his elbow and states that in May '90 he was working on an 8' lathe when the electrician turned it on. He fell in between the carriage and the lathe and hit his elbow on a sprocket. * * * *. Before this in '84, not '86 as my note states, he had a wrist injury but had some loss of motion of his elbow, he states, since then but that was primarily a wrist injury." (Ex 5-7).

The majority acknowledges that Dr. Bert lacks a complete history because he incorrectly stated that claimant had no prior right elbow injuries. The majority nevertheless finds that this shortcoming is not problematic because the prior injuries occurred "over twenty years" earlier and were "relatively insignificant." The majority's medical analysis is unfortunate. Any analysis should more appropriately be found in Dr. Bert's reports rather than in the majority's opinion. Further, the majority's characterization of claimant's prior injuries as "relatively insignificant" conflicts with the medical reports of Drs. Adams and Bufton, which indicate that claimant has had right elbow problems since at least 1984. The majority's characterization of those earlier right elbow injuries also conflicts with claimant's own testimony concerning the incidents.

Further, claimant has left elbow degeneration similar to his right elbow degeneration. Claimant also has symptoms of ulnar pathology on the left as well as the right. The majority reasons that the existence of bilateral ulnar problems supports Dr. Bert's opinion that claimant's right elbow neuritis is a consequence of the 1990 work injury. The logic of the majority's medical analysis is not apparent. In any event, again the difficulty with this reasoning is the absence of any discussion of these medical facts in Dr. Bert's opinion concerning causation.

Under these circumstances, I would find that Dr. Bert's reasoning regarding claimant's right ulnar condition is based on an incorrect history and is inadequately explained. Therefore, his causation conclusion is unpersuasive. Accordingly, I respectfully dissent from that portion of the majority's decision that finds claimant's right ulnar nerve condition to be compensable.

In the Matter of the Compensation of
DAVID M. CHANDLER, Claimant
WCB Case No. 95-08592
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that found premature a Determination Order that closed claimant's bilateral wrist tendinitis claim without an award of permanent disability. In his brief on review, claimant argues that, if we find his claim was not prematurely closed, he is entitled to an award of scheduled permanent disability. On review, the issues are premature closure and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant sustained compensable bilateral wrist tendinitis as a result of his work activities making hoop-type jewelry. On July 8 and August 8, 1994, claimant treated with Dr. Neary, M.D., for his bilateral wrist tendinitis condition. (Ex. 1-5, -6, -7). On August 8, 1994, Dr. Neary stated that claimant was "to continue at work with a maximum of 4 hrs per day of hoop making activity, and recheck with me in one month. At that time I anticipate medially [sic] stationary status." (Ex. 1-7). Claimant did not return to Dr. Neary for further treatment.

On October 5, 1994, claimant was examined by Dr. Stanford, M.D., on behalf of SAIF. (Ex. 4). Dr. Stanford stated that claimant needed no further treatment or studies for the bilateral wrist tendinitis, and found claimant medically stationary. (Ex. 4-5).

On October 12, 1994, SAIF accepted the claim for bilateral tendinitis, with a date of injury of January 3, 1994. SAIF classified the claim as a nondisabling injury. (Ex. 5). By Determination Order dated December 20, 1994, the Department reclassified the claim as disabling. (Ex. 6).

On February 7, 1995, a SAIF claims adjuster sent a letter to claimant, stating:

> "It appears you have recovered from your work injury of January 3, 1994 because you have not seen your physician, Jane M[.] Neary, MD, since 8-8-94. It is my understanding that no further appointments are scheduled. Your claim will be closed if you fail to seek medical treatment.
>
> "Please let your physician know that you have recovered and do not intend to seek further care or, if needed, schedule another appointment. If you have not contacted your physician within the next 10 days, I will assume that you have fully recovered from your injury and your claim will be closed." (Ex. 6A).

On February 22, 1995, SAIF requested that the Department close claimant's claim by Determination Order. (Ex. 6B). On March 14, 1995, a Determination Order issued which administratively closed claimant's claim, declared claimant medically stationary on February 21, 1995, and awarded temporary disability but no permanent disability. (Ex. 7). Claimant requested reconsideration, raising issues of premature closure and extent of permanent disability, among other issues, and requesting appointment of a medical arbiter. (Ex. 9). Subsequently, claimant withdrew his request for a medical arbiter and submitted a May 30, 1995 check-the-box report from Dr. Neary for consideration. (Exs. 8, 10A).

On July 5, 1995, an Order on Reconsideration issued which awarded chronic condition awards for 5 percent (7.5 degrees) scheduled permanent disability bilaterally for loss of use or function of the right and left wrists. (Ex. 12). This award was based on Dr. Neary's May 30, 1995 report. (Ex. 12-3, -4). The July 5, 1995 reconsideration order affirmed the March 14, 1995 Determination Order in all other respects. SAIF requested reconsideration.

The Department abated the July 5, 1995 Order on Reconsideration and requested clarification from Dr. Neary. (Exs. 13, 14). Dr. Neary stated that she had last seen claimant on August 8, 1994, and she was unable to assess claimant's medical condition at claim closure (March 14, 1995) because claimant was not medically stationary and was on work restrictions when she last saw him. Id. Based on Dr. Neary's clarification, the Department found that the evidence did not establish that claimant had any chronic condition impairment. (Ex. 15-3A). On July 25, 1995, the Department issued its Order on Reconsideration and affirmed the March 14, 1995 Determination Order in all respects. (Ex. 15).

Claimant requested a hearing, which was held on October 17, 1995. The record was closed December 21, 1995.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The ALJ found that SAIF's notice regarding administrative closure did not strictly comply with the Department's rules; therefore, the ALJ found the closure improper and premature. Accordingly, the ALJ remanded the claim to SAIF for processing. We agree.

Amended ORS 656.268(1)[1] provides the standards under which a claim may be closed. Pursuant to 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. Amended ORS 656.268(1)(b) applies to claimant's claim. Mark E. Cooper, 47 Van Natta 2223 (1995).[2]

Prior to the enactment of the amendments to ORS 656.268(1)(b), former OAR 436-30-035(7) provided that a worker would be presumed to be medically stationary when the worker had not sought medical treatment in excess of 28 days, unless so instructed by the attending physician, provided that the carrier had 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 had to be in strict compliance with former OAR 436-30-035 in order for the medically stationary presumption to apply. In this regard, in Bertha Paniagua, we reasoned that the purpose of the rule was 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, we held that "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.

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[1] 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:

"* * * *

"(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."

[2] In Mark E. Cooper, we determined that amended ORS 656.268(1)(b) applied retroactively to the claimant's claim where the time to appeal the Board's decision had not expired. We found that such retroactive application did not create an unjust and absurd result because, prior to the enactment of amended ORS 656.268(1)(b), pursuant to former OAR 436-30-035, the claimant was on notice that his claim could be closed if he failed to seek medical treatment without his attending physician's approval under essentially the same circumstances as provisions subsequently enacted in amended ORS 656.268(1)(b). Here, the Orders on Reconsideration and the hearing all took place after June 7, 1995, the effective date of Senate Bill 369 which enacted the amendments to ORS 656.268(1)(b). Therefore, there is even more reason to find that amended ORS 656.268(1)(b) applies to the present case.

In Mark E. Cooper, we determined that application of amended ORS 656.268(1)(b) did not necessarily result in a finding that the claim closure was proper. 47 Van Natta at 2225. We found that the Paniagua court did not overrule the fundamental premise that the merits of a premature closure issue remained irrespective of the procedural closure issue. Id. at 2224 n.3. On the other hand, we found that Paniagua required that the procedural closure issue be addressed before review of the merits of the premature closure issue could proceed. Id.

In addressing the procedural closure issue, we noted that, 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. Because the legal standard had changed while Board review of the case was pending and the record was devoid of evidence regarding whether the claimant's failure to seek medical treatment was attributable to reasons beyond his control, we found the record insufficiently developed. 47 Van Natta at 2225. Therefore, we remanded the matter for further development of the record regarding whether the claimant's failure to seek treatment was for reasons beyond his control.

Here, remand is not appropriate. Unlike Cooper, the legal standard did not change after the hearings record was developed. Instead, amended ORS 656.268(1)(b) was in effect well before the October 17, 1995 hearing date.[3] Therefore, we find no showing of good cause or other compelling basis that would justify remanding this case for evidence regarding whether claimant's failure to seek medical treatment was attributable to reasons beyond his control. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

The record contains no evidence as to the reason claimant failed to seek medical treatment. Therefore, claimant has failed to affirmatively establish that failure to seek medical treatment was attributable to reasons beyond his control. Amended ORS 656.268(1)(b). Thus, procedural closure of claimant's claim is not prohibited on that basis.

However, that does not end our inquiry. As noted above, 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 and procedural closure to be proper. Paniagua v. Liberty Northwest Insurance Corporation, supra; Bertha Paniagua, supra. When a rule specifically and unambiguously requires the carrier to follow a certain procedure, substantial compliance is not sufficient. SAIF v. Robertson, 120 Or App 1 (1993); Fairlawn Care Center v. Douglas, 108 Or App. 698 (1991); Eastman v. Georgia Pacific Corp., 79 Or App. 610 (1986). In addition, because amended ORS 656.268(1)(b) was enacted after former OAR 436-30-035 and the amended statute applies to claimant's claim, we shall interpret the former rule in a manner consistent with the amended statute.[4]

Claimant's claim was administratively closed pursuant to former OAR 436-30-035(7) and (8) (WCD Admin. Order 94-059), which provide, in relevant part:

> "(7) The worker will be presumed to be medically stationary when the worker no longer requires medical treatment, when:
>
> "(a) the worker has not sought medical care for a period in excess of 28 days, unless so instructed by the attending physician, and;
>
> "(b) the insurer has notified the worker by letter that claim closure may be requested for failure to seek medical treatment. The notification letter shall inform the worker of the responsibility to seek treatment if needed, and of the consequences, including but not limited to claim closure, for failure to seek medical treatment or a closing examination.
>
> "(8) Unless the attending physician has declared, or a preponderance of medical opinion is that, the worker is medically stationary on an earlier day, the worker is presumed to be medically stationary 14 days from the certified mailing date of the insurer's notification letter pursuant to section (7) of this rule. . . ."

Interpreting this former rule in a manner consistent with amended ORS 656.268(1)(b), a new element is added to the former rule in that procedural claim closure is not appropriate where the worker establishes that failure to seek medical treatment was attributable to reasons beyond his or her control. Amended ORS 656.268(1)(b). As discussed above, here, procedural closure is not prohibited on that basis. In addition, the "28 day" period without seeking medical treatment in former OAR 436-30-035(7)(a) becomes a "30 day" period under amended ORS 656.268(1)(b). Finally, we find that the "14 day" period provided in former OAR 436-30-035(8) is not inconsistent with the amended statute. For the following reasons, we find that SAIF's notice did not strictly comply with the relevant provisions of former OAR 436-30-035.

SAIF's February 7, 1995 notice stated that claimant had not seen his physician since August 8, 1994 and notified claimant that his claim would be closed if he failed to seek medical treatment. (Ex. 6A). The notice also stated that, if claimant did not contact his physician "within the next 10 days," the claims adjuster would assume claimant had fully recovered from his injury and his claim would be closed. Id. The ALJ found that, because SAIF's notice referenced a 10 day period within which claimant was to contact his physician and former OAR 436-30-035(8) provided a presumptive medically stationary date 14 days from the mailing date of the notification letter, SAIF's notice did not strictly comply with the provisions of OAR 436-30-035. SAIF argues that, since the 14 day period refers to the presumptive medically stationary date, and not a notification period, its notification strictly complied with the rule. We disagree with SAIF's argument and find that the ALJ correctly analyzed the rule.

SAIF argues that, since former OAR 436-30-035(7) provides the rules regarding notification and gives no specific time frame, its use of a "10 day" period does not violate the rule. However, SAIF overlooks the fact that the "10 day" period used in its notification letter does not appear anywhere in the rule. Furthermore, SAIF offers no support for its arbitrary directive to claimant to contact his physician within "10 days." The only date used in the rule is the "14 day" date in former OAR 436-30-035(8). Nevertheless, SAIF failed to include a statement in its notice that, unless claimant failed to seek treatment from his physician, the claim would be closed and claimant would be presumed medically stationary 14 days from the date of the notification letter. Former OAR 436-30-035(8). Instead, rather than notifying claimant of the potential ramifications should he fail to comply with the administrative directive, SAIF merely inserted its own "10-day" time limitation to claimant for contacting his physician.

Under such circumstances, we conclude that SAIF's administrative closure did not strictly comply with the rules. Thus, SAIF had no authority to request administrative closure of claimant's claim. In other words, because the rules were not strictly complied with, the procedural closure was improper. Therefore, the Determination Order and Order on Reconsideration that were based on this procedural closure are set aside. See Safeway Stores, Inc. v. Little, 107 Or App 316 (1991) (in the light of the initial invalid job offer that did not comply with the rule, employer was required to submit an offer to claimant that complied with the rule before it could terminate her benefits); Eastman v. Georgia Pacific Corp., supra (the carrier must strictly comply with administrative rule setting forth procedural requirements for terminating temporary total disability (TTD); if it does not strictly comply, it is not entitled to unilaterally terminate TTD under former ORS 656.268(3)(b)); Eulalio M. Garcia, 47 Van Natta 96 (1995) (same).

In reaching this decision, we note that SAIF makes no argument on the merits that claimant was medically stationary at claim closure. Instead, SAIF solely argues that the procedural closure was proper. Thus, it would not be appropriate to address the merits of the premature closure issue. Bertha Paniagua, 46 Van Natta at 55 (where the insurer never contended that the claimant should or could be found medically stationary based on the medical evidence and, instead, sought and obtained closure under former OAR 436-30-035 based upon a presumption to which it was not entitled, it was error for the Board to have based its original order on its review of the medical evidence).

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[3] We note that amended ORS 656.268(1)(b) was effective before the record for the July 5, 1995 Order on Reconsideration was developed. (Exs. 10A, 7).

[4] Effective February 17, 1996, the Department enacted rules applying amended ORS 656.268(1)(b). OAR 436-030-0034(1); WCD Admin. Order No. 96-052. OAR 436-030-0034(1)(b) provides that "[w]orkers shall be given 14 days to respond to the [insurer's] certified notification letter before any further action is taken by the insurer towards claim closure." Because this rule was not effective until February 17, 1996, it does not apply to SAIF's February 7, 1995 notification letter.

We also acknowledge our statement in Mark E. Cooper that the Paniagua court "did not overrule the fundamental premise that the merits of a premature closure issue remained irrespective of the procedural closure issue." 47 Van Natta at 2224 n.3. However, that statement regarding the merits of a premature closure issue was dicta in that the fundamental issue in Cooper was whether the record was adequately developed to determine whether the procedural closure was proper. In addition, in Cooper, we disagreed with the employer's argument that application of amended ORS 656.268(1)(b) necessarily results in a finding that the claim closure was proper. Id. at 2225. However, even if addressing the merits of a premature closure issue is not precluded when a procedural claim closure is proper, that does not mean that the merits of a premature closure issue are to be addressed when the procedural claim closure is improper.

Because we are setting aside the March 14, 1995 Determination Order, the July 5, 1995 Order on Reconsideration, as reconsidered July 25, 1995, we do not address claimant's arguments regarding the extent of scheduled permanent disability.

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

ORDER

The ALJ's order dated December 21, 1995 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
FRANK L. BUSH, Claimant
Own Motion No. 93-0149M
OWN MOTION ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Claimant seeks Board authorization of an approved fee for his attorney's services culminating in our June 27, 1996 Own Motion Order which: (1) directed the insurer to pay temporary disability commencing November 17, 1995 until such compensation could be lawfully terminated; and (2) assessed a penalty, payable in equal shares to claimant and his attorney. We have received the retainer agreement submitted by claimant's attorney.

Inasmuch as our prior order resulted in increased temporary disability, claimant's attorney is entitled to a portion of that increased compensation. See ORS 656.386(2); OAR 438-015-0080. Consequently, claimant's attorney is awarded an amount of 25 percent of the increased temporary disability compensation granted by our prior order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080. The penalty assessed in our June 27, 1996 order is unchanged by this decision.

Accordingly, our June 27, 1996 order is withdrawn. As amended herein, we adhere to and republish our June 27, 1996 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
VOLLINA DRAPER, Claimant
WCB Case No. 94-14143
ORDER OF DISMISSAL (REMANDING)
Willner & Associates, Claimant Attorneys
David F. Low, Attorney

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that affirmed the Director's determination that claimant was not a subject worker of the employer at the time of her alleged injury. On review, the issues are jurisdiction and subjectivity. We dismiss the request and remand.

FINDINGS OF FACT

Claimant filed a notice of a workers' compensation injury claim with the Director of the Department of Consumer and Business Services (Director). By letter dated October 19, 1994, the Director's designee informed claimant that her notice of injury would not be processed under ORS 656.054 because she was not a subject worker of the alleged employer at the time of the alleged injury.

Claimant filed a timely request for hearing from the Director's determination. The matter was litigated before ALJ Otto. The only issue before ALJ Otto was subjectivity, i.e., whether the employer was a subject employer and claimant a subject worker of the alleged employer at the time of the alleged injury. By Opinion and Order issued March 7, 1995, ALJ Otto affirmed the Director's determination that claimant was not a subject worker. The March 7, 1995 order included a notice of appeal rights to the Workers' Compensation Board. See ORS 656.289(3). Pursuant to that notice, claimant filed a timely request for Board review of ALJ Otto's order.

CONCLUSIONS OF LAW AND OPINION

Subsequent to the issuance of the ALJ's order, the court issued its decision in Copeland v. Lankford, 141 Or App 138 (1996). Based on that decision, we conclude that authority over this matter remains with the ALJ. We base this conclusion on the following reasoning.

In Copeland, supra, the court determined that the Board lacked appellate authority to review an ALJ order affirming the Director's determination that the claimant was not a subject worker. Relying on ORS 656.704(3), the court noted that the Board's appellate authority is limited to "matters concerning a claim" which are "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." The court reasoned that, because only a subject worker is entitled to seek compensation, the right to receive compensation is directly in issue only when a claimant is determined to be a subject worker and the claim is assigned to a carrier for processing.

Consistent with this reasoning, the court concluded that the Director's determination in Copeland that the claimant was not a subject worker was not a matter concerning a claim within the meaning of ORS 656.704(3). Thus, the court concluded that review of the ALJ's order was to the court under ORS 183.482, and not to the Board. The court further concluded that the ALJ's inclusion of an incorrect notice of appeal rights to the Board affected a substantial right of claimant. Citing Callahan v. Employment Division, 97 Or App 234 (1989), the court remanded the matter to the Board with instructions to dismiss the request for review and remand to the Director for issuance of a corrected order with appeal rights to the court.

Here, as in Copeland, claimant has requested Board review of an ALJ order affirming the Director's determination that claimant is not a subject worker. Thus, there has been no determination by the Director that claimant is a subject worker entitled to seek compensation, and the claim has not been assigned to a carrier for processing. Furthermore, as in Copeland, claimant has requested Board review pursuant to the ALJ's incorrect notice of appeal rights.

The facts in the present case are indistinguishable from those in Copeland. Consequently, the Copeland decision is controlling. Consistent with that decision, we conclude that review of ALJ Otto's order rests with the court under ORS 183.482. We further conclude that the incorrect notice of appeal rights in the ALJ's order affected a substantial right of claimant. Consequently, this matter must be remanded to ALJ Otto to issue a corrected order (on behalf of the Director) with the appropriate notice of appeal rights.

Accordingly, claimant's request for Board review is dismissed. This matter is remanded to ALJ Otto, with instructions to issue a corrected order with the proper notice of appeal rights in accordance with ORS 183.482 and Copeland.

IT IS SO ORDERED.

In the Matter of the Compensation of
MILDRED J. DRYDEN, Claimant
WCB Case No. 95-11344
ORDER ON REVIEW
Adams, Day, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that found that claimant was not entitled to an assessed attorney fee under ORS 656.386(1). On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In September 1994, the SAIF Corporation initially accepted a claim for "mild knee strain." In December 1994, claimant underwent a MRI which showed a torn left medial meniscus. In September 1995, claimant's attorney wrote to SAIF, requesting that it amend its acceptance to include a claim for a torn medial meniscus. Citing to ORS 656.262(7)(a), SAIF responded that it would answer the request within 90 days. On October 12, 1995, claimant requested a hearing, alleging a "de facto" denial of the torn meniscus. On November 16, 1995, SAIF accepted the claim for torn medial meniscus.

Claimant continued to hearing, alleging that her attorney was entitled to an assessed fee for overturning a "de facto" denial of the torn meniscus. The ALJ first concluded that ORS 656.262(6)(d),[1] rather than ORS 656.262(7)(a),[2] applied to the case after finding that "claimant's torn medial meniscus was among the diagnoses in existence prior to SAIF's September 28, 1995 [sic] acceptance." The ALJ further concluded that, because SAIF did not respond within 30 days of claimant's communication, claimant could allege a "de facto" denial at hearing. The ALJ ultimately concluded, however, that claimant's attorney was not entitled to an assessed fee under ORS 656.386(1) because there had been no "denied claim" under the statute.

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[1] That statute provides:

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

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

"After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing * * *. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. * * *"

On review, claimant continues to assert that SAIF "de facto" denied the torn medial meniscus condition under ORS 656.262(6)(d). Claimant also argues that the "de facto" denial constitutes a "denied claim" under ORS 656.386(1) and, because SAIF accepted the claim prior to hearing, she is entitled to an assessed attorney fee. SAIF responds that claimant's communication was for a "new medical condition" under ORS 656.262(7)(a) and, because it accepted the torn medial meniscus within 90 days of claimant's communication, there was no "de facto" denial. Furthermore, SAIF contends that, even if it "de facto" denied the torn medial meniscus, there was no "denied claim" entitling claimant to an award under ORS 656.386(1).

Assuming that ORS 656.262(6)(d) applies and there was a "de facto" denial pursuant to that provision, as explained below, we conclude there is no "denied claim" as required by ORS 656.386(1).

ORS 656.386(1) is the statutory provision for attorney fees in cases involving "denied claims." For purposes of that statutory section, a "denied claim" is one which the 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." In deciding whether there is a "denied claim," our orders focus on whether there is evidence that the carrier has refused to pay compensation because it questioned causation. E.g., Michael J. Galbraith, 48 Van Natta 351 (1996).

For instance, in Galbraith, the only evidence that arguably showed that the carrier challenged causation was its response to the claimant's request for hearing stating that "claimant is entitled to no relief." We found such evidence did not constitute proof that the carrier questioned causation and, thus, an assessed fee was not warranted. 48 Van Natta at 351-52. On the other hand, we concluded in Emily M. Bowman, 48 Van Natta 1199 (1996), that a carrier's response to a request for hearing denying that the claimant sustained a work-related injury or occupational diseases was a refusal to pay compensation on the express ground that the condition was not compensable. Hence, we found that the claimant was entitled to a fee under ORS 656.386(1).

Here, when claimant's attorney requested that SAIF amend its acceptance, SAIF indicated that it would respond to the request within 90 days and asked for additional information from claimant concerning her condition. The response, therefore, did not expressly deny compensability of the torn meniscus. Rather, SAIF indicated that it was investigating before making any determination. SAIF's response to the request for hearing indicated only that there was no basis to award a penalty and attorney fee and there was no "de facto" denial. At hearing, SAIF's attorney made no statements that questioned causation.[3]

Thus, because there is no evidence that SAIF expressly questioned the causal relationship of the torn meniscus, we agree with the ALJ that there was no "denied claim" under ORS 656.386(1). Thus, the ALJ appropriately concluded that claimant was not entitled to an assessed attorney fee.

ORDER

The ALJ's order dated February 1, 1996 is affirmed.

[3] In this regard, we note claimant's reliance on Elizabeth A. O'Brien, 47 Van Natta 2152, 2154 (1995), where we found a "denied claim" under ORS 656.386(1) based on the carrier's attorney's statements at hearing challenging the compensability of the disputed condition. We find O'Brien distinguishable from this case because, here, SAIF's attorney made no similar statements at the hearing.

July 10, 1996 Cite as 48 Van Natta 1507 (1996)

In the Matter of the Compensation of
RICHARD R. ELIZONDO, Claimant
WCB Case No. 94-03664
ORDER ON REMAND
Andrew H. Josephson, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. In our prior order, we held that the Hearings Division had jurisdiction over claimant's request for hearing concerning the managed care organization's (MCO's) disapproval of a request for surgery and further concluding that

the surgery was reasonable and necessary. Richard R. Elizondo, 47 Van Natta 377 (1995). Pursuant to its June 24, 1996 order, the court has remanded to the Board for reconsideration in light of DCBS v. Lopez, 139 Or App 322 (1996).

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) "Findings of Fact" except for the last six sentences.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable right leg injury. In May 1993, claimant's treating orthopedic surgeon, Dr. Grewe, requested authorization from claimant's MCO, CareMark Comp., to perform right knee surgery. CareMark denied the request on the basis that the proposed surgery was not necessary or reasonable. After Dr. Grewe requested reconsideration of its decision, CareMark's medical advisory council also disapproved the surgery.

In August 1993, Dr. Grewe performed the right knee surgery. Claimant then requested a hearing, in part alleging that the SAIF Corporation "de facto" denied medical services. SAIF moved to dismiss the request for hearing, arguing that the Hearings Division lacked jurisdiction because, inasmuch as claimant's medical services were governed by a MCO contract, his sole remedy to contest the denial of treatment lay in requesting review from the Director. The ALJ denied the motion and further concluded that claimant proved that the knee surgery was reasonable and necessary and, accordingly, compensable.

On review, relying on Job G. Lopez, 47 Van Natta 193 (1995), we agreed with the ALJ that the Hearings Division had jurisdiction over claimant's request for hearing. Richard R. Elizondo, supra. We also agreed that the knee surgery was compensable. Id.

SAIF petitioned for judicial review. Thereafter, the court remanded for reconsideration in light of DCBS v. Lopez, supra. We proceed with our reconsideration.

In Job G. Lopez, based on the language in former ORS 656.260(6), we reasoned that the Director was not vested with exclusive jurisdiction to review an MCO's decision regarding an attending physician's request for authorization of medical services. 47 Van Natta at 194-200. Moreover, we determined that the appropriate forum depended on the type of medical services in dispute. Id. at 200. Citing Martin v. City of Albany, 320 Or 175 (1994), we held that, if there had been no request for Director review, and the dispute concerned the reasonableness and necessity of treatment, the Hearings Division had jurisdiction to review the matter. Id. The legislature subsequently amended ORS 656.327(1)(a),[1] 656.260(6)[2] and 656.704(3),[3] which retroactively apply to this case. E.g., Job G. Lopez, 48 Van Natta 1098 (1996). Furthermore, as we have previously held, those statutes overruled our decision in Job G. Lopez, supra, and vest the Director with exclusive jurisdiction over all MCO medical services disputes, including those currently pending before the Board. Ronald R. Streit, Sr., 47 Van Natta 1577 (1994).

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[1] ORS 656.327(1)(a) now provides:

"If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so inform the parties."

[2] ORS 656.260(6) provides, in relevant part: "Any 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 * * *."

[3] ORS 656.704(3) now provides:

"For purposes of determining the respective authority of the director and the board to conduct hearings, * * * matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any disputes arising under ORS * * * 656.260, 656.327 * * *."

The matter is this proceeding concerns a dispute over medical services that is subject to a MCO contract. Consequently, exclusive jurisdiction of the matter lies with the Director.

On reconsideration of our prior order, we vacate the ALJ's order dated July 14, 1994. Claimant's request for hearing is dismissed for lack of jurisdiction.

IT IS SO ORDERED.

In the Matter of the Compensation of
KELLY P. FINUCANE, Claimant
WCB Case No. 93-15028
ORDER ON REMAND
Carney, 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 the court's June 24, 1996 order, this matter has been remanded for reconsideration in light of DCBS v. Lopez, 139 Or App 322 (1996). In our prior order, we affirmed the Administrative Law Judge's (ALJ's)[1] order that: (1) denied the SAIF Corporation's motion to dismiss claimant's hearing request, concluding that the Hearings Division had jurisdiction over a Managed Care Organization (MCO) proposed medical services dispute; and (2) awarded an attorney fee under former ORS 656.386(1) for prevailing without a hearing over SAIF's "de facto" denial of claimant's proposed low back surgery. Citing Lopez, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of his "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

We first summarize the relevant facts of this case. Claimant compensably injured his low back in February 1993. SAIF accepted a herniated disc at L5-S1. After an initial disc surgery, claimant's symptoms recurred and worsened. Dr. Mawk, neurosurgeon, ultimately became claimant's attending physician. Dr. Mawk is a member of CareMark Comp, an MCO with whom SAIF had contracted. Dr. Mawk requested authorization from SAIF to perform a second spinal surgery at the same level after diagnostic imaging revealed scarring and nerve root compression at the surgical site. SAIF forwarded the request to CareMark Comp, which disapproved the proposed surgery request. Shortly thereafter, claimant requested a hearing regarding SAIF's "de facto" denial of his claim for low back surgery.

Dr. Mawk appealed CareMark Comp's disapproval of the proposed surgery through its internal dispute resolution process, finally receiving approval of the procedure on March 22, 1994. Dr. Mawk performed the surgery on March 23, 1994. On April 22, 1994, SAIF informed claimant's attorney that it "acquiesced" to CareMark Comp's medical decision that surgery was reasonable and necessary.

At the May 31, 1994 hearing, claimant specified that the sole issue was his entitlement to an attorney fee under former ORS 656.386(1) for obtaining an acceptance of claimant's request for medical services without a hearing. SAIF, after contending that it had never denied compensability, moved to dismiss the hearing request, arguing that exclusive jurisdiction rested with the Director. The ALJ denied the motion, concluding that the Hearings Division, not the Director, had jurisdiction over the surgery request, and awarded claimant an attorney fee for prevailing without a hearing over the "de facto" denial of the medical services request. SAIF requested Board review.

On review, we affirmed the ALJ's order. In doing so, we relied on our decision in Job G. Lopez, 47 Van Natta 193 (1995), hereinafter Lopez I, in which we rejected the carrier's assertion that, under former ORS 656.260, the MCO statute, and former ORS 656.704(3), the Director had exclusive

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[1] Formerly referred to as "Referee."

jurisdiction over a MCO proposed medical services dispute. 47 Van Natta at 194-200. Rather, in Lopez I, we concluded that, in the MCO context, where jurisdiction lies depends on the type of medical services in dispute. Id. at 200. Citing Martin v. City of Albany, 320 Or 175 (1994), and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), rev den 320 Or 453 (1994), we held that, because the dispute involved a proposed surgery, the Hearings Division had exclusive jurisdiction to review the matter. 47 Van Natta at 201-02.

Applying the Lopez I holding to the facts of the present case, we determined that, because the request for the low back surgery involved proposed curative medical services, under Martin v. City of Albany and Jefferson v. Sam's Cafe, jurisdiction to review the request was vested solely in the Hearings Division. Accordingly, we affirmed the ALJ's decision denying SAIF's motion to dismiss.

SAIF requested judicial review. Citing DCBS v. Lopez, supra, the court remanded the matter for reconsideration. We proceed with our reconsideration.

Subsequent to our order, the legislature amended ORS 656.327(1)(a), 656.260(6), and 656.704(3). Amended ORS 656.704(3) now provides, in relevant part:

> "For purposes of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any disputes arising under ORS 656.245, 656.248, 656.260, 656.327 * * * " (Emphasis added).

Amended ORS 656.327(1)(a) now provides:

> "If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties." (Emphasis added).

Amended ORS 656.260(6) now provides, in relevant part: "Any issue concerning the provision of medical services to injured workers subject to a managed care contract * * * shall be subject solely to review by the director or the director's designated representatives, or as otherwise provided in this section." (Emphasis added).

Except as provided otherwise, the amendments of Senate Bill 369 (SB 369) apply 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, 134 Or App 625, aff'd on recon 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 572-73 (1995). Here, the Board's decision was appealed; however, because the court remanded for reconsideration, the Board's decision was not finally resolved on appeal. In addition, amended ORS 656.327(1)(a), 656.327(2), 656.260(6), and 656.704(3) are not among the exceptions to this general retroactivity rule, see SB 369, § 66 (listing exceptions to general retroactivity provision). Therefore, the amended versions of the statutes apply here.

In DCBS v. Lopez, supra, the court cited Newell v. SAIF, supra, and remanded for reconsideration our decision in Lopez I, supra.[2] In Newell v. SAIF, 136 Or App at 283, the court held that amended ORS 656.327(1)(a) and 656.704(3) provide that the director has exclusive jurisdiction to review proposed medical treatment. Because the treatment here concerned a proposed medical treatment, the Director has exclusive jurisdiction over this medical services issue.

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[2] On remand, applying the reasoning that follows in the body of the present order, we determined that exclusive jurisdiction of the MCO proposed medical services dispute rested with the Director. Job G. Lopez, on remand 48 Van Natta 1098 (1996), hereinafter Lopez II.

Furthermore, in Ronald R. Streit, Sr., 47 Van Natta 1577 (1995), we concluded that, under amended ORS 656.260(6), the Director has exclusive jurisdiction over all MCO medical services disputes, including those currently pending before the Board. We also found that amended ORS 656.704(3) supported this conclusion. In addition, we held that amended ORS 656.260(6) overruled our decision in Lopez I, supra.

Here, the matter at issue pertains to a MCO proposed medical services dispute. Accordingly, exclusive jurisdiction of this dispute lies with the Director, not the Hearings Division. Amended ORS 656.327(1)(a); 656.260(6); 656.704(3); Newell v. SAIF, supra; Ronald R. Streit, Sr., supra; Lopez II, supra.

Finally, given the fact that the medical services matter before the ALJ was solely within the jurisdiction of the Director, it necessarily follows that neither the ALJ nor the Board has authority to award attorney fees for "prevailing" in that matter. See ORS 656.385(1); Dewey W. Kennedy, 48 Van Natta 897 (1996) (where the basis of a penalty is disputed medical services over which the Director has exclusive jurisdiction, the Board is without authority to award a penalty relating to such a dispute).

Consequently, on reconsideration of our prior order, we vacate the ALJ's July 6, 1994 order. Claimant's request for hearing is dismissed for lack of jurisdiction.

IT IS SO ORDERED.

In the Matter of the Compensation of
FILIBERTO B. ROSAS, Claimant
WCB Case No. 95-10038
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Daughtry's order that: (1) found that claimant had timely requested reconsideration of a February 21, 1995 Notice of Closure; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 25 percent (80 degrees), as awarded by a Notice of Closure, to 29 percent (92.8 degrees). On review, the issues are jurisdiction and, potentially, extent of unscheduled permanent disability.

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

Timeliness of Appeal of February 21, 1995 Notice of Closure

Claimant has an accepted disabling claim with SAIF for a lumbosacral strain. The claim was first closed by a Notice of Closure on February 21, 1995 which awarded temporary partial disability from April 13, 1994 to October 31, 1994, and 25 percent unscheduled permanent disability. On April 5, 1995, SAIF issued a second Notice of Closure that changed the temporary partial disability award by awarding temporary partial disability from April 16, 1994 through October 31, 1994. The "corrected" Notice of Closure contained the following language:

> "On February 21, 1995, a Notice of Closure was issued on your claim. That Notice of Closure was incorrect and is hereby corrected as follows:
>
> "* * * * *
>
> "**Notice:** Any party has the right to request reconsideration (or a hearing if applicable) for a period of 180 days from the mailing date of this order **only** for those changes made by this order. This correction becomes a part of and should be attached to the Feb 21, 1995 Notice of Closure which remains the same in all other respects. Your aggravation rights remain unchanged." (Ex. 13, emphasis in original).

Claimant requested reconsideration on August 9, 1995, which was within 180 days of both the original and the corrected Notice of Closure. The request for reconsideration referenced the April 5, 1995 "corrected" Notice of Closure and raised the issue of unscheduled permanent partial disability.

On September 1, 1995, the Department issued an Order on Reconsideration which affirmed the April 5, 1995 Notice of Closure. In the "explanatory notes" attached to the Order on Reconsideration, the Department's appellate reviewer indicated that claimant had requested reconsideration only of the April 5, 1995 Notice of Closure and that the corrected February 21, 1995 Notice of Closure had become final by operation of law. The appellate reviewer found that since the "corrected" Notice of Closure dealt solely with temporary disability, the appeal rights for the issues of extent of permanent disability had expired. On the basis of this reasoning, the Department's reconsideration order did not address the issue of permanent disability.

On September 7, 1995, claimant requested a hearing challenging the September 1, 1995 Order on Reconsideration.

The ALJ found that the August 9, 1995 request for reconsideration was a request for reconsideration of both the February 21 and April 5, 1995 notices of closure. The ALJ based his conclusion on the fact that the April 5, 1995 "corrected" Notice of Closure specifically referred to the February 21 Notice of Closure and expressly noted that any changes made by the April 5 Notice of Closure were made a part of the February 21, 1995 notice. The ALJ reasoned that the language of the April 5, 1995 Notice of Closure suggested that the April 5, 1995 Notice of Closure was not separate and apart from the February 21, 1995 Notice of Closure, but rather was subsumed within it.[1]

For the following reasons, we agree with the ALJ that the request for reconsideration was of both the April 5 and February 21, 1995 notices of closure. Claimant's request for reconsideration specifically raised the issue of the extent of permanent disability. Only the February 21, 1995 closure notice addressed the issue of permanent disability. This fact suggests that both orders were being appealed. This conclusion is further supported by the language contained in the second notice of closure. That "corrected" notice specifically stated that it "becomes a part of and should be attached to the February 21, 1995 Notice of Closure which remains the same in all other respects." Given this language, the fact that the request raised the issue addressed by the first closure order, and the fact that the request was within 180 days of both the February 21 and April 5 "corrected" orders, we conclude that the request for reconsideration was a timely appeal of both closure orders.[2]

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[1] The ALJ also noted that the 180 days to appeal the February 21, 1995 Notice of Closure would have expired on August 20, 1995, absent an appeal. Reconsideration was requested by claimant on August 9, 1995 and took from August 9 to September 1, 1995. The time from the request for reconsideration until the reconsideration order is issued is not counted against the 180 days to request a hearing. See former ORS 656.268(6)(b). Thus, if claimant requested reconsideration of the February 21, 1995 notice on August 9, 1995, the last date on which claimant could timely request a hearing on the February 21, 1995 notice was September 12, 1995. Claimant requested a hearing on September 7, 1995. Thus, his hearing request was timely.

[2] SAIF argues that the ALJ's interpretation of the language of the "corrected" notice effectively renders former OAR 436-30-020(10) (now OAR 436-30-0020(13)) a nullity. We disagree. Former OAR 436-30-020(10) provided:

> "Requests for reconsideration of a Notice of Closure corrected pursuant to Section (9) of this rule must be received within 180 days of the mailing date of the corrected Notice of Closure. Requests for reconsideration of a corrected Notice of Closure may only address those areas changed by the corrected notice."

We agree with the ALJ that the language contained in the "corrected" notice gives the impression that the "corrected" notice becomes a part of the initial closure and that the two orders should be considered one. To that extent, the language contained in SAIF's "corrected" Notice of Closure is misleading. See former OAR 436-35-020(10). Here, however, we have found that claimant's request for reconsideration served to timely appeal both the corrected and the initial closure notices. Had claimant failed to timely appeal the initial closure notice, he would be able to challenge only the areas changed by the corrected notice. See Eugenia S. Torres, 48 Van Natta 125 (1996) (Chair Hall dissenting). Thus, contrary to SAIF's contention, the rule has not been nullified. Rather, the rule does not apply in this factual situation where both orders have been timely appealed.

We contrast this case to Eugenia S. Torres, supra.[3] In Torres, the carrier issued a September 29, 1993 Notice of Closure, as well as a January 17, 1994 "corrected" Notice of Closure. The corrected notice changed only the temporary disability awarded by the initial notice. Within 180 days of the corrected notice, but more than 180 days after the initial notice, the claimant requested reconsideration of the second closure notice. The claimant sought a permanent disability award.

We held that the claimant's appeal of the initial notice was untimely since more than 180 days had passed between its issuance and the claimant's request for reconsideration. Finding that claimant had timely appealed only the "corrected" closure order, we held that the claimant could challenge only those areas changed by the corrected notice. Because the corrected notice did not address permanent disability, we found that the claimant could not raise that issue.

Here, unlike in Torres, claimant requested reconsideration of the initial Notice of Closure within 180 days. Moreover, as we concluded above, claimant effectively requested reconsideration of both the April 5 and February 21, 1995 notices. Thus, claimant was entitled to raise any issues addressed by either notice of closure. Based on this reasoning, we agree with the ALJ that claimant was entitled to raise the issue of unscheduled permanent disability.

Unscheduled Permanent Disability

The only issue raised by the parties is the value for the adaptability factor. Specifically, the parties dispute the value for claimant's base functional capacity (BFC). The ALJ found that claimant's BFC was heavy. This conclusion was based on claimant's testimony and an undated work history. SAIF objects to the ALJ's reliance on claimant's testimony to conclude that claimant performed the duties of a "Farm Worker General II," DOT 421.687-0101. We agree with SAIF that claimant's testimony is not admissible under ORS 656.283(7). Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996); Dean J. Evans, 48 Van Natta 1092 (1996). Accordingly, claimant's hearing testimony cannot be considered to establish the adaptability factor.

SAIF contends that the undated work history is insufficient evidence on which to conclude that claimant performed the duties of a Farmworker, General II. The work history, which lists claimant's jobs for the last ten years, indicates that claimant had previously been a farmworker. Claimant describes the farmwork duties he performed as "everything from a farm." Based on this unrebutted work history, we conclude that claimant has performed general farm labor during the last ten years. We further find this unrebutted evidence sufficient to establish that claimant performed general farmworker duties, described by the DOT as Farmworker, General II, DOT # 421.687-010. The DOT describes this job as being in the heavy category. Thus, we agree with the ALJ that claimant's BFC is heavy and we affirm the ALJ's finding of an adaptability factor of 4.

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

ORDER

The ALJ's order dated January 10, 1996, as amended January 29, 1996, is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF.

[3] Although bound by the doctrine of stare decisis to follow the Torres holding, Chair Hall directs the parties' attention to his dissenting opinion.

In the Matter of the Compensation of
BENJAMIN G. SANTOS, Claimant
WCB Case No. 92-05344
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This case is before the Board on remand from the Court of Appeals. Santos v. Caryall Transport, 137 Or App 527 (1995). The court reversed our prior order which adopted and affirmed an Administrative Law Judge's (ALJ's) order that declined to award temporary disability compensation past claimant's medically stationary date. Noting that the amendments to ORS 656.262(4), 656.268(1), (2) and (3) may affect the outcome in this case, the court has remanded for reconsideration in light of the 1995 amendments to those statutes. In accordance with the court's instructions, and after consideration of the parties' supplemental briefs, we now proceed with our reconsideration.

FINDINGS OF FACT

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

By a January 6, 1993 Determination Order, claimant was found to be medically stationary on December 5, 1991. (Ex. 58).

We do not adopt the ALJ's "findings of ultimate facts."

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts and procedural background of this case. Claimant sustained a compensable low back and right hip injury on January 7, 1991. He was initially taken off work, but Dr. Flemming, claimant's then-attending physician, released him to light duty on February 8, 1991. In May 1991, claimant obtained work in a modified capacity with another employer.

Claimant returned to Dr. Flemming in December 1991, but Dr. Flemming made no comment regarding whether claimant was medically stationary or released to regular work. Thereafter, claimant saw Dr. Feldstein, who stated she was not authorizing time loss. In early 1992, claimant saw Dr. Tilson and again saw Dr. Feldstein. Neither physician authorized time loss.

SAIF paid temporary disability compensation through December 5, 1991. Claimant requested a hearing, contending that he was entitled to temporary disability compensation after December 5, 1991.

At hearing, the ALJ initially held that claimant was entitled to temporary partial disability compensation from December 6, 1991 through October 14, 1992, reasoning that claimant had been released only to modified work at the time SAIF terminated temporary disability compensation. The ALJ also assessed a penalty on the unpaid compensation for SAIF's unreasonable conduct.

SAIF requested reconsideration of the ALJ's order and moved to reopen the record. The ALJ reopened the record to admit the January 6, 1993 Determination Order, which determined that claimant was medically stationary on December 5, 1991. Consequently, on reconsideration, the ALJ held, relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), that temporary disability compensation after the medically stationary date could not be granted. Thus, the ALJ declined to award temporary partial disability after December 5, 1991.

Claimant requested Board review. The only issue raised by both parties was whether claimant was entitled to temporary disability compensation after the medically stationary date. On review, we affirmed the ALJ's order.

Claimant requested judicial review. The court reversed our decision, citing the 1995 amendments to ORS 656.262(4), 656.268(1), (2) and (3), and has remanded for reconsideration. Santos v. Caryall Transport, supra. Pursuant to the court's mandate, we proceed with our reconsideration.

As amended in 1995, ORS 656.262(4) provides, in material part, that temporary disability compensation shall be paid if authorized by the attending physician. ORS 656.262(4)(a). The statute further provides that temporary disability compensation is not due 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." ORS 656.262(4)(f). In addition, an attending physician's authorization of temporary disability under ORS 656.268 is effective to retroactively authorize the payment of temporary disability only 14 days prior to its issuance. Id.

Amended ORS 656.268 now provides, in material part,[1] that temporary disability benefits may be terminated upon the occurrence of any event that causes temporary disability compensation to be lawfully terminated under ORS 656.262(4). ORS 656.268(3)(d). In addition, the statute continues to provide that temporary disability may be terminated when the worker returns to regular or modified work, when the attending physician releases the worker to regular work, or when the worker is released to modified work, such work is offered in writing, and the worker fails to begin such employment. ORS 656.268(3)(a), (b), (c).

Except as provided otherwise, the amendments of Senate Bill 369 apply 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 (1993). Because amended ORS 656.262(4) and 656.268(1), (2) and (3) are not among the exceptions to this general rule, the amended versions of the statutes apply here. See Or Laws 1995, ch 332, § 66 (SB 369, § 66) (listing exceptions to general retroactivity provision).

The ALJ held that, consistent with Lebanon Plywood v. Seiber, supra, he had no authority to award temporary disability compensation after claimant's medically stationary date. In Seiber, the court held that the Board has no authority to award "procedural" temporary disability benefits beyond the medically stationary date. 113 Or App at 653-54. We find nothing in the 1995 amendments to the Workers' Compensation Law that warrants a different result. In our Order on Remand in WCB Case No. 93-11469, which issued this date, we rejected claimant's argument that ORS 656.268, as amended in 1990 and 1995, eliminated the distinction between procedural and substantive entitlement to temporary disability benefits. See Jimmie G. Clark, 45 Van Natta 2308, 2309 n.1 (1993); Soledad Flores, 43 Van Natta 2504, 2506-2508 (1991). Based on our review of the statutory text and legislative history, we concluded that amended ORS 656.268 continues to address a claimant's entitlement to "procedural" temporary disability benefits, i.e., payment of temporary disability benefits during an open claim.

Alternatively, were we to decide whether claimant was procedurally entitled to temporary disability compensation after December 5, 1991, we would find that he is not entitled to such compensation. Pursuant to amended ORS 656.262(4) and 656.268(3), a worker is procedurally entitled to temporary disability compensation only for such periods as authorized by an attending physician. See Daral T. Morrow, 48 Van Natta 497, 499 (1996). Here, the attending physician did not authorize temporary disability compensation after December 5, 1991. (Ex. 57-2; see also Exs. 18, 26, 28, 30, 46). Therefore, pursuant to amended ORS 656.262(4)(f) and 656.268(3)(d), claimant would not be entitled to procedural temporary disability compensation after December 5, 1991.

Accordingly, on reconsideration of our August 5, 1994 order, we affirm the ALJ's April 28, 1993 order, as reconsidered October 8, 1993.

IT IS SO ORDERED.

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[1] ORS 656.268(1) and (2) were also amended by Senate Bill 369. ORS 656.268(1) and (2) now provide that, under certain circumstances, a claim may be closed before the worker's condition is medically stationary. In this case, however, the claim was closed after claimant became medically stationary. Therefore, the amendments to ORS 656.268(1) and (2) do not affect the outcome in this case.

In the Matter of the Compensation of
BENJAMIN G. SANTOS, Claimant
WCB Case No. 93-11469
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This case is before the Board on remand from the Court of Appeals. Santos v. Caryall Transport, 138 Or App 701 (1996). The court reversed that portion of our prior order, Benjamin G. Santos, 46 Van Natta 1912 (1994), that adopted and affirmed an ALJ's order which affirmed an Order on Reconsideration that did not award claimant temporary disability compensation after his medically stationary date. The court has remanded for reconsideration in light of the 1995 amendments as they affect the temporary disability award. In accordance with the court's instructions, and after consideration of the parties' supplemental briefs, we now proceed with our reconsideration.

FINDINGS OF FACT

We republish the findings of fact from our prior order, Benjamin G. Santos, supra, 46 Van Natta 1912-13, with the following supplementation.

A January 6, 1993 Determination Order found claimant to be medically stationary on December 5, 1991, and awarded periods of temporary disability through December 5, 1991. (Ex. 32). Those portions of the Determination Order were affirmed by an Order on Reconsideration issued September 22, 1993. (Ex. 44-2).

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts and procedural history of this case. Claimant sustained a compensable low back and right hip injury on January 7, 1991. Claimant was initially taken off work, but Dr. Flemming, claimant's then-attending physician, released him to light duty on February 8, 1991. In May 1991, claimant obtained work in a modified capacity with another employer.

In June 1992, Dr. Flemming indicated that he last saw claimant on December 5, 1991, at which time he was medically stationary. (Ex. 25; see also Ex. 30). A Determination Order issued January 6, 1993, awarding periods of temporary disability until December 5, 1991, and declaring claimant medically stationary on that date. (Ex. 32). Claimant requested reconsideration of the Determination Order. (Ex. 40).

On reconsideration, the Appellate Unit affirmed the award of temporary disability through December 5, 1991, as well as that portion of the Determination Order that found claimant to be medically stationary on December 5, 1991. (Ex. 44). Claimant requested a hearing from the Order on Reconsideration.

At hearing on December 23, 1993, the ALJ affirmed the September 22, 1993 Order on Reconsideration. Regarding the temporary disability award, the ALJ rejected claimant's contention that he was entitled to temporary disability benefits from his medically stationary date to the date of the Determination Order. In doing so, the ALJ relied on our decision in Jimmie G. Clark, 45 Van Natta 2308 (1993). Claimant requested Board review.

On review, we affirmed the ALJ's order. Benjamin G. Santos, supra. Specifically, regarding the temporary disability issue, we adopted and affirmed that portion of the ALJ's order that held that claimant was not entitled to temporary disability compensation after his medically stationary date. In doing so, we relied on our decisions in Jimmie G. Clark, supra, and Thomas M. Aldrich, 46 Van Natta 1025 (1994), as well as the court's decision in Lebanon Plywood v. Seiber, 113 Or App 651 (1992).

Claimant petitioned for judicial review. The court affirmed that portion of our order that rated the extent of claimant's permanent disability. However, citing Volk v. America West Airlines, 135 Or App 565 (1995), the court reversed and remanded for reconsideration of the temporary disability award. Santos v. Caryall Transport, supra. Pursuant to the court's mandate, we proceed with our reconsideration.

Claimant challenged the Determination Order and Order on Reconsideration, contending that he was entitled to temporary disability benefits after December 5, 1991. Since claimant's claim is closed, the issue in this case is his substantive entitlement to temporary disability benefits. Substantive entitlement to temporary disability benefits, which is codified by ORS 656.210 and developed by case law, provides that temporary disability benefits are due for those periods during which the worker was disabled due to the compensable injury, prior to becoming medically stationary. See SAIF v. Taylor, 126 Or App 658 (1994); Lebanon Plywood v. Seiber, supra, 113 Or App at 653-54; Dorothy E. Bruce, 48 Van Natta 518, 519 (1996); Esther C. Albertson, 44 Van Natta 2058, 2059, aff'd Albertson v. Astoria Seafood Corporation, 116 Or App 241 (1992); Soledad Flores, 43 Van Natta 2504, 2506 (1991). ORS 656.210 was not amended in 1990, nor was it amended in any way material to this analysis in 1995.[1]

In Seiber, the court held that a worker is substantively entitled to temporary disability benefits only until the condition is medically stationary, and that the Board has no authority to award temporary disability benefits beyond the medically stationary date. Seiber, supra, 113 Or App at 653-54. Inasmuch as we find nothing in the 1995 amendments that warrants a different result, we conclude that Seiber remains good law. See Dorothy E. Bruce, supra.

Here, claimant's claim was closed by a January 6, 1993 Determination Order, which awarded periods of temporary disability through December 5, 1991 and found claimant to be medically stationary on that date. On reconsideration, the Appellate Unit also awarded temporary disability only through December 5, 1991, and affirmed the medically stationary date. Claimant requested a hearing, but did not challenge the medically stationary date. Since there is no dispute that claimant was medically stationary on December 5, 1991, and since he is entitled to substantive temporary disability compensation only until he is medically stationary, we conclude that claimant's temporary disability award was properly terminated on December 5, 1991.

We reject claimant's argument that ORS 656.268, as amended in 1990 and 1995, requires a different result. ORS 656.268 addresses a claimant's entitlement to temporary disability compensation during an open claim; that is, his entitlement to procedural temporary disability compensation. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 (1988); see also Thomas M. Aldrich, supra (holding that the 1990 version of ORS 656.268(3) applies to procedural entitlement to temporary disability benefits); Soledad Flores, supra, 43 Van Natta at 2506-08 (holding that 1990 amendments to ORS 656.268 did not eliminate distinction between procedural and substantive entitlement to temporary disability benefits). We have previously held that the 1990 amendments to ORS 656.268 did not eliminate the distinction between procedural and substantive entitlement to temporary disability benefits. See Jimmie G. Clark, supra, 45 Van Natta at 2309 n.1; Soledad Flores, supra.

We find nothing in the 1995 amendments to ORS 656.268 that requires a different result. Subparagraph (d), which was added to ORS 656.268(3) in 1995, merely provides another avenue for terminating procedural temporary disability during an open claim. Ivan E. Dame, 48 Van Natta 1228 (1996). The legislative history cited by claimant in his supplemental brief indicates as much.[2] Thus, we

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[1] The 1995 amendments to ORS 656.210 pertain to the rate of temporary disability compensation and the "three-day waiting period" prior to a worker's receipt of temporary disability benefits. Amended ORS 656.210(2), (3).

[2] Claimant cited Representative Mannix's remarks to the Senate Committee on Labor and Government, January 30, 1995, Tape 15B at approx. 210:

> "REP. MANNIX 656.268, sub (3)(e): Restates the conditions for terminating time loss or temporary disability. The reform bill in 1990 permitted the payment of benefits to be disallowed at claim closure. It didn't provide a procedural mechanism for those payments to be terminated at the time the conditions occurred. What happens, then, is you end up, procedurally, having to still pay the benefits. And later, when you close the claim, oh, gee, we knew all along we were overpaying; we had to overpay; we couldn't stop. This says, no, if you are aware that the event has occurred that allows you to eliminate the entitlement of temporary disability compensation, take the action at that time. Don't incur what is, in many cases, an automatic overpayment." (Claimant's Supp. Brief at 4).

Representative Mannix's comments indicate an intent to close the gap between procedural payments of temporary disability and substantive entitlement to such benefits in an effort to minimize procedural overpayments of compensation. Based on our review of the statutory text and legislative history, we conclude the legislature sought to close this gap by amending ORS 656.268(3) to authorize, in specific circumstances, earlier termination of procedural payments, not to extend substantive entitlement to temporary disability benefits beyond a claimant's medically stationary date.

find nothing in the 1995 amendments to ORS 656.268 that indicates an intention to eliminate the distinction between substantive and procedural entitlement to temporary disability benefits, and we conclude that amended ORS 656.268 continues to address a claimant's entitlement to procedural temporary disability benefits. For the aforementioned reasons, we decline claimant's invitation to overturn or otherwise modify our decision in Ivan E. Dame, Supra.

Here, however, the issue is claimant's entitlement to substantive temporary disability benefits. ORS 656.268 does not pertain to that determination. Therefore, we conclude that the 1995 amendments of Senate Bill 369 do not affect our prior decision regarding claimant's entitlement to substantive temporary disability benefits.

Accordingly, on reconsideration, as supplemented herein, we republish our September 27, 1994 order.

IT IS SO ORDERED.

July 11, 1996 Cite as 48 Van Natta 1518 (1996)

In the Matter of the Compensation of
THEODORE J. McVAY, Claimant
WCB Case Nos. 94-06509, 93-13545 & 93-05737
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Liberty Northwest Insurance Corporation (Liberty) requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is the preclusive effect of a stipulation. We affirm.

FINDINGS OF FACT

Claimant has been employed by Liberty's insured as a farm worker for many years. In late 1992, claimant began to experience hand numbness, primarily on the right side. On February 17, 1993, Dr. Blake, orthopedic surgeon, examined claimant for right wrist symptoms. (Ex. 26). Dr. Blake diagnosed deQuervain's syndrome.

On April 1, 1993, claimant filed a claim for right wrist tendonitis. (Ex. 33). Liberty issued a denial of right wrist deQuervain's syndrome in May 1993. (Ex. 37). Claimant requested a hearing to challenge the denial.

In July 1993, Dr. Nathan, orthopedic surgeon, examined claimant at Liberty's request. (Ex. 40). At that time, claimant reported bilateral hand symptoms that were more prominent on the right side. (Ex. 40-1). Dr. Nathan diagnosed right deQuervain's tenosynovitis, as well as bilateral carpal tunnel syndrome and bilateral lesion of the ulnar nerve. (Ex. 40-4). Dr. Nathan opined that the major contributing cause of claimant's deQuervain's tenosynovitis was his work activities. (Ex. 40-5). However, Dr. Nathan reported that "there is no evidence that hand activities have caused or altered the natural progression of the intrinsic neuropathic process [i.e., claimant's median and ulnar nerve entrapment neuropathies]." (Id.).

The parties entered into negotiations and, in January 1994, agreed to settle claimant's right wrist injury claim. The Stipulation and Order recited, in pertinent part:

> "Claimant filed a claim on April 1, 1993, alleging that he injured his right wrist at work on November 10, 1992.
>
> This claim was denied by letter dated May 13, 1993.
>
> Claimant filed a Request for Hearing raising the issue of compensability.

The parties agree to settle all issues raised or raisable at this time as follows:

Liberty Northwest Insurance Corporation shall rescind its denial dated May 13, 1993 and issue a Notice of Claim Acceptance accepting DeQuervain's tenosynovitis of the right thumb, and process said claim to closure.

"* * * * *

The Request for Hearing is dismissed with prejudice, as are all issues raised or raisable." (Ex. 48).

Liberty's counsel signed the stipulated agreement on January 17, 1994. Claimant's counsel signed the Stipulation and Order on January 18, 1994. Claimant signed the agreement on January 24, 1994. Liberty's claims examiner signed the agreement on January 26, 1994. Thereafter, Liberty forwarded the agreement to the Hearings Division for approval.

On January 25, 1994, Dr. Nye examined claimant. In a report dated the same day, Dr. Nye opined that claimant's CTS condition was work-related. (Ex. 47). Liberty and claimant's attorney received copies of Dr. Nye's report on January 31, 1994. (Ex. 48-1; Tr. 3).

On February 2, 1994, an ALJ approved the Stipulation and Order. (Ex. 48-2). Pursuant to the stipulation, on February 17, 1994, Liberty issued a Notice of Claim Acceptance of "Right Thumb deQuervain's tenosynovitis." (Ex. 50).

On April 25, 1994, Liberty denied that claimant's employment was the major contributing cause of claimant's bilateral CTS. (Ex. 51). The denial observed that claimant had entered into a Stipulation and Order whereby Liberty had rescinded its denial of claimant's right wrist injury claim and accepted deQuervain's tenosynovitis of the right thumb. The denial continued: "If carpal tunnel syndrome was an issue, it should have been brought up prior to signing the Stipulation." Claimant requested a hearing.

At hearing, the parties agreed that the claim for bilateral CTS was an occupational disease claim, not an accidental injury claim. (Tr. 7,10). Liberty argued that claimant was precluded from contesting the compensability of his bilateral CTS occupational disease claim because the February 1994 settlement concerning the right wrist injury claim settled "all issues raised or raisable." Liberty contended that, in view of Dr. Nathan's diagnosis of CTS in July 1993, compensability of CTS could have been negotiated at the time of the stipulation.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that, although Dr. Nye saw claimant on January 25, 1994, prior to approval of the settlement, claimant's attorney did not receive Nye's report relating the CTS to work activity until February 22, 1994 (three weeks after the stipulation was approved). Based on that finding, the ALJ concluded that the issue of the compensability of the CTS condition could not have been negotiated at the time of the stipulated settlement. We agree with the result reached by the ALJ; however, we base our conclusion on the following reasoning.

A party may not relitigate any issue resolved by a stipulation, since a party is bound to the terms of the agreement. Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993). Furthermore, when the agreement purports to resolve all issues which were raised or could been have raised, the settlement bars a subsequent claim for a condition that could have been negotiated at the time of the settlement. Good Samaritan Hospital v. Stoddard, 126 Or App 69, 73, rev den 319 Or 572 (1994). Based on the court's reasoning and holdings in those cases, we conclude that claimant's bilateral CTS disease claim is not precluded here.

The issue in Seney was whether a claim involving the worker's previously injured right shoulder was barred by a settlement agreement which provided, in part, "this stipulation resolves all issues which were raised or could have been raised by either party *on or before the date this settlement is approved by a Referee.*" 124 Or App at 453 (emphasis supplied). Prior to the then-referee's approval, the right shoulder condition had been characterized as an aggravation of the shoulder injury which was settled by the parties' agreement. However, after the settlement was approved, the claimant's physician opined that the condition was actually a new injury rather than an aggravation of the prior injury.

The court concluded that the claim, whether characterized as an aggravation or a new injury, was precluded by the agreement. The court first noted that, during negotiations, both parties believed the claimant had suffered an aggravation of the prior injury. Further, the claimant had sought treatment for this condition and had requested benefits. In addition, the employer had denied the benefits for the condition well before the settlement was approved. Based on these facts, the court concluded that whether "characterized as an aggravation or as a new injury, [claimant's] condition and the compensability of a potential claim were at issue during the negotiations and before approval of the settlement." Id. at 454. The court held that the claimant could not "escape his bargain by recharacterizing his claim after the fact." Id.

Similarly, in Stoddard, the dispute involved the preclusive effect to be given to a settlement agreement that expressly resolved "all issues which were raised or could have been raised *on or before the date this settlement is approved by a referee.*" 126 Or App at 72 (emphasis supplied). The claimant had experienced a compensable wrist strain. Following the injury, claimant also complained of forearm pain. The claimant's treating physician diagnosed a probable radial nerve entrapment condition. On the same day that the physician requested authorization to perform surgery for the nerve condition, the parties entered into a stipulated settlement concerning the accepted wrist claim. The agreement was approved by the Board one month later. Thereafter, the claimant requested a hearing to determine compensability of her nerve condition.

The court concluded that the nerve condition claim was barred by the parties' settlement agreement. Id. at 73. The court noted that the Board found the disputed condition to be related to the work injury which was the subject of the agreement. Id. at 73. Further, the Board found that the disputed condition had been diagnosed and medical treatment had been requested prior to the settlement. Based on these findings, the court concluded that the condition was an issue that could have been raised before the date the agreement was approved. Id.

Here, the stipulation provided that the "parties agree to settle all issues raised or raisable *at this time*[.]" The parties signed the proposed Stipulation and Order between January 17, 1994 and January 26, 1994. Consequently, the issue is whether claimant's bilateral CTS, which was first related to his work activities by Dr. Nye in a report received by Liberty and claimant on January 31, 1994, is barred because it could have been raised and negotiated at the time of the stipulation. We conclude that claimant's bilateral CTS claim is not barred by the parties' settlement agreement.

Unlike both Seney and Stoddard, there is no causal relationship between the medical condition settled by the parties (deQuervain's tenosynovitis) and the subsequently disputed condition (bilateral CTS). The two conditions here are separate diseases which happen to involve the same body part. The settlement agreement between the parties related to the deQuervain's tenosynovitis and referenced the Workers' Compensation Board number assigned to that claim.

Further, whereas the stipulated agreements in Seney and Stoddard expressly resolved issues that were raised or raisable "on or before the date this settlement is approved by a referee," the agreement here resolved issues raised or raisable "at this time." We conclude that, in this case, the phrase "at this time" most reasonably relates to the date the parties executed their agreement. Assuming for the sake of argument that the date of execution is the date of the final signature of the parties, so far as the parties were aware, only the diagnosis of deQuervain's tenosynovitis was related to claimant's work as of January 26, 1994. Because Dr. Nye's report, which related the CTS to claimant's work activities was received by the parties on January 31, 1994, the compensability of the CTS condition was not ripe for negotiation prior to that date. We find, therefore, that claimant is not precluded by the stipulation from litigating the compensability of his bilateral CTS occupational disease claim.

Our conclusion is consistent with our prior decision in Ronald A. Krasneski, 47 Van Natta 852 (1995). In that case, prior to entering into a stipulation, the claimant sought treatment for upper extremity pain. Multiple conditions were diagnosed. Two diagnoses were reportedly related to the claimant's work. We concluded that those diagnoses "could have been raised" before the settlement and, thus, were barred from subsequent litigation. However, in the absence of evidence relating the claimant's other diagnoses to work prior to the stipulated settlement, we concluded that claims for those conditions were not barred.

Having found that claimant is not precluded from litigating his bilateral CTS claim, we proceed to the merits. We adopt and affirm the ALJ's reasoning and conclusion that claimant's work activities were the major contributing cause of the bilateral carpal tunnel syndrome.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by Liberty Northwest Insurance Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 1, 1995 is affirmed. For services on Board review, claimant is awarded an assessed attorney fee of $1,200, payable by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
ROLLIE W. SHANDY, Claimant
WCB Case No. TP-96002
THIRD PARTY DISTRIBUTION ORDER
Burt, Swanson, et al, Claimant Attorneys
Brenda JP Rocklin (Saif), 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 whether the SAIF Corporation is entitled to recover, as a portion of its "third party" lien, payments made pursuant to a Claim Disposition Agreement (CDA), including attorney fees paid out of the CDA proceeds. We conclude that a distribution entitling SAIF to recover payments made pursuant to the CDA would be "just and proper."

FINDINGS OF FACT

On August 9, 1994, claimant suffered a compensable cervical and lumbosacral strain injury. SAIF accepted the claim and provided benefits. In June 1995, SAIF and claimant entered into a CDA, in which the parties agreed to "settle claimant's claim for compensation and payments of any kind due or claimed for all past, present and future conditions, except compensable medical services, for the total sum of $25,000.00 * * *." The CDA also provided that $4,375 of the $25,000 CDA settlement proceeds would be distributed to claimant's attorney as an attorney fee. Finally, the CDA also provided: "Nothing in this document affects or impairs any of SAIF's rights, including those arising under ORS 656.576 to 656.595."

Claimant initiated a lawsuit against an allegedly negligent third party for damages arising from his August 9, 1994 injury. In August 1995, SAIF advised claimant's attorney that it had determined that its lien against any judgment or settlement of the third party action was $46,056.59. The lien amount included time loss payments of $10,115.30, medical payments of $1,795.50, vocational rehabilitation payments of $500, a permanent disability award of $8,645.79, and CDA proceeds in the amount of $25,000.

In December 1995, SAIF approved a settlement between claimant and the third party for $205,000.

After the third party settlement was reached, claimant's attorney advised SAIF that claimant disagreed with the amount SAIF asserted as its lien against the third party settlement. Specifically, claimant disagreed with the inclusion in the lien of the $25,000 CDA proceeds. Thereafter, claimant petitioned the Board for a determination of a "just and proper" distribution of the third party settlement proceeds pursuant to ORS 656.593(3).

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.

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 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 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, claimant objects only to the inclusion in SAIF's lien of the $25,000 CDA proceeds. Specifically, claimant objects to the inclusion of the $4,375 attorney fee which was payable out of the $25,000 CDA proceeds and objects to the amount of the CDA proceeds attributed to future compensation under ORS 656.273 and 656.278. Claimant does not dispute that CDA proceeds are compensation which is generally reimbursable from a third party settlement. See Turo v. SAIF, 131 Or App 572 (1994).

With regard to the $4,375 attorney fee payable out of the CDA proceeds, claimant contends that the fee is not a reimbursable claim cost. We disagree. Attorney fees payable out of compensation retain their identity as compensation. Turo v. SAIF, supra; Steiner v. E.J. Bartells Co., 114 Or App 22, 25 (1992); Scott Turo, 47 Van Natta 965, 966 (1995). Thus, we agree with SAIF that the $4,375 fee is compensation that has been paid out in the claim.

With regard to the remainder of the CDA proceeds, SAIF argues, and claimant concedes, that amended ORS 656.593(1)(c)[1] applies to this claim. As amended, ORS 656.593(1)(c) now allows the paying agency to recover compensation which may become payable under ORS 656.273 or 656.278. However, citing the language in the statute which provides that a paying agency can recover the present value of its "reasonably to be expected future expenditures for compensation and other costs of the worker's claim," claimant argues that the amount allotted by SAIF for future compensation is excessive and unreasonable. Claimant argues that a determination must be made regarding what is a reasonable share of the CDA proceeds for future compensation under ORS 656.273 or 656.278.

We reject claimant's assertion that the amount of the CDA proceeds allotted for future compensation under ORS 656.273 or 656.278 is unreasonable. Claimant entered into the CDA and received $25,000, for release of past, present and future non-medical benefits. Specifically included in those benefits were permanent and temporary disability, as well as claimant's aggravation rights under ORS 656.273 and Own Motion rights under ORS 656.278. The CDA further expressly provided that

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[1] Amended ORS 656.593(1)(c) provides: "The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under this chapter. Such other costs include expenditures of the department from the Consumer and Business Services Fund, the Self-Insured Employer Adjustment Reserve and the Workers' Benefit Fund in reimbursement of the costs of the paying agency. Such other costs also include assessments for the Workers' Benefit Fund, and include any compensation which may become payable under ORS 656.273 or 656.278." (Emphasis added).

SAIF retained its rights under the third party statutes. Finally, because the CDA has been approved by the Board, it has been conclusively determined that the CDA is not unreasonable as a matter of law. See ORS 656.236(1). Under these circumstances, we do not find the amount of the CDA proceeds directed to future compensation to be unreasonable.[2]

After considering the circumstances of this case, we find that it is "just and proper" for SAIF to receive reimbursement for the CDA proceeds, including the "out-of-compensation" fee and any CDA proceeds allocated to future compensation under ORS 656.273 and 656.278. We reach this conclusion for the following reasons. First, it is undisputed that SAIF actually incurred the cost of the CDA, including the "out-of-compensation" fee. Second, the CDA contained a provision which expressly provided that SAIF's third party rights were unaffected by the CDA.[3] Finally, claimant will receive approximately $90,000 from the third party settlement in addition to receiving the $46,056 in workers' compensation benefits that have already been paid by SAIF.[4] Under these circumstances, we conclude that it is "just and proper" for SAIF to receive the full amount of its lien, including the $25,000 CDA proceeds. Accordingly, claimant's attorney is directed to forward the aforementioned sum to SAIF.

IT IS SO ORDERED.

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[2] Where the parties have agreed to a CDA, they have also conceded that the amount of the CDA reflects the value of the claim, including the value allotted for future benefits. An approved CDA is prima facie evidence of the value of past, present and future (non-medical) benefits in a claim. Thus, in the context of an approved CDA, an exact breakdown of what is specifically allotted for future benefits is unnecessary. In other words, when a CDA has been approved, the parties have agreed, and the Board has conclusively determined, that the value of the CDA (including that portion allotted to future compensation) is a reasonable reflection of the value of the claim.

[3] As we previously noted in Scott Turo, 45 Van Natta 995 (1993), it is not unusual for CDAs to include, as full or partial consideration, the paying agency's waiver or reduction of its lien against a specific and ascertainable third party settlement. Through such a disposition, the claimant releases his rights to past, present and future compensation in return for a greater share of his third party recovery. In the present case, claimant entered into the CDA while the third party action was still pending. Yet the CDA contains no mention of the third party action and SAIF did not waive all or any part of its lien. Under such circumstances, particularly where the CDA expressly preserves the paying agency's third party rights, we do not consider it unjust or improper for the paying agency to recover the full amount of the CDA proceeds.

[4] After claimant's 1/3 attorney fee ($68,333) and 1/3 statutory share ($45,556) are deducted from the third party settlement proceeds, the balance would be approximately $91,111. When SAIF's full lien of $46,056 is satisfied, approximately $45,054 remains. Thus, even after the full amount of SAIF's lien is satisfied, claimant would still receive approximately $90,000 from the settlement.

July 11, 1996 Cite as 48 Van Natta 1523 (1996)

In the Matter of the Compensation of
FRANK L. BUSH, Claimant
Own Motion No. 93-0149M
OWN MOTION ORDER OF ABATEMENT
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

The self-insured employer requests reconsideration of our June 27, 1996 Own Motion Order (as reconsidered on July 10, 1996), which: (1) directed the employer to pay temporary disability compensation commencing November 17, 1995 until such compensation could be lawfully terminated; and (2) assessed a penalty, payable in equal shares to claimant and his attorney. Our July 10, 1996 order awarded claimant's attorney an attorney fee in the amount of 25 percent of the increased temporary disability granted by our prior order, not to exceed $1,050.) The employer requests that the Board vacate that portion of our June 27, 1996 order which allows temporary disability from November 17, 1995 forward (on a procedural basis) and that portion of the order which orders a penalty to be paid for improper claims processing.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. Claimant is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL M. VALENCIA, Claimant
WCB Case No. 94-03439
ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Valencia, 140 Or App 14 (1996). The court has reversed our prior order which affirmed an Administrative Law Judge's (ALJ's) order that assessed a penalty pursuant to former ORS 656.268(4)(g) when an Order on Reconsideration increased claimant's scheduled permanent disability award from zero, as awarded by a Notice of Closure, to 32 percent (48 degrees) for loss of use or function of the right forearm. Relying on its holding in SAIF v. Cline, 135 Or App 155 rev den 321 Or 560 (1995), the court has reversed and remanded for reconsideration.

The relevant facts are as follows. A Notice of Closure awarded claimant no permanent disability for his compensable right hand injury. Claimant requested reconsideration. On reconsideration, the Department awarded 32 percent (48 degrees) scheduled permanent disability for the right forearm. Claimant requested a hearing. Finding that claimant was at least 20 percent disabled and that the disability award was increased at least 25 percent on reconsideration, the ALJ assessed a penalty under former ORS 656.268(4)(g).[1] SAIF requested review. On review, we adopted and affirmed the ALJ's order.

Citing SAIF v. Cline, supra, the court has reversed our order. In Cline the court found former OAR 436-30-050(13) valid. That rule provided that in order to be at least 20 percent disabled, a worker must have a total sum of 64 degrees of scheduled or unscheduled disability.

The Cline court reasoned that, because the text of former ORS 656.268(4)(g) refers to the disability of "the worker," not a particular body part, percentage of disability of a particular body part must be converted to a percentage of the whole worker before the statute may apply. Id at 159. The court instructed that, in order to determine the extent of disability of the whole worker, the disability must be translated into degrees, the statutory measuring unit. Id. Because 320 degrees comprises the whole worker, the court determined that the worker must have suffered at least 64 degrees of permanent disability (20 percent of 320 degrees) in order to be at least 20 percent disabled for purposes of former ORS 656.268(4)(g). Because former OAR 436-30-050(13) was consistent with that reasoning, the Cline court concluded that the rule was valid. Id.

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[1] Former ORS 656.268(4)(g) provided:

"If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

ORS 656.268(4)(g) was amended by the 1995 Legislature. Those amendments apply only to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. SB 369, § 66(4). Here, claimant became medically stationary on May 10, 1993. Consequently, amended ORS 656.268(4)(g) does not apply to this claim.

Here, claimant received a scheduled permanent disability award on reconsideration of 32 percent (48 degrees), scheduled permanent disability. Because claimant has received less than 64 degrees of disability, he is not entitled to a penalty under former ORS 656.268(4)(g). SAIF v. Cline, supra.

Accordingly, on reconsideration of our December 19, 1994 order, we reverse the ALJ's order dated June 10, 1994.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT W. WILMOT, Claimant
WCB Case No. 95-11112
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that affirmed an Order on Reconsideration that awarded 17 percent (25.5 degrees) scheduled permanent disability for loss of use or function of the left hand. Alternatively, claimant requests remand to the Director for the promulgation of a temporary rule. In its brief, the insurer contends that, pursuant to amended ORS 656.283(7), claimant should not have been permitted to testify at hearing. On review, the issues are evidence and extent of scheduled permanent disability. We do not consider claimant's testimony, and affirm the ALJ's permanent disability decision.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

The insurer argues that the ALJ should not have permitted claimant to testify at hearing, in light of amended ORS 656.283(7). We agree.

The amended statute provides, in part, that "[e]vidence 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." Amended ORS 656.283(7). That statute went into effect on June 7, 1995, before the issuance of the September 1995 Order on Reconsideration. Therefore, the amended statute applies to this case. Or Laws 1995, ch 332, § 66(1); see Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

Under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. Precision Castparts Corp. v. Plummer, 140 Or App at 231. However, the statute does not exclude evidence previously and properly admitted at hearing, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Id.

In Joe R. Ray, 48 Van Natta 325 (1996), we held that under amended ORS 656.283(7), evidence that was not submitted during reconsideration, is inadmissible at a subsequent hearing concerning extent of disability. In light of the court's decision in Plummer, that holding has been overruled, insofar as evidence concerning a worker's permanent disability, that was properly admitted, can be considered on review.

Nevertheless, where a hearing concerning extent of permanent disability was held after June 7, 1995, the prohibition on subsequent evidence is applicable, and we will continue to adhere to our

holding in Joe R. Ray, supra. Dean J. Evans, 48 Van Natta 1092 (1996). Here, the hearing was held on December 29, 1995. Accordingly, because claimant's hearing testimony was not submitted during the reconsideration process, we conclude that the testimony was inadmissible. Therefore, we do not consider claimant's testimony on review.

Extent of scheduled disability

Claimant's argument for an increased award of scheduled permanent disability is based on his contention that he has a loss of grip strength due to the compensable injury. Relying on the opinion of the medical arbiter, Dr. Smith, that claimant had full grip strength in the left hand, the ALJ concluded there was no basis for an award for loss of grip strength. For the following reasons, we agree that claimant has failed to establish an entitlement to an increased award.

On review, claimant argues that the ALJ should have relied on the opinion of Dr. Nolan, claimant's treating doctor. Claimant argues that, in March 1995, Dr. Nolan indicated grip and pinch strength deficiencies between the left and right hand. Specifically, claimant retained 54 percent grip strength on the left and 65 percent pinch strength on the left. (Ex. 18). In May 1995, Dr. Nolan reported that claimant had a loss of strength of the left hand. Dr. Nolan assigned a 4/5 rating, with grip strength down approximately 30 percent on the left. (Ex. 19). Additionally, claimant argues that the arbiter's report supports an award for loss of grip strength, as Dr. Smith noted 110 pounds of strength on the left as compared with 173 pounds on the right.

OAR 436-35-110(8) provides for a grip strength award for loss caused by peripheral nerve injury. In the present case, however, Dr. Smith reported that claimant had "excellent grip strength," and no loss of strength due to loss of muscle, nerve damage or disruption of the musculotendinous unit. (Ex. 24-2; 24-3). Furthermore, even if we consider the opinion of Dr. Nolan, we are unable to find evidence of loss caused by peripheral nerve injury. Accordingly, we do not find that claimant has proven a measurable grip strength impairment under OAR 436-35-110(8). See Kelly D. Mustoe, 46 Van Natta 285 (1994).

Remand/temporary rule

Alternatively, claimant argues that, if he has not established entitlement to an award under the "standards," this matter should be remanded to the Director for the promulgation of a temporary rule to address his disability. See Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993). The insurer contends, however, that because claimant did not seek a temporary rule at the time of reconsideration, his remand request at the Hearings and Board level is not timely. We need not address the insurer's argument, as we conclude that claimant has failed to establish that he has disability that is not addressed by the standards.

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, supra. Claimant has the burden of proving that his disability is not addressed by the standards. See ORS 656.266; Valorie L. Leslie, 46 Van Natta 1919 (1994); Susan D. Wells, 46 Van Natta 1127 (1994).

Here, the Director made an express finding that "this worker's disability is adequately addressed in the rating standards." (Ex. 25-5). Furthermore, the Order on Reconsideration awarded impairment values for lost range of motion and a chronic condition. (Ex. 25-4). Consequently, we conclude that, even if claimant established that he did have a loss of strength due to the injury, he has not proven that his disability is not addressed in the standards. See Terry J. Hockett, 48 Van Natta 1297 (1996). Accordingly, we decline to remand this matter to the Director to adopt a temporary rule. See Susan D. Wells, supra.

ORDER

The ALJ's order dated January 26, 1996 is affirmed.

In the Matter of the Compensation of
SANDRA ALLISON, Claimant
WCB Case No. 95-11113
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's occupational disease claim for left carpal tunnel syndrome (CTS). On review, the issue is compensability.

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

We begin by briefly summarizing the pertinent facts. In 1981, claimant experienced a non-work-related accident that severely cut both tendons and the median nerve of her right hand, which resulted in median nerve atrophy and numbness. (Ex. 19). For that reason, even though claimant is right-hand dominant, she relies more on her left hand, particularly for work that requires finger dexterity. (Tr. 11, 20).

In about November 1994, claimant, age 38, who worked for six years as an office specialist performing a variety of clerical duties, began to notice pain and numbness throughout the left wrist and fingertips which was worse at the end of her workday and diminished with rest. (Ex. 10). In January 1995, claimant sought treatment from Dr. Scherlie, her family doctor, who treated her with anti-inflammatory medication and a wrist brace. (Ex. 10). Claimant's condition did not improve, so Dr. Scherlie referred her to a more aggressive rehabilitation program, where she was treated by Dr. Nelson. Claimant was examined for SAIF on one occasion by Dr. Jewell. (Ex. 31).

Claimant's work activities were fast-paced and generally hand-intensive. They included answering the phone with her left hand, keyboarding on a typewriter or computer, filing, and other general office duties. See Tr. generally, pp 12-71.

Relying on Dr. Nelson's opinion that claimant's work activities were the major contributing cause of her left CTS, the ALJ concluded that claimant's occupational disease claim was compensable. SAIF argues on review that Dr. Jewell's opinion is more persuasive than that of Dr. Nelson, claimant's attending physician. Specifically, SAIF contends that Dr. Nelson did not have a complete history of claimant's work activities, that he was not aware of the limited amount of time claimant spent keyboarding, and that he failed to explain why claimant developed CTS in her left hand when she actually did more keyboarding with her right hand.

Considering the passage of time and claimant's employment exposures, the determination of the major cause of claimant's condition is complex and requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993). We generally defer to the medical opinion of an attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find no such reasons.

As noted above, Dr. Nelson, a rehabilitation specialist, began treating claimant in August 1995 upon referral from Dr. Scherlie. Dr. Nelson reported that claimant's symptoms had begun in November 1994, with increasing left wrist and hand pain with numbness and tingling and nocturnal dysesthesias, generally worsened by her work involving multiple activities of paperwork, keyboarding and general clerical work. Dr. Nelson initially opined that claimant's CTS condition was work-related. (Ex. 19). Subsequent to his review of Dr. Jewell's report, which included a detailed discussion of claimant's work duties, including the percentage of time claimant spent word processing, Dr. Nelson also opined that the major contributing cause of claimant's condition was her work activities, disagreeing with Dr. Jewell's opinion that the major contributing cause of claimant's condition was her lifestyle, age and gender. (Ex. 29). We conclude that Dr. Nelson was aware of all of claimant's duties, including the amount of time that claimant spent word processing.

Moreover, during his treatment of claimant, Dr. Nelson noted the fact that claimant's median nerve on the right had atrophied significantly to absent, with complete numbness in the right medial nerve distribution consistent with the prior laceration of the tendons in her right arm. (Ex. 19). He further noted that it would be unlikely for claimant to experience symptoms in the right carpal tunnel, given the injury to the median nerve. (Id.).

In contrast, although Dr. Jewell noted the injury to claimant's tendons and median nerve and her median nerve hypesthesia on the right, he nevertheless opined that if employment were the cause of claimant's condition, that it would be more likely that claimant would have developed bilateral or dominant (right) hand symptoms. (Ex. 31). Moreover, Dr. Jewell's conclusory opinion that claimant's lifestyle, age and gender were the major contributing cause of her CTS is not supported by any facts in the record regarding claimant's lifestyle, aside from her work activities. In addition, in response to a query by SAIF, Dr. Jewell opined that claimant's preexisting conditions (which he earlier identified as degenerative disc disease in the neck) combined with her employment and that the preexisting conditions are the major contributing cause of claimant's left carpal tunnel condition. (Ex. 31-2). Again, he offered no reasoning in support of his changed opinion on causation. Because Dr. Jewell's various opinions were conclusory and unexplained, we give them little weight. Somers v. SAIF, 77 Or App 249 (1986); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

For the same reason, we give Dr. Scherlie's opinions little weight. Id. Dr. Scherlie initially opined that claimant's condition was probably work related. (Ex. 19). Dr. Scherlie nevertheless concurred with Dr. Jewell's September 12, 1995 opinion that claimant's condition was not caused by work. (Ex. 27). Dr. Scherlie offered no reasoning regarding his change of opinion. Therefore, his changed opinion is not persuasive and we do not rely on it.

Because we are more persuaded by Dr. Nelson's opinion than those of Drs. Jewell and Scherlie, we conclude that claimant's work activities were the major contributing cause of her left CTS condition. Claimant's claim is compensable.

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

ORDER

The ALJ's order dated January 23, 1996 is affirmed. For services on review, claimant's counsel is awarded a fee of $1,000, to be paid by SAIF.

June 13, 1996 Cite as 48 Van Natta 1528 (1996)

In the Matter of the Compensation of
GEORGIA COLE, Applicant
WCB Case No. CV-95008
ORDER DENYING RECONSIDERATION (CRIME VICTIMS' ACT)
Mary Campbell, Assistant Attorney General

On May 9, 1996, Special Hearings Officer Celia Fitzwater issued Findings of Fact, Conclusions and Proposed Order which affirmed the Department of Justice Crime Victims' Compensation Fund's Order on Reconsideration dated December 15, 1995 that denied applicant's claim for crime victims' compensation. On May 29, 1996, we issued an Order on Reconsideration also concluding that applicant was not eligible for crime victims' compensation.

On May 31, 1996, we received a letter from applicant objecting to the Order on Reconsideration. By statute, our order is final and not subject to further administrative or judicial review. ORS 147.155(5). Consequently, we cannot further review applicant's case. Accordingly, applicant's request for further consideration of her claim is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
KAREN A. FALETTI, Claimant
WCB Case No. 93-09664
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. In our prior order, Karen A. Faletti, 47 Van Natta 411 (1995), we affirmed the Administrative Law Judge's (ALJ's)[1] order which denied the SAIF Corporation's motion to dismiss claimant's request for hearing for lack of jurisdiction over a Managed Care Organization (MCO) proposed medical services dispute.[2] Pursuant to its June 24, 1996 order, the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We first summarize the relevant facts of this case. Claimant's attending physician, Dr. Randle, requested authorization from SAIF for physical therapy for claimant. Caremark, SAIF's Managed Care Organization (MCO), disapproved the request. After the MCO denied reconsideration, claimant filed a request for hearing. SAIF moved to dismiss the hearing request on the grounds that jurisdiction to review the medical services issue did not lie with the Hearings Division, but rather with the Director under ORS 656.260(6).

The ALJ denied SAIF's motion for dismissal, reasoning that the MCO provisions of former ORS 656.260 did not abolish claimant's right to request a hearing concerning the reasonableness and necessity of her medical treatment.

On review of the ALJ's order, we relied on Job Lopez, 47 Van Natta 193 (1995) in rejecting SAIF's assertion that, under former ORS 656.260 (the MCO statute) and former ORS 656.704(3), the Director had exclusive jurisdiction over a MCO proposed medical services dispute. Citing Martin v. City of Albany, 320 Or 175 (1994), and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), rev den 320 Or 453 (1994), we held that, because the dispute involved proposed medical services, the Hearings Division had exclusive jurisdiction to review the matter. Consequently, we affirmed the ALJ's decision to deny SAIF's motion to dismiss. Karen A. Faletti, supra.

SAIF requested judicial review. The court has now remanded the matter for reconsideration. In accordance with the court's mandate, we now proceed with our reconsideration.

Subsequent to our order, the legislature amended ORS 656.327(1)(a), 656.260(6), and 656.704(3). Amended ORS 656.704(3) now provides, in relevant part:

> "For purposes of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any disputes arising under ORS 656.245, 656.248, 656.260, 656.327 * * * " (Emphasis added).

Amended ORS 656.327(1)(a) now provides:

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[1] Formerly referred to as "Referee."

[2] We also affirmed the ALJ's award of an assessed attorney fee under ORS 656.386(1) for the counsel's services in setting aside SAIF's "de facto" denial of the medical services claim. However, we reversed the ALJ's award of an assessed fee for SAIF's allegedly unreasonable claim processing.

> "If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties." (Emphasis added).

Amended ORS 656.260(6) now provides, in relevant part: "Any issue concerning the provision of medical services to injured workers subject to a managed care contract * * * shall be subject solely to review by the director or the director's designated representatives, or as otherwise provided in this section." (Emphasis added).

The amended versions of the statutes apply here and provide that the Director has exclusive jurisdiction to review proposed medical treatment, as well as exclusive jurisdiction over all MCO medical services disputes, including those currently pending before the Board. Job G. Lopez, 48 Van Natta 1098 on remand (1996) (citing Newell v. SAIF, 134 Or App 625, aff'd on recon 136 Or App 280 (1995) and Ronald R. Streit, Sr., 47 Van Natta 1577 (1995)).

Here, the matter at issue pertains to a MCO proposed medical services dispute. Accordingly, exclusive jurisdiction of this dispute lies with the Director, not the Hearings Division. Amended ORS 656.327(1)(a); 656.260(6); 656.704(3); Job G. Lopez, supra (order on remand).

Consequently, on reconsideration of our prior order, we vacate the ALJ's July 18, 1994 order. Claimant's request for hearing is dismissed for lack of jurisdiction.[3]

IT IS SO ORDERED.

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[3] ORS 656.385(5) provides that the Board may not award penalties or attorney fees for matters arising under the jurisdiction of the Director. Accordingly, we also lack jurisdiction to address the attorney fee issues decided by the ALJ. William E. Hays, 48 Van Natta 423 (1996).

In the Matter of the Compensation of
SCOTT J. MALONEY, Claimant
WCB Case Nos. 95-09774 & 95-02568
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

On June 7, 1996, we withdrew our May 28, 1996 Order on Review which had affirmed an Administrative Law Judge's order that: (1) set aside the insurer's denial of claimant's right carpal tunnel syndrome (CTS) condition; (2) affirmed an Order on Reconsideration that found a claim for right wrist strain was prematurely closed; (3) found claimant entitled to additional temporary disability; and (4) assessed a penalty for the insurer's allegedly unreasonable claims processing. We took this action at the parties' request to await consideration of their proposed settlement which is designed to resolve their dispute. Having received their "Disputed Claim Settlement and Stipulation," we proceed with our reconsideration.

The proposed settlement is intended to resolve all issues raised or raisable between the parties, in lieu of all prior orders. Pursuant to the settlement, claimant agrees that the insurer's denials and the notice of closure shall be affirmed. The settlement further provides that claimant's request for hearing "is dismissed with prejudice."

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 of
CHRIS G. STILL, Claimant
WCB Case No. 95-09407
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Alice M. Bartelt, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) affirmed an Order on Reconsideration (OOR) award of 26 percent (83.2 degrees) unscheduled permanent disability for claimant's neck condition; (2) increased the OOR award of scheduled permanent disability from 26 percent (39 degrees) to 30 percent (45 degrees) for loss of use or function of the right wrist; and (3) increased the OOR award of scheduled permanent disability from 22 percent (33 degrees) to 26 percent (39 degrees) for loss of use or function of the left wrist. In its brief, SAIF contends that the ALJ erred by excluding Exhibits 13, 14, 15, and 16. On review, the issues are evidence and extent of unscheduled and scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We do not adopt the ALJ's "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, SAIF argues that the ALJ erred in excluding Exhibits 13 through 16. The ALJ found that the exhibits were relevant, however, he concluded that the exhibits were immaterial, as the reports were based on examinations performed before claimant was medically stationary.

Although a particular exhibit might not be persuasive on an issue, the weight of a piece of evidence does not determine its admissibility. See Beverly A. Martell, 45 Van Natta 985 (1993). Here, we conclude that it is not necessary for us to decide whether the ALJ should have admitted the exhibits and given them the appropriate weight, or whether the exhibits were properly excluded. We conclude that, even if Exhibits 13 through 16 were admitted, the outcome of this case would remain the same.

Unscheduled/scheduled permanent disability

On review, SAIF argues that claimant is not entitled to any permanent impairment as the medical arbiter's report is not persuasive. We adopt the ALJ's Conclusions of Law and Opinion on the issue of extent, with the exception of the ALJ's award for a chronic condition. For the following reasons, we do not agree that claimant is entitled to an award for a chronic condition.

Claimant has three accepted conditions: right shoulder bursitis, right carpal tunnel syndrome, and cervical strain. In his report, Dr. Ballard, the medical arbiter, discussed each of claimant's accepted conditions and claimant's limitations arising from those conditions. Dr. Ballard reported his impression as "[b]ilateral upper extremity pain with continued paresthesias, possible reflex sympathetic dystrophy; status post bilateral carpal tunnel release and cervical strain." With respect to his findings, Dr. Ballard reported that claimant "does have some limitations in the ability to repetitively use his body part due to the diagnosed chronic and permanent medical condition." (Ex. 31-1).

Based on Dr. Ballard's notation, the ALJ found that claimant was entitled to a chronic condition award for each hand. We disagree.

In light of the fact that claimant has three accepted conditions, we are unable to construe Dr. Ballard's report as documentation of a chronic condition award for the wrists. Moreover, Dr. Ballard noted that claimant was unable to use a body part, which does not support an award for both hands. Accordingly, without further explanation from Dr. Ballard, we do not find the medical arbiter's report sufficient to establish an award for a chronic condition. We therefore reverse the ALJ's chronic condition award.

ORDER

The ALJ's order dated February 2, 1996 is modified. In lieu of the ALJ's award, the July 27, 1995 Order on Reconsideration is reinstated and affirmed in its entirety. Claimant's total award to date is 26 percent (83.2 degrees) unscheduled permanent disability, 26 percent (39 degrees) scheduled permanent disability for the right wrist, and 22 percent (33 degrees) scheduled permanent disability for the left wrist. The ALJ's approved attorney fee award is reversed.

In the Matter of the Compensation of
STEVEN L. WALTER, Claimant
WCB Case No. 95-11946
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Yeager's order that assessed a penalty for its allegedly unreasonable failure to pay compensation awarded by an Order on Reconsideration. On review, the issue is penalties.

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

SAIF argues that its failure to pay the October 17, 1995 Order on Reconsideration award was not unreasonable because the Department's order was internally inconsistent and in error. We disagree, for the following reasons.

First, the order was enforceable, even if it was wrong. See SAIF v. Roles, 111 Or App 597 (1991); see also Mark A. Crawford, on recon, 46 Van Natta 873, 874 (1994) ("If a [carrier] disagrees with an award made by an Order on Reconsideration, it is necessary to appeal it."). Second, considering the order's clear directive ("The insurer is ordered to pay the worker an award of $2,982.70. This is in addition to any previous award."), we do not find that contextual inconsistency elsewhere in the order reasonably supports noncompliance. (See Ex. 10-2). Third, SAIF's remedy was to timely appeal the order, not to ignore it. See ORS 656.313(1)(a); see also Karen S. McKillop, 44 Van Natta 2473, 2474 (1992) ("The insurer's apparent belief that the award [] was made in error may be grounds for an appeal []. It is not, however, a legitimate basis for the failure to comply with the order.").

Accordingly, we agree with the ALJ that SAIF's failure to comply with the order was unreasonable and a penalty was appropriate. See Gene G. Martin, 45 Van Natta 2102, 2104 (1993) (A carrier's failure to pay benefits awarded by a reconsideration order constituted unreasonable resistance to the payment of compensation, unless it requested a hearing within 30 days of the order). Inasmuch as penalties are not "compensation" for purpose of ORS 656.382(2), claimant is not entitled to an attorney fee for services on Board review. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated February 28, 1996 is affirmed.

In the Matter of the Compensation of
JERRY E. BISHOP, Claimant
WCB Case No. 94-14311
ORDER ON RECONSIDERATION (REMANDING)
David C. Force, Claimant Attorney
David O. Horne, Defense Attorney

On May 30, 1996, we affirmed an Administrative Law Judge's (ALJ's) order that declined to award interim compensation. Enclosing "newly-discovered evidence," claimant seeks to have this case returned to the Hearings Division for further development of the record. On June 12, 1996, we abated our order and permitted the insurer an opportunity to respond to claimant's request, which we treat as a motion for reconsideration of our May 30, 1996 order. Having received the insurer's response, we proceed with our reconsideration.

Here, following the August 4, 1995 closure of the record, the ALJ determined that the insurer's denial of claimant's claim was constructively served on claimant, as the denial was sent to claimant's attorney. Therefore, the ALJ found that the insurer's denial was effective to terminate compensation, and claimant was not entitled to the relief sought. On review, we did not address the issue of whether or not claimant or his attorney received the denial. Rather, we found that the parties' stipulation that "claimant was incapable of returning to his employment" did not constitute an authorization by an attending physician for the payment of temporary disability under the "new" law. Consequently, we affirmed the ALJ's order.

On reconsideration, claimant first argues that such authorization from the treating doctor was not required at the time of the claim in 1992. Accordingly, claimant argues that our retroactive application of the new law is unfair and possibly unconstitutional. In any event, claimant contends that we resolved this dispute based on an issue not raised by the parties, i.e., the adequacy of the stipulation for purposes of authorizing interim compensation. Therefore, claimant argues that this case warrants remand to the ALJ for the introduction of additional evidence regarding whether claimant's attending physician authorized temporary disability benefits. To support his request for remand, claimant has attached several medical reports and certificates regarding his condition or ability to perform work activity during the relevant time period.

Additionally, claimant has attached an affidavit of an attorney, which claimant contends pertains to the issue decided by the ALJ, i.e., whether claimant's attorney was served with the insurer's denial. Claimant also requests further development of the record on the representation/service issue.

On reconsideration, the insurer concedes that the "issue" of attending physician authorization was not contemplated by the stipulation, since the stipulation predated the 1995 statutory amendments which became effective June 7, 1995. (Response on Reconsideration, pg. 1). Furthermore, although the insurer opposes remand, it agrees that the submitted medical records and documents relating to the attending physician authorization may be admitted into the record. However, the insurer objects to the admission of documents pertaining to claimant's prior representation, as the insurer argues that such documents are irrelevant.

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).

We conclude that, in light of the insurer's concession that the parties' stipulation did not contemplate the attending physician authorization issue, a compelling basis exists for remand on that basis. We note that, although the insurer objects to remand, it agrees that documents pertaining to the attending physician issue can be considered. Nevertheless, our review is limited to the record developed at the hearing level. See Homer Betancourt, 46 Van Natta 2399 (1994). Consequently, we conclude that remand is both necessary and appropriate in order to admit the documents related to the authorization issue.

Accordingly, we vacate the ALJ's order and remand this matter to ALJ Black for admission of the reports/documents submitted regarding the issue of whether claimant's attending physician authorized temporary disability, and for the ALJ's determination of the effect, if any, that the Board's "attending physician/interim compensation" cases might have on this matter. See e.g. Debbie I. Jensen, 48 Van Natta 1235 (1996); Cheryl A. Trask, 48 Van Natta 871 (1996); Manuel Altamirano, 47 Van Natta 1499 (1995). The parties and the ALJ should also consider the effect, if any, amended ORS 656.319(6) may have on this case. See Gillander v. SAIF, 140 Or App 210 (1996).

Finally, we note that the insurer has opposed any further submissions regarding the issue of claimant's prior legal representation. OAR 438-007-0025 provides that the ALJ may, under certain circumstances, reopen the record to consider newly discovered evidence. Because we are remanding this matter to the ALJ, the parties may submit their respective positions to the ALJ regarding whether the record should be also reopened for further evidence on the issue of claimant's prior attorney/receipt of the denial.

Consistent with this order, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice, and will insure a complete and accurate record of all exhibits, examination, and/or testimony. Thereafter, the ALJ shall issue a final, appealable order.

Accordingly, we withdraw our May 30, 1996 order. On reconsideration, we vacate our prior order and remand this matter to the ALJ for further action consistent with this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD R. ELIZONDO, Claimant
WCB Case No. 92-06556
ORDER ON REMAND
Andrew H. Josephson, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Elizondo, 140 Or App 135 (1996). In our prior order, we held that claimant was entitled to the same vocational assistance benefits he would have received had his aggravation rights not expired. Citing Windom v. Dodge Logging, 139 Or App 130 (1996), and Volk v. America West Airlines, 135 Or App 565 (1995), rev den 322 Or 645 (1996), the court reversed and remanded for reconsideration.

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable right leg injury claim with the SAIF Corporation. Following claim closure, in August 1989, the claim reopened under the Board's Own Motion authority. A December 1991 Notice of Closure closed this claim. In 1992, claimant's treating physician recommended to SAIF vocational assistance for claimant. SAIF denied the request on the basis that the claim was in Own Motion status and claimant's aggravation rights had ended.

Claimant then requested review by the Director. See former ORS 656.283(2) (providing that a worker who is dissatisfied with the carrier's action concerning vocational assistance must first apply to the Director for administrative review of the matter). The Director dismissed the request, finding that the issue of entitlement was under the Board's Own Motion authority, which was outside the Director's jurisdiction. Claimant requested a hearing.

The ALJ found that the Director erred in dismissing claimant's request for administrative review, finding that neither the statutes nor the rules distinguished between workers whose claims were in Own Motion status and those whose aggravation rights had not yet expired.

Relying on David F. Meissner, 45 Van Natta 249, on recon 45 Van Natta 384 (1993),[1] we agreed with the ALJ's conclusion that the Director had jurisdiction to consider claimant's entitlement to vocational assistance. Furthermore, we concluded that claimant had satisfied the requirements for vocational assistance. The court has reversed and remanded our order for reconsideration in light of Windom v. Dodge Logging, supra, and Volk v. America West Airlines, supra. We proceed with our reconsideration.

Following our prior order, the legislature amended ORS 656.283(2). As before, a worker who is dissatisfied with the carrier's action regarding vocational assistance must apply to the Director for administrative review. Additionally, if the worker is dissatisfied with the Director's decision, and the dispute cannot be resolved by agreement, the Director must resolve the dispute in a written order ORS 656.283(2)(b). That administrative review order is subject to review only by the Director pursuant to a contested case hearing; the resulting order is then subject to judicial review. ORS 656.283(c), (d).

In Ross Enyart, 47 Van Natta 1540, 1541 (1995), we found the "plain and mandatory language of the statute clearly reveals the legislature's intent that vocational assistance disputes be resolved exclusively by the Director, not by the Board or Hearings Division." Consequently, we held that the Director now has exclusive jurisdiction over vocational assistance disputes. 47 Van Natta at 1542.

Thus, because this case concerns only entitlement to vocational assistance, pursuant to ORS 656.283(2) and Enyart, exclusive jurisdiction of the matter lies with the Director. On reconsideration of our prior order, we vacate the ALJ's September 3, 1992 order and dismiss claimant's request for hearing for lack of jurisdiction.

IT IS SO ORDERED.

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[1] Citing only to Harsh v. Harsco Corp., 123 Or App 383 (1993), rev den 318 Or 661 (1994), the court reversed our order in Meissner. All American Air Freight v. Meissner, 129 Or App 104 (1994). Harsh held that the only benefits available to a claimant whose aggravation rights had expired were medical services and temporary disability compensation. 123 Or App at 387.

July 16, 1996 Cite as 48 Van Natta 1535 (1996)

In the Matter of the Compensation of
LAVERNE L. LEE, Claimant
WCB Case No. 95-06303
ORDER ON REVIEW
Pozzi, Wilson, et al, 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) Otto's order that set aside its denial of claimant's occupational disease claim for a bilateral foot condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant, age 43 at the time of hearing, has had problems with pain in the arches of his feet since 1985. At all pertinent times, he has worked as a selector for the employer, a wholesale food distributor. His job duties require him to pull stock from shelves, load it on carts and roll the carts to distribution points in the employer's warehouse. He spends most of his ten to twelve hour shift on his feet, walking up and down the aisles of the warehouse.

In December 1994, after having spent the prior two years working on the wood-floored mezzanine level of the warehouse, claimant was transferred to work on the main floor, which is made of cement. Within two weeks of his transfer, claimant began to experience pain in the metatarsal area of both feet. The lateral three toes on his right foot also went numb and he developed stabbing pain in the toes with walking.

In early January 1995, claimant sought treatment from Dr. Livingston, who diagnosed probable tarsal tunnel syndrome and referred claimant for nerve conduction studies. Nerve studies showed abnormality and bilateral sensorimotor polyneuropathy with chronic denervation in the bilateral extensor digitorum brevis and abductor digiti quinti pedis and abductor hallucis. Based on the results of the nerve studies, Dr. Livingston modified claimant's diagnosis to bilateral sensory motor neuropathy, tarsal tunnel syndrome and pronated feet.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that although claimant's work activities did not cause his bilateral peripheral polyneuropathy, tarsal tunnel syndrome or pronated feet conditions, the work activities were the major contributing cause of a pathological worsening of the bilateral foot condition, and therefore claimant had established a compensable occupational disease claim under amended ORS 656.802(2).

On review, SAIF argues that claimant has not sustained his burden under ORS 656.802(2)(b) because the medical evidence does not establish that claimant's work activities were the major contributing cause of his combined bilateral foot condition and a pathological worsening of the underlying disease.[1] We agree.

The medical evidence persuasively establishes that claimant has preexisting bilateral foot conditions, including peripheral neuropathy. Dr. Livingston, claimant's treating doctor, opined that claimant's transfer to the concrete floor area combined with his preexisting conditions to cause his disability and need for treatment. (Exs. 18, 19-16). In his deposition, Dr. Livingston explained that although claimant's work activities did not result in any structural or anatomical changes to claimant's feet (Ex. 19-19), the walking on the hard cement put more pressure on claimant's already sensitive nerves, resulting in a "pathological change" because it caused his symptoms. (Ex. 19-21).

Dr. Thompson, an orthopedist who examined claimant at SAIF's request, also diagnosed peripheral polyneuropathy bilaterally of undetermined etiology along with probable plantar nerve neuroma between the second and third metatarsal heads, right foot, moderate pes planus bilaterally and tibial nerve neuritis bilaterally, probably related to the polyneuropathy. Dr. Thompson opined that claimant's underlying polyneuropathy was the major contributing cause of claimant's condition and complaints of pain, and that the onset of the polyneuropathy may have coincidentally occurred around the time of his transfer to the main concrete floor. Dr. Thompson further opined that standing and walking on concrete floors does not cause polyneuropathy, but may well result in a temporary aggravation of symptoms. (Ex. 12-7).

Dr. White, a neurosurgeon who performed a records review at SAIF's request, concurred with Dr. Thompson that claimant's work activity had nothing to do with the development of his peripheral neuropathy. Dr. White opined that the major cause of claimant's foot symptomatology and need for treatment was his underlying, preexisting polyneuropathy, and that claimant's work activities did not cause any pathological change to the underlying condition. (Ex. 17).

Given the above expert medical evidence, we are not persuaded that claimant's work activities are the major contributing cause of a pathological worsening of his preexisting bilateral polyneuropathy. Despite Dr. Livingston's use of the term "pathological change" to describe the irritation and increased pressure claimant's work activities placed on the already sensitive and diseased nerves of claimant's feet, we understand the treating doctor's testimony to be that claimant's work caused an exacerbation of symptoms without any change or worsening in the underlying polyneuropathy condition. In this regard, we find Dr. Livingston's opinion to be consistent with the opinion of Drs. Thompson and White, who agreed that claimant's work did not cause a pathological worsening of the preexisting polyneuropathy.

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[1] Amended ORS 656.802(2)(b) provides that if the occupational disease claim is based on the worsening of a preexisting disease or condition, "the worker must prove that the employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." See also Dan D. Cone, 47 Van Natta 2220 (1995) (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).

In addition, we find no persuasive evidence that claimant's work activities were the major contributing cause of his "combined condition." Although Dr. Livingston summarily concluded that claimant's work was the major cause of his need for treatment, he did not address and compare the relative contribution of claimant's preexisting polyneuropathy to his combined bilateral foot condition. We therefore give his opinion little weight. See Dietz v. Ramuda, 130 Or App 397 (1994) (determining major contributing cause involves evaluating the relative contribution of different causes and deciding which is the primary cause). Dr. Thompson and Dr. White, on the other hand, evaluated both claimant's preexisting, underlying condition and claimant's work activity and reported that although claimant's work on the cement surface may have contributed to a temporary aggravation of claimant's foot symptomatology, the preexisting condition was the major contributing factor of claimant's combined condition.

Lastly, we reject claimant's contention that his bilateral foot condition is compensable because his symptoms are the disease. See Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990); Georgia Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991). In this case, as discussed above, the medical evidence persuasively establishes that claimant's disease, bilateral peripheral polyneuropathy, is distinct from the symptoms arising from irritation and pressure on the affected nerves. See, e.g., Janet A. Robbins, 45 Van Natta 190 (1993).

Consequently, on this record, we conclude that claimant has failed to establish the compensability of his combined bilateral foot condition under amended ORS 656.802(2)(b).

ORDER

The ALJ's order dated January 19, 1996 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award in reversed.

In the Matter of the Compensation of
GARY L. ROOF, Claimant
WCB Case Nos. 94-09998 & 94-09997
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Robert Yanity (Saif), Defense Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

Geisy, Greer & Gunn (Geisy) requests review of those portions of Administrative Law Judge (ALJ) Otto's order which: (1) set aside its denial of claimant's "new injury" claim for a left shoulder rotator cuff tear condition; and (2) upheld the SAIF Corporation's denial of claimant's medical services claim for the same condition. SAIF initially cross-requested review of those portions of the ALJ's order which set aside its denial of claimant's "chronic neck pain and left arm pain." However, SAIF has subsequently withdrawn its appeal. On review, the issues are compensability and, potentially, responsibility for claimant's left rotator cuff condition. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his left arm and neck on August 29, 1985, while employed by SAIF's insured (Westwood). SAIF accepted a cervical strain, but claimant was subsequently diagnosed with cervical and lumbar strains, chronic pain syndrome and various psychological disorders. Claimant eventually received a total of 48 percent unscheduled permanent disability as a result of several Determination Orders.

On November 6, 1993, claimant began working for Daisy Kingdom, whose claims were processed by Geisy. On May 3, 1994, claimant experienced a sudden onset of sharp pain in the left shoulder and left hand numbness while lifting a 70 pound roll of material. Claimant sought treatment from his family physician, Dr. Rastal, who referred him to Dr. Sparling, who diagnosed subacromial tendonitis. Claimant was subsequently evaluated by numerous physicians. Both SAIF and Geisy denied compensability and responsibility for left arm, left shoulder and cervical conditions. The denials were amended at hearing to include left arm strain, chronic left neck and shoulder pain, subacromial tendonitis and left rotator cuff tear involving the supraspinatus tendon.

The ALJ upheld Geisy's denial of claimant's left arm strain, subacromial tendonitis and chronic neck pain. The ALJ also upheld SAIF's denial of left arm strain, subacromial tendonitis and left rotator cuff tear. However, the ALJ set aside SAIF's denial of claimant's chronic neck and left arm pain and Geisy's compensability and responsibility denial of a left shoulder rotator cuff tear. The ALJ found that claimant's May 3, 1994 industrial accident for Geisy (as claim processor for the self-insured employer, Daisy Kingdom) was the major contributing cause of claimant's left rotator cuff condition and need for treatment. In reaching this conclusion, the ALJ determined that, for various reasons, all medical opinions were unpersuasive, except that of examining physicians, Drs. Bobker and Wilson, who concluded that claimant's May 3, 1994 incident was the major contributing cause of a left rotator cuff tear. (Ex. 134-4).

On review, the sole issue concerns compensability and responsibility for claimant's alleged left rotator cuff tear. Geisy contends that the medical evidence does not establish that claimant has a left rotator cuff tear, of which the May 4, 1994 accident was the major contributing cause. Thus, Geisy asserts that the left rotator cuff claim is not compensable. Moreover, Geisy asserts that, even if claimant's left shoulder condition is compensable, SAIF is responsible for this condition as part of its accepted claim for the August 29, 1985 injury. For the following reasons, we agree with Geisy that claimant has failed to prove that claimant has a compensable left rotator cuff tear condition.

As previously noted, the ALJ analyzed the numerous medical opinions solicited by the parties and concluded that all were unpersuasive, except for the opinion of Drs. Wilson and Bobker. The ALJ reasoned that the Wilson/Bobker opinion was persuasive because it was based on complete information and an accurate history. While we agree for the reasons cited by the ALJ that the other medical opinions are not persuasive, we conclude for the following reasons that the Wilson/Bobker opinion is also not persuasive and does not establish that claimant has a compensable left rotator cuff tear condition.

Geisy argues that the Wilson/Bobker opinion is flawed because it is not based on an accurate and complete history and because the diagnosis of a left rotator cuff tear was based on a review of a radiologist's report of an MRI scan that merely "suspected" a left rotator cuff tear. Geisy's contentions are persuasive.

Drs. Bobker and Wilson noted the September 1994 report of an MRI scan in which the radiologist's (Dr. Belkin's) impression was "suspect small focal peripheral full thickness tear of the supraspinatus tendon." (Ex. 132, emphasis added). Dr. Belkin never provided a more definitive appraisal of the MRI scan. Although Drs. Wilson and Bobker themselves diagnosed a left rotator cuff tear, their report does not indicate that they ever reviewed the actual MRI scan, as opposed to the radiologist's summary. (Ex. 136-3). Moreover, Drs. Bobker and Wilson never explained how they arrived at their diagnosis, i.e., whether it was based on their clinical examination, the report of the MRI scan or a combination of both. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical opinion). Under these circumstances, we do not accept their diagnosis of claimant's condition. This, in turn, casts doubt on the reliability of their report, including their conclusion that the May 1994 incident was the major contributing cause of claimant's need for treatment.[1]

[1] Considering that Dr. Belkin only "suspected" a tear of the supraspinatus, we find that, in the absence of a more definitive appraisal of claimant's MRI, the radiology report also does not establish that claimant has a rotator cuff tear. We also note that the one other physician (Dr. Switlyk) to actually review the MRI film diagnosed probable rotator cuff tendonitis, not a rotator cuff tear. (Ex. 144).

There are additional reasons to discount the opinion of Drs. Bobker and Wilson. The history portion of their medical report is cursory and does not contain a reference to several important aspects of claimant's history. (Ex. 136-1). These include the results of June 14, 1994 x-rays that indicated a possible prior tendon injury and the fact that claimant was diagnosed with osteoarthritis and tendonitis of the left shoulder in 1993. (Id.). Inasmuch as the Bobker/Wilson report is poorly reasoned and based on an incomplete history, we do not find it persuasive. Somers v. SAIF, 77 Or App 259 (1986). Given our agreement with the ALJ that the other medical opinions addressing the causation issue are also unpersuasive, we conclude that claimant has failed to prove that his left shoulder condition is compensable.[2]

We also find that SAIF did not accept claimant's left shoulder condition under its 1985 claim. See Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996). In Messmer v. Deluxe Cabinet Works, 130 Or App 254, rev den 320 Or 507 (1995) (hereafter Messmer I), an employer failed to appeal a Determination Order which had awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease. The court held that, although an employer's payment of compensation, by itself, did not constitute acceptance of the degenerative condition, the employer's failure to challenge the award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that the condition was not part of the compensable claim. In Messmer I, the court reasoned that the result was not that the degenerative condition had been accepted, it was that the employer was barred by claim preclusion from denying that it was part of the compensable claim. Id at 258.

After the court's decision in Messmer I, the legislature amended ORS 656.262(10) (formerly ORS 656. 262(9)). As 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."

In light of the 1995 amendments, the court reexamined the Messmer case a second time, and issued its decision in Deluxe Cabinet Works v. Messmer, supra (hereafter Messmer II). In Messmer II, the court found that, if the legislature had intended to enact a statute that had the effect of overruling the court's prior decision, it had failed to do so. Specifically, the court held that the amended statute said nothing about the preclusive consequences of an employer's failure to appeal a determination order. Rather, the court noted that the amended statute provides only that payment of permanent disability benefits does not preclude an employer from subsequently contesting compensability. Accordingly, the court held that, because the legislature had not successfully changed the law, the court could not rewrite the statute to give effect to what the legislature may have intended. Consequently, the court concluded that the amended statute, ORS 656.262(10), did not effectively overrule its prior decision in Messmer Deluxe Cabinet Works v. Messmer, supra.

In accordance with Messmer II, we examine the issue of whether SAIF is precluded from denying a left shoulder condition as part of its acceptance of the 1985 claim. Claimant received a total of 48 percent unscheduled permanent disability as a result of the 1985 claim in three Determination Orders. The first two Determination Orders contain no reference to claimant's left shoulder. (Exs. 21, 56). Neither order is accompanied by a worksheet that explains how the permanent disability calculations were made. However, the Determination Order of March 28, 1990 does include a worksheet that indicates claimant's award was based on chronic cervical and lumbar strain and a psychological condition. (Ex. 71-2). No mention is made of the left shoulder.

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[2] To the extent that the correct diagnosis of claimant's left shoulder condition is subacromial tendonitis, we also conclude that this condition is not compensable. In this regard, we note that the ALJ upheld both Geisy's and SAIF's denials of claimant's subacromial tendonitis condition. Claimant has not contested the ALJ's determination regarding the compensability of that condition.

Although we do not necessarily limit our consideration to the Determination Orders themselves or to the worksheet, we conclude that, under the circumstances of this case, claimant's unappealed 48 percent unscheduled permanent disability award did not include an award for the left shoulder. See Olson v. Safeway Stores, Inc., 132 Or App 424 (1995) (Where it was not obvious from the Determination Order and Evaluator's worksheet that the unappealed determination orders awarded permanent disability for the claimant's preexisting degenerative condition, the court declined to address whether the employer could be barred from denying the degenerative condition by its failure to appeal the Determination Orders); but see Dennis L. Keller, 47 Van Natta 734 (1995) (where medical evidence related the claimant's disc bulges listed on Determination Orders to degenerative disc condition, Determination Orders were based, at least in part, on degenerative condition).[3] Accordingly, we conclude that SAIF is not responsible for claimant's left shoulder condition by reason of the unappealed Determination Orders.

In summary, we find that claimant failed to sustain his burden of proving that his left shoulder condition is compensable. Thus, we reverse the ALJ's decision finding that claimant had sustained a compensable left rotator cuff tear and assigning responsibility to Geisy.

ORDER

The ALJ's order dated December 15, 1995, as reconsidered January 10, 1996, is reversed in part and affirmed in part. That portion which set aside Geisy's denial of a left rotator cuff condition is reversed. Geisy's denial is reinstated and upheld. The ALJ's attorney fee award with respect to Geisy is also reversed. The remainder of the order is affirmed.

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[3] Geisy notes medical reports issued before the first two Determination Orders dated June 19, 1986 and May 12, 1989, which purport to document left shoulder impairment. (Exs. 12, 45, 51). However, given that SAIF accepted a cervical strain, and because claimant was diagnosed with multiple conditions (which did not include a left shoulder condition) prior to these closure orders, we are not persuaded that either Determination Order awarded permanent disability based on a left shoulder condition. Moreover, the final Determination Order of March 28, 1990 includes a worksheet that clearly indicates that claimant's permanent disability award was based on conditions other than the left shoulder. (Ex. 71-2). Accordingly, we conclude that, even considering medical evidence issued at the time of the closure orders, SAIF is not responsible for claimant's left shoulder condition because of the unappealed Determination Orders.

In the Matter of the Compensation of
WILLIAM R. WHITE, Claimant
WCB Case No. 95-11005
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Yeager's order that assessed a penalty and associated attorney fee for its allegedly unreasonable denial of claimant's left knee condition. On review, the issues are penalties and attorney fees.

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

The ALJ found that, although the insurer was aware that claimant had previous knee problems, the insurer denied the claim without asking for or receiving a single medical opinion on causation. The ALJ concluded that the insurer's "rush to judgment" was unreasonable and assessed a penalty and associated attorney fee.

The insurer argues that it had a legitimate doubt regarding causation of claimant's knee condition at the time it denied the claim on September 22, 1995. The insurer relies on the following

information: (1) claimant's "801" form indicated he had experienced previous left knee pain; (2) the insurer had received Dr. Bald's August 16, 1995 chart note that indicated claimant had a preexisting knee condition; and (3) claimant admitted during an interview that he had experienced previous knee symptoms approximately a year before the injury date.

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

In Lauri A. Terrell, 46 Van Natta 2273 (1994), at the time the denial was issued, the insurer had a medical opinion that indicated that, although the claimant had an acute lumbosacral strain, she also had a "long history" of lower back problems which "certainly play a significant role in this case." We found that, since the claimant had a preexisting back condition that contributed to her problems following the work incident, the insurer was aware that the claimant would probably be subject to the major contributing cause standard imposed by ORS 656.005(7)(a)(B). In light of the medical opinion that the claimant's (noncompensable) preexisting condition was a significant cause of back problems after her back strain, we concluded that the insurer legitimately doubted whether the work incident was the major cause of her subsequent condition and we did not assess a penalty.

Here, at the time the insurer issued its denial on September 22, 1995, the insurer had evidence that claimant had a preexisting left knee condition, but it had no medical opinions on causation. Unlike Lauri A. Terrell, supra, the insurer had no medical evidence that indicated that claimant's preexisting left knee condition combined with claimant's work injury to cause his disability or need for treatment. To the contrary, Dr. Bald's August 16, 1995 chart note indicated that claimant had a "prior history of a similar type injury several years ago to his left knee that resolved without sequelae, and he has had no history of surgery or other treatment." (Ex. 3; emphasis added). Thus, unlike Terrell, the insurer had no information available that indicated claimant could be subject to the major contributing cause standard. Compare Joyce E. Soper, 46 Van Natta 740 (1994) (the carrier's denial on the basis that the claimant's work exposure was not the major contributing cause of her current condition was reasonable where, at the time of the denial, the carrier had medical reports indicating that the claimant's preexisting condition was the major cause of the need for treatment).

In any event, the insurer did not deny the claim based on a "major contributing cause standard." Rather, the insurer denied the claim on the basis that "[i]nformation obtained during this investigation fails to establish your condition of lateral meniscus tear, left knee is related to your work activity with [the employer] on or about 8/14/95." (Ex. 10). The insurer asserted that claimant's condition did not arise out of and in the course and scope of his employment. (Id.) Claimant had submitted an "801" Form and an "827" Form indicating that he had injured his left knee at work. (Exs. 1, 2). Dr. Bald related claimant's left knee condition to an on-the-job injury. (Ex. 3). Claimant told the insurer's investigator that he injured his left knee at work. (Ex. 7a). There was no evidence in the record to the contrary. Therefore, we conclude that, at the time it issued the denial, the insurer did not have a legitimate doubt as to its liability for the claim, and we find its denial unreasonable. Accordingly, we affirm the ALJ's assessment of a penalty and associated attorney fee.

Claimant is not entitled to an attorney fee for services on review concerning the penalty and associated attorney fee 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)

ORDER

The ALJ's order dated March 11, 1996 is affirmed.

In the Matter of the Compensation of
JENNIFER L. WILSON, Claimant
Own Motion No. 94-0658M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, et al, Claimant Attorneys
Liberty NW, Insurance Carrier

Claimant requests review of the insurer's April 3, 1996 Notice of Closure which closed her claim with an award of temporary disability compensation from December 5, 1994 through March 20, 1996. The insurer declared claimant medically stationary as of March 26, 1996. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed. In the alternative, claimant requests that the Board authorize temporary disability compensation "through 5/13/96, the date of anticipated medically stationary status given by Claimant's treating physician."

Premature Closure

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 3, 1996 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Even though medical opinion established that claimant required ongoing care for an indefinite period of time, the ongoing care does not necessarily establish that claimant was not medically stationary. Maarefi v. SAIF, 69 Or App 527, 531 (1984).

On November 13, 1995, claimant was examined by her physician, Dr. Gallo, in a one-year (post-surgery) follow-up examination. In her medical report, Dr. Gallo opined that "[claimant] will [follow-up] here in 6 months at which point I think she will be at medically stationary status."

In a March 15, 1996 Independent Medical Examination (IME), as amended by a March 20, 1996 x-ray report, Dr. Gardner, neurologist, and Dr. Boyd, orthopedic surgeon, opined that:

> "In our opinion, [claimant] deserves another trial of a TENS unit for relief of pain. She also should be instructed to carry out an independent program of home exercise consisting of abdominal strengthening and aerobic fitness, if this has not already been done. Apart from these suggestions, we view her as medically stationary with respect to the October 10, 1975 injury."

When asked in the insurer's questionnaire when they would anticipate claimant becoming medically stationary, Drs. Gardner and Boyd opined that "we consider her medically stationary, subject to the minimal treatment recommendations made above."

Here, Dr. Gallo opined that she felt claimant would become medically stationary six months from the date of the November 13, 1995 examination. However, Dr. Gallo gives no objective reasons for that opinion. Dr. Gallo recommended no medical treatment, physical therapy or any other rehabilitating measures for claimant, and she released claimant to modified work on that date. We are not persuaded by Dr. Gallo's speculative assessment, because she failed to provide objective reasoning why claimant might not be medically stationary for six months. Finally, there is no subsequent opinion from Dr. Gallo confirming her previous opinion.

Contrarily, Drs. Gardner and Boyd, although examining claimant only once at the insurer's request, rendered their opinions utilizing x-rays taken on March 16, 1996, making objective comparisons with previous films as well as providing results of a physical examination. They noted that:

> "The last films present were dated November 13, 1995 and showed a similar appearance except that range of motion views were obtained, including flexion and extension, and showed no movement at segments L4-L5 and L5-S1, indicating a solid fusion."

These physicians recommended claimant undergo a home exercise program and another "trial of a TENS unit for relief of pain." Drs. Gardner and Boyd also opined that claimant was capable of sedentary work, and noted that claimant's "subjective complaints are somewhat out of proportion to her objective findings." Further, based upon their examination on that date, they twice opined that claimant was medically stationary on March 15, 1996, and recommended only "minimal treatment." We find the opinions of Drs. Gardner and Boyd persuasive, as they are based on objective findings rather than speculation. Weiland v. SAIF, supra; Somers v. SAIF, supra. In addition, although Dr. Gardner and Dr. Boyd suggested "minimal" treatment for relief of pain and for abdominal strengthening and aerobic fitness, we are not persuaded that the ongoing care would provide significant improvement in claimant's condition, particularly since claimant's treating physician did not recommend any further care. Maarefi v. SAIF, supra.

Based on this record, we find that claimant has not met her burden of proving that she was not medically stationary on April 3, 1996, when the insurer closed her claim. Therefore, we conclude that the insurer's closure was proper.

Temporary Disability Compensation

Claimant requests temporary disability compensation through May 13, 1996, the date of anticipated medically stationary status opined by Dr. Gallo. Because we have found that claimant has not established that she was not medically stationary on April 3, 1996, when the insurer closed her claim, we are unable to grant claimant's request. However, claimant may be entitled to substantive temporary disability compensation if she can establish that she was disabled due to the compensable injury prior to being declared medically stationary. Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Claimant was paid time loss benefits through March 20, 1996, and was declared medically stationary on March 26, 1996. Therefore, she must establish that she was disabled due to the compensable injury after March 20, 1996 and prior to March 26, 1996.

Dr. Gallo released claimant to modified (sedentary) work on November 13, 1995. Noting that claimant stated that "her husband can support her," Dr. Gallo reported that claimant was not interested in returning to work. On March 15, 1996, Drs. Gardner and Boyd also opined that claimant was capable of returning to sedentary work, but reported that claimant "does not believe she could even do sedentary work." The physicians also reported that claimant "does not feel that she has to work, however, because her husband is able to support her." Claimant has provided no evidence that she returned to modified work, even though the three physicians opined that she was capable of work.

On the record, we find that claimant has not established that she was disabled due to the compensable injury prior to being declared medically stationary. Therefore, no further temporary disability compensation is due.

Accordingly, we affirm the insurer's April 3, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
GREG H. BOOTH, Claimant
WCB Case No. 95-04876
SECOND ORDER ON RECONSIDERATION
Karl Goodwin (Saif), Defense Attorney

Pursuant to our June 24, 1996 Order on Reconsideration, we republished our May 23, 1996 order in which we affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for his sinus and upper respiratory condition. In reaching our decision, we also declined to remand this case to the ALJ for the admission of a "post-hearing" and "post-surgery" medical report. Claimant has now submitted additional letters and further evidence, and has requested remand "on the basis of compelling evidence not available formerly." Interpreting claimant's letters as another motion for reconsideration, we withdraw our prior orders.[1]

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 (1983). To merit remand for consideration of additional evidence, it must be clearly 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 (1986).

Here, although the particular doctor's letter submitted by claimant was not available at the time of hearing, we are not persuaded that the substantive matter contained in the report was unobtainable with the exercise of due diligence prior to hearing. In the letter, Dr. Lee states that he treated claimant since April 1994. Accordingly, we are not convinced that the current letter submitted by claimant contains information that was unobtainable at the time of the July 1995 hearing. See e.g. Steven J. Anderson, 47 Van Natta 2101 (1995).[2]

Additionally, we conclude that there is not a compelling reason to remand, as we find that the additional report submitted by claimant is not likely to affect the outcome of this case. Dr. Lee's report discusses claimant's "symptoms" as being related to work; however, that is not sufficient to meet claimant's burden of proof. ORS 656.802(2); Michael R. Langford, 48 Van Natta 102 (1996).

Accordingly, claimant's request for remand is denied. On reconsideration, as supplemented herein, we adhere to and republish or prior orders. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Inasmuch as it does not appear that SAIF has received copies of claimant's most recent letters, copies of those letters have been included with SAIF's counsel's copy of this order.

[2] Claimant also submits copies of documents regarding a 1979 nasal septal reconstruction surgery. Asserting that we erroneously referred to this operation as sinus surgery, he offers these materials to correct our misimpression. Since claimant offers no explanation for his failure to present these 1979 materials at the time of the July 1995 hearing, we are not inclined to consider it appropriate to remand for their consideration. In any event, because we did not refer to the surgery as sinus, but rather accurately described it a "nasal", we find no compelling reason to remand this case for introduction of these materials.

In the Matter of the Compensation of
CHRISTINE FALCONER, Claimant
WCB Case No. 95-06207
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board en banc.[1]

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Baker's order that set aside its denial of claimant's claim for a torticollis condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and briefly summarize the pertinent facts as follows:

Claimant works as a certified nursing assistant in a residential care facility. On March 19, 1995, claimant had a particularly stressful day at work, in which she had to care for an increased number of residents and train a new employee. Four days later, on March 23, 1995, she experienced the acute onset of neck and upper back pain while turning over in bed. She sought treatment and was diagnosed with torticollis and acute right neck strain and spasm.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that mental stress at work was the major contributing cause of claimant's torticollis condition and that claimant had established the compensability of her condition as a "mental disorder" under amended ORS 656.802. Citing to the new definition of "mental disorder" in amended ORS 656.802(1)(b), the ALJ determined that claimant's diagnosis of torticollis, a generally recognized neck condition, satisfied the diagnosis requirement of amended ORS 656.802(3)(c). The ALJ further found that the employment conditions producing claimant's condition existed in a real and objective sense and were conditions not generally inherent in every working condition.

SAIF argues on review that claimant's torticollis condition cannot be compensable as a mental disorder under ORS 656.802(3) because torticollis is not "a diagnosis of a mental disorder which is generally recognized in the medical or psychological community" which is required by ORS 656.802(3)(c). Specifically, SAIF contends that where, as here, the claim is for a physical condition caused or worsened by mental stress, the claimant must also prove a diagnosis of a generally recognized "mental or emotional disorder" (a psychological or psychiatric condition) in order to satisfy requirement of ORS 656.802(3)(c). We disagree.

In 1995, the legislature added subsection (1)(b) to ORS 656.802, which provides: "As used in this chapter, 'mental disorder' includes any physical disorder caused or worsened by stress." In amending the statute, the legislature did not alter the language of ORS 656.802(3)(c), which provides that a "mental disorder" is not compensable unless "[t]here is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community."

As the Court of Appeals recently confirmed in Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), our task in construing the language of a statute is to effectuate the intentions of the legislature, "if possible." ORS 174.020. To ascertain the legislature's intentions, we examine the text, its context and, if necessary, the legislative history. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-12 (1993). "In all events, however, we are constrained by the reasonable construction of the language that the legislature actually enacted. We are forbidden, both by statutory command and by constitutional principles, to insert language that the legislature, whether by design or by default, has omitted." Messmer, supra (citing ORS 174.010; Fernandez v. Board of Parole, 137 Or App 247 (1995)).

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[1] Since Board Member Moller has recused himself from this case, he has not participated in the Board's review. OAR 438-011-023.

It is a fundamental rule of statutory construction that when a word or phrase is used repeatedly in the same statute it is presumed to have the same meaning throughout absent clear indication of a contrary intent. Pense v. McCall, 243 Or 383, 389 (1966); Cherry Growers v. Emp. Div., 25 Or App 645, 649, rev den (1976). See also PGE v. Bureau of Labor and Industries, 317 Or 606, 611 (1993) (use of the same term throughout a statute indicates that the term has the same meaning throughout the statute). With regard to amended ORS 656.802, we find no clear indication in the plain language of the statute that the words "mental disorder" should carry a different meaning in paragraph (3)(c) than they do in paragraph (1)(b). On the contrary, amended ORS 656.802(1)(b) provides "[a]s used in this chapter, 'mental disorder' includes * * *" (emphasis added), indicating that the statutory definition of "mental disorder" that follows means the same throughout all of Chapter 656.

Relying on the plain language of the statute, we construe paragraph (3)(c) of ORS 656.802 in light of, rather than independent of, the definition of "mental disorder" in paragraph (1)(b). Thus, where the claim is for a mental stress-caused physical disorder, the "diagnosis" requirement of paragraph (3)(c) may be satisfied by a diagnosis of a stress-caused physical condition that is generally recognized in the medical or psychological community.

The dissent disagrees with this construction, and asserts that the terms of amended ORS 656.802 are ambiguous. We do not consider the statute's repeated use of the term "mental disorder" ambiguous (because the term is specifically defined in paragraph (1)(b)), and therefore see no reason to resort to legislative history. See PGE v. Bureau of Labor and Industries, supra, 317 Or at 611 (if the legislature's intent is clear from the text and context of the statute, further inquiry is unnecessary). We conclude, however, that even the legislative history does not support the dissent's and SAIF's construction of the statute.[2]

In describing the 1995 amendments to ORS 656.802, Representative Mannix, a co-sponsor of SB 369 stated:

> "[ORS] 656.802, sub (1): Redefines mental disorder. It's designed to get back to where we thought we were in 1990, and with some prior statutory changes even before then. It particularly has to do with mental disorders that are accompanied by physical disorders. This will say that standards for proving the compensability of a mental disorder, apply regardless of whether the disorder is sudden or gradual in onset; it's a mental disorder, let's apply these standards. And they apply to any physical disorder caused by mental stress. We are seeing some grandfathering in, that, well, while this stress claim itself may not be just compensable, here's a physical disorder resulting from it and we will say that's compensable. It's better than grandfathering, I should say bootstrapping. Now we will get back to evaluating the initial claim and the onset of disability alleged in the claim and see if it meets the standards for a mental disorder claim.
>
> " * * *
>
> "[16B-] 656.802, sub (3): Reaffirms the workers burden to prove stress claims as mental disorder type claims. And includes business cycles as normal business conditions." Tape Recording, Senate Labor and Government Operations Committee, January 30, 1995, Tape 16B.

In a later session, Representative Mannix and Jerry Keene, a workers' compensation defense attorney, stated:

> "[Rep. Mannix]: Section 56 tweaks the occupational disease statute as to mental disorders. It does include mental disorders which include any physical disorder caused or worsened by mental stress. * * *

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[2] The dissent also relies on legislative history from the 1987 enactment of ORS 656.802(3)(c) to support its position. At that time, however, the legislators were concerned about the legitimacy of mental stress conditions and were not considering the mental disorder statute's effect on stress-related physical disorders. Thus, the 1987 legislative history regarding a legitimate "mental disorder" diagnosis provides no guidance on the 1995 amendments and whether a "psychological" diagnosis is necessary when the mental disorder claim is based on a stress-related physical disorder.

> "[Jerry Keene]: It also gets out some of the language that was enacted in 1987 and we've had some experience with litigation of mental disorders and so-call stress claims and this addresses some of those cases and clarifies it." Tape Recording, House Committee on Labor, March 6, 1995, Tape 46B.

We can discern from the above-quoted legislative history that ORS 656.802(1)(b) was intended to overrule such cases as DiBrito v. SAIF, 319 Or 244 (1994) and Mathel v. Josephine County, 319 Or 235 (1994), which held that stress-caused physical disorders (e.g., an episode of colitis or a heart attack) should be analyzed as accidental injuries under ORS 656.005(7). We can also tell that the legislature intended that, to be compensable, a mental stress-caused physical disorder must meet the four requirements set out in amended ORS 656.802(3). See, e.g., Karen Hudson, 48 Van Natta 113, on recon, 48 Van Natta 287, 453 (1996). There is simply nothing in the testimony of Representative Mannix or Mr. Keene, however, indicating that the legislature intended to deny compensation to a worker with a mental stress-caused physical disorder that arose out of and in the course of employment simply because that physical disorder stands alone and is not accompanied by a diagnosed psychological condition.

Under the plain language of amended ORS 656.802, "mental disorder" now includes mental stress-caused physical disorders. As explained above, we find that under amended ORS 656.802, if a claimant has been diagnosed with a mental stress-caused physical disorder, and that disorder is generally recognized in the medical community, the claimant has satisfied the "diagnosis of a mental or emotional disorder" requirement of paragraph (3)(c). To hold otherwise, and conclude that paragraph (3)(c) requires a diagnosis of a psychological condition in addition to the stress-caused physical condition, would effectively insert language into the statute which we are forbidden by law to add.[3] See Deluxe Cabinet Works v. Messmer, supra.

Turning to the merits, we find claimant has established a compensable "mental disorder" under ORS 656.802. Dr. Arbeene, who examined claimant at SAIF's request, diagnosed torticollis and explained that torticollis is a physical disorder of the neck which developed as a result from the emotional stresses of claimant's work on March 19, 1995. The record establishes that on that day, claimant was required to care for an increased number of patients while explaining the employer's policies and procedures to a new employee.[4] For several days thereafter, claimant felt extremely achy and tense, and ultimately experienced an acute onset of neck pain while turning over in bed on the morning of March 23, 1995. On this record, we are convinced by the complete and well-reasoned opinion of Dr. Arbeene that claimant's torticollis arose out of and in the course of claimant's employment.[5]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, 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.

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[3] The dissent contends that our holding lessens the burden of proof for those persons attempting to prove the compensability of mental stress-caused physical disorders as opposed to workers with purely psychological conditions. We disagree. As we construe ORS 656.802(3)(c), both workers must prove a diagnosis "which is generally recognized in the medical or psychological community." The claimant with a mental-stress caused physical disorder "mental disorder" must prove that his or her diagnosed physical condition is generally recognized whereas a claimant with a purely psychological mental disorder must prove that his or her diagnosed mental condition is generally recognized. A claimant must also, of course, satisfy the other requirements of ORS 656.802(3). See Karen Hudson, supra.

[4] As the ALJ noted, the evidence concerning claimant's employment conditions was not hotly contested, since SAIF's main defense to the claim was that claimant had not proven a diagnosis of a mental disorder. Based on claimant's testimony and the absence of any other evidence to the contrary, we find that the employment conditions producing her stress-caused physical symptoms existed in a real and objective sense and were conditions other than those generally inherent in every working situation. See ORS 656.802(3)(a) and (b).

[5] Both Dr. Arbeene and Dr. Lynch, claimant's treating chiropractor, agreed that claimant's rolling over in bed did not cause the acute onset of neck pain. Contrary to Dr. Arbeene, Dr. Lynch diagnosed a "neck strain" caused by claimant's extensive physical activities at work on March 19, 1995. Because the record establishes that claimant's work activities that day were not any more physically demanding than usual, we find Dr. Lynch's opinion is unpersuasive.

ORDER

The ALJ's order dated November 9, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by SAIF.

Member Christian specially concurring.

I agree that, under amended ORS 656.802, any physical disorder that is caused or worsened by mental stress must be analyzed as an occupational disease claim for a mental disorder. I further agree that, when the claim is for a stress-caused physical disorder, a diagnosis of a generally recognized physical disorder that is caused or worsened by stress satisfies the "diagnosis" requirement ORS 656.802(3)(c). I write separately to discuss the distinction I see between the concept of "mental stress," a term that is not defined in the statute, and a "mental disorder," which is defined.

We have previously held that "mental stress," in and of itself, is not a condition which is generally recognized as a "mental disorder." See Keith D. Gregersen, 46 Van Natta 2249 (1994); Nancy L. Lucas, 43 Van Natta 911 (1991). Our decision today does not change that rule. Under amended ORS 656.802(1)(b), a "mental disorder" includes "any physical disorder caused or worsened by mental stress." The compensable "mental disorder" is not the "mental stress" itself, but rather the effect, or physical manifestation of, that stress.

Accordingly, where, as here, claimant proves by clear and convincing evidence that she has a "diagnosed" physical disorder which is caused or worsened by "mental stress" on the job and that her stressful employment conditions exist in a real and objective sense and are conditions other than those generally inherent in every working situation, then she is entitled to compensation for that stress-caused physical disorder as a "mental disorder" under amended ORS 656.802.

Board Member Haynes dissenting.

I disagree with the majority's construction of ORS 656.802(1)(b) as it relates to ORS 656.802(3)(c). The former statute provides that "mental disorder" "includes any physical disorder caused or worsened by mental stress" while the latter statute requires "a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community." According to the majority, a claimant proves the existence of "a diagnosis of a mental or emotional disorder" if there is a "physical disorder caused or worsened by mental stress." I believe such a construction is contrary to legislative intent and, therefore, dissent.

First, I disagree with the majority's conclusion that the "plain meaning" of ORS 656.802(1)(b) indicates that its definition applies in subsection (3)(c). Such reasoning ignores the language preceding subsection (3)(c) stating that, "[n]otwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes all of the following" requirements in subsections (a) through (d). ORS 656.802(3). In my opinion, because such language indicates that subsection (3)(c) should be applied independently of "any other provision of this chapter," and the plain meaning of "a diagnosis of a mental or emotional disorder" would not include a physical disorder, I find the question ambiguous concerning the effect of ORS 656.802(1)(b) on 656.802(3)(c). Thus, I think it appropriate to turn to legislative history. PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993).

As correctly noted by the majority, ORS 656.802(3)(c) was added by the 1987 legislature. Or Laws 1987, ch 713, § 4. Looking at the statute in isolation, the language is plain--it requires a diagnosis of an identifiable mental or emotional disorder. Senator Hill, Chairman of the Senate Labor Committee explained the amendment:

> "If we have no reference to any diagnosis or any requirement that it be a diagnosis of a generally recognized mental disorder, we're having it wide open to every M.D. saying, 'My client is suffering stress, he's extremely nervous, she can't eat.' That's not a generally recognized mental disorder that could be filed as a mental stress claim. That's my concern. We want to prevent that. We want only defined mental disorders, not just a doctor's feeling the patient is stressed out. That's my intent here. So it has to be something that's diagnosed by someone qualified, a psychologist or psychiatrist, as a legitimate identified mental disorder, not just being stressed out or freaked out or can't sleep or marital problems resulting from mental stress. So the intent here is to close the window from those claims that are flakier, frankly." Tape Recording, Minutes, Senate Labor Committee, June 8, 1987

Based on the clear import of the language, the Board has held that "stress," by itself, did not qualify as a "mental disorder" because it was not recognized as such in the psychological community. E.g., Ronald V. Dickson, 42 Van Natta 1102, 1108 (1990), aff'd Dickson v. Carolina Casualty, 108 Or App 499 (1991). Thus, the Board further held that only when physical conditions directly resulted from a diagnosed mental disorder could a stress-related physical condition be found compensable under ORS 656.802(3). Id. at 1108-09.

Subsequent to this legislation, the Oregon Supreme Court considered the appropriate statute to analyze a physical condition that results from work-related stress. Mathel v. Josephine County, 319 Or 235 (1994). In Mathel, the Court held that, when the condition upon which a claim is made is an "event" in the context of a compensable injury, the claim should be analyzed as an accidental injury rather than as a "mental disorder" under ORS 656.802(3). Id. at 242-43. The Court further stated that the cause of the condition was immaterial to this requirement. Id. at 243. Accord DiBrito v. SAIF, 319 Or 244 (1994) (holding that a claim for colitis was an event constituting an accident injury but that a claim for a personality disorder qualified as one for "mental disorder").

In 1995, the legislature enacted ORS 656.802(1)(c). Or Laws 1995, ch 332, § 56. Representative Mannix explained:

> "Redefines mental disorder. It's designed to get back to where we thought we were in 1990, and with some prior statutory changes even before then. It particularly has to do with mental disorders that are accompanied by physical disorders. This will say that standards for proving the compensability of a mental disorder apply regardless of whether the disorder is sudden or gradual in onset; it's a mental disorder, let's apply these standards. And they apply to any physical disorder caused by mental stress. * * *" Tape Recording, Senate Labor and Government Operations Committee, January 30, 1995, Tape 16B. (Emphasis added).

Representative Mannix and Jerry Keene, a defense attorney, similarly subsequently stated:

> "Section 56 tweaks the occupational disease statute as to mental disorders. It does include mental disorders which include any physical disorder caused or worsened by mental stress. * * *
>
> "It also gets out some of the language that was enacted in 1987 and we've had some experience with litigation of mental disorders and so-called stress claims and this addresses some of those cases and clarifies it." Tape Recording, House Committee on Labor, March 6, 1995, Tape 46B.

Based on such statements, I agree with the majority that the inclusion of ORS 656.802(1)(c) was intended to overrule the holdings in Mathel and DiBrito. That is, the legislature intended that, whether or not an event, if a physical condition resulted from work stress, it constitutes a claim for a mental disorder under ORS 656.802(3).

There is no indication, however, that the legislature also intended to overrule our prior line of cases construing ORS 656.802(3)(c) as requiring more than a physical disorder resulting from stress. Ronald V. Dickson, supra. As noted by the majority, the legislative history is simply silent concerning this issue. I disagree with the majority, however, that such silence gives it permission to itself take that approach. Instead, I understand the legislature's silence as indicating that the provisions should continue to be interpreted as they originally were meant to apply. Specifically, I would construe ORS 656.802(1)(b) as including physical disorders resulting from stress as a "mental disorder," whether or not an event; I would construe ORS 656.802(3)(c) as continuing to require a diagnosis of a mental disorder, whether or not the basis of the claim is for a physical disorder resulting from mental stress.

The majority's holding lessens the burden of proof for those persons attempting to prove compensability of physical disorders resulting from mental stress, as opposed to workers with purely psychological conditions, since those claimants need only show that their condition results from mental stress. I simply cannot agree that such a result was meant by the legislature in view of the context in which both statutes were enacted and the lack of any legislative intent to do so. Accordingly, I dissent.

In the Matter of the Compensation of
LINDA K. FISTER, Claimant
WCB Case No. 95-05569
ORDER ON REVIEW
Max Rae, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that increased claimant's unscheduled permanent disability for lumbar, thoracic and cervical spine conditions from the 14 percent (44.8 degrees) awarded by an Order on Reconsideration to 31 percent (99.2 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

On reconsideration of the Determination Order, claimant was determined to be medically stationary on August 12, 1994. (Ex. 35-2).

CONCLUSIONS OF LAW AND OPINION

The ALJ modified the Order on Reconsideration by awarding claimant an additional 17 percent unscheduled permanent disability due to cervical impairment (10 percent) and thoracic spine impairment (7 percent), for a total of 31 percent unscheduled permanent disability. Claimant does not contest the 7 percent impairment value awarded by the ALJ for loss of range of motion in the thoracic spine. However, claimant contends that she is entitled to an additional 12 percent unscheduled permanent disability, for a total of 43 percent unscheduled permanent disability, for the following reasons: (1) the adaptability value should be 4 instead of 2, based on a Base Functional Capacity (BFC) of "heavy" instead of "medium;" (2) claimant is entitled to an additional 4 percent impairment for reduced lumbar flexion; and (3) claimant is entitled to an additional 2 percent impairment for reduced cervical range of motion. We modify the ALJ's order.

Claimant was found to be medically stationary on August 12, 1994, and her claim was closed August 25, 1994. (Exs. 29, 35-2). The standards in effect on the date of the Determination Order control. Former OAR 436-35-003(2). Therefore, the disability standards contained in Workers' Compensation Department Administrative Orders Nos. 6-1992 and 93-056 apply to this claim. Id.

Adaptability/Base Functional Capacity

The ALJ affirmed that portion of the Order on Reconsideration that found that claimant's BFC was "medium" and her Residual Functional Capacity (RFC) was "medium/light," which entitled her to an adaptability value of 2. (Ex. 35-3). Claimant contests the BFC of "medium," contending that it should be "heavy." We agree with the ALJ's determination.

Adaptability is measured by comparing BFC to the worker's maximum RFC at the time of becoming medically stationary. Former OAR 436-35-310(2). Here, there is no dispute that claimant's RFC is "medium/light." The dispute focuses solely on claimant's BFC.

Under the facts of this case, where there is insufficient evidence to determine whether claimant met the training time requirement for a certified nurse assistant (CNA) and no second-level physical capacity evaluation was performed prior to the work injury, the BFC is determined by the job at injury. Former OAR 436-35-310(4)(c). The appropriate DOT classification is the one that most accurately describes the worker's job at injury. See Mary Hoffman, 48 Van Natta 730 (1996); Thomas D. Porter, 45 Van Natta 2218, 2219 (1993) and cases cited therein. Claimant has the burden of proving the nature and extent of any disability resulting from the compensable injury. ORS 656.266.

Claimant's at-injury job was a CNA. (Exs. 6, 35-5). Based on her testimony at hearing, claimant contends that her at-injury job should be classified as an "orderly," which has a strength requirement of "heavy." DOT 355.674-018. The ALJ concluded that the DOT that most accurately describes claimant's

at-injury job is "nurse assistant," which has a strength requirement of "medium." DOT 355.674-014. In reaching this conclusion, the ALJ determined that there were many job duties included in the "orderly" job description that claimant did not perform. Therefore, the ALJ concluded, considering the record as a whole, including claimant's testimony at hearing, that the most applicable DOT was "nurse assistant."

On review, relying on amended ORS 656.283(7) and our recent decision in Joe R. Ray, 48 Van Natta 325 (1996), the SAIF Corporation contends that claimant's hearing testimony pertaining to the extent of her unscheduled permanent disability was inadmissible.[1] We agree.

Amended ORS 656.283(7) provides, in part, that "[e]vidence on an issue regarding a notice of closure or determination that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing[.]" That statute went into effect on June 7, 1995, which was subsequent to the May 1, 1995 Order on Reconsideration, but prior to the August 1, 1995 closure of the hearing record. Therefore, the amended statute applies to this case. See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

Under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process is inadmissible at a subsequent hearing about the extent of an injured worker's permanent partial disability. Id. However, amended ORS 656.283(7) does not apply to exclude evidence that was previously and properly admitted at hearing, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Id.

In Joe R. Ray, supra, we held that under amended ORS 656.283(7), evidence that was not submitted during the reconsideration process and not made a part of the reconsideration record, is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent partial disability.[2] Nevertheless, in light of the court's decision in Plummer, that holding has been overruled to the extent that evidence concerning the extent of an injured worker's permanent partial disability that was properly admitted at hearing can be considered on review.

However, where a hearing concerning extent of permanent partial disability was held after June 7, 1995, the prohibition on subsequent evidence set forth in amended ORS 656.283(7) is applicable. Thus, we continue to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995. See Dean J. Evans, 48 Van Natta 1092 (1996).[3]

Here, the hearing was held on August 1, 1995. Because claimant's hearing testimony was not submitted during the reconsideration process, it is inadmissible at a hearing about the extent of her permanent partial disability. Joe R. Ray, supra; Donna M. Zavatsky, 48 Van Natta 1146 (1996). Therefore, we analyze the adaptability issue without considering that testimony.[4]

Turning to the merits, the written exhibits identify claimant's at-injury job as "CNA" or "certified nursing assistant," without further describing the work duties or lifting requirements. (Exs. 1, 6, 8, 8A, 10, 12-1, 17-1, -2, 24, 34-1). On this record, we agree with the ALJ that the DOT classification that most accurately describes claimant's job at injury is "nurse assistant/aide." DOT 355.674-014. This

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[1] Claimant argues that SAIF waived any objection to her hearing testimony because SAIF did not object to that testimony at hearing. However, given the express statutory limitation on evidence provided by amended ORS 656.283(7), we may consider the admissibility of the evidence even if a party does not object to it at hearing. See Joe R. Ray, supra 48 Van Natta at 327 n.3; David J. Rowe, 47 Van Natta 1295 (1995).

[2] Although a signatory to this order for purposes of *stare decisis*, Chair Hall continues to believe, for the reasons set forth in his concurrence/dissent in Joe R. Ray, supra, that amended ORS 656.283(7) should not be applied to those cases where the reconsideration record was developed before June 7,1995.

[3] Claimant asserts that retroactive application of amended ORS 656.283(7) violates her procedural due process rights under the Fourteenth Amendment to the United States Constitution. We addressed these procedural due process arguments in Joe R. Ray, supra, and Dean J. Evans, supra, and determined that retroactive application of amended ORS 656.283(7) does not violate workers' due process rights.

[4] The parties do not dispute the admissibility of the written exhibits. Therefore, we will consider them in analyzing claimant's adaptability.

job classification has a strength requirement of "medium." Therefore, claimant's BFC is medium. Former OAR 436-35-310(4)(c). Moreover, because claimant's RFC is medium/light, her adaptability factor is 2, as determined by the ALJ. Former OAR 436-35-310(6).

Impairment

The ALJ affirmed that portion of the Order on Reconsideration that excluded the lumbar flexion measurement made by the medical arbiter's panel because it did not meet the validity criterion set forth in WCD Bulletin No. 242 (Rev.), effective February 1, 1995. Claimant argues that application of WCD Bulletin No. 242 does not serve to eliminate consideration of her reduced lumbar flexion. We agree with claimant.

With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(2)(b)(B); former OAR 436-35-007(8) and (9); Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994); but see Tektronix, Inc. v. Watson, 132 Or App 483 (1995) (impairment findings from a physician, other than the attending physician, may be used, if those findings are ratified by the attending physician). In other words, impairment findings must be made by one of the above listed medical practitioners.

The Director's rules provide that only the methods described in the AMA Guides to the Evaluation of Permanent Impairment (3rd ed., 1990) and methods the Director may describe by bulletin shall be used to measure and report impairment. Former OAR 436-35-07(4). The Director has prescribed by bulletin the straight leg raising (SLR) method for testing the validity of lumbar flexion. That method provides that "measurements of true lumbar flexion are invalid if the tightest straight leg raising (SLR) angle is not equal to or within 10 degrees of the sum of the lumbar extension and flexion measured at midsacrum." Bulletin No. 242, supra, at 7. The same bulletin also provides, as a general principle, that "[m]easurements which do not meet the validity criterion shall be noted in the examiner's report." Id. at 2. Interpreting that language, we have concluded that the Director's bulletin contemplates that the validity determination will be made by the medical examiner performing the range of motion tests, and that any invalid measurements will be identified by that examiner. Harvey Clark, 47 Van Natta 136 (1995); Michael D. Walker, 46 Van Natta 1914 (1994); Benjamin G. Santos, 46 Van Natta 1912 (1994); Robert E. Roy, 46 Van Natta 1909 (1994).

Here, the medical arbiter panel did not note any measurements as being invalid. In fact, in the discussion section of their report, the panel concluded that claimant's "examination was valid, and that she does have some real findings, as mentioned, in the lower lumbar back." (Ex. 34-6). Thus, we conclude that, since the medical arbiter panel did not identify any invalid measurements, we have no basis for independently finding the measurements invalid. Compare Benjamin G. Santos, supra, (where the medical arbiter noted the lumbar flexion measurement was not valid based on the SLR method of testing the validity of lumbar flexion measurements, the Board found the lumbar flexion measurement was properly excluded from calculation of the claimant's impairment); Harvey Clark, supra, (where the medical arbiter found the claimant's range of motion findings invalid, the Board found that the claimant failed to prove impairment).

To hold otherwise would require us to independently apply the SLR test and determine the lumbar flexion measurements invalid. In addition, this determination would be done in the face of a specific finding from the medical arbiter panel that claimant's examination was valid, with no statement from the panel that any measurements were invalid. Given the fact that impairment must be measured by the medical arbiter or attending physician, we are not qualified to independently apply the SLR test and determine that the medical arbiter panel's impairment findings are invalid. Accordingly, inasmuch as we find that the medical arbiter panel's range of motion measurements satisfy the Director's validity criterion, we accept those measurements as valid.[5] Michael D. Walker, supra; Robert E. Roy, supra.

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[5] Alternatively, claimant argues that WCD Bulletin No. 242 cannot be used to eliminate consideration of the lumbar flexion measurements because disability standards must be in the form of rules, and WCD Bulletin No. 242 was not enacted as a rule. Because we find that proper application of WCD Bulletin No. 242 does not result in finding any range of motion measurements invalid, we need not address claimant's alternative argument. See also Jeana Larson, 48 Van Natta 1278 (1996) (Bulletin 242 need not have been promulgated as a rule under the Administrative Procedures Act because the Bulletin merely undertakes to explain the necessary requirements of an existing validly adopted rule).

Therefore, in addition to the other lumbar impairment, claimant is entitled to 4 percent impairment for loss of lumbar flexion, 44 degrees retained. Former OAR 436-35-360(19). The parties do not dispute the Appellate Reviewer's finding that claimant is entitled to 6 percent impairment for loss of lumbar range of motion, not including any loss of lumbar flexion. Thus, claimant's total impairment for loss of lumbar range of motion is 10 percent (6 percent + 4 percent). Former 436-35-360(22).

Additionally, regarding the extent of claimant's cervical spine impairment, the parties agree that claimant is entitled to an additional 2 percent. We agree that claimant's cervical spine impairment is equal to 12 percent, rather than the 10 percent found by the ALJ.[6] Adding claimant's losses of range of motion in the lumbar spine (10 percent), cervical spine (12 percent) and thoracic spine (7 percent) results in a total impairment of 29 percent. Former 436-35-360(22).

Finally, we note that the parties do not dispute the age factor (0) or the education factor (4) assigned by the Appellate Reviewer. We assemble all the factors as follows: Adding claimant's age (0) and education (4) values equals 4. Former OAR 436-35-280(4). Multiplying that sum by claimant's adaptability value (2) equals 8. Former OAR 436-35-280(6). Adding that sum to claimant's impairment value (29) results in a total of 37 percent unscheduled permanent disability. Former OAR 436-35-280(7). We modify the ALJ's order accordingly.

ORDER

The ALJ's order dated November 21, 1995 is modified. In lieu of the ALJ's award, and in addition to the Order on Reconsideration award of 14 percent (44.8 degrees), claimant is awarded an additional 23 percent (73.6 degrees), for a total award of unscheduled permanent disability to date of 37 percent (118.4 degrees). Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, provided that the total attorney fees approved by the ALJ and Board does not exceed $3,800, payable directly to claimant's attorney.

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[6] Pursuant to former OAR 436-35-360(13)-(16) and the medical arbiter panel's measurements (Ex. 34-3), claimant's cervical spine impairment is calculated as follows:

flexion	40 degrees	2.00 percent impairment
extension	32 degrees	3.44 percent impairment
right lateral flexion	32 degrees	.86 percent impairment
left lateral flexion	32 degrees	.86 percent impairment
right rotation	36 degrees	2.40 percent impairment
left rotation	40 degrees	2.00 percent impairment

Total cervical spine impairment is 11.56 percent, which is rounded up to 12 percent. Former OAR 436-35-007(11).

In the Matter of the Compensation of
JOHN M. HYDE, Claimant
WCB Case No. 95-11145
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Christian and Moller.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) declined to reopen the record to admit a report from the attending physician; and (2) set aside the insurer's partial denial of claimant's claim for a right hip injury. On review, the issues are evidence and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exceptions. We do not adopt those portions of the ALJ's third and fourth paragraphs of his findings of fact where he finds that claimant

injured his right hip during the July 28, 1994 fall at work and had bruising, swelling and pain in his right hip following that fall. Nor do we adopt the ALJ's findings that Drs. Dordevich and Smith, examining physicians, obtained incorrect histories that claimant fell on his left hip during the fall at work, whereas Drs. Waters, examining physician, and Bowman, medical arbiter, obtained correct histories that claimant fell on his right hip during the fall at work. Finally, we do not adopt the second paragraph of the ALJ's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Evidence

The ALJ denied the insurer's motion to reopen the hearings record to receive a medical report from Dr. Bills, claimant's attending physician, finding that the insurer could reasonably have discovered and produced the evidence contained in that medical report at hearing. We adopt the ALJ's reasoning and conclusions on this issue.

Compensability

The ALJ determined that claimant injured his right hip during his July 28, 1994 fall at work and this injury combined with claimant's preexisting degenerative arthritis in his right hip. Applying amended ORS 656.005(7)(a)(B), the ALJ concluded that claimant had met his burden of proving that the industrial injury was the major contributing cause of the disability or need for treatment of the combined right hip condition. Therefore, the ALJ set aside the insurer's partial denial of claimant's degenerative right hip condition as an industrial injury. The insurer contends that claimant did not injure his right hip when he fell at work. Alternatively, the insurer contends that the trauma from that fall is not the major contributing cause of claimant's combined right hip condition. We agree with the insurer's contentions.

We begin with a summary of the relevant facts. Claimant has preexisting degenerative arthritis of the right hip. (Exs. 3, 10, 14, 16). On July 28, 1994, claimant fell from the employer's loading dock while performing his work duties. Claimant sought immediate medical treatment from the Emergency Room, where he reported falling on his left hip and received treatment for the left hip. (Ex. 4). Subsequently, claimant developed right hip complaints, which became his major problem. As a result of the fall, claimant sustained a 20 percent compression fracture of the T6 vertebra and a right wrist navicular fracture. The insurer accepted these conditions. (Exs. 7, 11). However, the insurer denied claimant's right hip claim.

The initial question presented on review is whether claimant also injured his right hip in the fall. The ALJ found that claimant testified in a very credible and straightforward manner that he injured his right hip in the fall at work. The ALJ based this credibility finding on claimant's demeanor at hearing. Based, in part, on claimant's testimony, the ALJ concluded that claimant had injured his right hip in the fall at work. Although we generally defer to an ALJ's demeanor-based credibility finding, we decline to do so in this case. We find claimant's testimony that he injured his right hip at the time of the fall at work inconsistent with the contemporaneous medical documentation, as evidenced by the following medical reports. We, therefore, give it little weight. See Erck v. Brown Oldsmobile, 311 Or App 519, 528 (1991); Davies v. Hamel Lumber Co., 67 Or App 35 (1984); Steve L. Nelson, 43 Van Natta 1053 (1991), aff'd mem 113 Or App 474 (1992).

On the day of the fall at work, claimant sought treatment in the Emergency Room. (Ex. 4). At that time, claimant reported to the Emergency Room physician that he fell from a six foot loading dock onto his left hip/back. Id. The Emergency Room physician also referenced the left "SI" joint and treated claimant with an injection of Toradol in the left hip. Id. In addition, the Emergency Room nurse's notes indicate claimant landed on his left buttocks. Id. The contemporaneous Emergency Room report contains no mention of the right hip. Id.

During claimant's Emergency Room treatment, an x-ray was taken of his pelvis, which showed degenerative arthritis in the right hip but an otherwise "unremarkable" pelvis with no fractures or dislocations. (Ex. 3). This x-ray does not support a finding that claimant injured his right hip in the fall at work because the only mention of the right hip is in regard to the degenerative arthritis. Id.

The Emergency Room physician referred claimant to Dr. Bills, M.D., who became claimant's attending physician. (Exs. 4, 5). Dr. Bills' reports and chart notes provide no description of a work injury to claimant's right hip, except for a reference to "right hip" in listing the "nature and location of

injury or exposure" on the August 4, 1994 Change of Attending Physician form. (Ex. 5). Furthermore, Dr. Bills' reports confused "left" and "right" to such an extent that the insurer initially accepted a "left" wrist fracture when claimant clearly compensably fractured his right wrist. (Exs. 6, 7, 8, 9, 11). Therefore, we do not find that Dr. Bills' opinions support finding a right hip injury.

On January 11, 1995, claimant was examined by Dr. Waters, M.D., on behalf of the insurer. (Ex. 9A). At that time, claimant reported that he "landed on his right side" when he fell from the loading dock. (Ex. 9A-1). However, on July 20, 1995, when claimant was examined by Drs. Dordevich, examining rheumatologist, and Smith, examining orthopedist, he reported he fell on his left side and denied "any difficulties with his left hip, the side that he fell on." (Exs. 10-1, -3). On December 1, 1995, claimant was examined by Dr. Bowman, M.D., medical arbiter. At that time, claimant reported that he hit his right hip when he fell from the loading dock. (Ex. 16-1).

It is claimant's burden to prove the compensability of his claim by a preponderance of the evidence. ORS 656.266. Given the differing reports claimant made to the various medical practitioners, we are not persuaded that claimant injured his right hip when he fell at work, particularly since claimant reported landing on his left hip to the Emergency Room staff on the day of the fall and received treatment only for his left hip at that time. (Ex. 4). On this record, claimant has failed to meet his burden of proving a right hip injury.

In the alternative, even if we assume that claimant struck his right hip during the fall at work, the medical evidence does not establish a compensable right hip claim. Claimant argues that Dr. Bowman's opinion establishes the compensability of the right hip condition. We disagree.

The evidence clearly establishes that claimant had preexisting degenerative arthritis in his right hip. (Exs. 3, 10, 14, 16). Dr. Bowman opines that the preexisting degenerative joint condition combined with claimant's fall on his right hip at work. (Ex. 16).

When a preexisting disease or condition combines with a compensable injury to cause or prolong disability or the need for treatment, the combined condition is compensable only if the compensable injury is the major contributing cause of the combined 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). Determining the "major contributing cause" of a disease or injury involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. See Dietz v. Ramuda, 130 Or App 397 (1994) (the "precipitating" or immediate cause of an injury may or may not be the "major contributing cause"); see also Alec E. Snyder, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to causation than all other causative agents combined. McGarrah v. SAIF, 296 Or 145, 166 (1983).

Based on claimant's history that he hit his right hip during the fall at work, Dr. Bowman opined that:

> "The MRI report of a cystic herniation would tend to support the fact that the fall on the hip, with the obvious contusion also, would have caused increased pressure in the hip joint itself in the osseous structures causing the herniation to take place. Among those of us who have done a considerable number of total hip replacements, it is a frequent finding that somebody comes in with end stage arthritis after what appears to be a rather trivial direct blow to the hip area and from that they do not recover back to the status that they were prior to the injury. Therefore, it is my opinion that [claimant's] complaints about the hip constitute a permanent aggravation of a pre-existing lesion." (Ex. 16-4).

Dr. Bowman's opinion does not evaluate the relative contribution of different causes of an injury or disease and decide which is the primary cause, as required by Dietz v. Ramuda, supra. Although acknowledging the preexisting degenerative joint disease, Dr. Bowman does not evaluate the contribution of that disease process. In discussing the effects of a "rather trivial direct blow" on "end stage arthritis," Dr. Bowman is, in effect, using a "but for" analysis, not evaluating the relative contribution of the different causes. Dietz v. Ramuda, supra; Alec E. Snyder, supra. Therefore, we do not find Dr. Bowman's opinion persuasive.

Dr. Waters' opinion has the same problems as Dr. Bowman's opinion. (Ex. 9A). In addition, Dr. Waters' opinion was rendered before the MRI was taken, so it is based on less information. Dr. Waters acknowledges that x-rays show preexisting degenerative changes; however, he does not evaluate the relative contribution of these changes and the work injury, except to state that it is difficult to attribute all of the radiographic changes to the work injury. (Ex. 9A-2). Therefore, we do not find Dr. Waters' opinion persuasive.

The remaining medical opinions do not support claimant's position. Although claimant reported to Drs. Dordevich and Smith that he fell on his left side, they indicated that claimant "possibly" suffered some soft tissue trauma to his right hip in the fall. (Exs. 10-1, -3, -7). However, they found no relationship between the fall and the degenerative arthritis of the right hip, opining that the fall "had no adverse affect on the natural progression of [claimant's] end-stage right hip disease." (Ex. 10-7, -8). They also opined that claimant's ongoing need for treatment for his right hip was solely related to the preexisting degenerative arthritis.

In a check-the-box opinion, Dr. Bills concurred with the report from Drs. Dordevich and Smith. (Ex. 12). In addition, Dr. Bills submitted a narrative report in which he explained his opinion. (Ex. 14). After reviewing claimant's x-rays and MRI, Dr. Bills explained that the MRI findings suggested an "old underlying disorder of the hip such as a slipped capital femoral epiphysis or possible Legg-Perthes disease." (Ex. 14-1). Dr. Bills opined that the "degenerative joint disease is the primary cause for [claimant's] continued symptoms and I could not attribute the fall of 07/28/94 as causing the need for further treatment regarding the right hip." (Ex. 14-2).

On this record, claimant has failed to establish a compensable right hip claim. Accordingly, we reverse that portion of the ALJ's order that set aside the insurer's partial denial of the right hip claim.

ORDER

The ALJ's January 30, 1996 order is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the insurer's partial denial of claimant's right hip injury claim is reversed. The partial denial of the right hip injury claim is reinstated and upheld. The ALJ's award of an attorney fee is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
PATRICK L. OSWALT, Claimant
WCB Case No. 95-05498
ORDER DENYING MOTION TO DISMISS
Bottini, et al, Defense Attorneys

Claimant, pro se, has requested Board review of Administrative Law Judge (ALJ) Hazelett's June 3, 1996 order which upheld the insurer's denial of claimant's low back injury claim and his occupational disease claim for chemical exposure. Stating that it is "uncertain as to whether [claimant's review] request was directed to the Workers' Compensation Board, as opposed to [ALJ] Hazelett," the insurer moves for dismissal of claimant's request for review. The motion is denied.

FINDINGS OF FACT

Claimant requested a hearing regarding the insurer's denial of his low back injury claim and chemical exposure claim. The ALJ's Opinion and Order issued on June 3, 1996. Concluding that claimant had not carried his burden of proving the compensability of either claim, the ALJ upheld the insurer's denial.

On July 8, 1996, the Board received claimant's pro se request for review of ALJ Hazelett's order. The request was mailed to "WCB Appeal," and the envelope indicated that the request was mailed on July 3, 1996, by certified mail. The request did not indicate whether a copy of the request had been mailed to the employer, the insurer or their attorney.

A computer-generated acknowledgment of claimant's request for review was mailed by the Board on July 10, 1996.

Noting that a copy of claimant's request for review was received in the insurer's attorney's office on July 8, 1996, the insurer's counsel moved to dismiss. In his July 9, 1996 letter, the insurer's attorney enclosed a copy of the envelope in which claimant's request was received. That envelope copy exhibits a postmark date of July 3, 1996. Also noting that it was "uncertain as to whether [claimant's] request was directed to the Workers' Compensation Board, as opposed to [ALJ] Hazelett," the insurer requested a "ruling on this issue."

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).

The failure to timely file and serve all parties with a request for Board review requires dismissal. Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992). "Party" means 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(21). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of prejudice to a party, timely service of a request for review on an employer's insurer or the attorney for the party is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. Argonaut Insurance v. King, supra.

Here, the 30th day after the ALJ's June 3, 1996 order was July 3, 1996. Inasmuch as claimant's request for review was mailed, by certified mail, to a permanently staffed office of the Board on July 3, 1996, it was timely filed. See ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b). In response to the insurer's request, we advise that it is unimportant whether the request was mailed to "the Workers' Compensation Board, as opposed to [ALJ] Hazelett." The determinative issue is whether it was mailed to a permanently staffed office of the Board prior to expiration of the 30-day period for appeal. Debra A. Hergert, 48 Van Natta 1052 (1996); John E. Bafford, 48 Van Natta 513 (1996).

Claimant's service by mail upon the insurer's attorney is uncontested. Further, based on the insurer's attorney's submission of a copy of the envelope in which claimant's request was received, because that envelope bears a July 3, 1996 postmark, we are persuaded that the request for Board review was mailed to the insurer's attorney prior to the expiration of the aforementioned 30-day period. Harold E. Smith, 47 Van Natta 703 (1995). Inasmuch as no contention has been made that the insurer or the employer has been prejudiced by not directly receiving a copy of claimant's request for review, we hold that claimant's timely service by mail upon the insurer's counsel is adequate compliance with ORS 656.295(2). See Nancy C. Prevatt-Williams, 48 Van Natta 242 (1996); Argonaut Insurance Co. v. King, supra. In reaching this conclusion, we emphasize that the insurer's attorney's receipt of a copy of claimant's appeal is not determinative; instead, the pivotal issue is when a copy of the request was mailed to the insurer's attorney. Nancy C. Prevatt-Williams, supra; Juan A. Hernandez, 47 Van Natta 2421 (1995); Judy W. Louie, 47 Van Natta 383 (1995). Consequently, we retain appellate jurisdiction to consider claimant's appeal. See ORS 656.295(2); Harold E. Smith, supra; Nancy C. Prevatt-Williams, 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
STEVEN D. WINDSOR, Claimant
WCB Case Nos. 95-03437 & 95-03436
THIRD ORDER ON RECONSIDERATION (REMANDING)
Parker, Bush & Lane, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On June 5, 1996, we abated our May 7, 1996 Second Order on Reconsideration that declined to remand the case to the Administrative Law Judge (ALJ) for consideration of additional documents and adhered to our conclusion that claimant did not prove the compensability of a cervical condition. In requesting reconsideration, claimant submits a report from Dr. Mandiberg dated June 3, 1996, stating that, based on treatment provided to claimant following the hearing, he now agrees that claimant's cervical condition was caused by a January 1993 injury. Having received the SAIF Corporation's response and claimant's reply, we proceed with our reconsideration.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. Bailey v. SAIF, 296 Or 41, 45 n 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

In our prior orders, we found most persuasive Dr. Mandiberg's opinion that claimant's cervical condition was caused by a nonwork-related motor vehicle accident. In his June 3, 1996 report, Dr. Mandiberg indicates that his opinion has changed based on treatment rendered in February 1996. We find that, because such treatment was not provided until after the June 1995 hearing, Dr. Mandiberg's opinion was not obtainable. Furthermore, because Dr. Mandiberg now indicates that he supports a causal relationship between the cervical condition and the January 1993 injury, we find that such evidence likely will affect the outcome. Consequently, we conclude that remand is warranted for submission of additional evidence concerning the compensability of claimant's cervical condition.[1] See Parmer v. Plaid Pantry #54, 76 Or App 405 (1985).

SAIF argues that, if we allow remand, it should be allowed an opportunity to cross-examine Dr. Mandiberg concerning his changed opinion. Additionally, SAIF contends that it should be allowed to submit for admission into the record a Disputed Claim Settlement (DCS) which claimant signed in February 1995; according to SAIF, the DCS precludes claimant from litigating the compensability of the cervical condition.

In response, we note that, after remanding, the ALJ may proceed in any manner that will achieve substantial justice. Therefore, we leave it to the ALJ to rule on those matters raised by SAIF. See OAR 438-007-0025(1).

Accordingly, that portion of the ALJ's order dated August 2, 1995, our Order on Review dated March 19, 1996, our Order on Reconsideration dated April 10, 1996, and our Second Order on Reconsideration dated May 7, 1996, concerning the compensability of claimant's cervical condition is vacated. This matter is remanded to ALJ Herman for further proceedings consistent with this order. Following these proceedings, the ALJ shall issue a final, appealable order. The remaining portions of the aforementioned orders are republished.

IT IS SO ORDERED.

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[1] As we have previously noted, at hearing, claimant also challenged a denial, issued on behalf of Clackamas Community College, of a thoracic condition. The ALJ found that claimant did not timely appeal the denial. We adopted and affirmed that portion of the ALJ's order. In his numerous requests for reconsideration, claimant has not challenged this conclusion, nor submitted additional evidence concerning this issue. Consequently, we emphasize that we are remanding only for admission of additional evidence concerning the compensability of the cervical condition.

In the Matter of the Compensation of
SALVADOR PRECIADO, Claimant
WCB Case No. C601897
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Phil H. Ringle, Jr., Claimant Attorney
Peter C. Davis (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

On July 1, 1996, 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 agreement.

A CDA must contain the terms, conditions and information prescribed in OAR 438-009-0022. The Board's rules define a "claim disposition agreement" as a written agreement executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim. (Emphasis added).

Here, the proposed CDA indicates that claimant has an accepted claim for a left chin injury which occurred on October 28, 1994. The proposed CDA further states that claimant filed a new claim for right hearing loss which he believed was a consequence of the October 28, 1994 injury. According to the proposed CDA, this claim was denied by SAIF in September 1995. The proposed CDA further provides:

> "As a condition of this Claim Disposition Agreement, SAIF agrees to accept the following conditions in that [denied right ear hearing loss] claim: contusion left chin and repair of right ear prosthesis, displacement, repaired; and claimant agrees that his claim for right ear hearing loss in [claim number] 7805375E shall remain in denied status, and he will withdraw his Request for Hearing in that matter."

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

In addition to accepting a denied condition, the proposed CDA also attempts to dispose of a denied claim for right ear hearing loss. A CDA concerns an accepted claim. See OAR 438-009-0001(1). Denied conditions cannot be disposed of by CDA. See Debra L. Smith-Finucane, 43 Van Natta 2634 (1991) (CDA which attempted to accept one condition and dispose of a denied aggravation claim set aside as unreasonable as a matter of law); see also Randi E. Morris, 43 Van Natta 2265 (1991) (CDA that attempted to dispose of denied claims was unreasonable as a matter of law).

Moreover, by agreeing that claimant shall not appeal the denied claim, the parties have essentially entered into a disputed claim settlement. See OAR 438-009-0001(2); Debra L. Smith-Finucane, supra. Claim disposition agreements must be in separate documents from disputed claim settlement agreements. OAR 438-009-0020(2). Here, the disputed claim settlement is in the same document as a claim disposition agreement. Thus, the proposed agreement impermissibly exceeds the bounds of OAR 438-009-0020(2).

Because the proposed agreement attempts to dispose of a denied claim and is in the same document as a disputed claim settlement, we find the agreement unreasonable as a matter of law. ORS 656.236(1)(A). Thus, we set aside the agreement.

The improper portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration. Therefore, we conclude that we cannot approve any portion of the proposed disposition. Lynda J. Thomas, supra; Karen A Vearrier, 42 Van Natta 2071 (1990).

Inasmuch as the proposed disposition has been disapproved, SAIF shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-060-0150(5)(k), (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM E. BENT II, Claimant
WCB Case No. 95-10763
ORDER ON REVIEW (REMANDING)
Kenneth P. Russell, (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Lipton's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal order. We remand.[1]

FINDINGS OF FACT

On September 25, 1995, the Board received claimant's request for hearing appealing the SAIF Corporation's denial of his claim. On October 2, 1995, the Board mailed a Notice of Hearing to the parties, announcing that a December 18, 1995 hearing was scheduled in Portland.

When claimant did not appear at the scheduled hearing, SAIF moved for dismissal of the hearing request. On December 29, 1995, the ALJ issued an Order to Show Cause, advising claimant that his hearing request would be dismissed unless, within 15 days, he established good cause for his failure to appear at the hearing.

On January 30, 1996, SAIF referred a letter from claimant to the ALJ. In his letter, claimant requested a list of attorneys, as well as a hearing around the fifth day of the month. Additionally, claimant noted that he needed time to subpoena certain laboratory records.

On January 31, 1996, in response to claimant's letter, the ALJ wrote to claimant to again inform him that if he did not satisfactorily explain his failure to appear at the hearing, his request for hearing would be dismissed.

On March 19, 1996, the ALJ issued a Dismissal Order. The ALJ found that claimant failed to demonstrate any reason for his failure to appear at the previous hearing. Accordingly, the ALJ dismissed the hearing request.

On March 22, 1996, the Board received claimant's letter asserting that; (1) he had already requested a list of attorneys; (2) he received notice of the hearing only two weeks before the scheduled date; (3) he lacked funds to attend the hearing; and (4) he needed a delay in the proceedings to subpoena laboratory records.

Claimant's letter was treated as a request for Board review of the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant and his attorney fail to attend a scheduled hearing unless extraordinary circumstances justify postponement or continuance of the hearing. OAR

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[1] Inasmuch as no appellate briefs have been filed in accordance with the briefing schedule implemented on May 20, 1996, we have proceeded with our review without the assistance of the parties' written arguments.

438-006-0071(2). We have previously held that an ALJ must consider a motion for postponement even after an order of dismissal has been issued. Olga G. Semeniuk, 46 Van Natta 152 (1994); Mark R. Luthy, 41 Van Natta 2132 (1989). In Luthy, we treated a "post-hearing" request to reschedule a hearing as a motion for postponement.

Here, in response to the ALJ's March 19, 1996 dismissal order, claimant sought another opportunity to present his arguments. In his "brief," claimant contends that he attempted to, but could not obtain, a list of attorneys to represent him. Claimant also contends that he did not receive notice of the scheduled hearing until two weeks before the date of hearing. Further, claimant argues that he did not have the funds to travel to Oregon to attend the hearing. Additionally, claimant contends that he needed a delay in the hearing in order to obtain certain records. Inasmuch as the ALJ did not rule on the motion, this matter must be remanded to the ALJ for consideration of the motion. See Randy L. Nott, 48 Van Natta 1 (1996); Olga G. Semeniuk, supra.

In reaching this conclusion, we note that, as a matter of policy, we generally do not remand in cases in which an ALJ has issued a "show cause" order prior to dismissing the case. See, e.g., Stephanie J. Thomas, 43 Van Natta 1129 (1991). In such cases, as the appellate body, we consider it appropriate to review the ALJ's rationale in addressing a party's explanation for failing to appear at a hearing. Additionally, the ALJ has presumably had the opportunity to make the first decision on a party's "postponement request," and to create a record for purposes of review.

Here, as acknowledged in his January 31, 1996 letter, the ALJ received claimant's letter which raised several questions and concerns regarding the scheduling of a hearing. Considering that the letter was received after issuance of the ALJ's Order to Show Cause, and since claimant was raising matters pertaining to rescheduling of a hearing, we conclude that the letter constitutes claimant's explanations for failing to appear at the previously scheduled hearing. Nevertheless, the ALJ dismissed the matter on the ground that "no reason" had been provided for claimant's failure to appear. In effect, the ALJ did not address the substance of claimant's "explanation" for his failure to appear at the hearing. Considering such circumstances, in keeping with the long-standing policy expressed in the holdings cited above, we conclude that this matter should be remanded.

In determining that remand is appropriate, we wish to emphasize that our decision should not be interpreted as a ruling on the substance of any of the representations contained in claimant's submission or a finding on whether postponement of the previously scheduled hearing is warranted. Rather, as we have explained in similar rulings, we take this action because we consider the ALJ to be the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Randy L. Nott, supra; Olga G. Semeniuk, supra.[2]

Accordingly, on remand, it will be claimant's responsibility to persuade the ALJ that his reason for failing to appear at the scheduled hearing was justified and constituted extraordinary circumstances beyond his control. The presentation of this "justification" may be made in any manner that the ALJ deems appropriate. If the ALJ finds that claimant's explanation satisfies the "extraordinary circumstances" standard, a hearing will be convened on the issues raised by claimant's hearing request.

The ALJ's order dated March 19, 1996 is vacated. This matter is remanded to ALJ Lipton to determine whether a postponement of claimant's hearing request is justified. In making this determination, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice, and that will insure a complete record of all exhibits and testimony. If the ALJ finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ finds that a postponement is not justified, the ALJ shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

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[2] The SAIF Corporation may present its objections, if any, to claimant's motion for postponement of the hearing to the ALJ when this case is returned to the Hearings Division.

In the Matter of the Compensation of
JOE ANN COLLINS, Claimant
WCB Case No. 95-12628
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's aggravation claim for a left knee condition. On review, the issue is aggravation.

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

The insurer argues that the record contains no medical evidence that any worsening is more than the waxing and waning of symptoms contemplated by the previous permanent disability award. We disagree.

In Carmen C. Neill, 47 Van Natta 2371 (1995), we held that an "actual worsening" under ORS 656.273(1) is established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the condition greater than that anticipated by the prior award of permanent disability.

On January 19, 1995, claimant received a 12 percent scheduled permanent disability award for her left leg (knee). (Ex. 22). Therefore, claimant must prove that the "worsening" of her left knee exceeded the waxing and waning contemplated by her prior award. See Carmen C. Neill, supra; ORS 656.273(8); ORS 656.214(7).

We agree with the ALJ's reasoning and conclusion that Dr. Puziss' opinion is more persuasive than the opinion of Drs. Duff and Dordevich. Drs. Duff and Dordevich found that claimant's left knee condition was medically stationary and they concluded that there was no indication for further treatment. (Ex. 31).

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). Here, we find no persuasive reasons not to defer to Dr. Puziss' opinion. Based on Dr. Puziss' reports, we conclude that claimant has established an "actual worsening" of her compensable left knee condition.

At claimant's closing examination on August 22, 1994, prior to her 12 percent scheduled permanent disability award, Dr. Higgins found no visible swelling and did not report any grinding or popping of the left knee. (Ex. 15). Claimant testified that her knee symptoms changed between January 1995 and June 1995. (Tr. 14). She noticed that her left knee would "crack" and "grind" and she could not walk as easily. (Tr. 16-18). Claimant testified that her left knee gets discolored, swollen and becomes hot. (Tr. 15, 16).

Dr. Puziss examined claimant on June 15, 1995 and reported "obvious patellar snapping with motion." (Ex. 23). Dr. Puziss was concerned that claimant had persistent tearing of the medial meniscus or recurrent tearing. (Id.) On July 12, 1995, Dr. Puziss reported that claimant had some symptoms of internal derangement, including swelling and sensation of catching that required a subtle manipulation to make it move. (Ex. 26). Dr. Puziss ordered a bone scan to assess possible arthritis.

Dr. Puziss subsequently concluded that claimant did not have any significant arthritis, based on the results of the bone scan. (Ex. 29). Dr. Puziss believed that the MRI demonstrated evidence of possible persistent tearing and he recommended an arthroscopy for diagnostic purposes. Dr. Puziss reported that claimant's recurrent swelling was not typical of a normal or even arthritic knee, but was more typical of mechanical derangement, such as a torn meniscus. (Id.) On January 4, 1996, Dr. Puziss reported that he had reviewed claimant's arthrogram and "there is a double shadow seen on at least two occasions in the posterior horn of the medial meniscus, highly suggestive of a tear." (Ex. 39). Dr. Puziss acknowledged that the radiologist read the arthrogram as negative.

Dr. Puziss believed that claimant's knee condition had objectively worsened since January 1995. (Ex. 38). Dr. Puziss recommended a diagnostic arthroscopy due to chronic post-surgical painful popping

and a possibly positive MRI scan and arthrogram. (Id.) Since claimant had a negative bone scan, Dr. Puziss believed that arthritis was not causing the pain, but it was more likely that claimant had a persistent, internal derangement (a recurrent or persistent medial meniscus tear). (Id.)

Although Dr. Puziss did not use the words "actual worsening" in evaluating claimant's current condition, 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); Nobuko Starr, 48 Van Natta 954 (1996) ("magic words" not required to establish an "actual worsening"). Dr. Puziss reported symptoms of internal derangement, including swelling and a sensation of catching. Dr. Puziss commented that claimant's recurrent swelling was not typical of a normal or an arthritic knee, but was more typical of mechanical derangement, such as a torn meniscus. Dr. Puziss recommended a diagnostic arthroscopy due to chronic post-surgical painful popping and a possibly positive MRI scan and arthrogram. Dr. Puziss concluded that claimant's knee condition had objectively worsened since January 1995. (Ex. 38).

Based on Dr. Puziss' reports, we conclude that claimant's left knee condition has worsened. Moreover, Dr. Puziss' reports establish that claimant's worsening is more than any waxing and waning of symptoms contemplated by the previous permanent disability award. There is no evidence that, at the time of claim closure, claimant was experiencing "popping" noises in her knee or chronic swelling, nor is there any evidence that those symptoms were anticipated at the time of claimant's prior disability award.[1] We conclude that claimant has established an "actual worsening" of her compensable left knee condition.

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

ORDER

The ALJ's order dated March 6, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

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[1] We also note that there is no evidence that a recurrent medial meniscus tear was anticipated at the time of claimant's prior disability award. However, since Dr. Puziss commented that the MRI scan and arthrogram were "possibly positive" (Ex. 38), we do not rely on the meniscus tear to establish a "pathological worsening" of claimant's compensable condition.

In the Matter of the Compensation of
DONALD J. BOIES, Claimant
WCB Case Nos. 95-07781 & 95-04236
ORDER OF ABATEMENT
Emmons, Kropp, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our June 21, 1996 Order on Review, which affirmed the Administrative Law Judge's (ALJ's) order that: (1) set aside its responsibility denial of claimant's occupational disease claim for bilateral hearing loss; and (2) upheld the self-insured employer's (Boise Cascade's) denial of an occupational disease claim for the same condition.

In order to allow sufficient time to consider the motion, we withdraw our June 21, 1996 order. Claimant and Boise Cascade are granted an opportunity to respond to SAIF's 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
LORRAINE M. DUNLAP, Claimant
WCB Case No. 95-08481
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Hall, Christian and Haynes.

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

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 12, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,500, payable by the self-insured employer.

Board Member Haynes dissenting.

I disagree with the majority that claimant proved the compensability of her mental disorder claim. Claimant works as a housekeeper in a medical clinic. The ALJ, whose reasoning the majority adopted and affirmed, concluded that claimant proved she was "overworked" and subject to unreasonable disciplinary action in March 1995. I am convinced that such conclusions are unfounded.

On Thursday, March 23, 1995, and Friday, March 24, 1995, claimant was absent from her job due to illness. On Monday, March 27, 1995, claimant's supervisor, Janet Moore, gave a verbal warning to claimant based on complaints from a patient and staff and her own investigation showing that the bathrooms for which claimant was responsible for cleaning were unacceptably dirty.

The ALJ (and the majority) indicate an understanding that Ms. Moore received complaints about the bathrooms on Monday, March 27. According to the ALJ, the verbal warning was not reasonable because it did not take into account claimant's absence from her job the preceding Thursday and Friday. I believe the preponderance of evidence shows that Ms. Moore received the complaints and examined the bathrooms on Thursday, March 23, the first day of claimant's absence. (Exs. 25, Tr. 141 (Day 1), Tr. 129 (Day 2)). Thus, the dirty condition of the bathrooms was discovered while claimant was absent. Consequently, Ms. Moore's conclusion that claimant had not properly cleaned the bathrooms at least the previous day (when claimant was present) was accurate. Therefore, I would find the verbal warning to be reasonable discipline.

I also disagree that the record supports the ALJ's conclusion that claimant was "overworked." According to claimant's treating psychiatrist, Dr. Lange, claimant's work load had "tripled" since she first began working at the clinic because the number of patients treated in her work area had increased. There simply is no corroborating evidence to support Dr. Lange's history. At the hearing, there was lengthy testimony concerning the surgical procedures performed in claimant's work area. Even the testimony most sympathetic to claimant's case, however, does not support her assertion to Dr. Lange that her work had "tripled." Consequently, because Dr. Lange relied on an inaccurate understanding of claimant's work conditions, his opinoin is not persuasive. Finally, even if claimant's depiction of her work load was accurate, I find no basis for concluding that an increase in work is not generally inherent in every working situation.

For all these reasons, I dissent.

In the Matter of the Compensation of
DANIEL S. GRIFFITHS, Claimant
WCB Case No. 94-05901
ORDER OF DISMISSAL (REMANDING)
Bryant, Emerson, et al, Claimant Attorneys
Virgil Osborn, Department of Justice

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that affirmed the Director's determination that claimant was not a subject worker of the employer at the time of his alleged injury. On review, the issues are jurisdiction and subjectivity. We remand.

FINDINGS OF FACT

Claimant filed a notice of a workers' compensation injury claim with the Director of the Department of Consumer and Business Services (Director). By letter dated April 12, 1994, the Director's designee informed claimant that his notice of injury would not be processed under ORS 656.054 because he was not a subject worker of the alleged employer at the time of the alleged injury.

Claimant filed a timely request for hearing from the Director's determination. The matter was litigated before ALJ Kekauoha. The only issue before the ALJ was subjectivity, i.e., whether the employer was a subject employer and claimant a subject worker of the alleged employer at the time of the alleged injury. By Opinion and Order issued November 8, 1994, the ALJ affirmed the Director's determination that claimant was not a subject worker. The November 8, 1994 order included a notice of appeal rights to the Workers' Compensation Board. See ORS 656.289(3). Pursuant to that notice, claimant filed a timely request for Board review of the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Subsequent to the issuance of the ALJ's order, the court issued its decision in Copeland v. Lankford, 141 Or App 138 (1996). Based on that decision, we conclude that authority over this matter remains with the ALJ. We base this conclusion on the following reasoning.

In Copeland, supra, the court determined that the Board lacked appellate authority to review an ALJ order affirming the Director's determination that the claimant was not a subject worker. Relying on ORS 656.704(3), the court noted that the Board's appellate authority is limited to "matters concerning a claim" which are "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." The court reasoned that, because only a subject worker is entitled to seek compensation, the right to receive compensation is directly in issue only when a claimant is determined to be a subject worker and the claim is assigned to a carrier for processing.

Consistent with this reasoning, the court concluded that the Director's determination in Copeland that the claimant was not a subject worker was not a matter concerning a claim within the meaning of ORS 656.704(3). Thus, the court concluded that review of the ALJ's order was to the court under ORS 183.482, and not to the Board. The court further concluded that the ALJ's inclusion of an incorrect notice of appeal rights to the Board affected a substantial right of claimant. Citing Callahan v. Employment Division, 97 Or App 234 (1989), the court remanded the matter to the Board with instructions to dismiss the request for review and remand to the Director for issuance of a corrected order with appeal rights to the court.

Here, as in Copeland, claimant has requested Board review of an ALJ order affirming the Director's determination that claimant is not a subject worker. Thus, there has been no determination by the Director that claimant is a subject worker entitled to seek compensation, and the claim has not been assigned to a carrier for processing. Furthermore, as in Copeland, claimant has requested Board review pursuant to the ALJ's incorrect notice of appeal rights to the Board.

The facts in the present case are indistinguishable from those in Copeland. Consequently, the Copeland decision is controlling in this case. Consistent with that decision, we conclude that review of the ALJ's order rests with the court under ORS 183.482. We further conclude that the incorrect notice of appeal rights in the ALJ's order affected a substantial right of claimant. Consequently, this matter must be remanded to the ALJ to issue a corrected order (on behalf of the Director) with the appropriate notice of appeal rights. See Vollina Draper, 48 Van Natta 1505 (1996).

Accordingly, claimant's request for Board review is dismissed. This matter is remanded to ALJ Kekauoha, with instructions to issue a corrected order with the proper notice of appeal rights in accordance with ORS 183.482 and Copeland.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRIAN D. PRIVETTE, Claimant
WCB Case Nos. 95-07463, 95-05678 & 95-04952
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Co-Gen II, requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) set aside its denial of claimant's aggravation claim for his low back condition; (2) upheld Argonaut Insurance Company's denial, on behalf of Bio Mass One, of claimant's aggravation claim for the same condition; and (3) upheld the SAIF Corporation's denial, on behalf of Co-Gen II, of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the pertinent facts. Claimant sustained a compensable, nondisabling low back injury in February 1989, when he lifted a door while working for Argonaut's insured. Claimant received treatment for low back pain extending into the left upper leg and right buttock. Dr. Butler diagnosed a low back strain. Claimant lost no time from work and experienced no continuing symptoms. (Exs. 1 through 10; Tr. 21).

Claimant sustained another compensable low back injury in June 1990, while working for Liberty's insured. Claimant experienced a sharp pain in his low back when he twisted after raking grates and wheelbarrowing rock waste. Dr. Driver treated claimant for pain radiating into his left buttock, the back of his left thigh and down toward his left heel and toes. Dr. Driver diagnosed possible left L-5 nerve root radiculopathy. (Exs. 11 through 13). Liberty accepted a nondisabling low back strain. In November 1990, Dr. Parsons treated claimant for low back pain on the right, radiating into the gluteal area. Dr. Parsons diagnosed a lumbosacral strain with right sciatic syndrome. (Exs. 15, 16).

Subsequent to the 1990 injury, claimant's low back and leg symptoms recurred every two or three months after exertion, and lasted about three or four days. He sought no medical treatment. (Ex. 31-4; Tr.13, 14, 20).

Claimant continued to work for the same employer; SAIF became the insurer. On or about November 12, 1994, claimant lifted a 100 pound sack of sand and experienced low back discomfort. Dr. Driver diagnosed lumbar spasm. Claimant initially complained of bilateral lumbar pain that extended into the left thigh and buttock. Claimant was referred to Dr. Freeman, neurosurgeon, who noted that claimant's pain had progressed down both legs into the calf. Dr. Freeman diagnosed bilateral L5-S1 nerve root irritation with L4 components. (Exs. 17 through 23). A January 1995 MRI revealed degenerative disc disease at L3-4, L4-5 and L5-S1 with disc bulges at L3-4 and L4-5 and a small herniated disc at L5-S1. (Ex. 26). Subsequently, in November 1995, a myelogram and CT scan confirmed bulging discs but did not substantiate the existence of an L5-S1 herniated disc. (Exs. 56, 57, 58).

Claimant filed a claim with each potentially responsible insurer. After Liberty rescinded its denial of compensability, a ".307" order issued and the parties went to hearing to decide responsibility.

Applying ORS 656.308(1), the ALJ concluded that responsibility for claimant's 1994 low back injury claim remained with Liberty because it failed to prove that the 1994 lifting incident when SAIF was on the risk was the major contributing cause of claimant's current low back condition.

On review, Liberty asserts that the ALJ erroneously assigned it responsibility, as claimant's 1994 injury involved a different condition from its 1990 accepted low back strain. Specifically, Liberty contends that, because the medical opinions relating claimant's 1994 condition to the 1990 injury were based on a suspected herniated disc, and the 1990 claim did not involve a herniated disc, ORS 656.308(1) does not apply.[1] Liberty further contends that the persuasive medical evidence establishes that the 1994 injury, when SAIF was on the risk, is the actual cause of claimant's subsequent disability and need for treatment.

As noted above, claimant sustained two compensable low back strain injuries in 1989 (when Argonaut was on the risk) and 1990 (when Liberty was on the risk). Claimant also experienced an exacerbation of his low back condition after a lifting incident at SAIF's insured in November 1994. 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." To establish a new injury under the statute, claimant's employment activity in November 1994 must have been the major contributing cause of claimant's disability or need for medical treatment. ORS 656.308(1); Keith Thomas, 48 Van Natta 510 (1996). However, ORS 656.308(1) applies only if claimant's current condition is the "same condition" as that previously accepted by Argonaut in 1989 or Liberty in 1990. Smurfit Newsprint v. DeRosset, 118 Or App 368, 371-72, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993). Thus, our initial inquiry is whether claimant's current condition is the "same condition" as that accepted by Argonaut or Liberty. The answer to that question is "yes."

In 1989, Dr. Butler diagnosed a low back strain. Although Dr. Butler noted pain in the upper left leg and in the right buttock and recommended ruling out disc disease, x-rays showed only a possible minimal disk space narrowing at L4-5. (Exs. 3, 5). Claimant's 1990 injury involved pain radiating down the back of his left thigh into the toes with some discomfort on the right side. Dr. Driver diagnosed a low back strain with possible L-5 radiculopathy. (Ex. 12). About five months later, claimant experienced right low back pain radiating into his right buttock. Dr. Parsons diagnosed a lumbosacral strain with right sciatic syndrome. (Ex. 15).

In 1994, claimant initially experienced low back pain radiating into the left thigh and buttock. Dr. Driver diagnosed a lumbar spasm and referred claimant to Dr. Freeman. (Exs. 18, 20). Dr. Freeman diagnosed bilateral L5-S1 nerve root irritation with L4 components. (Ex. 23). Claimant's symptoms failed to subside and Dr. Freeman ordered an MRI, which indicated degenerative disc disease at L3-4, L4-5 and L5-S1, disc bulges at L3-4 and L4-5, and a disc herniation at L5-S1. (Ex. 26). Subsequently, a myelogram and CT scan confirmed the degenerative disease and disc bulges, but did not substantiate a herniated disc at L5-S1. (Exs. 56, 57, 58).

Because each of claimant's low back injuries involved a lumbar strain with radicular symptoms, and because the disc herniation revealed by the MRI was not substantiated by further tests,[2] we find that the 1994 injury involved the same condition that claimant experienced in 1989 and 1990, namely, a bilateral lumbosacral strain with bilateral radicular symptoms. We therefore find that, under ORS 656.308(1), Liberty is presumptively responsible for claimant's current low back condition. To shift responsibility to SAIF, Liberty must establish that claimant experienced a new compensable injury while

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[1] Liberty is correct in its contention that the record does not support a conclusion that a herniated disc was involved in its accepted 1990 claim (or, we note, in Argonaut's accepted 1989 claim). However, the medical evidence also does not support a conclusion that claimant's 1994 injury involved a herniated disc. (See Exs. 56 and 57).

[2] We note that Dr. Dickerman interpreted the same MRI as not showing a herniated disc at L5-S1. (See Ex. 44-14). Moreover, subsequent to the myelogram and CT scan, even Dr. Freeman recognized that an L5-S1 herniated disc had not been substantiated. (Ex. 58).

working for SAIF's insured. As noted above, Liberty must prove that claimant's 1994 injury is the major contributing cause of the disability and need for treatment of claimant's combined condition. Keith Thomas, supra.

Claimant was treated by Dr. Freeman and was examined for Liberty by Drs. Watson and Laycoe and for SAIF by Drs. Donahoo and Dickerman. Considering claimant's extensive history of complaints and employment exposures, the determination of the major cause of claimant's condition is complex and requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967). We generally defer to the medical opinion of an attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons to do otherwise.

Dr. Freeman initially opined that the major cause of claimant's current low back condition was the work incident in November 1994, based on claimant's report that he had not had any leg pain prior to November 1994. Subsequently, after reviewing Dr. Dickerman's report and additional information establishing the presence of claimant's pre-1994 leg symptoms, Dr. Freeman opined that claimant's radicular complaints (and herniated disk at L5-S1) initiated in 1990. (Ex. 48). However, despite this apparent change of opinion, Dr. Freeman then proceeded to concur with the opinion of Drs. Watson and Laycoe, who also based their opinion that the 1994 incident was the major contributing cause of claimant's current condition on their belief that claimant had been asymptomatic subsequent to his July 1990 injury. This is contrary to claimant's testimony at hearing, prior medical records, and to the information provided to Drs. Donahoo and Dickerman. (Exs. 31-3, -4; 44-3, -4; Tr. 13-14). Because the changes in Dr. Freeman's opinions were unexplained, we give his opinions little weight. Somers v. SAIF, 77 Or App 259, 263 (1986). Moreover, because Drs. Watson and Laycoe's opinions were based on an incorrect history regarding claimant's radicular symptoms, we also give their opinions little weight. Id.

In contrast, Dr. Donahoo performed an extensive review of the medical records and took a thorough history from claimant. (Ex. 31). During Dr. Donahoo's examination, claimant averred that radicular symptoms had been present prior to the November 1994 incident. (Ex. 31-4). These radicular symptoms were documented in the medical records. Based on claimant's history of radicular symptoms going back to 1990, Dr. Donahoo opined that the major cause of claimant's current need for treatment was the July 1990 injury.[3] (Ex. 31).

Dr. Dickerman also reviewed all of the medical reports and took a thorough history from claimant, which included the history of flare-ups of pain in the lower extremities. (Ex. 44). After reviewing the MRI, he found that it revealed multi-level degenerative disc disease from L3-4 to L5-S1 with disc bulges at these levels, but no disc herniation. (Ex. 44-14). Dr. Dickerman opined that claimant's symptoms date back to 1989 and worsened in 1990. He further opined that the 1994 incident pathologically worsened claimant's underlying condition, making it significantly more symptomatic, but that the 1994 incident was a material cause, not the major contributing cause, of claimant's current need for treatment. (Ex. 44-15).

We find both Dr. Donahoo's and Dr. Dickerman's opinions to be persuasive. Somers v. SAIF, supra. Accordingly, we conclude that claimant's November 1994 work incident is not the major contributing cause of his subsequent disability or need for treatment. Thus, Liberty has not established that claimant sustained a new compensable injury in 1994. Therefore, responsibility for claimant's current low back condition does not shift from Liberty to SAIF under ORS 656.308.

ORDER

The ALJ's order dated January 9, 1996 is affirmed.

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[3] Although Dr. Donahoo initially assumed that claimant had an L5-S1 herniated disk per Dr. Osborne's interpretation of the MRI, he found no reason to change his opinion on causation after additional tests failed to sustain that diagnosis, concluding that the 1994 work incident had caused no new pathology. (Ex. 60).

In the Matter of the Compensation of
DONALD M. CRISS, Claimant
WCB Case No. 95-02870
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) upheld the self-insured employer's partial denial of claimant's L5-S1 degenerative disc bulge and L3-4 disc protrusion; and (2) declined to award penalties or attorney fees for allegedly unreasonable claim processing or discovery violations. In its brief, the employer requests a sanction for an allegedly frivolous deposition. On review, the issues are compensability, penalties, attorney fees, and sanctions.

FINDINGS OF FACT

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

Penalties and Attorney Fees

We need not address claimant's contentions on these matters (in the penalty and attorney fee context) because all compensation due under the compensable claim was timely paid and claimant has not established entitlement to additional compensation. See Lloyd Monroe, 47 Van Natta 1307, 1309 (1995).

Sanction

The employer seeks a sanction under ORS 656.390, based on claimant's allegedly frivolous pursuit of his request for hearing regarding numerous alleged discovery violations.[1] Specifically, the employer asks that claimant be required to pay the cost of the deposition of its claim examiner regarding the discovery issue. (See Ex. 70).

ORS 656.390(1) gives the ALJ and the Board authority to impose an appropriate sanction against an attorney who files a frivolous request for hearing or review. "'Frivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2); see Westfall v. Rust International, 314 Or 553 (1992) (defining "frivolous" under former ORS 656.390).

In this case, we find that claimant's pursuit of the discovery issue was not "frivolous" within the meaning of the statute. In reaching this conclusion, we note that the employer concedes that two documents were not timely provided to claimant. (Respondent's Brief, p. 10; see Ex. 70-21-22 & Deposition Exhibit 2). Furthermore, claimant raised colorable arguments regarding the discovery issue that were sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Gerard R. Schiller, 48 Van Natta 854 (1996); Rhonda L. Hittle, 47 Van Natta 2124 (1995). Under these circumstances, we cannot say that claimant's request to depose the claim examiner on the discovery issue was "frivolous." Accordingly, the employer's request for a sanction is denied.

ORDER

The ALJ's order dated January 31, 1996 is affirmed.

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[1] We note the employer's contention that the discovery issue was not properly before the ALJ because claimant did not separately request a hearing on that issue after the alleged discovery violations. However, claimant raised the discovery issue at hearing. (Tr. 2,4). Furthermore, the employer did not object to this issue at hearing but, instead, raised the issue of sanctions under ORS 656.390 in response to the discovery issue. (Tr. 4-5). Under these circumstances, we find that the discovery issue was timely raised. Former OAR 438-06-031.

In the Matter of the Compensation of
RONALD F. GLASCOCK, Claimant
WCB Case No. C601777
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller and Hall.

On June 18, 1996, we received 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. We approve the proposed disposition.

After the parties' CDA was received, the parties submitted a separate, stipulated order for Board approval which provided for an advance of $26,000 on claimant's CDA proceeds prior to the expiration of the 30 day waiting period. In the proposed stipulation, the parties agreed to offset future permanent total disability payments to repay the advance in the event the CDA was not approved by the Board.

Here, claimant is not represented by an attorney. Thus, under ORS 656.236(1)(a)(C), the Board must wait until the expiration of the 30 day waiting period before it can approve the CDA. See ORS 656.236(1)(b) (the 30 period cannot be waived if the worker is unrepresented). Here, because claimant is unrepresented, we lack the statutory authority to approve the CDA prior to the expiration of the 30 day waiting period. Thus, we are likewise unable to approve the advance of a portion of the CDA proceeds before the 30 day waiting period has expired.[1]

Although we cannot approve the advance prior to the expiration of the 30 day period, there is no prohibition against a carrier advancing all or a portion of the CDA proceeds to an unrepresented worker prior to the expiration of the 30 day period. In this respect, we note that, although the issue is not before us in this case, the insurer would have a method to recoup an advance if a CDA settlement somehow "fell through" or was not approved. Specifically, if the insurer could prove that such an advance had been made, the statute provides for, and we could approve, an appropriate offset. ORS 656.268(13).

Therefore, although we cannot, and have not, approved the separate stipulation allowing an advance of the CDA proceeds prior to the expiration of the 30 days, the CDA itself contains no such agreement. Accordingly, inasmuch as it is in accordance with the terms and conditions prescribed by the Board, we approve the CDA. ORS 656.236(1)(a); OAR 438-009-0020(1).

IT IS SO ORDERED.

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[1] We distinguish this case from other cases which refer to "advances" of CDA proceeds. See Carolyn L. Thom, 43 Van Natta 637 (1991); Julian H. Combs, 43 Van Natta 327 (1991). In those cases, the parties did not request approval of an advance in a separate agreement prior to Board approval of the CDA itself. Rather, the parties informed us in the CDA that the insurer was making an advance (on submission of the CDA) and would seek an offset if the CDA was not approved. Additionally, the law in effect at the time these cases were decided did not provide an express prohibition against the approval of an unrepresented worker's CDA before the expiration of the statutory 30 day period.

In the Matter of the Compensation of
LEONARD W. KIRKLIN, Claimant
WCB Case No. 95-11373
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order which dismissed his request for hearing for lack of jurisdiction. On review, the issues are jurisdiction and, potentially, penalties. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable neck injury on or about March 8, 1991. At the time, the self-insured employer's claims were processed by Helmsman Northwest. On January 1, 1993, SAMIS assumed responsibility for processing the claim. SAMIS issued a "back-up" denial of compensability on January 22, 1993. Claimant requested a hearing, which occurred on April 27, 1993.

The ALJ set aside the denial in an October 8, 1993 order (republished in a November 30, 1993 reconsideration order), which directed SAMIS to pay a 25 percent penalty based on all compensation due claimant as a result of that order because of its allegedly unreasonable denial. (Ex. 18-6). The employer sought review by the Board.

We affirmed the ALJ's order on September 8, 1994. (Ex. 32). The Court of Appeals affirmed without opinion on May 10, 1995. (Ex. 34). The Supreme Court denied review on September 5, 1995. (Ex. 36).

In the meantime, JELD-WEN, the employer's current claims processor, assumed responsibility for processing the claim in early 1994. It received no payment summaries or medical bills from the previous two processors. (Tr. 12). Payment of compensation was stayed while the compensability issue was on appeal. Id.

After issuance of the Supreme Court's September 5, 1995 order denying review, claimant's counsel wrote the employer's counsel to request payment of benefits stayed while the compensability issue was on appeal. Claimant's counsel specifically noted the prior ALJ's 25 percent penalty assessment based on "amounts due" as a result of the order. (Ex. 37).

On October 3, 1995, claimant's counsel forwarded medical bills incurred by claimant to employer's counsel. (Ex. 39). On October 5, 1995, JELD-WEN's claims examiner wrote claimant explaining what benefits would be paid and how it calculated claimant's penalty. (Ex. 40). The employer failed, however, to base its penalty calculation on medical bills. Id. In response, claimant filed a request for hearing, alleging entitlement to penalties based on all benefits due as a result of the prior ALJ's order. (Ex. 41-1).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant raised the issues of the amount of the penalty awarded by the prior ALJ, penalties for nonpayment of the prior ALJ's penalty assessment, and penalties for the employer's method of offsetting overpaid temporary disability. (Trs. 2, 3, 5). The employer contended that the Hearings Division lacked jurisdiction over the issues under ORS 656.262(11)(a), alleging, instead, that the Director had jurisdiction because the sole issue concerned the "assessment and payment of the additional amount" described in the statute. The ALJ agreed and dismissed claimant's hearing request for lack of jurisdiction.

On review, claimant asserts that the Board and the Hearings Division have jurisdiction to enforce the prior ALJ's order awarding a 25 percent penalty. Claimant also argues that the employer should have paid the 25 percent penalty based on the value of medical bills not paid at the time of the prior ALJ's order.

For the following reasons, we hold that the Hearings Division has authority to address the issues raised by claimant's request for hearing. We also agree that the prior ALJ's penalty assessment should

be based on all compensation, including medical bills that may not have been in the possession of the employer's current processing agent. However, we find that the penalty should be based on medical services rendered as of the date of the previous hearing, rather than the date of the previous ALJ's order.

Jurisdiction

In Harry E. Forrester, 43 Van Natta 1480 (1991), the claimant sought relief in the form of the unpaid benefits awarded by a prior Board order and penalties for the carrier's unreasonable failure to pay those benefits. We found that we had jurisdiction over this penalty issue combined with an enforcement action regarding a Board order that had not been satisfied by the carrier.

Consequently, consistent with the rationale expressed in Forrester, as reaffirmed in subsequent decisions, see, e.g. Robert Geddes, 47 Van Natta 2388, 2390 (1995), we have jurisdiction over enforcement requests not satisfied by a carrier and the assessment of any penalties flowing therefrom. Inasmuch as this case pertains to an enforcement request concerning a prior order that claimant alleges was not satisfied by the employer, we find that the Hearings Division has jurisdiction over the issues claimant has raised. Harry Forrester, supra. Thus, we reverse the ALJ's dismissal of claimant's hearing request.[1]

Penalty

Having determined that we have jurisdiction over claimant's hearing request, we proceed to the issue of whether the employer properly calculated claimant's penalty. This necessarily involves a determination of the meaning of the phrase "all compensation due" as used in the prior ALJ's order. (Ex. 18-6).

The employer contends that it properly calculated claimant's penalty because the record does not establish that medical bills were forwarded to the employer for payment between its January 22, 1993 denial and the April 27, 1993 hearing. We disagree.

It is irrelevant that the employer's processing agent did not receive any bills or that payment of compensation was stayed pending appeal. The prior ALJ assessed a penalty on "all compensation due" for an unreasonable "back-up" denial. Under such circumstances, any compensation that was eventually paid retroactively for treatment provided as of the date of the hearing before the previous ALJ is subject to the 25 percent penalty. Ben Santos, 44 Van Natta 2228, on recon 44 Van Natta 2385, 2386 (1992) (basis of the penalty for the unreasonable denial is the amount then due at hearing, including medical services).[2]

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[1] In reaching this conclusion, we distinguish this case from Robert Geddes, supra, and Raymond J. Dominiak, 48 Van Natta 108 (1996). In both Geddes and Dominiak, we held that the Board lacked jurisdiction regarding the claimants' hearing requests regarding assessment of a penalty. In Geddes, the sole issue raised was a penalty and related attorney fee for the insurer's allegedly unreasonable delay in paying the proceeds of a CDA. The insurer, however, paid the CDA proceeds prior to the request for hearing. Thus, we concluded that, because the carrier's obligation was fully satisfied prior to hearing, leaving the penalty and attorney fee issues only, we lacked jurisdiction over this matter. In Dominiak, the claimant characterized the case as an enforcement action regarding delayed payment of benefits under a stipulation. However, he did not seek benefits under the stipulation. Instead, he solely sought a penalty under ORS 656.262(11). Thus, we held that the only issue was a penalty under ORS 656.262(11) and that the Director had exclusive jurisdiction over that issue.

In contrast to the claimants in Geddes and Dominiak, claimant here is seeking enforcement of a prior ALJ's order, which he alleges the carrier has not satisfied. Under these circumstances, the proceeding does not involve solely the assessment of a penalty within the meaning of ORS 656.262(11). Consequently, we have jurisdiction over claimant's hearing request.

[2] The employer asserts that, because it never received any billings between the date of its "back-up denial" and the date of the prior hearing, there are no amounts due. We disagree. It is the carrier's duty to process a claim, not the claimant's. See Alda S. Carbajal, 47 Van Natta 1596, 1601, on recon 47 Van Natta 1949 (1995); Dennis R. Lewis, 46 Van Natta 2408, 2409, on recon 46 Van Natta 2502 (1994). JELD-WEN's claims examiner testified that she received billings for dates of treatment in 1993. (Tr. 14). Thus, we conclude that JELD-WEN had sufficient information on which to calculate the penalty. While the change of processing agents in 1994 and the failure of prior processing agents to forward claim documents may have complicated processing of the claim, we are unwilling to excuse JELD-WEN from its claim processing obligations. Those obligations include obtaining the information necessary to insure the accurate determination of the amount of a penalty assessed as a result of a prior ALJ's determination that a previous claim processor's denial was unreasonable.

ORDER

The ALJ's order dated February 23, 1996 is reversed. Claimant's request for hearing is reinstated. Pursuant to the prior ALJ's October 8, 1993 order (republished on November 30, 1993), the self-insured employer is assessed a penalty equal to 25 percent of any compensation, including medical bills, retroactively paid through the date of the previous hearing (April 27, 1993). This penalty shall be shared equally by claimant and his attorney.

July 19, 1996 Cite as 48 Van Natta 1573 (1996)

In the Matter of the Compensation of
DOROTHY VANDERZANDEN, Claimant
Own Motion No. 95-0103M
OWN MOTION ORDER
Pozzi, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

The self-insured employer initially submitted claimant's request for temporary disability compensation for claimant's compensable low back at L4-5 injury. Claimant's aggravation rights expired on August 10, 1989. The employer opposed reopening the claim on the grounds that: (1) claimant's current condition is not causally related to the compensable injury; (2) the employer is not responsible for claimant's current condition; and (3) claimant's request for L4-5 discectomy and foraminotomy of L4-5 and L5-S1 surgery is not reasonable and necessary treatment for her compensable condition. Claimant requested a hearing with the Hearings Division. (WCB Case No. 94-15363).

On April 14, 1995, Administrative Law Judge (ALJ) Lipton issued an Opinion and Order that upheld the employer's denial of claimant's current low back condition and her proposed surgery request. Claimant requested Board review of the ALJ's order. On November 6, 1995, the Board issued its Order on Review which vacated those portions of the ALJ's order which pertained to the issue of the appropriateness of the proposed surgery, and reinstated the employer's denial of claimant's current low back condition. Claimant appealed the medical services issue to the Medical Review Unit (MRU) of the Workers' Compensation Division, as jurisdiction over medical service disputes currently resides with the director subsequent to enactment of SB 369. See amended ORS 656.245(6), 656.260, 656.327 and 656.704(3). On November 16, 1995, the Board issued its order postponing action on the own motion matters pending outcome of the medical services dispute.

On January 30, 1996, the MRU issued a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute, which found that the proposed surgery was not appropriate medical treatment for claimant's compensable injury. Claimant appealed that decision.

In a June 11, 1996 Proposed and Final Contested Case Hearing Order, Administrative Law Judge (ALJ) Ella Johnson affirmed the MRU's January 30, 1996 order. The contested case order became final on July 11, 1996.

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

Here, the dispute regarding the reasonableness and necessity of claimant's proposed surgery has been resolved. ORS 656.327. Because it has been determined that the employer is not responsible for claimant's proposed medical treatment, we are unable to find that claimant is entitled to temporary disability compensation for surgery which has been determined not reasonable and necessary for claimant's compensable condition. However, should claimant's circumstances change, and the employer accept responsibility for his proposed surgical treatment, claimant may again request own motion relief.

Accordingly, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN C. KATONA, Claimant
WCB Case No. 95-07727
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Schultz's order that: (1) excluded a medical report by Dr. Coletti; (2) admitted claimant's testimony at hearing; and (3) increased claimant's unscheduled permanent disability for a back condition from zero, as awarded by an Order on Reconsideration, to 31 percent (99.2 degrees). The employer also moves to remand the case in light of a subsequent order from another ALJ. Claimant cross-requests review of that portion of the order that found the employer was not required by ORS 656.262(7)(h) to issue a denial. On review, the issues are remand, evidence, and extent of unscheduled permanent disability. We deny the motion to remand, reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for those findings based on claimant's testimony at hearing.

CONCLUSIONS OF LAW AND OPINION

Evidence

In his order, the ALJ found inadmissible a report by examining orthopedic surgeon, Dr. Coletti. Dr. Coletti generated his report prior to the reconsideration proceeding before the Director and it was part of the record during reconsideration. In making the ruling, the ALJ apparently agreed with claimant that ORS 656.245(2)(b)(B) prohibited the admission of the report. The employer objects to this conclusion, asserting that the ALJ abused his discretion in excluding the report because it was included with the record developed during reconsideration.

ORS 656.245(2)(b)(B) provides that "only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." In construing the statute, the court has held that the Board may not consider evidence of impairment unless it is produced or concurred in by the attending physician. E.g., Weckesser v. Jet Delivery Systems, 132 Or App 325, 328 (1995). As a practical matter, there is little distinction between consideration of a medical report and its admissibility since, even though admissible, if the report cannot be considered in determining permanent disability, it has no relevance to deciding the issue. Thus, inasmuch as we may not consider Dr. Coletti's report, whether or not admissible, we need not address the propriety of the ALJ's ruling.

Relying on ORS 656.268(7) and 656.283(7), the employer also objects to the ALJ's admission of claimant's testimony at hearing. Claimant acknowledges that our order in Joe R. Ray, 48 Van Natta 325 (1996), is contrary to the ALJ's ruling.

ORS 656.283(7) provides, in relevant part:

> "Evidence that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

In Ray, based on the text, context, and legislative history, we held that evidence that was not submitted at reconsideration, and included in the reconsideration record, is inadmissible at a subsequent hearing regarding extent of permanent disability. 48 Van Natta at 327. Thus, because the claimant's testimony was not submitted at the reconsideration proceeding, we did not consider it in determining the extent of permanent disability. Id. at 333. After extensively considering the claimant's constitutionality challenge to the statute, we concluded that the absence of a full evidentiary hearing did not render the statute constitutionally infirm. Id.

Subsequent to our decision, the court considered whether a claimant's testimony at hearing was admissible under ORS 656.283(7). Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996). The court found the statute "purports to bar from admission at hearing evidence not previously offered on reconsideration" without making any "provision concerning the review of evidence previously and properly admitted." Because the hearing occurred before the enactment of the amended version of the statute, the court further found that the "claimant's testimony was admissible when it was offered and considered by the ALJ and the Board" and, thus, it reviewed the claimant's testimony "as we review the other evidence in the record."

Unlike Plummer, in this case, the hearing first convened on September 13, 1995, after the June 7, 1995 date of enactment of amended ORS 656.283(7). Thus, this record was developed pursuant to the statute. On that basis, we find that the holding in Plummer does not govern. Rather, because ORS 656.283(7) applied at hearing and now on review, we follow the holding in Ray. Dean J. Evans, 48 Van Natta 1092 (1996). Consequently, we conclude that claimant's testimony is not admissible and do not consider it for purposes of deciding permanent disability.

Extent of Unscheduled Permanent Disability/Remand

Claimant has an accepted claim for cervical strain and low back strain. An October 1994 Notice of Closure, amended by a March 1995 Notice of Closure, awarded only temporary disability. The Order on Reconsideration affirmed. Relying on the medical arbiter's impairment findings, the ALJ found claimant entitled to 31 percent unscheduled permanent disability.

The employer contends that claimant has not shown that any impairment is due to the accepted conditions rather than a preexisting degenerative condition. Thus, the employer argues that claimant is not entitled to any permanent disability. The employer also moves to remand the case for consideration of ALJ Tenenbaum's March 29, 1996 order, which upheld the employer's denial of an occupational disease claim for cervical and lumbar degenerative disc disease. According to the employer, the ALJ in this case awarded claimant permanent disability for the degenerative condition.

Under the circumstances of this case, the only evidence we may consider in determining claimant's permanent disability is from medical arbiter Dr. Dinneen. In his report, Dr. Dinneen notes that claimant went through two employer-arranged examinations that found "degenerative type changes and no verifiable relationship to his reported incident of June 23, 1994." (Ex. 46-2). Dr. Dinneen also measured some lost range of motion in the lumbar and cervical spine, which is consistent with claimant's compensable low back and cervical injuries. Furthermore, even though he knew that other examiners had found a degenerative condition, Dr. Dinneen did not attribute the lost range-of-motion findings to a noncompensable cause. Consequently, we find Dr. Dinneen's report sufficient to show that claimant's impairment is related to her compensable injuries. Inasmuch as the parties do not object to the ALJ's calculation of claimant's permanent disability based on such findings, we adopt this portion of the ALJ's order.

We turn to the employer's motion to remand. After considering ALJ Tenenbaum's order, we deny the motion. Because we construe Dr. Dinneen's impairment findings as caused by claimant's compensable injury, rather than a degenerative condition, we find ALJ Tenenbaum's decision that claimant's degenerative condition is not compensable to have little relevance. Thus, because admission of ALJ Tenenbaum's order would not change the result, we find no compelling reason upon which to remand the case. See Compton v. Weyerhaeuser, 301 Or 641, 646 (1986).

Finally, we note claimant's argument that the employer is precluded by ORS 656.262(7)(b)[1] from contending that any impairment exhibited by claimant is due to a preexisting degenerative condition rather than the compensable injuries. Inasmuch as we have rejected the employer's argument on the merits, we do not address claimant's contention.

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[1] That statute provides:

"Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

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

ORDER

The ALJ's order dated December 22, 1995 is reversed in part and affirmed in part. That portion of the order admitting claimant's testimony at hearing is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
JACQUELINE S. COLBERT, Claimant
WCB Case No. 95-06761
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) declined to admit Exhibit 12 into the record; (2) upheld the SAIF Corporation's denial of claimant's mental disorder claim; and (3) declined to assess a penalty for SAIF's allegedly unreasonable denial. On review, the issues are evidence, compensability and penalties.

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

Claimant argues that Exhibit 12 should have been admitted into the record. Claimant asserts that Exhibit 12 was inadvertently misfiled in her attorney's office and, thus, was excluded from the original exhibits by clerical error. Claimant attempted to correct the error before the record closed.

An ALJ is 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 matter that will achieve substantial justice. ORS 656.283(7). The ALJ is given broad discretion on determinations concerning the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1991) (the ALJ's decision to admit or exclude evidence is limited only by the consideration that the hearing as a whole achieve substantial justice). We review the ALJ's evidentiary ruling for abuse of discretion. James D. Brusseau II, 43 Van Natta 541 (1991).

The ALJ declined to admit Exhibit 12 for several reasons: it had not been offered previously, the hearing was not continued for the receipt of Exhibit 12 and claimant had not shown that it could not have been obtained and offered prior to hearing. We find no abuse of discretion with the ALJ's ruling to exclude a report that reasonably could have been produced by the date of the hearing. See Ronald E. Harp, 46 Van Natta 1522 (1994). Furthermore, we note that, even if we considered Exhibit 12, it would not affect the outcome of this case.

ORDER

The ALJ's order dated February 2, 1996 is affirmed.

In the Matter of the Compensation of
KENNETH D. LEGORE, Claimant
WCB Case No. 94-14696
ORDER ON REVIEW (REMANDING)
Nancy F. A. Chapman, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Neal's order that upheld the self-insured employer's denial of his claim for a left rotator cuff disruption. Claimant also renews his objection to the ALJ's decision to admit Exhibits 44 and 45. In addition, claimant challenges the ALJ's interim orders that: (1) found that claimant's left rotator cuff disruption had not been accepted by the employer; and (2) declined to direct the employer to turn over to claimant surveillance videotapes. The employer cross-requests review of that portion of the ALJ's order that set aside its denial of claimant's headache condition. We remand.

FINDINGS OF FACT

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

Claimant, age 49 at the time of hearing, was working as a truck driver when, on November 27, 1993, he was involved in a motor vehicle accident on icy roads near The Dalles, Oregon. He sustained a bump on his head and bruises on his face, neck, and chest.

Claimant sought treatment upon his return home to Forest Grove, complaining of soreness and stiffness in his neck, head and left shoulder. He continued treating with his family physician, Dr. Gray, for a cervical, thoracic and left shoulder girdle strain, head contusions and TMJ dysfunction.

On March 1, 1994, the employer accepted claimant's condition as "Contusion - Head (Lt. Occipital Region), Strain - Cervical, Thoracic & Lt. Shoulder, Bruise - Rt. Hip, TMJ Dysfunction." On November 10, 1994, the employer issued a partial denial, denying that various other conditions, including a left rotator cuff disruption, were associated with his compensable injuries. On February 8, 1995, the employer issued another partial denial, contending that claimant's headache condition was not compensably related to the November 1993 accident. Claimant requested a hearing challenging the denials.

Following the hearing, claimant requested that the ALJ rule on the discoverability of certain evidence, including surveillance videotapes of claimant recorded in late 1994 and early 1995. On July 25, 1995, the ALJ issued an interim order finding the surveillance videotapes not discoverable under amended ORS 656.283(7).

CONCLUSIONS OF LAW AND OPINION

With regard to the discovery issue, the ALJ found that the surveillance videotapes were not subject to disclosure under amended ORS 656.283(7) because they constituted impeachment evidence other than medical or vocational reports.[1] Specifically, the ALJ determined that the videotapes were not

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[1] Amended ORS 656.283(7) provides, in pertinent part:

"Neither the board nor an Administrative Law Judge may prevent a party from withholding impeachment evidence until the opposing party's case in chief has been presented, at which time impeachment evidence may be used. Impeachment evidence consisting of medical or vocational reports not used during the course of a hearing must be provided to any opposing party at the conclusion of the presentation of evidence and before closing arguments are presented. Impeachment evidence other than medical or vocational reports that is not presented as evidence at hearing is not subject to disclosure."

This provision was enacted as part of SB 369, which took effect June 7, 1995, while the compensability dispute was pending before the ALJ.

intended to be used at the hearing and were instead intended to be used for purposes of impeachment at a future hearing, and were therefore not subject to disclosure in this proceeding.[2]

OAR 438-007-0015(5) sets forth 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. The only recognized exception to this "full disclosure" policy is the withholding of "impeachment evidence." We review the ALJ's discoverability ruling for abuse of discretion. See ORS 656.283(7) (the ALJ is not bound by formal rules of procedure and may conduct a hearing in any matter that will achieve substantial justice).

Citing SAIF v. Cruz, 120 Or App 65 (1993), claimant argues that, in order to rule on the discovery question, the ALJ must have viewed the video tapes in camera to determine whether they were relevant only for purposes of impeachment. We agree.

In Cruz, the court held that the Board has the responsibility to determine, "after an evaluation of the record and the withheld evidence," whether the party withholding evidence could reasonably have believed that the evidence was relevant only for purposes of impeachment. There, the issue being litigated was the compensability of claimant's back injury. The insurer had interviewed the claimant through an interpreter before the claimant retained an attorney. The insurer taped the interview and later transcribed a paraphrased version of it. The insurer then refused to turn over the paraphrased statement until after the hearing, contending the statement was relevant and material only for purposes of impeachment. The court held that the Board erred in relying on the insurer's representations as to its intentions for the use of claimant's statement and that it should have made an independent evaluation to determine whether the evidence was only relevant for impeachment purposes.

Although Cruz was decided prior to the enactment of SB 369, we find that it remains good law. Even when a party withholds "impeachment evidence"[3] under amended ORS 656.283(7), a fact finder should evaluate that withheld evidence to determine if it is relevant only for impeachment purposes. See Ronald E. Oachs, 47 Van Natta 1663, n 1 (1995).

In this case, we find the ALJ erred in declining to view the withheld surveillance video tapes in camera before ruling that they were "impeachment evidence" and therefore not discoverable. Because we are remanding the case to the ALJ with instructions to view the videotapes to determine whether they constitute "impeachment evidence" only or are relevant and material for other purposes,[4] we do not address the other issues raise on review.

Accordingly, we vacate the ALJ's order and remand the case to ALJ Neal for further proceedings consistent with this order. Those proceedings may be conducted in any matter the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[2] We also note that under former OAR 438-07-017(3) (in effect at the time of the February 24, 1995 and May 24, 1995 hearings in this case), a surveillance video tape of a party "may be withheld solely for impeachment purposes, unless the video tape or surveillance film has been reviewed by a medical or vocational expert."

[3] The term "impeachment evidence" is not defined in Chapter 656 or the administrative rules. In case law, however, to "impeach" a witness is "to attack or discredit the witness and to attack the jury's belief in his or her testimony." Simpson v. Sisters of Charity of Providence, 284 Or 547, 564 (1978). Therefore, impeachment evidence is evidence that tends to destroy a witness or claimant's credibility in the estimation of the trier of fact. State v. Johanesen, 319 Or 128, 130 n.2 (1994).

[4] Citing OAR 438-007-0015(5), the employer argues that the surveillance tapes are not discoverable in this proceeding because they are not relevant to the matter being litigated. Only after viewing the tapes in camera, however, can the ALJ determine whether they are, or are not, relevant to this proceeding or relevant only for purposes of impeachment at a future proceeding concerning this claim.

Chair Hall specially concurring.

I agree that a fact finder should evaluate withheld evidence before ruling on its discoverability. After all, evidence may be withheld only if it is for "impeachment" and unless that is established, then the evidence must be disclosed. See OAR 438-007-0015(5).

We should not lose sight of the legal (if not statutory) definition of "impeachment" (see footnote 3 of the Order on Review (Remanding), supra). Evidence that is otherwise discoverable does not become "impeachment" evidence simply by declaring it so. The very fact that a party argues that withheld evidence is not for the purpose of impeaching a witness at this time but may be used in an attempt to impeach the witness at a later date in another proceeding illustrates that the evidence is not now "impeachment" evidence and thus should be disclosed. To allow otherwise promotes gamesmanship, i.e., holding back on evidence to see if a person will eventually act in such a way that the withheld evidence will become impeaching. To prevent such gamesmanship and to promote full disclosure, I agree that the ALJ should review the evidence and determine if it is relevant only for purposes of impeachment.

July 22, 1996 Cite as 48 Van Natta 1579 (1996)

In the Matter of the Compensation of
ROBERT J. RUCH, Claimant
WCB Case No. 95-09484
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) denied its motion to continue the hearing for the presentation of rebuttal medical evidence; and (2) set aside its denial of claimant's injury claim for a left knee condition. On review, the issues are the ALJ's evidentiary ruling and compensability.

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

The hearing initially convened on November 13, 1995. At that time, claimant offered for admission Exhibit 11, a "check-the-box" report from claimant's treating internist, Dr. Harris. According to the document, Dr. Harris completed the report on November 13, 1995.

The employer asked the ALJ for a continuance in order to obtain rebuttal medical evidence. The ALJ ruled that the employer was limited to a continuance only for the purpose of cross-examining Dr. Harris. On December 19, 1995, the employer deposed Dr. Harris. The resulting transcript was admitted and the record then closed.

On review, the employer moves for remand for the opportunity to obtain evidence rebutting Dr. Harris' report. According to the employer, its case is prejudiced by the denial of such an opportunity because only Dr. Harris was able to review, and base an opinion on, a September 27, 1995 MRI. It asserts that it should have the same opportunity to provide medical opinions based on the MRI.

The ALJ may continue a hearing for further proceedings, in part, "upon a showing of due diligence if necessary to afford reasonable opportunity to cross-examine on documentary medical or vocational evidence" or "upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence or for any party to respond to an issue raised for the first time at a hearing." OAR 438-006-0091(2), (3).

We first note that, because the employer focuses on its inability to obtain medical evidence that considered the September 27, 1995 MRI results, it bases its assertion of prejudice on the late submission of the MRI report. At hearing, however, it did not object or request a continuance with regard to this report. Consequently, we decline to address any argument on review concerning the MRI report and whether the employer should have an opportunity to obtain additional evidence in response to the report. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

We further find no abuse of discretion with the ALJ's ruling limiting the continuance to allowing the employer an opportunity to cross-examine Dr. Harris since the rule expressly allows for a

continuance for cross-examination of documentary medical evidence. The rule does provide a continuance for "the party bearing the burden of proof to obtain and present final rebuttal evidence[.]" This provision, however, does not apply to the employer since it does not have the burden of proof in this case. Consequently, we find no support for the employer's position that the ALJ abused his discretion in limiting the continuance to obtaining only Dr. Harris' deposition.

The employer also challenges the ALJ's finding that claimant sustained a work related injury in April 1995. According to the employer, the record contains too many inconsistencies concerning the injurious incident for claimant to have proven the event.

On April 11, 1995, claimant sought treatment from Dr. Battalia, complaining of progressive left knee pain following "multiple episodes of twisting left knee while in and around his desk work place this week." (Ex. 4-1). The Form 801, also dated April 11, 1995, indicates a left knee strain while "moving bio hazard boxes" on April 6, 1995. (Ex. 1).

On May 5, 1995, claimant provided a recorded telephonic statement describing "several incidents at work, which have occurred over a period of time, with the most severe incident occurring on April 6, 1995." According to the statement, claimant "was moving bio-hazard boxes to a loading dock" and, "while turning, he strained his left knee." (Ex. 12-1).

On May 11, 1995, claimant saw Dr. Jones, who reported "several episodes when [claimant] has been turning and his knee has been hurting but there is no specific injury." (Ex. 8-1). Finally, on September 15, 1995, claimant saw Dr. Harris, who indicated that, in April 1995, claimant "twisted his left knee while moving materials at work." (Ex. 10).

At hearing, Brian Gorsek, a coworker, testified that, while he and claimant were moving large biohazard containers, claimant twisted his leg and exhibited pain behavior. (Tr. 10). Mr. Gorsek agreed with counsel's statement that this incident occurred "around" April 7, 1995. (Id. at 11). Claimant testified that, on April 6 and 7, he was moving biohazard containers when, on both days, his knee "wrenched" and he felt pain. (Id. at 18-19, 27).

Claimant's reporting of his injury to the physicians was consistent with his testimony at hearing. Except for telling Dr. Battalia that he felt pain while moving around his desk, claimant uniformly indicated that he twisted his knee while moving the biohazard containers. Mr. Gorsek also provided corroborating testimony. Thus, the ALJ properly found claimant credible and, based on claimant's testimony and the history in the medical records, we disagree with the employer's assertion that claimant failed to prove the occurrence of the injury.

For the reasons stated by the ALJ, we agree that Dr. Harris provided the most persuasive opinion. We further note that Dr. Harris persuasively explained why, even if claimant was not completely asymptomatic following the 1993 surgery, the work injury was the major contributing cause of his current left knee condition. (Ex. 14-21, 14-22, 14-29).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 22, 1996 is affirmed. For services on review, claimant's attorney is awarded an assess fee of $1,750, to be paid by the self-insured employer.

In the Matter of the Compensation of
RANDAL R. BLANKENBAKER, Claimant
WCB Case No. 95-09398
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial of claimant's low back injury/occupational disease claim, reasoning that the claim should be analyzed as an occupational disease claim because claimant's condition developed gradually and not as a result of a discrete "event." See Mathel v. Josephine Co., 319 Or 235 (1994). Finding the medical opinions of the examining physicians (Drs. Tesar, Wilson) and a physician who reviewed the medical records (Dr. Dickerman) more persuasive than that of the attending physicians (Drs. Rosenbaum and Mathews), the ALJ held that claimant had failed to sustain his burden of proving that his work activities were the major contributing cause of his L5-S1 herniated disc condition.

On review, claimant contends that the ALJ mistakenly analyzed the claim as an occupational disease claim and should have instead applied the material contributing cause standard for an accidental injury claim without a preexisting condition. See ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991). Moreover, claimant asserts that, regardless of whether a major or material causation standard is applied, his low back condition is compensable because the medical opinion of Dr. Rosenbaum satisfies his burden of proof under either legal standard. We agree.

Claimant, a utility worker, began working for a municipality in 1990. He began doing heavier work in 1994, such as jackhammering and manual shoveling. On June 5, 1995, claimant noticed the gradual onset of low back and leg pain while operating a jackhammer, digging holes and replacing water pipes. There was no specific incident of injury.

On June 6, 1995, claimant consulted Dr. Mathews to whom he reported his belief that his injury was an "accumulative injury" due to the type of work he performed. (Ex. 14). Dr. Mathews diagnosed a lumbar strain with radiculopathy, a condition that did not respond to conservative treatment. This prompted a referral to a neurosurgeon, Dr. Rosenbaum, who assumed the role of attending physician. Dr. Rosenbaum diagnosed a herniated disc at L4-5 and later performed a discectomy at that level on September 7, 1995, after SAIF had issued a denial of claimant's low back condition on August 10, 1995.

Although Drs. Tesar, Wilson and Dickerman attributed claimant's low back condition to degenerative disc disease (Exs. 19, 23-9, 23-10, 24), Dr. Rosenbaum opined that claimant did not have a "significant" preexisting condition and that his degenerative disc disease was consistent with someone of claimant's age. (Ex. 20A-2). On August 28, 1995, Dr. Rosenbaum opined that degenerative disc disease was not the etiology of claimant's lumbar disc herniation and that the herniation was a "separate pathological event." (Ex. 22-1).

In the same report, Dr. Rosenbaum acknowledged that it was "extremely difficult" to determine whether a disc protrusion is related to a work activity. (Ex. 22-2). Dr. Rosenbaum reiterated, however, that in an individual with a lumbar disc herniation, with no preexisting symptomatology and without functional overlay, the spontaneous onset of symptoms during the work day would be "presumed" to be secondary to work activity. Id.

When there is a dispute between medical experts, we rely on those medical opinions which are both well reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). In addition, we normally defer to the treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find no persuasive reasons not to rely on Dr. Rosenbaum's opinion.

Dr. Rosenbaum's opinion was based on a complete and accurate history of the circumstances surrounding the onset of claimant's symptomatology on June 5, 1995. Moreover, Dr. Rosenbaum's opinion is well-reasoned and thoroughly explained. Finally, Dr. Rosenbaum's opinion is persuasive because he performed claimant's surgery and was in the best position to determine the extent of claimant's degenerative disc disease. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Accordingly, based on Dr. Rosenbaum's cogent medical opinion, we find that claimant has sustained his burden of proving that his low back disc herniation is compensable.[1]

We find additional support for our conclusion in Dr. Mathews' opinion. Dr. Mathews reported that the kind of work claimant performed generated a "significant amount of torque" on the spine, "predisposing a person to having structural breakdowns in the vertebral column." (Ex. 23A-1). Dr. Mathews concluded that "to the best of my knowledge, [claimant's] work activities were the sole cause of his disability." (Id., emphasis added). Because it is based on an accurate understanding of claimant's work activity and is well-reasoned, we find that Dr. Mathews' medical opinion is also convincing evidence that claimant's L5-S1 disc herniation is compensable.[2] Somers v. SAIF, supra.

The remaining medical opinions from Drs. Tesar, Wilson and Dickerman relate claimant's back condition to degenerative disc disease. However, Drs. Tesar and Wilson provide little explanation for their conclusion that degenerative disc disease is the major contributing cause of claimant's condition and need for treatment. (Ex. 19-8). Moreover, we find Dr. Rosenbaum's opinion regarding the extent of claimant's degenerative disc disease more persuasive since he performed the surgery at L5-S1 and could actually observe claimant's lumbar spine. Argonaut v. Mageske, supra. Inasmuch as Drs. Tesar, Wilson and Dickerman base their opinions on the belief that claimant has significant degenerative disc disease, and because (based on Dr. Rosenbaum's persuasive opinion) we have concluded otherwise, the medical opinions of the examining and reviewing physicians are not persuasive.

In conclusion, we find that the medical evidence establishes that claimant's work activities were either a material or the major contributing cause of his L5-S1 disc condition. Because claimant's low back condition is compensable, we reverse the ALJ's decision upholding SAIF's denial.

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[1] We agree that this claim should be analyzed as an injury claim. In determining the appropriate standard for analyzing compensability, we focus on whether claimant's herniated disc condition was an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. Mathel v. Josephine County, supra; James v. SAIF, 290 Or 343 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261 (1983), rev den 296 Or 350 (1984); Valtinson v. SAIF, supra. Although there was no specific incident of injury, claimant's low back disc herniation occurred while performing work activity during a short, discrete period of time on June 5, 1995. Moreover, Dr. Rosenbaum opined that claimant's disc herniation occurred as a result of a separate pathological "event." In addition, claimant knew precisely when the symptoms of his low back disc herniation began: June 5, 1995 while performing his work activities. See Joseph R. Huff, 47 Van Natta 731 (1996) (left shoulder condition that developed suddenly and unexpectedly on specific date was properly characterized as accidental injury). Thus, we conclude that the claim should be categorized as one for an accidental injury. In addition, Dr. Rosenbaum concluded that claimant's preexisting degenerative disc disease was not significant. Therefore, in the absence of persuasive evidence of a "combined condition," we do not apply the major contributing cause standard of ORS 656.005(7)(a)(B). See Leon M. Haley, 47 Van Natta 2056, 2057, on recon 47 Van Natta 2206, 2207 (1995). Instead, the material causation standard for an accidental injury applies. Mark N. Weidle, supra. Dr. Rosenbaum's opinion easily satisfies that legal standard. Alternatively, even assuming that the major contributing cause standard were applicable, we would find that Dr. Rosenbaum's opinion satisfies that standard as well.

[2] In a "check-the-box" report to claimant's counsel, Dr. Jansen, a chiropractor who had treated claimant for low back complaints prior to June 1995, agreed with Dr. Rosenbaum's analysis and confirmed that claimant had not displayed any symptoms of a herniated disc during his treatment prior to June 1995. (Ex. 27). However, we give little weight to Dr. Jansen's unexplained opinion. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical opinion).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $4,800, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs, and counsel's statement of services), the complexity of the issues, the value of the interest involved, and the risk that counsel might have gone uncompensated.

ORDER

The ALJ's order dated February 20, 1996 is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,800, to be paid by SAIF.

In the Matter of the Compensation of
ROSALIE A. HYLAND, Claimant
WCB Case Nos. 94-04429 & 94-04308
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Hyland v. Kaiser Health, 139 Or App 398 (1996). The court has reversed our prior order which affirmed an Administrative Law Judge's (ALJ's) order that affirmed Orders on Reconsideration awarding claimant 3 percent (9.6 degrees) unscheduled permanent disability for a low back condition and 3 percent (9.6 degrees) unscheduled permanent disability for a neck condition. Citing Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996), the court has remanded for reconsideration.[1]

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," and summarize the pertinent facts as follows:

Claimant compensably injured her low back in 1991 and her neck and upper back in 1992. She was released to return to her regular work on January 6, 1993. A January 11, 1994 Notice of Closure awarded claimant 3 percent unscheduled permanent disability arising out of her 1991 low back injury. Another Notice of Closure issued January 11, 1994 and awarded claimant 3 percent unscheduled permanent disability arising out of her 1992 neck injury. In both cases, claimant was given an adaptability value of zero because she returned to her regular job without restrictions.

An April 5, 1994 Order on Reconsideration affirmed the January 11, 1994 Notice of Closure concerning the neck injury and an April 6, 1994 Order on Reconsideration affirmed the other January 11, 1994 Notice of Closure concerning the low back injury.

CONCLUSIONS OF LAW AND OPINION

Relying on the Board's decision in Therese L. Petkovich, 46 Van Natta 1038 (1994), the ALJ determined that an adaptability value of zero was a valid modification of the factors of age, education and adaptability under the standards. See former OAR 436-35-280(1) (giving the neutral value of zero when the worker's wage earning capacity is not affected). The ALJ therefore affirmed the two Orders on Reconsideration awarding unscheduled permanent disability based solely on impairment. We subsequently affirmed the ALJ's order on review, and claimant petitioned for judicial review.

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[1] On May 8, 1996, the Board permitted the parties the opportunity to file supplemental briefs following issuance of the court's remand order. The parties have submitted such briefs, which address the impact of Carroll, supra, as well as the extent of claimant's unscheduled permanent disability awards under the applicable standards.

In reversing our prior order, the court cited Carroll v. Boise Cascade Corp., supra. In Carroll, the court relied on England v. Thunderbird, 315 Or 633 (1993), which held that former administrative rules that gave no value for age, education, or adaptability for workers who have returned to their usual and customary work, were inconsistent with former ORS 656.214. That statute provided that "[e]arning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job." The court in Carroll also held that OAR 436-35-310(2), which gave a zero adaptability value when a worker had returned to work, conflicted with ORS 656.214(5) and 656.726(3)(f)(A), and was, therefore, invalid. Carroll v. Boise Cascade Corporation, supra.

We have previously applied the Carroll decision to former OAR 436-35-280(1) (WCD Admin. Order No. 93-056). Joe R. Ray, 48 Van Natta 325 (1996). In Ray, because the claimant's residual functional capacity (RFC) was equal to his base functional capacity (BFC), his adaptability factor under the former OAR 436-35-280(1)(a) was zero. Moreover, because that factor was used as a multiplier, former OAR 436-35-280(6), the claimant was not allowed a value for age, education, or skills. In light of Carroll, however, we concluded that former OAR 436-35-280(1) was inconsistent with ORS 656.726(3)(f)(A). We therefore declined to apply the rule. Rather, we found that the value for the age, education and skills factor should be added to the impairment value to determine the amount of the unscheduled permanent disability award. That analysis essentially resulted in assigning a value of 1 to the adaptability factor.

This case is governed by the same rules as those that were at issue in Joe R. Ray. Here, as in Ray, claimant's BFC and RFC are equal because she was released to regular work by her treating physician. Consequently, under former OAR 436-35-280(1), claimant's adaptability value is zero. Because that analysis is inconsistent with Carroll and Joe R. Ray, we must reevaluate the extent of claimant's unscheduled permanent disability awards. As we did in Joe R. Ray, supra, we assign a value of 1 to claimant's adaptability factor, so that we can add the values for claimant's age, education and skills to her impairment value to determine the amount of her awards. See also Donna J. England, 45 Van Natta 1480 (1993); Carroll v. Boise Cascade Corporation, supra.

Assembling the factors with regard to claimant's 1991 low back injury, the total value for claimant's age (1), and education and skills (2) is multiplied by the adaptability factor of 1, for a total of 3. This value is added to the impairment factor of 3, for a total award of 6 percent unscheduled permanent disability.

In assembling the same factors with regard to claimant's 1992 neck injury,[2] we are mindful of former OAR 436-35-007(3)(b), which provides, in pertinent part:

> "A worker is not entitled to be doubly compensated for permanent loss of earning capacity in an unscheduled body part which would have resulted from the current injury but which had already been produced by an earlier injury and had been compensated by a prior award. Only that portion of such lost earning capacity which was not present prior to the current injury shall be awarded."[3]

Under this rule, we must consider the 6 percent unscheduled permanent disability award for claimant's 1991 low back injury in arriving at the appropriate unscheduled permanent disability award for her 1992 neck injury.[4] See ORS 656.214(5); see also Mary A. Vogelaar, 42 Van Natta 2846 (1992); Kerri A. Houghton, 47 Van Natta 11 (1995). This determination is not a mathematically precise process. Rather, we consider to what extent a prior loss of earning capacity resulted from the same permanent limitations

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[2] The total value for claimant's age, education and skills (3) is multiplied by the adaptability factor (1) for a total of 3, which is added to the impairment factor of 3 for the injury to claimant's neck, for a total of 6 percent unscheduled permanent disability.

[3] This rule also sets forth the factors to be considered when determining the extent of the current disability award, including "[t]he extent to which the current loss of earning capacity includes impairment and social-vocational factors which existed before the current injury." Former OAR 436-35-007(3)(b)(D).

[4] Even though both claims were closed on the same date (January 11, 1994), we consider claimant's 1992 neck injury to be the "current injury" and her 1991 back injury to be the "earlier injury" in applying former OAR 436-35-007(3)(b) because the back injury occurred prior to the neck injury.

and vocational factors as are relied upon in the current evaluation of permanent disability. Haughton, supra.

In other words, in this case, we must decide whether the 6 percent unscheduled permanent disability award claimant would otherwise receive for her 1992 neck injury reflects any disability for which she has already been compensated in connection with her 1991 low back injury. If so, the 1992 neck injury award must be reduced by an amount that represents the previously compensated loss of earning capacity.[5] See id.; Mary A. Vogelaar, supra.

After considering the record, we conclude that 3 percent of the award for claimant's neck condition (the impairment value) represents permanent disability that was not present prior to the 1992 neck injury. The other 3 percent (representing the social, vocational and adaptability factors) reflects a loss of earning capacity for which claimant has already been awarded benefits in connection with her 1991 low back injury.

Accordingly, on reconsideration, the ALJ's order dated July 15, 1994 is modified. In addition to the 3 percent unscheduled permanent disability for a low back condition awarded by the April 6, 1994 Order on Reconsideration, claimant is granted 3 percent (9.6 degrees) unscheduled permanent disability for a total award of 6 percent (19.2 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's counsel. That part of the ALJ's order which affirmed the April 5, 1994 Order on Reconsideration awarding claimant 3 percent unscheduled permanent disability for a neck condition, is affirmed.

IT IS SO ORDERED.

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[5] Citing Sara J. Smith, 46 Van Natta 895 (1994), claimant argues that she is entitled to an adaptability rating of 1 for both conditions. Smith is distinguishable, primarily because, under the specific facts of that case, the separate rating of claimant's age, education and adaptability factors arising from her separate low back and cervical injuries did not result in any windfall or "double compensation" to the claimant. In other words, the award for one claim did not represent all or any portion of loss of earning capacity previously awarded for the other claim. We therefore did not apply OAR 436-35-007(3)(b) or address such cases as Mary A. Vogelaar, supra.

July 25, 1996 Cite as 48 Van Natta 1585 (1996)

In the Matter of the Compensation of
ALAN T. SPAETH, Claimant
WCB Case Nos. 95-10954 & 95-08437
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Roberts, et al, Defense Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Geisy Greer & Gunn (Geisy) requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its denial of claimant's "new injury" claim for a bilateral upper extremity condition; (2) upheld Cigna Insurance's (Cigna's) denial of claimant's aggravation/occupational disease claims for the same condition; and (3) awarded a carrier-paid attorney fee, payable by Geisy. In its respondent's brief, Cigna contests the ALJ's determination that claimant's upper extremity condition is compensable. On review, the issues are compensability, responsibility and attorney fees.

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

Compensability

The ALJ found that claimant's bilateral upper extremity condition was compensable, reasoning that the medical opinion of claimant's current attending physician, Dr. Long, was more persuasive than that of an examining physician, Dr. Nolan. Dr. Long diagnosed claimant's condition as a myofascial muscular condition, of which claimant's work activities were the major contributing cause. (Exs. 20-4, 26). On the other hand, Dr. Nolan diagnosed Reynaud's phenomenon secondary to Reynaud's disease,

which he concluded was "idiopathic." (Ex. 24-3). Dr. Nolan opined that claimant's employment was not the major contributing cause of this vascular condition. Id.

On review, Cigna contends that the ALJ should have found Dr. Nolan's opinion more persuasive and determined that claimant's upper extremity condition was not compensable. We disagree.

For the reasons cited by the ALJ, we agree that Dr. Long's opinion is more persuasive than Dr. Nolan's. Moreover, we generally rely on medical opinions with the most accurate and complete history. See Somers v. SAIF, 77 Or App 259 (1986). In this case, we find that Dr. Nolan's history concerning the onset and course of claimant's symptoms to be cursory in comparison to Dr. Long's extensive history recorded in his initial consultation with claimant on May 30, 1995. (Compare Ex. 14-1 with Ex. 24-1).

In particular, we note Dr. Nolan's comment that claimant's symptoms first arose in early 1989 during a "particularly stressful" period. (Ex. 24-1). However, it is not clear from Dr. Nolan's report what is meant by the word "stressful," i.e., whether the reference is to emotional or physical stress. In contrast, Dr. Long's history makes it clear that claimant's symptoms arose in conjunction with claimant's physical work activities. Because Dr. Long's report contains the more detailed account of the history of claimant's condition, and, moreover, because it is consistent with claimant's credible testimony, we give more weight to Dr. Long's conclusions. Somers v. SAIF, supra. Accordingly, we agree with the ALJ that claimant's bilateral upper extremity condition is compensable.

Responsibility

Claimant, then a bookkeeper, performed considerable data entry when he first developed bilateral pain in his hands (left greater than right) in the spring of 1989, while Cigna insured the employer. Claimant filed a claim for the left arm and wrist only. Cigna accepted the claim as "nondisabling." Claimant sought treatment on one occasion from Dr. Button who diagnosed an overuse syndrome. (Ex. 3).

In October 1989, the employer's workers' compensation coverage changed to Geisy. In December 1989, claimant consulted Dr. Zeller, who had nerve conduction studies performed which were negative. Claimant's symptoms subsided when his computer work decreased. From 1990 through 1994, claimant sought no additional treatment, but did not become completely asymptomatic.

In late 1994 and early 1995, claimant's symptoms worsened, prompting claimant to return to Dr. Zeller in April 1995. (Ex. 9). Claimant was referred to Dr. Long after he became frustrated with the lack of progress in resolving his problems. Geisy denied responsibility for the claim in July 1995. (Ex. 19). Cigna denied compensability on September 20, 1995 after Dr. Nolan's September 19, 1995 examination. (Ex. 23).

The ALJ found that claimant's current bilateral upper extremity condition was the "same condition" that claimant suffered from in 1989. See ORS 656.308(1). Applying ORS 656.802, the ALJ then determined that, to shift responsibility from Cigna to Geisy, claimant had to prove a new occupational disease claim against Geisy. The ALJ reasoned that, to do so, claimant's work activities in 1994 and 1995 must have been the major contributing cause of claimant's current combined condition and the major contributing cause of a worsening of the condition that existed in 1989. See ORS 656.802(2)(b). Deferring to the opinion of Dr. Long as claimant's current attending physician, the ALJ determined that claimant's most recent work activities were the major contributing cause of claimant's current combined condition. Accordingly, the ALJ found Geisy responsible for claimant's current bilateral myofascial condition.

On review, Geisy first asserts that Cigna's 1989 acceptance encompassed claimant's bilateral upper extremity condition, as opposed to merely the left hand/wrist. Thus, Geisy contends that Cigna has the burden of shifting responsibility for both the left and right upper extremities to Geisy. Alternatively, Geisy argues that, even if Cigna did not accept the right arm condition, claimant's first treatment for the right upper extremity condition was in 1989, while Cigna was on the risk. Therefore, citing the last injurious exposure rule (LIER), Geisy reasons that Cigna would also be initially responsible for claimant's bilateral upper extremity condition, even if it had not accepted claimant's right upper extremity condition in 1989. See Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994). Geisy then argues that Cigna did not sustain its burden of proving either a new occupational disease claim or that claimant's work activities while it was on the risk actually contributed to a worsening of claimant's bilateral overuse condition.

Regardless of what theory is used to analyze this case, we agree with the ALJ that Geisy is responsible for claimant's current bilateral upper extremity condition. In other words, even if Cigna's acceptance encompassed claimant's right arm as well as his left, we would conclude that claimant sustained a new occupational disease during Geisy's coverage, since we agree with the ALJ's reasoning that claimant's work activities were the major contributing cause of a worsening of claimant's overuse/myofascial syndrome. Alternatively, if responsibility is determined under LIER, and further assuming that claimant's first medical treatment was in 1989, see Timm V. Maley, supra, we would conclude that claimant's work for Geisy independently contributed to a worsening of his condition.

In reaching these conclusions, we agree for the reasons cited by the ALJ that Dr. Long's opinion is the most persuasive. Geisy argues, however, that the medical opinions of the examining physicians (Drs. Martens and Brown) and Dr. Zeller are more persuasive. We disagree with Geisy's contention.

Drs. Martens and Brown concluded that claimant's 1989 injury was the major contributing cause of claimant's overuse syndrome. (Ex. 16). However, we do not find this report persuasive because it contains no explanation of their conclusion. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical opinion). We acknowledge that Dr. Zeller concurred with the opinion of Drs. Brown and Martens. (Ex. 21). While we would ordinarily give considerable weight to the opinion of a physician who treated claimant for both the 1989 claim and the subsequent worsening in 1994 and 1995, see Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986), we decline to do so in this case. Because Dr. Zeller's concurrence with the report of Drs. Martens and Brown was expressed in an unexplained "check-the-box" letter, the persuasiveness of that concurrence is reduced. Blakely v. SAIF, 89 Or App 653, rev den 305 Or 672 (1988).

Based on our de novo review of the medical evidence, we agree with the ALJ's determination that Geisy is responsible for claimant's bilateral upper extremity condition.

Attorney fees

The ALJ assessed a $2,750 fee against Geisy for denying the compensability of claimant's claim. The ALJ reasoned that, although its denial was couched in terms of responsibility, Geisy's counsel took the position at hearing that claimant suffered from Reynaud's phenomenon and that, therefore, his condition was not compensable.

On review, Geisy asserts that the ALJ's attorney fee award should be reversed because it never denied compensability. In particular, it contends that, since its denial was of responsibility only, it could not contest compensability without the express agreement of the parties. Geisy further argues that, because the parties restricted the scope of its denial to responsibility only, any comments by its counsel regarding Dr. Nolan's report constituted creation of a "road map" for the ALJ and should not be construed as an amendment of the express language of its denial. See Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993) (employers are bound by the express language of their denials). For the following reasons, we disagree with Geisy's position.

As noted by Geisy, the ALJ stated that Geisy only denied responsibility during the discussion of issues at the beginning of the hearing. (Tr.1). The parties agreed with that statement. (Tr. 2). However, Geisy's counsel later commented that "this is not a walk-through on the compensability issue by--by any means." (Tr. 6). Counsel subsequently stated: "So if you get to responsibility, our position is that it's a Cigna case; however, Dr. Nolan's conclusions, evaluation--evaluation is very thorough and compelling on compensability." (Tr. 7).

Based on the discussion of the issues and counsel's opening statement, we conclude that Geisy amended its responsibility denial to include compensability. While we are sympathetic to Geisy's contention that we should not discourage free and open discussion of the issues during a hearing, we nonetheless conclude that Geisy's counsel's comments on Dr. Nolan's medical report crossed the line from "fair comment" on the issues to oral amendment of Geisy's denial to include a compensability defense.

Inasmuch as the parties did not object to Geisy's amendment of its denial, there was at least an implicit agreement by the parties to try a compensability issue that fell outside the express terms of Geisy's denial. See Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for

the ALJ and Board not to decide that issue); Michael A. Beall, 48 Van Natta 487, 487 (1996) (where the parties tried the issue of whether the claimant's injury occurred in the course of his employment by implicit agreement, i.e., without objection, the issue was properly before the ALJ).[1]

Therefore, we conclude that the ALJ correctly assessed a carrier-paid attorney fee pursuant to ORS 656.386(1) against the responsible carrier, Geisy. However, Geisy does not contest compensability on review, while Cigna does so. Because claimant's compensation remained at risk due to Cigna's continued compensability defense, claimant's counsel is entitled to an assessed fee under ORS 656.382(2) for services rendered on review, payable by Cigna. See International Paper Co. v. Riggs, 114 Or App 203 (1992); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, payable by Cigna. 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 counsel is not entitled to an assessed fee for time devoted to the attorney 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 January 12, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, payable by Cigna.

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[1] Geisy cites Larry R. Burnside, 47 Van Natta 2040, 2041 (1995), in support of its argument that the scope of its denial was restricted to responsibility only. However, unlike the facts of Burnside, where the carrier's denial and its counsel's comments at hearing expressly ruled out a causation issue, Geisy's counsel in this case raised a compensability issue during its opening statement. Given the lack of objection to Geisy's attempt to raise a compensability defense, we find that there was at least an implied agreement to try a compensability issue with respect to Geisy. Michael A. Beall, supra.

In the Matter of the Compensation of
JOANN E. THOMAS-TRACY, Claimant
WCB Case Nos. 95-12117, 95-11839, 95-12116 & 95-11838
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The self-insured employer, Rogue Valley Transportation, requests review of Administrative Law Judge (ALJ) Livesley's order[1] that: (1) set aside its disclaimer of responsibility for claimant's left arm condition; and (2) upheld the SAIF Corporation's disclaimer of responsibility for the same condition, issued on behalf of the employer. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We add that, on October 24, 1995, the Department issued an order designating SAIF as the paying agent under ORS 656.307.

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[1] The ALJ referred to his order as an "Arbitrator's Order" and to himself as "Administrative Law Judge/Arbitrator." Under former law, when an order issued under ORS 656.307(1), the ALJ acted as an arbitrator in resolving the responsibility dispute. Former ORS 656.307(2). Under present law, a proceeding to determine the responsible paying party is conducted in the same manner as any other hearing. ORS 656.307(2). Because this case is decided under the present version of the statute (the hearing convened on January 30, 1996), the ALJ conducted the hearing as an Administrative Law Judge.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked as a bus driver for the employer since 1977. The employer was self-insured until July 7, 1994, when SAIF began providing coverage. On February 12, 1992, the employer accepted "overuse syndrome of shoulder-left wrist" and "overuse syndrome of low back-hip." (Ex. 10). A March 2, 1992 Notice of Closure closed the claim. On August 10, 1995, claimant filed a claim for left carpal tunnel syndrome (CTS). Both the employer, in its self-insured status, and SAIF disclaimed responsibility.

The ALJ found the employer responsible under either ORS 656.308 or the last injurious exposure rule based on the ALJ's finding that claimant's condition had not pathologically worsened. The employer challenges this conclusion, asserting that ORS 656.308 is not applicable and SAIF should be found responsible for claimant's left CTS.

ORS 656.308(1) provides, in relevant part:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

In order to determine if the statute applies, we first consider whether claimant's accepted overuse of the shoulder and left wrist is the "same condition" as the left CTS. After examining the record, we find no medical evidence directly addressing this issue. As the ALJ noted, Dr. Korpa, osteopath, who treated claimant in 1991, referred to both overuse and CTS. (Exs. 8-1, 8-2). In December 1995, however, Dr. Korpa indicated that the left CTS developed after his treatment ended in early 1992, thus indicating that he had treated only an overuse syndrome and not a left CTS. (Ex. 35-2). In January 1992, examining physician Dr. Smith, orthopedic surgeon, diagnosed overuse syndrome of the left wrist and left CTS, thus indicating that the conditions were separate and not synonymous. Based on such evidence, we conclude that the left wrist overuse syndrome was not the same condition as left CTS. Thus, inasmuch as left CTS has not previously been accepted, responsibility properly is analyzed under the last injurious exposure rule rather than ORS 656.308(1). SAIF v. Yokum, 132 Or App 18 (1994).

Under the last injurious exposure rule, when a worker proves that an occupational disease was caused by work conditions that existed when one or more carrier's were on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade v. Starbuck, 296 Or 238, 244 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for 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 184, 188 (1994).

Here, as explained above, claimant was at least diagnosed with left CTS by Dr. Smith in January 1992. Following claim closure in March 1992, claimant did not again seek treatment for her left arm and hand until January 1995, when Dr. Walters became her treating physician. Nerve conduction studies confirmed the diagnosis of left CTS.

Examining neurologist Dr. Dickerman found that the medical records "clearly suggest that [claimant] has had intermittent symptomatology since at least 1990 which can be construed as carpal tunnel symptomatology." (Ex. 23-9). Dr. Dickerman also indicated that claimant's bus driving was the major contributing cause of the condition. (Id. at 10). Dr. Walters concurred with the report. (Ex. 29). Dr. Walters also concurred with a report written by the employer's attorney stating that claimant's CTS "is primarily related to then current work activities." (Ex. 36-1).

As discussed above, Dr. Korpa indicated that any CTS would be caused by work activities subsequent to his treatment. (Ex. 35).

We conclude that, whether the onset of disability from the CTS was in 1990 or 1991, as asserted by Dr. Dickerman and Dr. Walters, or after January 1995, as indicated by Dr. Korpa, SAIF is responsible for the claim. That is, even if initial responsibility is assigned to the employer because claimant first received treatment or experienced time loss during its period of liability, we find that the medical evidence shows that claimant's subsequent employment during SAIF's coverage independently contributed to the cause or worsening of the left CTS. In particular, we rely on Dr. Walters' opinion that claimant's condition was due primarily to her "then current work activities," which we construe as indicating that claimant's work as of the time of Dr. Walters' treatment beginning in January 1995 was the major cause of claimant's left CTS.

Thus, having found that claimant's work activities when SAIF was on the risk beginning on July 1, 1994 independently contributed to the cause or worsening of claimant's left CTS, we conclude that SAIF is responsible. Timm v. Maley, supra.

ORDER

The ALJ's order dated February 23, 1996 is reversed. The self-insured employer's disclaimer of responsibility for claimant's left carpal tunnel syndrome is reinstated and upheld. The SAIF's Corporation's disclaimer of responsibility for the same condition is set aside and the claim is remanded to SAIF for processing according to law. The ALJ's attorney fee award is payable by SAIF, rather than the self-insured employer.

In the Matter of the Compensation of
DOUGLAS L. TUGG, Claimant
WCB Case Nos. 95-12343 & 95-02521
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's occupational disease claim for a left middle finger triggering condition. The insurer contends that the claim is precluded by its September 14, 1994 partial denial. On review, the issue is res judicata and, if the claim is not precluded, compensability. We reverse in part and modify in part.

FINDINGS OF FACT

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

Claimant's current left middle finger condition is the same as the left middle finger condition which the insurer denied on September 14, 1994.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's current injury claim for a left middle finger triggering condition is precluded by the insurer's September 14, 1994 partial denial of a claim for the same condition. However, the ALJ also found that claimant's current occupational disease claim for the same condition is compensable.

The insurer argues that claimant's current claim for a left middle finger triggering condition is precluded by the unappealed 1994 partial denial of the same condition. In response, claimant acknowledges that he must establish a "work-related" worsening of his condition subsequent to the unappealed denial. After conducting our review, we are not persuaded that claimant has satisfied this requisite burden of proof.

Claimant bears the burden of proving that his work activities were the major contributing cause of his left middle finger triggering condition. ORS 656.802. A finding of major causation requires that work-related causes contribute more to the claimed condition than all other causes, explanations, or

exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-10 (1983).

Here, because claimant did not appeal the September 14, 1994 partial denial of his left middle finger triggering condition, the condition was not compensable as of the date of the denial. See Popoff v. J.J. Newberrys, 117 Or App 242 (1992). Consequently, claimant can only prevail with his current occupational disease claim if he establishes a pathological worsening of his condition since the denial and that such worsening was caused in major part by work activities since the denial. See Rex. D. Haller, 47 Van Natta 1603 (1995); Mary L. Miller, 46 Van Natta 369 (1994).

The medical evidence relates claimant's current left trigger finger condition to idiopathic factors or to his work exposure as a whole. (Ex. 50, 52, 58, 64, 65). Because there is no evidence relating the condition to claimant's work since the unappealed denial, we conclude that the current claim is precluded.

The ALJ awarded an attorney fee for claimant's attorney's services regarding the bilateral carpal tunnel syndrome and bilateral middle finger trigger conditions. Because claimant has not prevailed against the insurer's denial of his left trigger finger condition (pursuant to our order), the ALJ's attorney fee award must be modified. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the bilateral carpal tunnel syndrome and right trigger finger conditions is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 19, 1995 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's claim for a left finger triggering condition is reversed. The denial is reinstated and upheld. In lieu of the ALJ's attorney fee award, claimant is awarded $3,500 for prevailing over the insurer's denial of claimant's claims for bilateral carpal tunnel syndrome and a right middle finger triggering condition. The remainder of the order is affirmed.

July 25, 1996 Cite as 48 Van Natta 1591 (1996)

In the Matter of the Compensation of
DANALEE R. WILCOX, Claimant
WCB Case No. 95-11889
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Daughtry's order that upheld the SAIF Corporation's partial denial of claimant's right ankle neuroma condition.[1] On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the fourth paragraph on page 2. We modify the third paragraph on page 2 as follows: Claimant had no right ankle injuries or problems prior to the January 20, 1995 accepted right ankle contusion.

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[1] As noted by the ALJ, claimant has been diagnosed with an internal derangement of the right ankle, due to either a synovial meniscoid or a superficial peroneal nerve neuroma, or both. Although SAIF formally denied a "neuroma" prior to hearing, the parties treated both conditions as denied at hearing and on review. We include both conditions under the rubric of "right ankle neuroma."

We briefly summarize the relevant facts. Claimant, who worked as a motel housekeeper, compensably injured her right ankle on January 20, 1995, when she banged her ankle on a broken bed. Dr. Peurini diagnosed an ankle contusion and, on January 23, 1995, released claimant to regular work. On January 30, 1995, Dr. Peurini noted that claimant's ankle symptoms had worsened with weight bearing. He found numbness and focal pain on the tendons just anterior to the lateral malleolus on the right (front of the right outer ankle). He diagnosed right ankle tendinitis and placed claimant on modified work. (Exs. 6, 8, 9, 10). SAIF accepted a disabling right ankle contusion.

On February 13, 1995, claimant resumed weight-bearing, but, although the swelling over her right ankle resolved, pain over the anterior lateral malleolus persisted. (Exs. 12, 13, 14, 15).

On March 1, 1995, Dr. Peurini referred claimant to Dr. Zirschky, orthopedist, who diagnosed a dystrophic or dysesthetic process and prescribed physical therapy and desensitization. (Exs. 15, 16). When desensitization failed to eliminate claimant's symptoms, Dr. Zirschky injected the peroneal sheath behind the malleolus and into the sinus tarsi area. The injections resulted in only partial relief. (Ex. 16). Claimant's condition continued to be refractory to treatment so, in June 1995, Dr. Zirschky referred claimant to Dr. Woll, Assistant Professor, Division of Orthopedics and Rehabilitation at the Oregon Health Sciences University, for a second opinion. (Exs. 16-4, 19).

Dr. Woll diagnosed a neuroma of the lateral branch of the right superficial peroneal nerve and recommended desensitization, and, if unsuccessful, a nerve block and, if the nerve block was unsuccessful, neurolysis of the nerve. (Exs. 19, 20). In July 1995, Dr. Zirschky reported that claimant continued to demonstrate hypersensitivity and dysesthesias. He accordingly injected the superficial peroneal nerve, as Dr. Woll had recommended. (Ex. 16-4). Claimant continued to limp, although she reported that most of her pain was gone. (Ex. 16-5). In August 1995, Dr. Zirschky repeated the injection, which resulted only in temporary relief. (Ex. 16-7). Dr. Zirschky planned to go forward with a neurectomy or neurolysis, as recommended by Dr. Woll. (Id.).

On August 31, 1995, Dr. Fuller examined claimant for SAIF. He concluded that claimant had no nerve involvement and that her symptoms were a subjective pain dysfunction syndrome. (Ex. 23). Dr. Zirschky initially concurred with his opinion, as did Dr. Strukel, who performed a records review for SAIF. (Exs. 23, 24, 25).

On October 13, 1995, SAIF closed claimant's right ankle contusion claim with no permanent disability award and issued a partial denial of "frank neuroma of the lateral branch of the right superficial peroneal nerve." (Ex. 27). Dr. Zirschky subsequently changed his concurrence, opining that claimant may have a neuroma of the lateral branch of the superficial peroneal nerve, but that the only way to tell was to perform surgery or neurolysis. (Ex. 28).

On November 15, 1995, claimant was again examined by Dr. Woll, who diagnosed her condition as an internal right ankle derangement, secondary to either a synovial meniscoid or to a lateral branch, right superficial peroneal nerve neuroma. (Exs. 30, 31).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to prove that her compensable right ankle injury was a material cause of her right ankle neuroma condition under ORS 656.005(7)(a). The ALJ determined that Dr. Woll's opinion on causation was not persuasive because it was based on "possibility" rather than "probability," and because it was based on a temporal sequence of events. We disagree.

Claimant had no right ankle injuries or problems prior to the accepted injury. Dr. Woll opined that, given claimant's history of trauma to the right ankle, her condition arose directly from the industrial injury. (Ex. 31). Dr. Woll's opinion is supported by the medical record. (See, e.g., Exs. 1, 2, 4, 9, 12, 13,16,19, 20, 30, 31). There is no contrary opinion on this particular point. Accordingly, in order to establish the compensability of her right ankle neuroma condition, claimant must establish, by medical opinion supported by objective findings, that the industrial accident is a material contributing cause of her condition and need for treatment. ORS 656.005(7)(a).

Due to the number of potential causes and the passage of time, the causation issue is a complex medical question which requires expert medical evidence for its resolution. See Uris v. Compensation

Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Although we ordinarily give great weight to the opinion of the treating physician, Weiland v. SAIF, 64 Or App 810, 814 (1983), we do not do so here, as resolution involves expert analysis rather than expert external observation.

Four doctors provided opinions regarding claimant's condition: Dr. Fuller, Dr. Strukel, Dr. Zirschky, and Dr. Woll. Dr. Fuller, who examined claimant for SAIF, opined that claimant's ankle contusion had resolved. He concluded that she did not have a neuroma because she did not have dysesthesia[2] into the toes supplied by the right superficial peroneal nerve and because Dr. Zirschky's injection did not provide immediate relief of her pain. Dr. Fuller also rejected Dr. Woll's diagnosis because he did not palpate a growth on the nerve. In short, Dr. Fuller concluded that claimant had no "objective findings" of a neuroma and diagnosed claimant's condition as "severe subjective pain dysfunction syndrome." (Ex. 16). Aside from declining to comment on claimant's psychological response to her injury, Dr. Strukel concurred with Dr. Fuller's opinion. (Ex. 24).

As noted by the ALJ, however, Dr. Zirschky had diagnosed dysesthesia over the dorsolateral ankle and sinus tarsi area in March 1995 and Dr. Woll had elicited a positive Tinel's over the anterolateral right ankle with pain that radiated down the lateral branch of the superficial peroneal nerve in June 1995. Moreover, Dr. Zirschky reported continuing hypersensitivity and dysesthesia in July 1995, which he continued to treat. The ALJ concluded that claimant had shown objective findings in support of her neuroma claim. We agree and, accordingly, do not find Dr. Fuller's opinion (or Dr. Strukel's concurrence) persuasive. ORS 656.005(19); Somers v. SAIF, 77 Or App 259 (1986).

Prior to Dr. Fuller's opinion, Dr. Zirschky had been treating claimant's neuroma condition according to Dr. Woll's recommended protocol. Subsequent to Dr. Fuller's opinion, however, Dr. Zirschky changed his mind and agreed with Dr. Fuller that claimant's condition was merely a subjective pain syndrome and that she had no nerve condition that would require additional treatment (Ex. 23). Subsequently, in response to a query by claimant's attorney, Dr. Zirschky again changed his mind, stating that he did not completely agree with Dr. Fuller's report. He now indicated that claimant may indeed have a neuroma of the lateral branch of the right superficial peroneal nerve, and that only surgery or neurolysis (at OHSU, where they had the capability of such treatment) would give a definitive diagnosis. (Ex. 28). Dr. Zirschky nevertheless continued to opine that the major cause of claimant's limp and complaints was her pain behavior, although, at the same time, he indicated that the neuroma may be a source of the pain. As Dr. Zirschky offered no reasons for his changes of opinion, we do not find his opinion persuasive. Weiland v. SAIF, supra; Moe v. Ceiling Systems, 44 Or App 429 (1980).

Dr. Woll initially diagnosed a right superficial peroneal nerve lateral branch injury, which he based on claimant's history of pain on the anterolateral aspect of the ankle that radiated from the sinus tarsi to the lateral forefoot, worsened by weight-bearing activities; his review of claimant's x-rays, MRI, and bone scan; and on his clinical examination, which revealed a positive Tinel's over the area of claimant's maximum symptoms. After a subsequent examination, Dr. Woll diagnosed claimant's condition as an internal derangement of the right ankle, possibly secondary to a synovial meniscoid, possibly resulting from a neuroma in the lateral branch of the superficial peroneal nerve, right leg. Dr. Woll explained that a synovial meniscoid is an enlargement and thickening of the lining of the ankle joint which impinges in the lateral gutter of the ankle, and that a neuroma in the lateral branch of the superficial peroneal nerve is a scar which forms on a nerve and becomes a hypersensitive area on the nerve. He further explained that both conditions result from trauma and both show the same symptoms of tenderness in the same lateral gutter area; thus, it is impossible to distinguish between them by palpation because the superficial peroneal nerve overlies the same lateral gutter area as the synovial meniscoid. Dr. Woll concluded that, although he was unable to differentiate which condition claimant has, she "more likely than not" has one of those conditions, and, given claimant's history of trauma on the right ankle, her condition resulted directly from her traumatic injury. (Exs. 30, 31).

After our review of the record, we conclude that Dr. Woll's use of the word "possibly" was made only in reference to his differential diagnosis, not to his opinion on causation. (See Exs. 30, 31).

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[2] Dysesthesia is an impairment of any sense, especially that of touch; or is a painful and persistent sensation induced by a gentle touch of the skin. Dorland's Illustrated Medical Dictionary at 482 (25th ed. 1974).

Moreover, Dr. Woll's reports indicate that claimant "more likely than not" had one of the conditions he diagnosed. The lack of a definitive diagnosis does not per se defeat a claim, nor is it necessary that the medical experts know the exact mechanism of a disease. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988); Robinson v. SAIF, 78 Or App 581 (1986). However, the causation issue, as opposed to the question of diagnosis, must be resolved. Stewart E. Myers, 41 Van Natta 1985 (1989).

As discussed above, Dr. Woll opined that claimant's right ankle "neuroma" condition arose as a direct result of the accepted industrial injury. However, unlike the ALJ, we are persuaded that Dr. Woll's opinion on causation is not based solely on the temporal relationship between claimant's work and symptoms. See Bronco Cleaners v. Velazquez, 141 Or App 295 (May 29, 1996) (evidence of causation that goes beyond a chronological connection is legally sufficient to establish causation). Instead, Dr. Woll's reasoning is based on claimant's entire medical history, including not only the fact that she had no prior ankle problems and that her neuroma condition appeared in concert with her accepted traumatic right ankle injury, but the location of claimant's symptoms; his analysis of claimant's x-rays, MRI, and bone scan; his own clinical examination; and his expertise regarding the mechanism of the condition.

In sum, we find Dr. Woll's persuasive opinion that claimant's right ankle "neuroma" condition arose as a result of her accepted right ankle injury is sufficient to establish causation. Bronco Cleaners, supra; Somers v. SAIF, supra. We accordingly conclude that claimant has proven that her accepted industrial injury is a material cause of her right ankle "neuroma" condition. Consequently, her 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record 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 14, 1996 is reversed. For services at hearing and on review, claimant's attorney is awarded $3,000, to be paid by the SAIF Corporation.

July 26, 1996 Cite as 48 Van Natta 1594 (1996)

In the Matter of the Compensation of
TROY M. GARNER, Claimant
WCB Case No. 95-07778
ORDER ON REVIEW
Ormsbee & Corrigall, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Christian and Haynes.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) held that the employer was estopped from contending that claimant was precluded from asserting an occupational disease claim for bilateral hearing loss; (2) set aside the employer's denial of claimant's occupational disease claim for bilateral hearing loss; and (3) awarded a $5,500 attorney fee under ORS 656.386(1). Claimant cross-requests review, contesting the ALJ's decision to: (1) allow the employer to amend its denial at hearing to include the claim preclusion defense; (2) admit medical opinions from a physician and an audiologist that were solicited by the employer (Exhibits 12A and 16); and (3) exclude excerpts from a medical treatise offered into evidence by claimant (Exhibit 12B). On review, the issues are claim preclusion, equitable estoppel, the ALJ's procedural and evidentiary rulings, compensability and attorney fees.

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

The employer challenges the ALJ's conclusion that it is estopped from arguing that claimant's bilateral hearing loss claim is barred under the res judicata doctrine of claim preclusion. We adopt the ALJ's analysis on the estoppel issue.

Furthermore, there is an equally persuasive alternative basis for the conclusion that the hearing loss claim is not barred. The claim at issue here was filed in March 1995. Claimant had previously filed a claim for the same condition in January 1994. Claimant subsequently was told that the employer was unhappy that he had filed the January 1994 claim. He responded by contacting the employer's claims representative to determine if he could withdraw the claim. At that time, the claims representative informed claimant that he could "close" his 1994 claim and reopen it later with no repercussions. On March 4, 1994, the employer sent claimant a letter which included the following language:

> "You contacted our office on February 25, 1994 and stated that you did not wish to file a Workers' Compensation claim for hearing loss at this time. I advised you that I would need to issue a denial in your claim based on your statement that you did not wish to file a claim.
>
> "Please be advised that this does not affect your right to file a claim for binaural hearing loss in the future should you choose to do so.
>
> "Therefore, without waiving other possible defenses, we must deny your claim for binaural hearing loss.
>
> "I am required to advise you that, 'IF YOU THINK THAT THIS DENIAL IS NOT RIGHT, WITHIN 60 DAYS AFTER YOU ARE NOTIFIED OF THIS DENIAL, YOU MUST FILE A LETTER WITH THE . . . WORKERS' COMPENSATION BOARD. . . . IF YOU DO NOT FILE A REQUEST WITHIN 60 DAYS, YOU WILL LOSE ANY RIGHT YOU MAY HAVE TO COMPENSATION UNLESS YOU CAN SHOW GOOD CAUSE FOR DELAY BEYOND 60 DAYS. AFTER 180 DAYS, ALL YOUR RIGHTS WILL BE LOST . . . ."

Claimant did not file a request for hearing from this letter based on the claims representative's assurance that he could reopen his claim at a later date with no repercussions, and the language in the letter advising him that it would not affect his right to file a claim in the future. Claimant then filed a second claim for bilateral hearing loss on March 8, 1995, shortly before he terminated his employment.

The employer argues that its March 4, 1994 letter is a final denial of claimant's bilateral hearing loss condition, and that the March 1995 claim at issue here is barred under the res judicata doctrine of claim preclusion. We disagree. The employer's March 4, 1994 letter is not the type of final resolution of a claim that triggers the doctrine of claim preclusion.

In reaching this conclusion, we rely on our decision in William C. Becker, 47 Van Natta 1933 (1995). In Becker, the claimant filed an 801 Form with an employer insured by the SAIF Corporation. The claimant subsequently sent a fax to SAIF in which he stated that he did not want to pursue the claim at that time. The claimant sent this fax prior to the expiration of the statutory 90-day claims processing period under ORS 656.262(6). The employer subsequently confirmed to SAIF that claimant wished to withdraw the claim. SAIF then issued a denial of the claim on the ground that claimant's work activity was not the major contributing cause of the claimed condition. Claimant asked SAIF to rescind the denial. It did not and claimant requested a hearing. The matter proceeded to hearing and on to Board review.

In our decision on review, we noted that a claimant can withdraw a claim. See Michael A. Dipolito, 44 Van Natta 981 (1992), as discussed in Allen B. Miller, 44 Van Natta 2122 (1992). As the claimant in Becker had withdrawn his claim prior to expiration of the statutory 90-day claims processing period and before issuance of SAIF's denial, we found that there was no claim outstanding when SAIF issued the denial. Thus, we concluded that the denial was null and void and without legal effect. See Larry J. Bergquist, 46 Van Natta 2397 (1994); William F. Hamilton, 41 Van Natta 2195 (1989).

The rationale set forth in Becker is equally applicable in the present case. Claimant withdrew the first hearing loss claim within the statutory claims processing period and before the employer issued

its March 4, 1994 letter. That fact is established by claimant's unrebutted testimony at hearing and the language of the employer's letter. As there was no claim outstanding when the employer issued the March 4, 1994 letter, the denial language included in the letter is null and void and without legal effect. Consequently, there is no claim preclusion bar to the second hearing loss claim at issue here.

Given our conclusion regarding the claim preclusion and equitable estoppel issues, we need not address claimant's alternative argument that the ALJ erred in allowing the employer to raise the claim preclusion defense at hearing. Furthermore, because we adopt and affirm the ALJ's conclusion that the hearing loss claim is compensable on the merits, we need not address claimant's objections to the evidence admitted and excluded by the ALJ.

Finally, we note that the ALJ incorrectly cited to OAR 438-009-0010(4) in explaining the basis for his assessed attorney fee award. The correct citation is to OAR 438-015-0010(4). Subject to this correction, we adopt the ALJ's assessed attorney fee award.

Claimant's attorney is entitled to a reasonable assessed fee for prevailing over the employer's request for Board review. After considering the factors at OAR 438-015-0010(4), we conclude that $1,750 is a reasonable fee. In setting this fee, we have particularly considered the complexity of the legal and factual issues presented by the employer's appeal, the value of the interest involved, the results achieved, and the risk that claimant's counsel might go uncompensated. We further note that claimant's counsel is not entitled to a fee for services regarding the ALJ's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated January 29, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,750, to be paid by the self-insured employer.

In the Matter of the Compensation of
MURIEL D. NELSON, Claimant
WCB Case No. 95-10716
ORDER ON RECONSIDERATION
Rasmussen, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our June 27, 1996 Order on Review that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). SAIF contends that we did not address the requirement that there be a pathological worsening of the disease. Having received claimant's response, we proceed with our reconsideration.

SAIF argues that ORS 656.802(2)(b) applies to this case because claimant has preexisting conditions in the form of predisposing factors of "being female and slightly overweight." (Ex. 8-6). According to SAIF, since claimant has preexisting conditions, she must prove that there has been a pathological worsening of the underlying condition.

In our previous order, we referred to the opinion of Drs. Strum and Wilson, which stated that a "person who develops carpal tunnel syndrome has to have a predisposition to that condition[.]" (Ex. 8-5, -6). Drs. Strum and Wilson identified claimant's predisposing factors as "being female and slightly overweight." (Ex. 8-6). We were not persuaded by Drs. Strum and Wilson's opinion because it was too generic, addressing the general predisposition of all woman to develop CTS. On reconsideration, we adhere to that conclusion.

Drs. Strum and Wilson were asked to identify any preexisting factors that may have lead to the development or worsening of claimant's CTS. They responded:

> "We can only state that [claimant] is a female, and she is slightly overweight but not a lot. Those who are females, who are overweight, are more prone to the condition of carpal tunnel syndrome. We also know that a person who develops carpal tunnel syndrome has to have a predisposition to the condition, and sometimes work activities may bring out the symptoms." (Ex. 8-5, -6).

ORS 656.005(24) defines a "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, or that precedes a claim for worsening pursuant to ORS 656.273." (Emphasis added).

Based on the facts of this case, we are not persuaded that claimant's "being female and slightly overweight" constituted preexisting conditions. To begin, based on the persuasive opinion authored by Dr. Dodds (one of claimant's treating physicians), the record does not establish that claimant had a preexisting condition. In any event, although Drs. Strum and Wilson identified claimant's "being female" as a predisposing factor, "being female" does not fit within the definition of a preexisting condition because it is not an "injury, disease, congenital abnormality, personality disorder or similar condition."

Similarly, although Drs. Strum and Wilson opined that females who are overweight are more prone to CTS, they did not explain why being "slightly overweight but not a lot" was a predisposing factor to CTS. Being "slightly overweight but not a lot," without further explanation, does not fit within the definition of a preexisting condition because it is not an "injury, disease, congenital abnormality, personality disorder or similar condition." Drs. Strum and Wilson did not explain why or how "being female" and "slightly overweight but not a lot" contributed or predisposed claimant to disability or need for treatment for CTS. See ORS 656.005(24). Furthermore, we are not persuaded by their conclusory opinion that a "person who develops carpal tunnel syndrome has to have a predisposition to that condition[.]" (Ex. 8-6).

On reconsideration, SAIF relies on claimant's "predisposing factors" of "being female and slightly overweight" to argue that ORS 656.802(2)(b) applies to this case. Even if we assume that "being female" and "slightly overweight" constitute "preexisting conditions," ORS 656.802(2)(b) would not apply. 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 the employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." (Emphasis added).

Claimant's occupational disease claim is not based on a worsening of her alleged "predisposing factors" of "being female and slightly overweight." Rather, claimant asserts that her employment conditions were the major contributing cause of her CTS. ORS 656.802(2)(a). Since claimant's occupational disease claim for CTS is not based on the "worsening of a preexisting disease or condition pursuant to ORS 656.005(7)," ORS 656.802(2)(b) does not apply.

In contrast, Dr. Dodds indicated that claimant did not have any predisposing factors or preexisting conditions. (Ex. 14-2). Dr. Dodds agreed that claimant was slightly overweight, but was not obese. (Id.) Dr. Dodds agreed that, absent any arthritis, diabetes, thyroid condition or family history of CTS, the only causative factors that he was aware of were claimant's life activities. (Id.) Claimant did not have any family history of CTS. (Id.) Dr. LaFrance tested claimant for diabetes, thyroid imbalance and metallic imbalance and there were no clinical indications for any of those conditions. (Ex. 15-1).

We are persuaded by Dr. Dodds' opinion (as supported by Dr. LaFrance's testing) that claimant did not have any factors that contributed or predisposed her to disability or need for treatment. Consequently, we reject SAIF's argument that claimant must prove that there has been a pathological worsening of a preexisting condition pursuant to ORS 656.802(2)(b). Rather, for the reasons expressed in our previous order and this order, we continue to adhere to our conclusion that, based on Drs. Thompson, La France and Dodds' opinions, claimant's work activities were the major contributing cause of her CTS.

Claimant's counsel is entitled to an additional assessed attorney fee for time spent responding to SAIF's reconsideration request. See Susan A. Michl, 47 Van Natta 167 (1995). After considering the factors set forth in OAR 438-015-0010(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

$250, to be paid by SAIF. 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.

Accordingly, we withdraw our June 27, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our June 27, 1996 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
JULIA A. WATSON, Claimant
WCB Case No. 95-09693
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian, and Hall.

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

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

On review, claimant argues that she raised only the issue of "threshold" compensability of a low back strain. Therefore, she argues, the effects of her preexisting degenerative disc disease and the "combined condition" standard of proof under ORS 656.005(7)(a)(B) are not relevant to her claim. Claimant cites John F. O'Neall, Jr., 47 Van Natta 2115 (1995), in support of her argument.

We find John F. O'Neall, Jr. distinguishable on its facts. In O'Neall, the claimant raised at hearing only the narrow issue of whether an incident at work resulted in a need for medical treatment. The carrier did not object to the claimant's characterization of the issue either at hearing or in the closing argument. Therefore, we found that the only issue raised at hearing was whether an initial compensable injury had occurred at work. Thus, we did not consider the carrier's alternative argument on review regarding the issue of whether the claimant's low back condition remained compensable under ORS 656.005(7)(a)(B). 47 Van Natta at 2115.

Here, claimant also attempted to limit the issue to the compensability of a low back strain injury occurring on a specific date at work. (Tr. 1-2). However, unlike the carrier in O'Neall, SAIF objected to claimant's characterization of the issue and raised a "cross-issue," asserting that, if the low back strain combined with preexisting degenerative disc disease, claimant could not limit her claim to compensability of the low back strain. Id. Therefore, contrary to claimant's argument, the issue at hearing was not limited to the compensability of the low back strain in isolation from her preexisting degenerative disc disease. 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).

Our "first task is to determine which provisions of the Workers' Compensation Law are applicable." Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994)); see also Michelle K. Dibrito, 47 Van Natta 970 (1995). Each of those holdings support the proposition that it is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995).

Here, we agree with the ALJ's reasoning and conclusions that the medical evidence establishes

that claimant's work incident combined with her preexisting degenerative disc disease.[1] (Exs. 32, 36, 37). Accordingly, as the ALJ found, 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. ORS 656.005(7)(a)(B). For the reasons explained by the ALJ, we find that claimant failed to meet her burden of proof.

ORDER

The ALJ's order dated January 8, 1996 is affirmed.

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[1] There is no question but that claimant has preexisting degenerative disc disease; that condition was present in the May 1995 Emergency Room x-rays. (Ex. 25). The dissent notes that the early medical reports focus on the low back strain, with no discussion of whether the low back strain combined with the degenerative disc disease until the August 10, 1995 letter from Dr. Butdorf, attending physician. (Ex. 32). On that basis, the dissent concludes that the low back strain did not combine with the preexisting condition until August 1995. We disagree with that reasoning.

Dr. Butdorf's August 10, 1995 letter is in response to a letter from SAIF wherein the claims examiner asked Dr. Butdorf whether claimant's current need for treatment is caused in major part by the underlying degenerative disc disease or a prior work injury. (Ex. 29). This is the first query as to the relationship between the low back strain and the preexisting degenerative disc disease. Dr. Butdorf responded that the degenerative disc disease and the prior work injury "underlie [claimant's] current problem," noting that claimant's underlying condition contributed to claimant's need for treatment. (Ex. 32). Furthermore, we agree with the ALJ that Dr. Butdorf's later opinion as to causation is nothing more than the "but for" analysis that was rejected in Dietz v. Ramuda, 130 Or App 397 (1994). (Ex. 37). We find that Dr. Butdorf's opinions, read as a whole, establish that the low back strain and the degenerative condition combined at the outset. We also agree with the ALJ's reasoning that the opinions of Drs. Hunt and Watson, examining physicians, do not support claimant's claim.

Board Chair Hall dissenting.

The majority adopts and affirms the ALJ's order which found that: (1) claimant's May 22, 1995 low back strain injury combined with her preexisting degenerative disc disease; and (2) claimant failed to prove that the back strain injury was ever the major cause of claimant's disability or need for treatment for the combined condition. Because I find that both the ALJ and the majority incorrectly analyzed this claim, I respectfully dissent.

In the first place, I agree with claimant that her claim has always been solely for a low back strain. (Exs. 22, 23, 24, 26, 27-2, 32). Claimant has never contended that the preexisting degenerative disc disease was compensable, either as a separate condition or in combination with the low back strain. Furthermore, as explained below, and contrary to the majority's reasoning, claimant is permitted to make a separate claim for a low back strain so long as the strain injury has not yet combined with any preexisting condition. I base this statement on the following reasoning.

In Charles L. Grantham, 48 Van Natta 1094 (1996), the preponderance of the evidence established that the claimant's preexisting degenerative disc disease combined with a work-related lumbar strain at the outset, and that the preexisting disease was the major contributing cause of the combined condition. However, the claimant asserted that the "combined condition" analysis under former ORS 656.005(7)(a)(B) did not apply to the initial work-related lumbar strain, but applied only to his condition after the initial strain resolved. The Board found that the court in Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590, rev den 318 Or 27 (1993), had rejected the "two-step" analysis proposed by the claimant. Specifically, in Nazari, the court explained that former ORS 656.005(7)(a)(B) was applicable in the context of an initial injury claim, if in the initial claim the "the disability or need for treatment is due to the combination of the injury and a preexisting, noncompensable condition." 120 Or App at 594.

In Grantham, the Board found that the Nazari analysis remained viable under amended ORS 656.005(7)(a)(B), which provides that if "an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause" of the disability or need for treatment of the combined condition." Amended ORS 656.005(7)(a)(B). In Grantham, because the work injury combined with the claimant's preexisting degenerative disc disease at the outset, the Board concluded that compensability of the claim was properly analyzed under amended ORS 656.005(7)(a)(B).

In a special concurrence, I reasoned that, because amended ORS 656.005(7)(a)(B) spoke of an otherwise compensable injury combining at any time with a preexisting condition, a preexisting condition could combine at a time later than at the outset as in Nazari. Under such circumstances, the Nazari analysis would not apply until "combination" occurred. Therefore, I reasoned, in applying amended ORS 656.005(7)(a)(B) and Nazari, it is first necessary to determine both whether and when a compensable injury has combined with a preexisting condition. In Grantham, because the medical evidence established that the claimant's otherwise compensable injury combined at the outset with his preexisting condition, I concurred that the claim was properly analyzed under amended ORS 656.005(7)(a)(B) and Nazari.

Absent persuasive evidence of an otherwise compensable injury combining with a preexisting condition and when such a combination occurred, the test for compensability of the "injury" remains material contributing cause. In other words, until the point of combination, the "injury" is a separate condition that may be found compensable on the basis of material cause. Under these circumstances, compensability of the "combined condition" (and amended ORS 656.005(7)(a)(B)) necessarily do not come into play until the injury combines with the preexisting condition. Until then, it is only the "injury" that is compensable.

Here, I do not find that the medical evidence establishes that claimant's otherwise compensable lumbar strain injury combined at the outset with her preexisting degenerative disc condition. During claimant's Emergency Room visit on May 23, 1995, although x-rays were taken that showed "mild" degenerative disc disease at L5-S1, the diagnosis was "exacerbation back strain - Acute L-S strain." (Exs. 22, 23, 24). In addition, the 801 form identifies the injury as "strain lower back." (Ex. 26). Finally, Dr. Butdorf, attending physician, diagnosed "L/S strain, slow to resolve," "chronic low back pain with recent exacerbation" in his chart notes through August 10, 1995. (Exs. 27-2, 31). Thus, until August 10, 1995, there is no indication that the strain injury combined with the preexisting degenerative disc disease.

It is not until Dr. Butdorf's August 10, 1995 letter that the question of "combining" first comes into play. (Ex. 32). The August 10 letter was in response to the insurer's inquiry concerning claimant's current condition and need for treatment. (Ex. 29). Dr. Butdorf indicated that a prior injury and the degenerative disc disease "underlie [claimant's] current problem." (Ex. 32). However, Dr. Butdorf did not relate this back to the time of the initial May 1995 low back strain injury, he spoke only in terms of claimant's "current problem."[1]

Furthermore, on November 7, 1995, Drs. Hunt, M.D., and Watson, M.D., examined claimant on behalf of SAIF. (Ex. 37). They opined that claimant suffered a strain in May 1995 that had resolved. (Ex. 37-10). They stated that claimant's preexisting degenerative disc disease is now the cause of her symptoms and her current loss of range of motion. (Ex. 37-11). They further opined that the May 1995 injury did not pathologically worsen claimant's preexisting condition. Id.

On this record, I would find that claimant established that the initial low back strain in May 1995 was caused in material part by her work activities. Thus, the low back strain injury is compensable. This low back strain injury did not combine with the preexisting degenerative condition until August 1995. (Ex. 32). At the time of combining, amended ORS 656.005(7)(a)(B) came into play. Grantham, supra; Nazari, supra. After the low back strain injury and the preexisting condition combined, the preexisting condition became the major contributing cause of the combined condition. (Exs. 32, 37-10, -11). Thus, claimant has established a compensable low back strain for the period from May 22, 1995, when the strain injury occurred, until August 10, 1995, when the medical evidence establishes that a combination of the strain injury and the preexisting condition occurred, and the preexisting condition became the major contributing cause of the combined condition.

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[1] The majority appears to overlook the fact that Dr. Butdorf is focusing on claimant's "current problem" when they conclude that Dr. Butdorf's opinions, read as a whole, establish that the low back strain and the degenerative condition combined "at the outset." (See majority fn. 1).

In the Matter of the Compensation of
ROBERT L. SCHAUSS, Claimant
Own Motion No. 93-0644M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Douglas L. Minson, Attorney
Employers Insurance of Wausau, Insurance Carrier

Claimant requests review of the insurer's April 16, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from October 11, 1993 through March 26, 1996. The insurer declared claimant medically stationary as of March 26, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 16, 1996 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

In order to be medically stationary, all compensable conditions must be medically stationary. Rogers v. Tri-Met, 75 Or App 470 (1985). Although medical opinion establishes that a claimant requires ongoing care for an indefinite period of time, the ongoing care does not necessarily establish that a claimant was not medically stationary. Maarefi v. SAIF, 69 Or App 527, 531 (1984). In those cases where a claimant's medically stationary status is contingent upon undergoing a recommended surgery, we have held that a claim is not prematurely closed if the claimant refuses the surgery. E.g. Karen T. Mariels, 43 Van Natta 2452 (1992); Stephen L. Gilcher, 43 Van Natta 319, 320 (1991). In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

In a March 26, 1996 chart note, Dr. Waldram, claimant's treating physician, opined that "[claimant] persists to have back pain. He is doing poorly by his thoughts and by his thoughts even worse than he had been doing before." Further, Dr. Waldram opined that, after consulting with Drs. Nelson and Thompson regarding claimant's seven prior back surgeries, "[i]t is my impression that surgery [for claimant] would be a low yield." On that date, Dr. Waldram also opined that:

> "I don't have any specific recommendations at this time, other than a consideration of some pain management program. There are implantable devices that can be done. I am not positive whether he is a candidate for something like this. [Claimant] has been to Dr. Bedders in the past[. E]ither he or another pain management center (i.e.: Emanual Hospital) could advise him on any other alternatives that might be present."

Further, Dr. Waldram opined that:

> "From my perspective, I will probably re[-]x-ray [claimant] in 6-12 months. Were there some overt serious instability developing it would change my mind and surgery would be potential in the future, not the immediate future. Under the circumstances, that I am not recommending any specific further orthopedic treatment, [claimant] is stable. I would defer to pain management relative to thoughts on other alternative care out of my specialty."

In a June 13, 1996 chart note, Dr. Waldram, noted that claimant was having a lot of pain, and was desperate to find a solution for his pain problem. Dr. Waldram advised that:

> "[Claimant] has not yet been through a pain management evaluation which we had advised back on March 26, 1996. With [claimant's] history of having 7 back operations and under the circumstances that I am planning further surgery at this time, that he would be a candidate for at least an evaluation for pain management."

Finally, Dr. Waldram reported that claimant had stated that, because his physician opined that he was "orthopedically stable" on March 26, 1996, the insurer closed his claim. Dr. Waldram stated that it was his intent that claimant should have this evaluation, which could be coupled with a psychological assessment, if the insurer desired, "but I feel that [claimant] is so dysfunctional at this time that he should at least have some consideration to this end."

Here, Dr. Waldram opined that claimant was medically stable (with respect to his accepted back condition) on March 26, 1996, even though claimant "by his thoughts" had pain and felt worse than "before." The record does not establish that he has revised that diagnosis of claimant's back condition, nor that he has withdrawn that opinion. Dr. Waldram opined that claimant's pain management, and possibly his psychological needs, needed to be addressed if the insurer agreed. However, the record does not indicate that a pain condition or any other psychological condition has been accepted by the insurer. Therefore, unless the insurer has accepted either the pain condition or a psychological condition, claimant must establish that he was not medically stationary at closure with respect to his accepted back condition. Rogers v. Tri-Met, supra.

On June 13, 1996, Dr. Waldram opined that he was "planning further surgery at this time." Contrarily, Dr. Waldram had opined in March 1996 that surgery would be of low yield, and, having consulted with two other physicians, unless a serious instability of claimant's medical condition developed, he would consider surgery in the future, but "not the immediate future." Therefore, we are unable to conclude that the medically stationary status of claimant's compensable condition at claim closure was dependent on a surgery, because no surgery had been requested or proposed. See Karen T. Mariels, supra; Stephen L. Gilcher, supra; Jerry Simmons, 47 Van Natta 2423 (1995); Richard Uhing, 48 Van Natta 465 (1996).

Dr. Waldram recommended on both March 26, 1996 and on June 13, 1996 that claimant should be evaluated for treatment in a pain center. In a June 17, 1996 chart note, Dr. Waldram noted that the insurer "ok'd a pain center eval[uation]." Here, although the insurer has consented to a pain center evaluation, the provision of ongoing care or "management" care does not necessarily mean that claimant was not medically stationary at claim closure. Maarefi v. SAIF, supra. Dr. Waldram had recommended the evaluation on the same date that he declared claimant medically stationary with respect to his back condition.

Finally, because Dr. Waldram's June 13, 1996 opinion was rendered three months after he declared claimant medically stationary, we do not find that it addresses claimant's condition at the time of closure. Scheuning v. J.R. Simplot & Co., supra. Further, we are persuaded that Dr. Waldram's June 13, 1996 opinion the claimant is currently "dysfunctional" relates to claimant's pain management condition rather than to the medical status of his accepted back condition.

On this record, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's April 16, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANDREW D. KIRKPATRICK, Claimant
WCB Case No. 95-00554
ORDER OF ABATEMENT
Coons, Cole, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant has requested reconsideration of our July 3, 1996 order which upheld the insurer's denial of claimant's aggravation claim.

In order to allow sufficient time to consider the motion, we withdraw our July 3, 1996 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response should be submitted within 14 days of the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH G. ABEL, Claimant
WCB Case No. 95-09264
ORDER ON REVIEW
Myrick, Seagraves, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of claimant's psychological condition claim; and (2) awarded an assessed attorney fee of $7,000. On review, the issues are compensability and attorney fees.

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

Claimant worked as the service manager for the employer, a car dealership. On review, SAIF asserts that claimant bases his psychological claim on factors generally inherent in the work place. Specifically, according to SAIF, claimant developed his mental condition because he worked unreasonably long hours, felt he had insufficient authority to manage his department, and was threatened with losing his job. SAIF contends that such conditions are generally inherent in working as a manager and, thus, the claim should fail. ORS 656.802(3)(b).

We disagree with SAIF's characterization of the claim. Rather, the medical evidence shows that the major contributing cause of claimant's psychological condition was his treatment by the general manager. As described by his treating psychiatrist, Dr. Williamson, claimant's "work situation runs on a kind of atmosphere of fear and accusations of incompetence and a domination by a management staff that does its best to convince the workers that they are inadequate and doing a bad job." (Ex. 14-20). Dr. Williamson's understanding was based on reports that the general manager regularly shouted and screamed at claimant, threatening to fire him if he did not perform in a certain way. (Id. at 32).

We agree with the ALJ that the record shows that claimant was subjected to treatment by the general manager that is not generally inherent in all work situations. There was corroborating evidence of claimant's testimony that the general manager regularly shouted at claimant, sometimes in front of customers, using demeaning language such as telling claimant he was "stupid" and to "get his head out of his ass," and throwing objects. (Ex. 16-8, 16-9; Tr. 86, 124, 129, 180, 232, 236, 237 (Day 1), 24, 25, 31, 77 (Day 2)). Based on such evidence, and the medical opinion of Dr. Williamson, we also conclude that claimant satisfied the remaining requirements of proving compensability, including clear and convincing evidence that his mental disorder arose out of and in the course of employment. ORS 656.802(3).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that our attorney fee award does not include claimant's counsel's services devoted to the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated January 19, 1996 is affirmed. For services on review, claimant's attorney is awarded an assess fee of $1,500, payable by the SAIF Corporation.

In the Matter of the Compensation of
LOIS F. BARTON, Claimant
WCB Case No. 95-11774
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that upheld the SAIF Corporation's denial of her right ankle 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 "Stipulation of the Parties" and the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant works in the employer's nursing home facility. The employer's premises include a house where the residents live, a front lot designated as a visitor parking lot, and a back lot designated as an employee parking lot. On the date in question, the back parking lot was uneven, multi-level, and, for the most part, covered with grass, although there were two graveled paths with grass growing through the gravel. Some employees, including claimant and the nursing home's administrator, routinely parked in the upper level of the back parking lot and walked down a grassy slope to the back door to the house (where a time clock is located).

On June 20, 1995, claimant parked her car in her usual location in the employee parking lot and proceeded towards the rear entrance of the employer's building. While claimant was walking down the wet, grassy slope, her foot hit "one of the little holes," causing her foot to roll to the right, resulting in injury.

A "compensable injury" is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability. ORS 656.005(7)(a). As a general rule, injuries sustained by employees when going to and coming from their regular workplace are not deemed to arise out of and in the course of their employment. SAIF v. Reel, 303 Or 210, 216 (1987); Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171 (1991). There are, however, exceptions to the general rule. One such exception is the "parking lot rule." The "parking lot rule" holds that, if an injury occurs in a parking lot or other off-premises area over which the employer has some control, the injury may be compensable. Boyd v. SAIF, 115 Or App 241 (1992).

In Norpac Foods v. Gilmore, 318 Or 363 (1994), the Supreme Court elaborated on the "parking lot rule." The Court explained that application of this rule establishes only that the time, place, and circumstances of the injury are sufficiently work-related to satisfy the threshold "in the course of" element, but that the second element of the work-connection inquiry must also be satisfied. Thus, to prove compensability, claimant must also establish that her injury "arose out of" her employment. That is, claimant must also establish a sufficient causal connection between her employment and the injury to prove compensability. Id. at 368-69.

In a "parking lot" case, that causal connection exists when the claimant's injury was brought about by a condition or hazard associated with premises over which the employer exercises some control. See Montgomery Ward v. Malinen, 71 Or App 457 (1984) (fall on icy pavement the employer had legal duty to maintain); Linda N. Kief, 46 Van Natta 2290 (1994) (fall on icy pavement on the employer's premises); Christopher C. Ciongoli, 46 Van Natta 1906 (1994) (motorcycle accident caused by gravel displaced from a large pothole on the employer's premises); Ronald. R. Nelson, 46 Van Natta 1094 (1994) (fall on rough pavement on employer-controlled driveway); see also William F. Gilmore, 46 Van Natta 999, 1000 (1994) (order on remand) (injury sustained while the claimant entered his vehicle on employer's parking lot held not compensable, because it did not arise from risk associated with the lot). In other words, claimant must prove that her employment conditions put her in a position to be injured. See Henderson v. S.D. Deacon Corporation, 127 Or App 333, 338-39 (1994).

Finding that claimant's injury occurred on the employer's premises, the ALJ concluded that claimant had satisfied the "course of employment" element. The ALJ reasoned, however, that claimant had "created the risk of harm to [herself]" when she "chose to access the building by using the grassy slope" when she "could have used . . . a walk area which is graveled, to access the employer's building." Thus, the ALJ found that there was not a sufficient relationship between the injury and the employment to find the injury "arose out of" claimant's employment.

On review, claimant contends that, because the grassy slope was a risk associated with her employment, she has sustained her burden of proof that her employment conditions put her in a position to be injured. Considering all the circumstances, we agree that claimant has established the second element of the work-connection inquiry, i.e., that her injury "arose out of" her employment.

At hearing, claimant testified that she was walking down an uneven, wet, grassy slope which comprises a portion of the employee parking lot, when her foot hit a "little hole," causing her foot to roll to the right. SAIF does not dispute claimant's assertions concerning the conditions of the parking lot. Instead, citing Lane v. Gleaves Volkswagen, 39 Or App 5 (1979), SAIF argues that a worker places herself outside the scope of her employment when she chooses an unreasonable and unsafe manner of entering or leaving the employer's premises. In this regard, SAIF argues that, because there was a safer alternative for claimant to get from the upper parking lot to the building entrance (other than attempting to traverse the uneven grassy slope), claimant's decision to walk down the uneven incline was unreasonable, placing her outside the scope of her employment and rendering the injury not compensable. We are not persuaded by SAIF's argument.

In Lane, the claimant climbed over a seven-foot-tall fence while leaving work, rather than going through a building and out a door. Reasoning that there was a safe alternative, the court found the claimant's decision to climb over the fence was "so unreasonable" as to place the claimant outside the course of his employment. 39 Or App at 7. We do not find claimant's conduct in the present case -- merely walking over the natural terrain that comprised the employee parking lot -- rises to the level the court found unreasonable in Lane. Moreover, while there may have been an alternative route through the parking lot to the building entrance, and that route may have been "safer," that, in and of itself, does not establish that claimant's decision to walk down the uneven incline was per se unreasonable.[1]

Finally, SAIF's argument is incongruent with the court's decision in SAIF v. Marin, 139 Or App 518 (1996). In Marin, the court explained that where an employee drives to work and parks in the parking lot, it is generally necessary for the employee to walk to and from the parking lot while entering and leaving work. Thus, "in a general sense," the court viewed walking through an employer-controlled parking lot as a condition of the employee's employment.

We recently applied the Marin court's reasoning in another "parking lot" case. In Lisa M. Bean, 48 Van Natta 1216 (1996), we found that the claimant's injury occurred under circumstances the Marin court has suggested are sufficient to find the requisite causal connection.[2] There, the claimant arrived at work and parked in the employer-controlled parking lot. When struck by a co-worker's vehicle, the claimant was simply walking through the parking lot to enter her immediate work area. There was no evidence that the claimant engaged in any activity that removed her from normal ingress to work. In accordance with the Marin rationale, considering that the claimant was walking to her work site after parking in the employer-controlled parking lot when she was struck by a co-worker's vehicle, we concluded the sufficient causal connection required by the Norpac and Marin holdings had been satisfied. Consequently, we were persuaded that the claimant's injuries "arose out of" her employment.

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[1] See Andrews v. Tektronix, Inc., 323 Or 154 (1996) (A violation of an employment rule does not render a claim per se noncompensable. Rather, the compensability determination is made by evaluating all of the factors that are pertinent to the question of work-connectedness, and weighing those factors in light of the policy underlying the Workers' Compensation Act); see also Clark v. U.S. Plywood, 288 Or 255 (1980) (The view "that compensability is determined by the reasonableness of the worker's conduct has no foundation in the workers' compensation statutes or in Oregon case law. The rule is generally to the contrary: If an act is within the course and scope of employment, and arises therefrom, reasonableness of the employee conduct is irrelevant.")

[2] In Lisa M. Bean, supra, we recognized that the Marin court's statements are dicta and not controlling. Nevertheless, we found that the court's rationale provides further guidance to us in evaluating the "arising out of" (causal connection) prong of the Norpac analysis.

In the instant case, claimant's injury was brought about by a condition or hazard (viz., uneven terrain) associated with the employee parking lot over which the employer exercised control, while claimant was merely walking to her work site through the employer-controlled parking lot. Under the circumstance, we find that claimant has proved that her employment conditions put her in a position to be injured. See SAIF v. Marin, supra; Henderson v. S.D. Deacon Corporation, supra. Accordingly, we are persuaded that claimant's injuries "arose out of" her employment. Consequently, we conclude that claimant has established a sufficient causal connection between her conditions of employment and the injury to establish compensability. Norpac Foods v. Gilmore, supra.

Claimant is entitled to an attorney fee for her counsel's services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is $3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 16, 1996 is reversed. The SAIF Corporation's denial is set aside, and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded an attorney fee of $3,000, payable by SAIF.

In the Matter of the Compensation of
JERRY D. HARDIN, Claimant
WCB Case No. 95-09880
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Yeager's order which found that the SAIF Corporation had properly calculated the rate of claimant's temporary disability benefits based on his average earnings over a 26 week period. On review, the issue is rate of temporary disability benefits.

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

Claimant was hired by the employer, who provides maintenance services to mills on scheduled maintenance days, as a millwright. He did not work continuously; instead, the employer would call claimant when he needed an extra person for a day, or claimant would call the employer when he was not working elsewhere to see if the employer could use him for a day. If claimant was working on another job when he received a call from the employer, he was not expected to quit that job and work for the employer. When working on a job for the employer, claimant would work one day only for a guaranteed minimum of 8 hours' pay at $15 per hour plus $30 for travel. Once the job was over, neither party had any obligation to the other to continue the employment relationship.

Claimant worked for the employer for one day during the week of December 12-18, 1993; one day during each of the weeks of January 2-8; February 27-March 5; April 10-16; and June 19-25, 1994. Claimant was injured on June 22, 1994. The June 22 job was scheduled for only one day.

SAIF initially paid claimant's temporary disability rate based on an average weekly wage of $360 pursuant to former ORS 656.210(2)(a)(A), which provides that a worker who is regularly employed one day per week receives benefits calculated by multiplying the daily wage by three. In May 1995, SAIF notified claimant that it had incorrectly calculated his TTD rate and that, pursuant to former OAR 436-60-025(5)(a), his TTD rate should be calculated on the basis of his average weekly earnings of $23.58 for the previous 26.4 weeks.

The ALJ found that SAIF properly recalculated claimant's temporary disability rate using claimant's average weekly earnings for the 26 weeks prior to his injury. In doing so, the ALJ determined that there were no "extended gaps" in claimant's employment with the maintenance company. See former OAR 436-60-025(5)(a). The ALJ further determined that, even if the periods between claimant's individual jobs for the employer were "extended gaps," the intent at the time of hire did not permit the calculation of claimant's rate of temporary disability compensation under OAR 436-60-025(2)(b).

On review, claimant contends that the periods between the individual jobs were "extended gaps," and that each date of employment constituted a "rehire" for a specified date. Thus, claimant reasons, the intent of the parties was that claimant would work one day per week and, accordingly, his TTD rate should be calculated under former ORS 656.210(2)(b) by multiplying the daily wage times three. We disagree.

Because claimant was employed "on call,"[1] OAR 436-60-025(5) governs this case. OAR 436-60-025(5)(a) provides:

> "For workers employed on call * * *, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average. For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker."

An extended gap must include not only a break in the work for the employer, but the "break" must cause a change in the work relationship between the employer and the employee. Earin J. Hadley, 48 Van Natta 216 (1996); Steven Caldwell, 44 Van Natta 2566 (1992). Each particular work relationship must be examined to determine whether the break in the performance of the work activities constituted a change in that work relationship. This determination must be made on a case-by-case basis.

Here, we find, as did the ALJ, that the breaks in claimant's work activities did not change the work relationship between claimant and his employer. Both parties understood that the employment was sporadic, depending on the need of the employer and the availability of claimant. Moreover, both parties understood that claimant could, and infact did, return to work for one day as needed and available. Additionally, the fact that claimant worked for a different employer prior to the day he worked in June 1994 did not change the relationship between claimant and this employer, because both parties continued in their understanding that claimant could return to this employment under the same circumstances delineated above.

Accordingly, we conclude that the breaks in claimant's work activities with the employer did not cause a change in the employment relationship between claimant and this employer. See Steven Caldwell, supra. Therefore, there were no "extended gaps" in claimant's work activities with this employer. Thus, SAIF correctly recalculated claimant's TTD benefits.

Similarly, we find that claimant should not be considered as entering into a "new" employment relationship with the employer each time he went to work for the employer. There was nothing in claimant's "lay offs" or his returns to work that suggests that a "new" employment relationship was begun with each return to work. Moreover, the understanding between the parties regarding the employment contract did not change during the overall period claimant worked for the employer. Consequently, we conclude that SAIF properly recalculated claimant's average weekly wage based on the previous 26 weeks' wages prior to claimant's compensable injury.

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[1] "'Employment on call' means sporadic, unscheduled employment at the call of an employer without recourse if the worker is unavailable." OAR 436-60-005(12). Here, claimant was hired sporadically, i.e., only on the occasion when the employer needed an extra worker for the day; if claimant were unavailable, the employer had no recourse.

ORDER

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

Board Chair Hall dissenting.

The majority has adopted and affirmed the ALJ's conclusion that the SAIF Corporation had properly calculated the rate of claimant's temporary disability benefits based on his average earnings over a 26 week period. The majority reasoned that claimant had not entered into a "new" employment relationship with the employer each time he went to work for the employer, nor were the periods between claimant's individual jobs "extended gaps." Unlike the majority, I am convinced that each day claimant worked for the employer was a "new" hire. Moreover, because each employment was a discrete employment, claimant's employment had no "extended gaps." Thus, claimant's rate of temporary disability compensation should be calculated pursuant to former ORS 656.210(2)(A).[1]

Former ORS 656.210(2)(a) provides: "For the purpose of this section, the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving: (A) By 3, if the worker was regularly employed not more than three days a week."

I reason as follows. The employer kept a list of persons qualified to perform maintenance work, one of whom was claimant. If the employer needed a worker to perform maintenance duties under the employer's contract, he could call claimant from his list of qualified people, or, if claimant were not working elsewhere, claimant could call the employer to see whether the employer could use him for a day. If claimant was working on another job when he received a call from the employer, he was under no obligation to quit that job to go to work for the employer. Moreover, neither the employer nor claimant had any intent to continue their employment relationship. Thus, once the job was over, the employment relationship terminated.

Claimant worked for the employer for one day during the week of December 12 to 18, 1993. Once that job was over, the employment relationship terminated. Claimant next worked for the employer for one day during the week of January 2-8, 1994. Once that job was over, the employment relationship again terminated. Claimant subsequently worked for the employer on one day during the week of February 27-March 5, 1994, one day during the week of April 10-16 and on June 22, 1994, the day on which he was injured. The record indicates that each of these discrete days of work depended entirely on the three variables: (1) the availability of maintenance work; (2) whether the employer chose to call claimant from his list; and (3) the availability of claimant. At no time did the employer or claimant intend to continue their employment relationship beyond the day of work agreed upon. Therefore, I would conclude that the lengths of the breaks in work caused a change in the work relationship between claimant and the employer. See Earin J. Hadley, supra; Steven Caldwell, supra. Consequently, I would find that each employment constituted a "new" employment.

The rate of compensation for regularly employed workers shall be computed as outlined in former ORS 656.210 and OAR 436-60-025. OAR 436-60-025(2). "Regularly employed" means actual employment or availability for such employment. ORS 656.210(2)(b)(c); OAR 436-60-025(2). Claimant was actually employed at the time he was injured and was paid a wage by the day. Consequently, the rate of compensation shall be computed as follows: For workers employed one or two days per week, insurers shall use the worker's daily wage times three to arrive at a weekly wage. Former ORS 656.210(2)(a)(A); former OAR 436-60-025(2)(b).

In summary, because claimant was actually employed at a daily wage for one day, his weekly wage should be ascertained according to former ORS 656.210(2)(a)(A). Consequently, I respectfully dissent and would order SAIF to recalculate claimant's temporary disability benefits as outlined above.

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[1] The amendments to ORS 656.210(2)(a) by Or Laws 1995, ch 332, § 15 apply only to injuries occurring on or after June 7, 1995. Or Laws 1995, ch 332, § 66(2). Claimant was injured on June 22, 1994. Accordingly, former ORS 656.210(2)(a) applies in this case.

In the Matter of the Compensation of
IRMA D. MEDINA, Claimant
WCB Case No. 95-10821
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's partial denial of her claim for thoracic and cervical strains. On review, the issue is compensability.

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

Claimant was injured at work on March 17, 1995. The insurer accepted a right shoulder impingement syndrome. Claimant seeks to establish the compensability of separate neck and thoracic strains that she suffered as a result of the March 1995 injury.

The ALJ found that, although claimant had experienced upper back and neck symptoms as a result of the compensable injury, they were actually symptoms of the shoulder impingement problems, rather than separable conditions that had to be independently accepted and processed by the insurer. The ALJ commented that the insurer had paid for all treatment for claimant's shoulder problem, as well as the neck and upper back. The ALJ concluded that the insurer's acceptance of the shoulder condition had the effect of accepting any and all treatment compensably related to that condition, which included treatment for the neck and upper back. The ALJ upheld the insurer's partial denial of the separate conditions.

On review, the insurer does not dispute that claimant's current neck and upper back complaints are part of the accepted condition. We interpret the insurer's denial as a partial denial of a separate neck and thoracic strain.[1]

Claimant relies on the deposition testimony of her treating physician,[2] Dr. Lawton, to establish that she sustained a separate neck and thoracic strain at the time of the injury. Claimant asserts that Dr. Lawton's deposition testimony supercedes his earlier opinions, which were based on incomplete information.

Dr. Lawton originally believed that claimant was injured when she was lifting basket trays to a higher shelf and there was a crack in one of the baskets which caught and she had to push hard to get it to slide back. (Ex. 4). At a post-hearing deposition, Dr. Lawton was informed that claimant was injured when she lifted a basket of cherries on a moving conveyor belt and the belt caught part of the basket. (Ex. 28-4). Dr. Lawton acknowledged that the mechanism of injury was different than he understood, but he said that they both involved similar positions of the shoulder. (Ex. 28-5). Dr. Lawton testified:

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[1] Claimant contends that if we uphold the insurer's denial, the insurer could later refuse to process anything associated with the neck and upper back, including medical treatment, temporary or permanent disability and mileage reimbursement. We note, however, that the only issues raised in claimant's request for hearing were compensability and attorney fees. We have not been asked, nor is this the appropriate time, to address whether any specific benefits are compensably related to the accepted injury. We do note, however, that claimants current neck and upper back complaints for which treatment has been provided are a component of her accepted sholder condition.

[2] Although claimant asserts that Dr. Lawton was her treating physician, the record indicates that both Dr. Hall and Dr. Lawton were her treating physicians for different time periods. Dr. Lawton indicated on October 9, 1995 that he did not consider himself to be claimant's treating physician since he had not seen her since August 1, 1995. (Ex. 23). Dr. Lawton suggested that Dr. Hall, claimant's primary care physician, would be able to assess claimant's current condition. Under these circumstances, Dr. Lawton's opinion is not entitled to any more deference as a treating physician than Dr. Hall's opinion.

"Whether she's shoving on something that doesn't move or she's resisting something that wants to move, I think we're still having the same impact of forces across the shoulder joint itself that I -- that I had understood even though the mechanism was slightly different." (Id.)

Claimant's attorney asked Dr. Lawton to assume that claimant had an immediate onset of the shoulder, neck, upper back and right arm symptoms. (Id.) Dr. Lawton agreed that it made a difference to his evaluation if claimant's neck and back symptoms had been immediate rather than gradually coming on later. (Id.) Given the clarification that claimant's neck and back pain had been immediate, Dr. Lawton said that pointed more to a direct injury to the muscles of the neck and upper back. (Ex. 28-10). However, Dr. Lawton testified that Dr. Hall would have been in a better position to evaluate whether claimant had an immediate cervical or thoracic condition because Dr. Hall examined claimant earlier. (Exs. 28-17, -18).

Dr. Hall examined claimant on March 21, 1995, four days after her injury. Dr. Hall confirmed in the deposition that his understanding of claimant's mechanism of injury was as claimant's attorney described it. (Ex. 27-3). Dr. Hall commented that claimant's initial exams did not show as much of the neck and upper back discomfort and across the supraspinatus muscles as did subsequent exams. (Ex. 27-9). Dr. Hall explained that shoulder inflammation commonly triggers protective muscle spasms and guarding of the neck and upper back, causing further symptoms. (Ex. 27-10). Dr. Hall reiterated his earlier opinion that claimant did not have a separate thoracic or cervical condition as a result of the industrial injury. (Ex. 27-13, -14).

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). Dr. Hall indicated that, although claimant initially had neck and upper back discomfort, her discomfort increased in her later exams. In light of Dr. Lawton's testimony that Dr. Hall was in a better position to evaluate whether claimant had an immediate cervical or thoracic condition, we are persuaded by Dr. Hall's opinion that claimant did not have a separate thoracic or cervical condition as a result of the industrial injury. We find that Dr. Hall's opinion was based on an accurate history and was well reasoned. Furthermore, Dr. Hall's opinion is supported by the report of Drs. Stanford and Wilson, which concluded that claimant did not sustain a thoracic or neck strain. (Ex. 19).

ORDER

The ALJ's order dated March 22, 1996 is affirmed.

In the Matter of the Compensation of
CHRISTI L. McCORKLE, Claimant
Own Motion No. 95-0353M
OWN MOTION ORDER OF ABATEMENT
Pozzi, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The self-insured employer requests reconsideration of our July 3, 1996 Own Motion Order Reviewing Carrier Closure which: (1) set aside the employer's April 3, 1996 Notice of Closure as premature; (2) assessed a 25 percent penalty for the employer's unreasonable claims processing; and (3) awarded an approved attorney fee in the amount of 25 percent of the increased temporary disability allowed under our order. The employer requests that we reconsider our finding that claimant was not medically stationary at closure, and that it unreasonably processed claimant's claim.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. Claimant is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
EUGENIA J. RIFE, Claimant
WCB Case No. 95-08596
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that upheld the SAIF Corporation's partial denial of claimant's claim for a psychological condition. On review, the issue is compensability.

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

Claimant developed a bilateral carpal tunnel syndrome which SAIF accepted as disabling. Subsequently, Dr. Christopherson diagnosed claimant with an adjustment disorder with anxious and depressed mood, which SAIF denied. Claimant contends that the major contributing cause of her consequential psychological condition is her compensable claim, because the employer made it difficult for her to return to work. We disagree.

Here, the sole medical evidence regarding the cause of claimant's psychological condition is provided by Dr. Christopherson, her treating psychiatrist. Dr. Christopherson stated:

> "The reason [claimant] is seeing me is because she has had a very difficult time having her case handled by the SAIF Corporation, who has found innumerable reasons not to process her claim, including claims that the carpal tunnel syndrome is secondary to her endogenous obesity and her age rather than the fact that she had worked in repetitive manual labor for a number of years, including crab shucking. [Claimant] apparently had a number of unreasonable offers by both employer and the SAIF Corporation to help compensate her for her problems and this has markedly exacerbated (sic) her stress. * * * [Claimant] is an extremely functional individual who feels that she is getting a horrendous run-around through the SAIF Corporation and her job site, which I believe is based on reality.
>
> "Therefore, I must state to a reasonable degree of medical certainty that [claimant's] acute psychiatric condition and the need for psychiatric treatment is primarily being caused by the stress of processing her claim by the SAIF Corporation and/or her employer." (Emphasis supplied). (Ex. 60A).

As the court explained in Roseburg Forest Products v. Zimbelman, 136 Or App 75, 79 n. 2 (1995), a claimant's reaction to the amount of compensation and to claims processing is not caused by the compensable injury; instead, it is caused by the process by which the claimant is compensated for the injury. The court concluded that because those causes are collateral to the injury, they cannot be considered as "caused by" the compensable injury.

The claimant in Zimbelman developed bilateral carpal tunnel syndrome, which the employer accepted. Thereafter, the claimant developed a cervical condition, which the employer denied. The claimant underwent surgery, which left him temporarily totally disabled. After the surgery, the claimant became "focused" on his disability and the denial of his claim, and, for two weeks prior to his death, the claimant's physical and emotional condition deteriorated. The claimant became "extremely worried" that he would not receive the amount of compensation to which he thought he was entitled. When he received his compensation check, he believed that it was not sufficient. He became extremely agitated, suffered a myocardial infarction, and died.

The claimant's beneficiary sought compensation for the claimant's myocardial infarction on the ground that it was a "consequential condition" caused by the stress of his compensable injuries. The employer denied the claim, the ALJ set aside the denial. The Board affirmed after holding that claimant's emotional upset over his inability to work, his pain, and his reaction to the employer's claim processing, including the disputed temporary disability check, were sequelae of claimant's compensable injury, and, as such, were the major cause of claimant's myocardial infarction.

The court held that, although the claimant's emotional condition could not be considered as part of the original compensable injury, it could be compensable as a consequential condition if it were caused in major part by the original compensable injury, and, if the emotional condition were found to be compensable as a consequence of the original injury, the myocardial infarction could, in turn, be compensable as a consequential condition if caused in major part by the claimant's emotional condition. The court also noted that, to the extent that the claimant's stress was caused by his reaction to the claims process, it could not be considered as being caused by the compensable injury.

On remand, after reviewing the medical evidence, we determined that the claimant's emotional condition was not caused in major part by the compensable carpal tunnel syndrome and the cervical condition. Relying on Zimbelman, supra, we reasoned that the events surrounding the processing of the claimant's claim cannot be considered to be caused by the injury and cannot be attributed to the compensable carpal tunnel and cervical claims. Thus, where one physician attributed the condition in question wholly to claims processing and another partially to claims processing without differentiating between two or more possible causes, the claimant failed to establish that the compensable injury was the major contributing cause of the disputed condition. Ronald R. Zimbelman, Deceased, 48 Van Natta 177, on recon 48 Van Natta 544 (1996).

Similarly, in Baar v. Fairview Training Center, 139 Or App 196 (1996), the claimant argued that an employer's or insurer's delay in providing compensation in an injury claim should be considered part of the direct consequence of the industrial injury itself. The court disagreed, reasoning that, if a claimant's stress pertaining to the claims process cannot be said to be caused by the compensable injury, it necessarily follows that the actions of an employer/insurer in processing an injury claim are not part of the compensable injury. Thus, actions of an employer/insurer in processing an injury claim are "non-injury" factors for purposes of ORS 656.005(7)(a)(A).

Here, claimant's physician opined that her psychological condition and need for psychiatric treatment were primarily being caused by the stress of processing her claim by SAIF and the employer.[1] Because the medical evidence does not establish that the compensable carpal tunnel syndrome is the major contributing cause of claimant's psychological condition, claimant has failed to establish compensability of her psychological condition.

ORDER

The ALJ's order dated February 9, 1996 is affirmed.

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[1] Claimant has requested "clarification" of Dr. Christopherson's report to see if he meant processing of the claim alone or the whole situation surrounding claimant's injury, including job reassignments, etc. We treat claimant's request for "clarification" as a motion for remand. We may remand the case if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). We will remand for receipt of newly discovered evidence if the evidence could not have been submitted to the ALJ with the exercise of due diligence. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Kienow's Food Stoves v. Lyster, 79 Or App 416 (1986). Claimant offers no reason for her failure to seek "clarification" of Dr. Christopherson's May 17, 1995 report prior to the October 1995 hearings. Therefore, we are unable to conclude that claimant exercised due diligence in obtaining such evidence. Remand is denied.

In the Matter of the Compensation of
ERROL L. SCHROCK, Claimant
WCB Case No. 95-09794
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its alleged "de facto" denial of claimant's tenosynovitis condition of the right ring and small fingers; (2) awarded an attorney fee pursuant to ORS 656.382(1) for allegedly unreasonable claim processing; and (3) awarded an attorney fee pursuant to ORS 656.386(1) for prevailing over the "de facto" denial. On review, the issues are compensability, 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 May 8, 1995, Dr. Witczak, attending physician, noted that claimant reported triggering of the right ring and small fingers over the last few weeks. (Ex. 17). Dr. Witczak noted objective findings of triggering and noticeable popping when claimant flexed and straightened his fingers. Id. Dr. Witczak diagnosed "stenosing tenosynovitis right ring and small fingers" and discussed with claimant the various treating options for this condition. Id.

On August 30, 1995, claimant requested a hearing regarding the insurer's failure to respond to the tenosynovitis claim. On September 27, 1995, the insurer responded to claimant's request for hearing by denying that claimant sustained a work-related injury or occupational disease. At hearing, the insurer contended that it had not denied compensability of anything, had not denied payment of any medical bills, and that its Notices of Acceptance in Exhibits 3 and 8 included the tenosynovitis condition. (Tr. 5).

Claimant testified that all medical bills and physical therapy had been paid by the insurer. (Tr. 10).

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts. On November 28, 1994, claimant sustained a compensable injury when his right hand was crushed between two inventory boxes each weighing approximately 200 to 300 pounds. The insurer initially accepted the claim for a "right hand contusion," and later amended its acceptance to include compressive neuropathy ulnar nerve at the level of canal of Guyon, right hand. (Exs. 3, 8).

In March 1995, claimant underwent surgery for the compressive ulnar nerve neuropathy, performed by Dr. Witczak, attending physician. Dr. Witczak continued to follow claimant's progress after the surgery. In May 1995, claimant complained to Dr. Witczak of triggering in his right ring and little fingers over the past few weeks. (Ex. 17). Dr. Witczak diagnosed "stenosing tenosynovitis right ring and small fingers" and discussed with claimant the various treating options for his stenosing tenosynovitis.

By letter received by the insurer on June 30, 1995, claimant's attorney requested that the insurer issue a supplemental Notice of Claim Acceptance accepting the tenosynovitis condition of the right ring and small fingers. (Ex. 20). The insurer did not issue a written acceptance or denial of the claim within 90 days of receipt of the claim. On August 30, 1995, claimant requested a hearing regarding the insurer's failure to respond to the tenosynovitis claim. On September 27, 1995, the insurer responded to claimant's request for hearing by denying that claimant sustained a work-related injury or occupational disease. At hearing, the insurer contended that: (1) it had not denied any condition; and (2) its acceptances included the tenosynovitis condition. (Tr. 5).

Compensability

The ALJ found that: (1) the tenosynovitis condition was a new medical condition, separate and distinct from the right hand contusion and the ulnar nerve condition; and (2) the tenosynovitis condition was not included in the acceptances of the right hand contusion and the ulnar nerve condition. In addition, the ALJ found that, on the merits, claimant had established that the tenosynovitis condition was caused by the work injury. We adopt the ALJ's reasoning and conclusions regarding the compensability issue with the following supplementation.

The insurer cites Debra S. Harrison, 48 Van Natta 420 (1996), Patrick M. Wilson, 48 Van Natta 300 (1996), and Leslie C. Muto, 46 Van Natta 1685 (1994), in support of its argument that its acceptances include the tenosynovitis condition. Those cases are distinguishable on their facts. In those cases, although the claimants were given differing diagnoses for the same conditions they had since the original injuries, there was no evidence that they sought treatment for new or different conditions. Therefore, in those cases, we concluded that the conditions in question were the same conditions the claimants had since the original injuries.

Here, claimant sought treatment for a new and different condition, namely the stenosing tenosynovitis condition.[1] (Ex. 17). In addition, Dr. Witczak opined that this tenosynovitis condition had an onset some time after claimant sustained his work injury, but that it was "secondary to [the] work injury." (Ex. 27). The insurer relies on Dr. Witczak's statement that "the tenosynovitis is 'part and parcel' of [claimant's] accepted condition" in support of its argument that the tenosynovitis condition was part of the accepted claim. Id. However, we agree with the ALJ that this statement was made in the context of discussing the causation of the tenosynovitis. Id.

On review, the insurer cites to that portion of amended ORS 656.262(7)(a) which provides that "[t]he insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable condition." We interpret this reference as an argument from the insurer that its acceptance reasonably apprised claimant and his medical providers that the "nature of the compensable condition" included the tenosynovitis condition. We disagree.

Dr. Witczak opined that the major contributing cause of the tenosynovitis condition was the contusion caused by the work injury. (Ex. 27). However, Dr. Witczak explained that the tenosynovitis was a separate condition, with an onset sometime after claimant sustained the work injury. Id. This record is insufficient to find that the "nature of the compensable condition" included the tenosynovitis condition.

For these reasons, as well as those discussed by the ALJ, we find that the tenosynovitis condition is a new and different compensable condition that was not included in the insurer's acceptances.

ORS 656.262(11) Penalty / ORS 656.382(1) Attorney Fees

The ALJ found that, inasmuch as claimant met the requirements for filing a claim for a new

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[1] In support of its contention that the tenosynovitis was part of the accepted claim, the insurer argues that claimant did not receive any treatment for a condition different from the conditions it accepted. At the time Dr. Witczak diagnosed the tenosynovitis condition, he ordered claimant's physical therapy continued. (Ex. 17). Even if this continued physical therapy is not considered evidence of treatment for the tenosynovitis condition, that does not alter the fact that claimant sought treatment for the tenosynovitis condition. Id. When a worker suffers a work-related injury, he or she is entitled to know the extent of the injury and whether any treatment would be appropriate. Kelly Barfuss, 44 Van Natta 239 (1992); see Finch v. Stayton Canning Co., 93 Or App 168, 173 (1988). Here, Dr. Witczak discussed the treatment options regarding the tenosynovitis condition with claimant. Id. On this record, we find that claimant sought treatment for a new condition related to the work injury.

medical condition under amended ORS 656.262(7)(a),[2] the insurer was required to issue a written acceptance or denial of the new medical condition within 90 days of receipt of the claim. Furthermore, although the insurer had received claimant's written request for acceptance of the tenosynovitis condition on June 30, 1995, the insurer had not issued a written acceptance or denial of that condition as of the date of the November 22, 1995 hearing. Therefore, the ALJ found that the insurer was untimely in processing the claim, having unreasonably delayed acceptance or denial of the claim. However, because there were no "amounts then due" upon which to base a penalty under to ORS 656.262(11), the ALJ awarded claimant an assessed attorney fee pursuant to ORS 656.382(1).

On review, the insurer does not dispute the ALJ's findings regarding claimant's compliance with the requirements in amended ORS 656.262(7)(a). In any event, the record establishes that claimant complied with those requirements. (Ex. 20). Instead, the insurer argues that, because all compensation was paid, there is no basis for either a penalty under ORS 656.262(11) or an assessed attorney fee under ORS 656.382(1). We agree.

Here, there is no evidence of any unpaid compensation. (Tr. 10). Therefore, as the ALJ found, there are no "amounts then due" upon which to base a penalty under ORS 656.262(11)(a). Furthermore, even if the insurer's conduct was unreasonable, the record does not establish that any compensation was unpaid at the time of the insurer's conduct. Because the insurer cannot unreasonably resist the payment of compensation that has been paid, SAIF v. Condon, 119 Or App 194, rev den 317 Or 162 (1993), no basis exists for an attorney fee award under ORS 656.382(1). See Jerrie L. Jones, 48 Van Natta 833 (1996); Bruce Hardee, 46 Van Natta 2261 (1994) (in absence of any evidence of unpaid compensation at the time of carrier's allegedly unreasonable conduct, no fee is warranted under ORS 656.382(1)). Accordingly, we reverse the ALJ's award of an attorney fee pursuant to ORS 656.382(1).

ORS 656.386(1) Attorney Fee

Finding that claimant had prevailed over a denied claim, the ALJ awarded a $2,500 assessed attorney fee pursuant to ORS 656.386(1). The insurer argues that the requirements of ORS 656.386(1) that would permit assessment of an attorney fee are not met in the present case. Specifically, the insurer argues that, here, there was no "denied claim" as that term is defined in ORS 656.386(1). We agree with the ALJ that an attorney fee under ORS 656.386(1) is appropriate under the facts of this case.

Under ORS 656.386(1), a claimant's attorney is entitled to a fee "in cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial. A "denied claim" is defined 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 compensation." ORS 656.386(1).

Here, the insurer accepted "right hand contusion" and "compressive neuropathy ulnar nerve of level of canal of Guyon, [right] hand" as caused by the work injury. (Exs. 3, 8). By letter received by the insurer on June 30, 1995, claimant's attorney requested that the insurer also accept the tenosynovitis condition of the right ring and small fingers. (Ex. 20). The insurer did not issue a written acceptance of the tenosynovitis condition. On August 30, 1995, claimant requested a hearing regarding the insurer's failure to respond to the tenosynovitis claim. On September 27, 1995, the insurer responded to claimant's request for hearing by denying that claimant sustained a work-related injury or occupational disease. However, at hearing, the insurer contended that its previous acceptances included the tenosynovitis condition and that it had never denied any condition. (Tr. 5).

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[2] Amended ORS 656.262(7)(a) provides:

"After claim acceptance, written notice of acceptance or denial of claims for aggravations or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions. Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."

We find that the insurer's response to claimant's request for hearing (which denied that claimant had sustained a work-related injury or occupational disease) meant that the unaccepted claim was "denied" within the meaning of ORS 656.386(1) (i.e., the insurer answered claimant's request for hearing by denying her allegations on the express ground that this condition was not compensable).[3] Emily M. Bowman, 48 Van Natta 1199 (1996). Because this claim was only accepted at hearing after claimant requested a hearing, we further find that claimant's attorney was instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge and claimant is therefore entitled to an attorney fee under ORS 656.386(1).

After considering the factors of OAR 438-015-0010(4), we conclude that $2,500 was a reasonable assessed fee for claimant's counsel's services in obtaining the acceptance at hearing for the claim for the tenosynovitis condition.

ORS 656.382(2) Attorney Fee

The insurer initiated the request for review and we have found that claimant's compensation should not be disallowed or reduced; therefore, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Finally, we note that claimant is not entitled to an attorney fee for services on review regarding the attorney fee issues. Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The ALJ's order dated January 4, 1996 is reversed in part and affirmed in part. That portion of the order that awarded attorney fees under ORS 656.382(1) is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded $1,200, to be paid by the insurer.

[3] We find this case distinguishable from Michael J. Galbraith, 48 Van Natta 351 (1996). In Galbraith, the carrier responded to the claimant's request for hearing by asserting that the worker was "entitled to no relief." Because there was no refusal to pay compensation on the express ground that the condition was not compensable or that claimant was not otherwise entitled to compensation, there was no "denied claim" as required by ORS 656.386(1). Here, in contrast, the carrier's response to the request for hearing expressly denied that claimant had sustained a work-related injury or disease. Because the carrier's response in this case constitutes a refusal to pay compensation on the express ground that the condition is not compensable, it is a "denied claim" within the meaning of ORS 656.386(1).

July 30, 1996 Cite as 48 Van Natta 1616 (1996)

In the Matter of the Compensation of
ALFONSO I. SEVILLA, Claimant
WCB Case No. 95-11584
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall, Christian and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's occupational disease claim for chemical paint exposure [solvent intoxication] and headache conditions. On review, the issue is compensability.

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

While we generally defer to the medical opinion of the attending physician, we do not do so when the issue involves expert analysis rather than external observation, as is the case here. See Weiland v. SAIF, 64 Or App 810 (1983); Allie v. SAIF, 79 Or App 284 (1986). We agree with the ALJ that Dr. Eusterman, who performed a record review on behalf of claimant, presents the most persuasive

medical opinion. In addition, Dr. Davis, claimant's attending physician, agrees with Dr. Eusterman that the medical record does not support a viral cause of claimant's condition, contrary to the opinion of Dr. Burton, examining physician. Finally, Dr. Eusterman's opinion is well reasoned and based on accurate and complete information. Therefore, based on Dr. Eusterman's opinion, as supported by Dr. Davis' opinion, we find that claimant has established a compensable occupational disease claim. Somers v. SAIF, 77 Or App 259 (1986).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 29, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the SAIF Corporation.

Board Member Haynes dissenting.

Because I disagree with the majority that the medical evidence in this record establishes a compensable occupational disease claim, I respectfully dissent.

Claimant alleges that he sustained an occupational disease due to his exposure to organic solvents on the job. In order to establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of the disease. Amended ORS 656.802(2)(a); see also amended ORS 656.802(1)(a)(A).

Because multiple factors could potentially contribute to claimant's condition, the cause of his occupational disease is a complex medical question which requires expert medical opinion to resolve. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). In resolving complex medical causation issues, such as those presented here, medical opinions which are well-reasoned and based on accurate and complete histories are relied on. See Somers v. SAIF, 77 Or App 259 (1986). Three physicians present medical opinions regarding the cause of claimant's condition: Dr. Davis, M.D., attending physician, Dr. Burton, M.D., examining physician, and Dr. Eusterman, M.D., who conducted a record review on behalf of claimant.

Dr. Burton examined claimant on September 13, 1995, and opined that claimant's symptoms, laboratory findings, and clinical course all indicate that claimant probably experienced a viral illness with associated abnormalities of liver function studies. (Ex. 20-7). Dr. Burton noted that claimant's symptoms were not transient as would be expected following an acute exposure and were not accompanied by symptoms of intoxication, without which it was highly improbable that exposure to organic solvents would result in elevation of liver function tests. (Ex. 20-8). In addition, he noted that claimant's SGOT raised from 87 U/L on August 17, 1995, to 145 U/L on August 22, 1995, during a period claimant was restricted from painting. (Id.; Exs. 2b, 9b). Furthermore, Dr. Burton noted that claimant continued to have an elevated SGOT at present, in spite of complete removal from any possible exposure to organic solvents for the past four weeks. (Ex. 20-8).

Dr. Burton found such a clinical course incompatible with liver function abnormalities due to organic solvent exposure, but found that such a clinical course was "typical of a viral infection, chronic alcohol consumption, medication (both prescription and over-the-counter) as well as other causes." Id. Based on claimant's symptoms, Dr. Burton concluded that the most likely etiology for claimant's symptoms and his liver test abnormalities is a viral illness that had essentially resolved.

Dr. Davis initially diagnosed solvent exposure supported by elevated SGOT tests. (Exs. 8a, 9b, 10b). However, after reviewing Dr. Burton's report, Dr. Davis agreed that claimant's chronically elevated liver function tests did not support a chemical cause in that a chemical cause would result in transiently elevated liver functions. (Ex. 25). On the other hand, Dr. Davis found that Dr. Burton's assumption of a viral cause was not supported by any medical evidence. Id. Ultimately, Dr. Davis stated that claimant's "earliest symptoms, headache, sharp chest pain, watery eyes, confusion and light-headedness could be related to his paint exposure." (Ex. 25-2).

Dr. Eusterman stated that claimant's "liver function abnormalities were transient, supporting a chemical exposure cause." (Ex. 27-2) (emphasis in original). Dr. Eusterman also criticized Dr. Burton's opinion that the cause of claimant's condition was a viral infection, noting that it is unusual for a viral infection to attack both the lungs and liver and that only screening tests were done, with the available results not suggesting an acute viral hepatitis. Id. Dr. Eusterman ultimately concluded that the major contributing cause of claimant's symptoms and need for treatment is his work exposure with the employer. (Ex. 28).

On this record, I find the preponderance of the medical evidence establishes that claimant's liver enzymes were chronically, not transiently, elevated; therefore, the laboratory tests do not support a chemical exposure cause of claimant's condition. (Exs. 20, 25). I do not find Dr. Eusterman's unexplained statement to the contrary persuasive. Furthermore, there is no evidence that claimant was exposed to organic solvents after August 17, 1995. Dr. Burton explained that the fact that claimant's liver enzymes raised considerably after that date before they began their decline does not follow the clinical course for a chemical exposure cause but instead follows the clinical course for a viral cause. (Ex. 20-8). In contrast, Dr. Eusterman does not address the fact that claimant's liver enzymes raised after his exposure to organic solvents ended.

I find no persuasive reason not to defer to the opinion of Dr. Davis, the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). Although Dr. Davis initially indicated that claimant suffered from solvent intoxication, after reviewing Dr. Burton's report, he agreed that the laboratory tests do not support solvent exposure as the major cause of claimant's symptoms. (Ex. 25). In addition, both Drs. Burton and Davis opine that a toxic exposure cause would show transient liver enzyme elevation, whereas claimant exhibited chronically elevated liver enzymes. (Exs. 20, 25). Given the fact that Dr. Davis ultimately does not support a chemical exposure cause for claimant's condition, his criticism of a non-work related viral cause is not relevant. Finally, Dr. Davis' opinion that claimant's initial symptoms "could" have been caused by work exposure is insufficient to meet claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055 ("possibility" is insufficient).

Based on the medical opinion of Dr. Davis, as supported by the well-reasoned opinion of Dr. Burton, I would find that claimant has failed to establish a compensable occupational disease.

In the Matter of the Compensation of
TREVOR E. SHAW, Claimant
WCB Case No. 95-01654
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) declined to direct the insurer to pay the Board's prior awards of temporary disability compensation and penalties; and (2) declined to award an additional penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are claim processing and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

The insurer's appeal of the Board's September 8, 1994 Order on Review was dismissed on January 5, 1995, not at the time of the January 17, 1994 claim closure.

In a July 19, 1995 Order on Review, the Board modified a December 15, 1994 Opinion and Order, finding that claimant was medically stationary on January 7, 1994, and that he had failed to prove entitlement to substantive temporary disability benefits subsequent to June 7, 1993. Claimant requested judicial review.

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the relevant facts. Claimant sustained a compensable disabling injury on April 30, 1993. The insurer unilaterally terminated claimant's temporary disability payments on June 4, 1993. In a prior order, ALJ Menashe held that the insurer had no statutory authority to stop paying temporary disability benefits until June 20, 1993, ordered payment of temporary disability benefits through that date, and assessed a penalty for the insurer's unauthorized unilateral termination of temporary disability benefits. (Ex. 15-3). The insurer requested Board review and, pending its appeal, did not pay the benefits granted by the ALJ's order.

On September 8, 1994, the Board affirmed ALJ Menashe's order insofar as he concluded that the insurer had no statutory authority to terminate temporary disability payments after June 4, 1993, and further concluded that the insurer had no statutory authority to terminate temporary disability payments after June 20, 1993. In addition to its affirmance of ALJ Menashe's order, the Board ordered payment of temporary disability from June 20, 1993 until such benefits could be lawfully terminated and assessed a penalty based on those amounts. (Exs. 35, 36). The insurer appealed the Board's order, but withdrew its petition for judicial review in January 1995. (Ex. 42). The insurer paid no temporary disability compensation or penalties pursuant to the Board's final order.

In the interim, the insurer closed the claim by Notice of Closure on January 17, 1994, finding claimant medically stationary on January 7, 1994, and awarding substantive temporary disability benefits through June 6, 1993. (Ex. 24). An Order on Reconsideration affirmed the medically stationary date, but awarded temporary disability through June 20, 1993. (Ex. 34-2). A December 15, 1994 order (also by ALJ Menashe) found claimant medically stationary on June 7, 1993, and the last date of claimant's entitlement to temporary disability benefits to be June 7, 1993.[1] (Ex. 40).

When the insurer failed to pay the compensation and penalty awarded under ALJ Menashe's first order and our September 8, 1994 final order, claimant brought this enforcement proceeding. The present ALJ declined to order the insurer to pay temporary disability or penalties awarded by the above orders. In reaching this conclusion, the ALJ reasoned that the insurer had properly stayed payment of temporary disability benefits under ALJ Menashe's first order pending its appeal to the Board. Furthermore, because claimant's substantive entitlement to temporary disability benefits had been established by the time that our September 8, 1994 order became final, the ALJ reasoned that claimant had no entitlement to additional temporary disability pursuant to Lebanon Plywood v. Seiber, 113 Or App 651 (1992) (Board cannot order a procedural overpayment of temporary disability to which a claimant was not substantively entitled).

On review, claimant contends that the insurer was required to pay temporary disability benefits and a penalty in compliance with our final September 8, 1994 Order on Review within 14 days of the January 5, 1995 dismissal of the request for judicial review, and that, because the December 15, 1994 order (ALJ Menashe's second order) has not yet become final, temporary disability benefits are due for the period between June 4, 1993 and January 17, 1994, the date of claim closure. Claimant reasons that our final September 8, 1994 order establishes the following: The insurer failed to comply with any of the claim closure provisions of former ORS 656.268(3) or the suspension of benefits requirements of former ORS 656.262(4) prior to June 20, 1993. Therefore, because there was no change in circumstances subsequent to June 20, 1993 that would have permitted the insurer to terminate temporary disability benefits prior to claim closure, such benefits are due and payable to the date of claim closure pursuant to our final order.

Citing Lebanon Plywood v. Seiber, supra, the insurer contends that our September 8, 1994 final order has, in effect, become moot as a result of the subsequent litigation establishing that claimant's substantive entitlement to temporary disability benefits ceased on June 7, 1993. In other words, the insurer is contending that claim closure and the ensuing series of orders establishing a lesser period of "substantive" temporary disability supersede a final Board order that requires the payment of additional "procedural" temporary disability on what was an open claim.

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[1] On review, the Board has since held that claimant was medically stationary on January 7, 1994 and affirmed the temporary disability award. Trevor E. Shaw, 47 Van Natta 1383 (1995) (WCB Case 94-10424). Claimant has requested judicial review of this order.

Although we agree with the insurer's contention that claimant is not procedurally entitled to an award of temporary disability beyond the date established by his entitlement to "substantive" temporary disability benefits, that does not necessarily mean that the related penalty issue is also moot.

Temporary Disability Payments

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

Because ALJ Menashe's first order awarded temporary disability for a discrete period of time prior to the date of his order, those "pre-litigation order" benefits were lawfully stayed pending the insurer's appeal to the Board. ORS 656.313(1); Eulalio M. Garcia, 47 Van Natta 991 (1995). While the insurer's appeal was pending, the insurer's closure of the claim on January 17, 1994, established claimant's substantive entitlement to temporary disability. Our September 8, 1994 order established that the insurer had no statutory authority to terminate "procedural" temporary disability benefits on the claim prior to the January 17, 1994 claim closure. Thus, when the insurer appealed our September 8, 1994 order to the court, any "procedural" benefits awarded by our order were also lawfully stayed under former ORS 656.313.

By the time our procedural temporary disability order became final in January 1995, claimant's substantive temporary disability award had been reconsidered and subsequently affirmed by ALJ Menashe. Therefore, the insurer was not legally obligated to pay "substantive" temporary disability benefits beyond June 7, 1993, and any procedural award beyond that date would create a procedural overpayment.[2]

We are without authority to impose a procedural overpayment by awarding temporary disability benefits beyond the date that claimant is substantively entitled to such benefits. Seiber, supra. Therefore, the ALJ correctly declined to order the payment of temporary disability from June 7, 1993 through claim closure.

Payment of Penalties Due as a Result of our Final Order

Even though we have no authority to order payment of "procedural" temporary disability beyond claimant's substantive entitlement (June 7, 1993), ALJ Menashe's first order and our September 8, 1994 order ordered payment of penalties based on the insurer's unreasonable failure to pay temporary disability benefits on an open, accepted claim through the date of claim closure, where there was no basis for the insurer to unilaterally terminate the payment of such benefits prior to closure. See Seiber, supra, 113 Or App at 654; Pascual Zaragoza, 45 Van Natta 1221 (1992), aff'd mem 126 Or App 544, rev den 319 Or 81 (1994). Accordingly, the insurer is required to pay penalties of 25 percent of the temporary disability compensation that was due from June 4, 1993 through February 17, 1994, the date of claim closure. One half of that penalty shall be payable to claimant's attorney in lieu of an attorney fee. ORS 656.262(11).

Penalties for Insurer's Failure to Comply with Board's Order

Claimant contends that he is entitled to a second assessment of penalties for the insurer's allegedly unreasonable refusal to comply with the Board's order. We disagree.

We have already assessed a penalty of 25 percent of the temporary disability compensation that was due from June 4, 1993 through February 17, 1994. Under ORS 656.262(11), only one penalty of up to 25 percent may be assessed on a single amount "then due." Patrick H. Smith, 45 Van Natta 2340 (1993); Laurie A. Bennion, 45 Van Natta 829 (1993); see Conagra, Inc., v. Jeffries, 118 Or App 373, 376 (1993). We cannot assess more. Moreover, since a penalty is not "compensation," we have no authority to assess a penalty or related attorney fee for the insurer's failure to timely pay the penalty. Benjamin G. Parker, 42 Van Natta 2476 (1990).

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[2] As noted above, claimant argues that, because ALJ Menashe's second order establishing claimant's entitlement to "substantive" temporary disability to June 7, 1993, has not become final, it has no effect on claimant's entitlement to "procedural" temporary disability through the January 17, 1994 date of claim closure. We disagree. It is well settled that, where a claimant is seeking more temporary disability than that awarded by a Notice of Closure or Determination Order, the remedy is to appeal that closure order. E.g., John L. Desmond, 45 Van Natta 1455 (1993).

ORDER

The ALJ's order dated May 24, 1995 is affirmed in part and reversed in part. The portion of the ALJ's order that declined to order payment of the Board's penalty assessment is reversed. Consistent with the Board's September 8, 1994 order, the insurer shall pay a penalty of 25 percent of the temporary disability compensation due from June 4, 1993 through February 17, 1994. One half of that penalty shall be payable to claimant and one half to claimant's attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
DAVID R. SILLS, Claimant
WCB Case No. 95-04428
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Kenneth Russell, (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's hepatitis type C condition. In his brief, claimant objects to those portions of the ALJ's order that: (1) did not admit two medical reports; and (2) upheld SAIF's denial of claimant's rhinitis condition. On review, the issues are evidence, res judicata, and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, claimant submitted proposed Exhibits 7 and 7A, medical reports dated June 1991 and July 1991, respectively. The ALJ ruled not to admit them. (Tr. 6-7). Claimant objects to this ruling, asserting that the ALJ abused his discretion in failing to admit the reports because they are "relevant to determine the operative facts" for purposes of applying res judicata.

We first note that the ALJ's order states that "Exhibits 1-26 were admitted." In his order, the ALJ also explicitly referred to, and quoted from, the June 1991 report. Thus, we consider the ALJ to have reversed his ruling with regard to Exhibit 7, the June 1991 report, and admitted the report. Glow I. Meissner, 45 Van Natta 43 (1993).

Secondly, after reviewing proposed Exhibit 7A, we find no abuse of discretion by the ALJ in refusing to admit it. The record contains an earlier report by the same physician which describes claimant's condition and causation. Thus, we find that proposed Exhibit 7A provides little or no information that is not already in the record.

Res Judicata

In April 1992, ALJ Mongrain issued an Opinion and Order finding that claimant had proven that he was exposed to a toxic chemical at Webco Forest Products (Webco) in 1985 through 1986 that caused liver dysfunction and related disorders. Further concluding that claimant proved compensability, ALJ Mongrain set aside SAIF's denial. On review, we affirmed ALJ Mongrain's order, agreeing that claimant had proven a compensable occupational disease claim for toxic exposure. Pursuant to these orders, in February 1993, SAIF issued an acceptance for "chronic Hepatitis, non-A, non-B, resulting from your exposure at Webco Forest Products."

In April 1995, however, SAIF denied treatment for "Hepatitis C, allergic rhinitis, and episodic sinus infections with associated headaches," stating that such conditions were not caused in major part by employment conditions at Webco or related to the accepted Hepatitis non-A, non-B condition. The ALJ set aside the denial on the basis that SAIF was precluded by the prior litigation from challenging the compensability of Hepatitis C, but not allergic rhinitis. The ALJ further concluded that claimant did not prove compensability of the latter condition.

On review, SAIF asserts that the current litigation concerns a different claim for a different condition and, thus, claim preclusion should not apply. Specifically, SAIF contends that, because Hepatitis C is virally-induced and the prior litigation concerned toxic exposure, the present proceeding involves a different set of operative facts.

The doctrine of res judicata, or "preclusion by former adjudication," is comprised of two rules: issue preclusion and claim preclusion. Issue preclusion refers to future litigation of issues that were "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. Drews v. EBI Companies, 310 Or 134, 139 (1990). Here, we find that the issue "actually litigated and determined" in 1992 was whether employment conditions at Webco were the major contributing cause of claimant's liver condition and resultant need for treatment. In determining whether issue preclusion applies here, we focus on whether the current liver condition, which was denied by SAIF and is the subject of this current proceeding, is the same condition which was actually litigated before ALJ Mongrain in 1992. Based on our review of the medical record, we conclude it is the same condition.

Following SAIF's February 1993 acceptance of "chronic Hepatitis, non-A, non-B," claimant began treating with Dr. Kerwin, who diagnosed chronic Hepatitis C. (Ex. 10-4). Dr. Bardana, allergy specialist, reviewed claimant's medical records on behalf of SAIF and concluded that claimant's chemically-induced hepatitis had resolved when he stopped working at Webco and been replaced with chronic Hepatitis C. (Ex. 14-11). Dr. Bardana further stated that Hepatitis C is a chronic viral infection and in no way related to work exposure. (Id.)

Dr. Benner, hepatologist, also reviewed the medical records at SAIF's request. Dr. Benner explained that the Hepatitis C virus was discovered in 1989 and accounts for the condition diagnosed as Hepatitis non-A, non-B during the 1970's and 1980's. (Ex. 15-2). Dr. Benner diagnosed claimant's current condition as Hepatitis C and found that he had suffered from this condition at least since the mid-1980's. (Id., Ex. 29-21, 29-25). Finally, because claimant had not been exposed to any known risk factors for Hepatitis C while working at Webco, Dr. Benner found no causal relationship between claimant's Hepatitis C and his employment. (Ex. 15-3).

Examining physician Dr. Burton agreed that claimant had a history consistent with chronic Hepatitis C subsequent to 1987. (Ex. 23-12). Dr. Burton also indicated that such a condition was not caused by chemical exposure. (Id. at 13).

Like the ALJ, we are more persuaded by the opinions of Drs. Benner and Burton that claimant's liver condition actually is Hepatitis C rather than Hepatitis non-A, non-B. Dr. Benner explained why claimant's enzyme pattern since the late 1980's is consistent with Hepatitis C and that claimant was not accurately diagnosed because the Hepatitis C virus was not identified until 1989. Dr. Bardana, who indicated that claimant's chemically-induced Hepatitis resolved to be replaced by Hepatitis C, provided little reasoning for his opinion. Consequently, relying on the opinions of Drs. Benner and Burton, we conclude that claimant's actual condition has been, and is, Hepatitis C.

Nonetheless, SAIF contends that the current issue is different from the issue previously litigated because the present Hepatitis C condition is virally-induced, whereas the prior litigation involved toxic exposure. Reasoning that the diagnosis and etiology of the current liver condition are different from the diagnosis and etiology of the liver condition litigated in 1992, SAIF argues that the two conditions are not the same. We disagree. Essentially, SAIF is attempting to avoid the preclusive effect of the prior determination of ultimate fact, (i.e., that employment conditions were the major contributing cause of the liver condition), by presenting new evidentiary facts relating to the diagnosis and etiology of the liver condition. That is prohibited by the rule of issue preclusion. Section 27 of the Restatement (Second) of Judgments (1982) states, in relevant part:

> "An issue on which relitigation is foreclosed may be one of evidentiary fact, of "ultimate fact" (i.e., the application of law to fact), or of law....Thus, for example, if the party against whom preclusion is sought did in fact litigate an issue of ultimate fact and suffered an adverse determination, new evidentiary facts may not be brought forward to obtain a different determination of that ultimate fact." Id. at 253.

Accordingly, once a determination of ultimate fact has been finally made, the parties are precluded from asserting new evidentiary facts to obtain a different determination of ultimate fact.

Application of issue (or claim) preclusion prevents harassment by successive proceedings and promotes economy of resources in the adjudicatory process. North Clackamas School Dist v. White, 305 Or 48, 50 (1988).

Here, ALJ Mongrain finally determined in 1992 that Webco's employment conditions were the major contributing cause of claimant's liver condition. That determination of ultimate fact was essential to his decision setting aside SAIF's denial. See Katherine T. Hecker, 46 Van Natta 156 (1994) (essential factual finding was that work was the major contributing cause of condition requiring treatment or resulting in disability, not the diagnosis of the condition). Inasmuch as we find the current liver condition is the same condition that ALJ Mongrain found compensable in 1992, SAIF may not avoid ALJ Mongrain's final determination by asserting new evidentiary facts. We conclude, therefore, that SAIF is barred by issue preclusion from relitigating the compensability of claimant's liver condition.

Claimant objects to the ALJ's conclusion that SAIF was not precluded from denying his allergic rhinitis condition. Claimant asserts that, because a medical opinion that was part of the record in the prior action referred to "fatigue, sore throat, headaches," and ALJ Mongrain's order found that claimant's chemical exposure caused his liver dysfunction and "related disorders," the issue of the compensability of allergic rhinitis was actually litigated.

We disagree with claimant's construction of ALJ Mongrain's order. In discussing compensability, ALJ Mongrain found that employment conditions were the major contributing cause of claimant's "subsequent liver, blood and immunological abnormalities." (Ex. 8-4). ALJ Mongrain did not refer to sinus or nasal difficulties. Consequently, we find that ALJ Mongrain's use of "related disorders" referred to blood and immunological abnormalities and not allergic rhinitis or any sinus condition. Thus, we conclude that allergic rhinitis was not actually litigated and issue preclusion does not apply.

The record also shows that claimant was not diagnosed with allergic rhinitis until after the first action was finally determined. Therefore, we also conclude that the parties did not have the opportunity to litigate this issue and it was not part of the factual transaction of the first proceeding. Hence, we conclude that claim preclusion does not apply with regard to the allergic rhinitis condition. We proceed to address the merits concerning this issue.

Compensability of Allergic Rhinitis Condition

The only medical opinion supporting a causal relation between claimant's work exposure and allergic rhinitis is by Dr. Kerwin, claimant's treating physician. He explained that "allergies can be exacerbated by irritant exposures" and, thus, chemical exposure at Webco could have caused the onset of claimant's allergic condition. (Exs. 11-4, 17A). Dr. Kerwin, however, alludes to only a possible, rather than probable, causal relationship. Consequently, we find his opinion insufficient to satisfy claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055, 1059 (1981). Thus, we agree with the ALJ that claimant did not prove his allergic rhinitis, and related headache and sinus conditions, to be compensable.

Attorney Fee on Review

Claimant's attorney is entitled to an assessed fee for services on review concerning the hepatitis condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 6, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, payable by the SAIF Corporation.

In the Matter of the Compensation of
CRAIG D. SMITH, Claimant
WCB Case Nos. 95-07632, 94-04225 & 93-13258
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of responsibility for claimant's current low back condition; and (2) upheld Josephine County's denial of responsibility for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact as amended by her Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the facts. Claimant was compensably injured in January 1985 while employed by SAIF's insured. As a result of the 1985 injury, SAIF accepted "lumbodorsal spine strain." Claimant has experienced multiple aggravations of the 1985 claim. In 1989, claimant underwent microlumbar diskectomy and medial facetectomy surgery at L3-4 as a result of the 1985 injury. Claimant also received vocational training as a result of the 1985 injury. Claimant's 1985 claim was last closed by a February 1993 Notice of Closure, as corrected on March 2, 1993, with an award of temporary disability. Claimant has received a total award of 28 percent (89.6 degrees) unscheduled permanent disability as a result of the 1985 low back injury claim with SAIF.

On May 30, 1993, while performing his job duties for Josephine County as a police officer, claimant again injured his low back while subduing a suspect. Claimant filed a claim, which was accepted for "minor low back strain" by Josephine County.

Both SAIF and Josephine County denied responsibility for claimant's current low back condition. Claimant requested a hearing from those denials. The ALJ found SAIF responsible for claimant's current low back condition.

On review, SAIF asserts that, by accepting a low back strain, Josephine County has conceded that there has been a new compensable injury involving the same condition and that, consequently, responsibility for the low back condition shifts to Josephine County under ORS 656.308(1). Josephine County argues that its acceptance was not for the same condition as SAIF's earlier acceptance and that, consequently, the "last injury rule" rather than ORS 656.308(1) governs this dispute. Josephine County further argues that it has rebutted the presumption of Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), by establishing that there is no causal connection between claimant's current low back condition and its accepted May 1993 injury. On this basis, Josephine County contends that responsibility for claimant's low back condition rests with SAIF.

ORS 656.308(1) provides:

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

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. See 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. De Rosset, 118 Or App 371-72, on remand Armand J. DeRosset, 45

Van Natta 1058 (1993). Conversely, ORS 656.308(1) does not apply when a claimant's further disability or treatment involves a condition different than that which has already been processed as part of a compensable claim. See Armand J. DeRosset, supra.

Here, SAIF accepted claimant's 1985 claim for "lumbodorsal spine strain." However, in addition to the lumbodorsal spine strain, SAIF's accepted 1985 claim also involved an L3-4 disc condition and surgery. Moreover, the persuasive medical evidence establishes that claimant has an underlying mechanical weakness resulting from his 1985 injury and surgery. Thus, although Josephine County has an accepted claim for "minor low back strain," we conclude that claimant's May 1993 minor low back strain condition is a different condition from his 1985 claim (which involved an L3-4 disc condition and surgery, mechanical weakness, and a lumbodorsal strain).[1]

Because claimant's 1993 accepted claim is not for the same condition as the 1985 accepted claim, ORS 656.308(1) is not applicable to claimant's claim. See Armand J. DeRosset, supra. Instead, because there are two accepted claims involving the same body part, but not the same condition, we agree with Josephine County that the analysis contained in Industrial Indemnity Co. v. Kearns, Supra, is applicable to this case.

Kearns created a rebuttable presumption that, in the context of successive accepted injuries involving the same body part, the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. Encompassed in the "Kearns presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. Id. at 587. The carrier with the last accepted injury can rebut the Kearns presumption by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. Id. at 588.

Because it is the last carrier with an accepted claim for the low back, Josephine County is presumptively responsible for claimant's current low back condition. Id. After our review of the medical evidence, however, we conclude that Josephine County has rebutted the "Kearns presumption.".

There are four medical opinions regarding the cause of claimant's current low back condition. Dr. Louie is claimant's treating physician. Dr. Louie noted that claimant has had multiple episodes of back strain since his back surgery. Dr. Louie believes that the repeated aggravations are related to claimant's mechanical back weakness secondary to his 1985 injury and surgery. Dr. Louie also believes that claimant's mechanical back weakness from the 1985 injury predisposes him to lumbar strains. Dr. Louie opined that claimant's back strain in May 1993 was primarily due to the altercation at work (in which claimant subdued a suspect). However, Dr. Louie further opined that the May 1993 strain resolved by September 1993 and that any need for treatment after September 1993 was most likely related to claimant's previous (1985) injury.

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[1] Relying on our decision in Bonni J. Mead, 46 Van Natta 775, on recon 46 Van Natta 1185 (1994), SAIF contends that because Josephine County accepted claimant's claim for a low back strain, Josephine County remains responsible for claimant's current low back condition. We find Mead distinguishable. There, the claimant sustained a compensable injury to her low back while working for AIAC's insured. The claim was accepted for chronic lumbosacral strain. Approximately one year later, the claimant again injured her low back while employed by Liberty Northwest's insured. Liberty accepted the claim for "temporary exacerbation of chronic lumbosacral strain." On the same date, Liberty partially denied claimant's current chronic lumbosacral strain condition. AIAC denied responsibility.

We concluded that by accepting the claimant's claim for a back injury, Liberty conceded that the condition was compensable, i.e., that a new compensable injury had occurred for purposes of ORS 656.308(1). We further concluded that the second injury at Liberty's insured involved the same condition as the 1991 AIAC injury. We reasoned that although Liberty accepted a "temporary exacerbation of chronic lumbosacral strain," the medical record indicated that both the claimant's injury at Liberty and her injury at AIAC involved the same condition, lumbosacral strain. Inasmuch as the low back condition in dispute between the parties was the same condition which was accepted by Liberty, we concluded that Liberty, as the last insurer with an accepted claim for that condition, remained responsible unless and until the claimant sustained a new compensable injury involving the same condition.

In the present case, unlike in Mead, claimant's 1985 and 1993 claims did not involve the same condition. Thus, ORS 656.308(1) is inapplicable and our holding in Mead is distinguishable.

Drs. Bernstein and Donahoo examined claimant on behalf of SAIF. These physicians opined that claimant's May 1993 injury was a new and specific incident which resulted in claimant's need for treatment.

Dr. Mass performed a records review on behalf of SAIF. Dr. Mass opined that claimant's new job exposure as a police officer was the major contributing cause of his current need for treatment.

Dr. Dickerman examined claimant on behalf of Josephine County. Dr. Dickerman concluded that claimant may have experienced a minor back strain from the May 1993 incident, but did not have a pathological worsening of his low back condition. Dr. Dickerman further opined that claimant's back strain as a result of the May 1993 incident had totally resolved by September 1993. Dr. Dickerman concluded that the May 1993 incident was responsible for the increase in symptoms of claimant's low back condition, but that the 1985 injury remained the major contributing cause of the current complaints and need for treatment.

After reviewing the medical evidence, we are most persuaded by the opinions of Drs. Louie and Dickerman. Both of these physicians have given well reasoned opinions which are based on accurate histories. See Somers v. SAIF, 77 Or App 259, 262 (1986) (When medical experts disagree, we rely on those opinions which are both well reasoned and based on complete information). Moreover, as claimant's treating physician, Dr. Louie's opinion is entitled to deference in the absence of a persuasive reason not to rely on his opinion. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Based on the persuasive medical opinions of Drs. Louie and Dickerman, we conclude that claimant's 1993 low back strain has resolved and that there is no causal relationship between his current low back condition and the May 1993 accepted injury with Josephine County. Rather, the persuasive medical evidence establishes that claimant's current low back condition is causally related to his 1985 injury. Under such circumstances, we find that Josephine County has rebutted the "Kearns presumption." Accordingly, we affirm the ALJ's order assigning responsibility for claimant's low back condition to SAIF.

ORDER

The ALJ's order dated June 30, 1995, as reconsidered on December 29, 1995, is affirmed.

July 30, 1996 Cite as 48 Van Natta 1626 (1996)

In the Matter of the Compensation of
SUEYEN A. YANG, Claimant
WCB Case No. 95-13430
ORDER ON REVIEW
James L. Francesconi, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. In its brief, the insurer requests that we remand the case for a new hearing before a different ALJ because it allegedly failed to receive a fair and impartial hearing. The insurer also contends that the ALJ improperly excluded testimony from claimant's supervisor. On review, the issues are remand, compensability and evidence.

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

The ALJ set aside the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. In doing so, the ALJ determined that the medical opinion of a consulting physician, Dr. Rosenbaum, was more persuasive than that of Dr. Radecki, an examining physician. Dr. Rosenbaum had opined that claimant's work activity was the major contributing cause of her bilateral carpal tunnel syndrome. (Exs. 11, 12). On the other hand, Dr. Radecki had attributed claimant's condition to "personal factors" such as age, wrist ratio and body mass. (Ex. 10-5).

On review, the insurer first contends that the case should be remanded for a new hearing before a different ALJ, because ALJ Galton was "prejudiced" against Dr. Radecki and relied on evidence not admitted in the record. The insurer asserts that it did not receive a "fair and impartial" hearing. For the following reasons, we decline the insurer's request for remand.

Reciting a portion of a medical report from Dr. Radecki, the ALJ wrote that "this record demonstrates Dr. Radecki believes that no work activities, absent a wrist fracture, can be the major contributing cause of a worker's [carpal tunnel syndrome]. Accordingly, his predictable opinion is entitled to little weight." The ALJ later commented: " While Dr. Radecki is a forceful but nonindependent advocate for his position, I adopt Dr. Rosenbaum's unbiased and convincing opinion that claimant's bilateral [carpal tunnel syndrome] 'was caused by her work.'"

An ALJ must conduct a hearing in a manner so as to achieve substantial justice. ORS 656.283(7); Philip G. Michael, 46 Van Natta 519, 520 (1994). However, we are not persuaded that the comments in his order establish that the ALJ conducted the hearing in a manner that failed to achieve substantial justice. Moreover, even if we were otherwise persuaded, our review of the record is de novo. ORS 656.295(6); Veronica M. Strackbein, 48 Van Natta 88, 89 (1996) . Therefore, we are statutorily authorized to make our own appraisal of the evidence. Thus, we find no compelling reason to remand for a new hearing before a different ALJ to assess the persuasiveness of the medical evidence.[1] Michael A. Beall, 48 Van Natta 487, 488 (1996) (no remand in absence of "compelling" reason).

The insurer next contends that the ALJ incorrectly set aside its denial, asserting that the ALJ mistakenly determined that Dr. Rosenbaum's opinion was more persuasive than Dr. Radecki's. We disagree.

In order to prove a compensable occupational disease claim, claimant must prove that her work activities were the major contributing cause of her disease. ORS 656.802(2)(a). It is well-settled that we give the greatest weight to medical opinions that are well-reasoned and based on a complete and accurate history. Somers v. SAIF, 77 Or App 259 (1986); Michelle L. Andreasen, 48 Van Natta 515 (1996). Applying this criteria, we find that the ALJ correctly found Dr. Rosenbaum's opinion to be most persuasive.

In support of his opinion that claimant's work activity caused her bilateral carpal tunnel condition, Dr. Rosenbaum reasoned that carpal tunnel is a mechanically induced condition evidenced by visible compression of the median nerve. (Ex. 11-2). Dr. Rosenbaum further noted that, in most cases, carpal tunnel is caused by the swelling of the flexor tendon induced by repetitive hand use. Dr. Rosenbaum emphasized that Dr. Radecki's observations that "personal" factors such as age, weight and wrist configuration can influence nerve conduction values and possibly a person's susceptibility to developing carpal tunnel syndrome was not at odds with the basic concept that carpal tunnel syndrome is often caused by hand use. Dr. Rosenbaum concluded that the "personal factors" noted above in no way disproved work-related causation.

Based on our de novo review of Dr. Rosenbaum's medical opinion, we agree with the ALJ that it is well-reasoned and based on a complete and accurate history. Accordingly, we find it persuasive. Somers v. SAIF, supra. Moreover, we reject the insurer's argument that Dr. Radecki's medical opinion is more cogent.[2]

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[1] In addition, we reject the insurer's assertion that the ALJ relied on evidence not admitted in the record. The insurer refers to the ALJ's comment that Dr. Rosenbaum, to whom the ALJ referred as a co-author of a 1993 article, Carpal Tunnel Syndrome and other Disorders of the Median Nerve, was far more persuasive than Dr. Radecki. The insurer argues that, because the ALJ relied on the article (not admitted in the record) in finding Dr. Rosenbaum's opinion more persuasive, the ALJ's order should be set aside. We disagree. Dr. Rosenbaum's own medical report, admitted without objection into the record (Tr. 3), mentions that he co-authored the above article on carpal tunnel syndrome. The ALJ apparently considered this fact in assessing the qualifications and persuasiveness of Dr. Rosenbaum's opinion. However, there is no indication that the ALJ relied on the substance of the article itself. Thus, we do not find that the ALJ relied on evidence not admitted into the record.

[2] Dr. Szeto, claimant's attending family physician, opined that the major contributing cause of claimant's condition was her overall work activities as a housekeeper. (Ex. 8A). However, we are not inclined to give this opinion much weight since it is unexplained. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Harry N. Crane, 48 Van Natta 307 (1996).

Dr. Radecki opined that, based on his review of medical literature and application of a mathematical formula that predicts median nerve slowing on the basis of "personal factors" (such as age, wrist ratio, and body mass index), claimant's carpal tunnel condition was not related to employment activities. (Ex. 10). Although the insurer strenuously argues the merits of Dr. Radecki's analysis, we are not persuaded by it.

We have previously held that medical evidence grounded in statistical analysis is not persuasive because it is not sufficiently directed to a claimant's particular circumstances. See Steven H. Newman, 47 Van Natta 244, 246 (1995); Catherine M. Grimes, 46 Van Natta 1861, 1862 (1994); Mark Ostermiller, 46 Van Natta 1556, 1558, on recon 46 Van Natta 1785 (1994). In this case, Dr. Radecki relies on statistically based studies that purport to show a causal connection between carpal tunnel syndrome and intrinsic factors such as age, body mass index and wrist ratio. (Ex. 10). Because these studies are not directed toward this claimant's particular circumstances, we do not find Dr. Radecki's opinion to be persuasive. Steven H. Newman, supra.

The insurer argues, however, that Dr. Radecki addressed claimant's own circumstances when he applied a mathematical formula which Dr. Radecki stated predicted claimant's median nerve slowing within one-millionth of a second. Dr. Radecki asserted that such mathematical proof is "undeniable" evidence that median nerve injury in the carpal canal is caused by age, body mass and wrist ratio. (Ex. 10-5).

However, Dr. Radecki conceded that the exact mechanism by which body mass index causes median nerve slowing is "somewhat theoretical." (Id. at 3). Moreover, Dr. Radecki acknowledged that "the exact mechanism of median nerve injury due to aging, body mass index and wrist ratio is still a bit uncertain..." (Id. at 4). Inasmuch as Dr. Radecki was unable to explain how these "personal factors" actually caused this claimant's carpal tunnel syndrome, we do not find his medical opinion, grounded in mathematical formulas and statistical analysis, to be cogent and convincing. Thus, we conclude that the ALJ properly discounted Dr. Radecki's medical opinion.

Finally, the insurer asserts that the ALJ incorrectly excluded testimony from claimant's supervisor concerning whether she had filed a claim for carpal tunnel syndrome. (Tr. 13). The supervisor testified under an offer of proof that she did not have a carpal tunnel claim, even though she performed similar work. (Tr. 14).

We review an ALJ's evidentiary rulings for abuse of discretion. Mary J. Richards, 48 Van Natta 390 (1996). The ALJ is given broad discretion on determinations concerning the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1991) (the ALJ's decision to admit or exclude evidence is limited only by the consideration that the hearing as a whole achieve substantial justice). Here, we do not find that the ALJ abused his discretion in sustaining claimant's objection to the insurer's question regarding the filing of a carpal tunnel claim by claimant's supervisor. Moreover, even if we were to consider the supervisor's testimony under the offer of proof, we would still conclude that claimant has sustained her burden of proving a compensable occupational disease.

In summary, the ALJ correctly determined that claimant proved that her work activities were the major contributing cause of her bilateral carpal tunnel syndrome. The ALJ, therefore, properly set aside the insurer's denial.

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

ORDER

The ALJ's order dated March 7, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
ERIC G. ZOLNIKOV, Claimant
WCB Case No. CV-96003
CRIME VICTIM ORDER

Eric Zolnikov (hereafter referred to as "applicant"), has requested Board review of the Department of Justice's March 27, 1996 Order on Reconsideration. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on a finding that applicant substantially provoked his assailant and contributed to his own injuries.

Following our receipt of the request for Board review, applicant was advised that he was entitled to present his case to a hearing officer. To exercise his right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed him a copy of its record. The Department mailed a copy of its record to applicant on May 6, 1996. Having received no hearing request within the requisite time period, we have conducted our review based solely on the record.

FINDINGS OF FACT

On the night of June 3, 1995, applicant and his two roommates, Barrett and Ramirez, had been out drinking. After returning home, applicant went into Barrett's room at least three times trying to "start shit with him." Barrett told applicant to leave him alone. When applicant did not leave him alone, Barrett "went after" applicant and some punches were thrown. Barrett and applicant ended up in the kitchen area of their residence. Barrett broke a beer bottle against the refrigerator. As applicant was falling to the floor, Barrett put the broken beer bottle up to applicant's neck. At this point, Ramirez intervened and pulled Barrett off of applicant. Applicant suffered lacerations to his neck, nose and scalp from the broken beer bottle.

The police were called by applicant. When the police officer arrived, the officer observed that applicant was intoxicated and unstable on his feet. The officer could smell a strong odor of alcohol on applicant's breath. While interviewing Barrett and Ramirez in the kitchen of the house, the officer observed that the kitchen was a shambles and there was broken glass and spilt beer all over the floor. There were about 30 to 40 beer bottles on the floor and counters. The officer observed that Barrett and Ramirez were also intoxicated and that their breath smelled strongly of alcohol. Ramirez pointed out a broken beer bottle next to the refrigerator which had blood on the jagged edges and indicated that it was the bottle Barrett had held to applicant's throat. The beer bottle was taken by the police officer as evidence.

Barrett was arrested for assault. He was later convicted of Assault IV.

Applicant applied for crime victims' benefits. On December 14, 1995, the Department issued a decision denying applicant's request for crime victims' compensation on the ground that applicant substantially provoked his assailant and contributed to his injuries.

Applicant requested reconsideration of the Department's denial in a letter dated January 8, 1996. Applicant asserted that he was not intoxicated at the time of his injuries, that he had not thrown any punches at Barrett, and that Barrett started the fight and was at fault. In a January 25, 1996 Order on Reconsideration, the Department found, based on the police officer's report, that applicant had been intoxicated at the time of the altercation. Based on the statement of Ramirez, a neutral witness to the incident, the Department concluded that applicant had substantially provoked Barrett and contributed to his own injuries. The Department found no basis on which to alter its original order.

Including evidence that Barrett had been convicted of the crime of Assault IV, applicant again requested reconsideration of the Department's decision in a letter received by the Department on March 26, 1996. In a March 27, 1996 Order on Reconsideration, the Department explained that it had not denied applicant's request for benefits on the ground that there had not been a compensable crime. Rather, the Department reiterated that applicant's request was denied on the ground that the Department had found that applicant had substantially provoked his assailant and had contributed to his own injuries. Thus, the Department declined to alter its initial decision.

On April 22, 1996, the Board received applicant's request for Board review of the Department's March 27, 1996 Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

A person is eligible for crime victims' compensation if the person is a victim of a "compensable crime." ORS 147.015(1). A "compensable crime" is an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state." ORS 147.005(4). Applicant is entitled to crime victims' compensation if, among other things, the injury to the victim "was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim." ORS 147.015(5).

Based on the report of the police officer who investigated the assault, we conclude that applicant was intoxicated when the altercation took place between him and Barrett. The officer observed that applicant was unsteady on his feet and that his breath smelled strongly of alcohol. The officer also observed 30 to 40 beer bottles in the kitchen of applicant's residence. Moreover, the statement of Ramirez, who was a neutral party not involved in the assault, also confirms that he, applicant and Barrett had "been doing a lot of drinking" the night of applicant's injuries. Accordingly, we are persuaded that applicant was intoxicated on the evening of the assault.

Applicant's version of the events of June 3, 1995 differs substantially from the versions of Ramirez and Barrett. On June 3, 1995, at the hospital, applicant told the police that he and his roommates were drinking and had bought some beer and gone to a bar earlier in the evening. According to applicant, the three returned home and continued to drink. Applicant stated that he was listening to music when Barrett became upset because it was not the music he wanted to listen to. Applicant told the police that Barrett called him a "pussy" and a "faggot." Applicant stated that he thought he saw Barrett grab a steak knife from the kitchen counter. According to applicant, Barrett grabbed him and pushed him to the floor. Barrett cut his face and neck. Applicant's other roommate then broke up the fight. According to applicant, Barrett told applicant he was going to kill him. Barrett left the room and applicant called the police.

On November 12, 1995, applicant gave a written statement to the Department. He told the Department that he came home and became involved in an argument with Barrett. Applicant stated that he noticed that Barrett was "heavily under the influence of alcohol." According to applicant's written statement, Barrett began arguing with applicant. Applicant could not remember what Barrett said, but stated that Barrett began yelling and swearing and using foul language. Barrett then pushed applicant to the ground and broke a 40 ounce bottle and said: "How does it feel to have someone take your life." Applicant stated that he tried to reason with Barrett, but Barrett cut him in the face and neck with the bottle. Thereafter, applicant called the police.

Ramirez's version of the events differs substantially from applicant's. According to Ramirez, there has always been "bad blood" between applicant and Barrett and the two never seemed to get along and were always fighting or yelling at each other. Ramirez stated that he and applicant and Barrett had been doing a lot of drinking and that when they returned home, applicant would not leave Barrett alone and went into Barrett's room at least three times "trying to start shit with him." He stated that he heard Barrett tell applicant to "leave him the f--- alone." According to Ramirez, when applicant did not leave Barrett alone, Barrett went after applicant. Some punches were thrown and the two ended up in the kitchen area. Ramirez said that he saw Barrett break a beer bottle and go after applicant with it. Barrett placed the beer bottle to applicant's neck as applicant was falling to the kitchen floor. At this point, Ramirez broke up the fight. Barrett's version of the altercation was consistent with that of Ramirez.

Given the inconsistency between applicant's versions of the altercation, we rely, instead, on the account of Ramirez, who was a neutral party. Based on Ramirez's account of the altercation, we find that applicant substantially provoked Barrett by repeatedly going into his room to "start shit with him" and by ignoring Barrett's request to leave him alone. Accordingly, we affirm the Department's order denying benefits.

ORDER

The Department's December 14, 1995 order, as reconsidered on January 26, 1996 and March 27, 1996, is affirmed.

In the Matter of the Compensation of
JOYCE B. MAUCERI, Claimant
WCB Case No. 95-12555
ORDER ON RECONSIDERATION
Estell & Smith, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

On July 1, 1996, the insurer requested reconsideration of our June 14, 1996 Order on Review which affirmed an Administrative Law Judge's (ALJ's) order that awarded 4 percent (12.8 degrees) unscheduled permanent disability for a low back condition, whereas an Order on Reconsideration had awarded none. In order to consider the insurer's motion, we abated our order on review. Having received claimant's response, and the insurer's reply, we proceed with our reconsideration.

On reconsideration, the insurer contends that claimant is not entitled to any permanent disability. The insurer first argues that, by "rubber stamping" the ALJ's order, we have adopted a "rule of law," that an examination performed after a claimant returns to work will "always" be used for purposes of determining impairment, as opposed to an examination performed while claimant is off work. The insurer asserts that, as applied in this case, that conclusion is "patently without merit." Assuming that the insurer's use of the term "rubber stamping" is a reference to our determination to adopt and affirm the ALJ's order, we disagree with the insurer's contention that we have, thereby, adopted any particular "rule of law." We also reject the insurer's assertion that the timing of Dr. Scheinberg's examination in relation to claimant's return to employment is irrelevant because claimant became medically stationary several months earlier.

The medical record in this case supports the use of an examination undertaken after claimant had returned to work as an accurate reflection of her injury-related condition. In this regard, both Dr. Arbeene and Dr. Scheinberg noted that claimant's symptoms varied depending on activity. In his closing examination, Dr. Arbeene advised claimant that she would have to adjust her activities in response to her symptomatology. (Ex. 11). Dr. Arbeene also recorded right buttock pain on straight leg raising and other positive right-sided testing results. (Id.). Similarly, Dr. Scheinberg noted claimant's complaints of pain in the right lower back with radiating pain to the right leg "associated with more intense activity." (Ex. 15-1). Further, both Drs. Arbeene and Scheinberg noted that claimant experiences good days and bad days in terms of pain. (Exs. 9 & 15-1). Given these circumstances, including claimant's consistent reports of waxing and waning of her symptoms in response to physical activity, we remain persuaded that the report of Dr. Scheinberg's arbiter examination most accurately reflects claimant's permanent loss of earning capacity due to her compensable injury. See ORS 656.214(5). Our decision is based on the medical record in this case; it is not premised on a "rule of law" of general applicability.

We also reject the insurer's argument that claimant's medically stationary status renders the timing of any medical examination legally irrelevant. As statutorily defined, an injured worker is "medically stationary" when "no further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). The statute does not state that an injured worker, whose condition waxes and wanes over time with activity, is not medically stationary. One whose medical condition fluctuates may still be medically stationary in this sense. Maarefi v. SAIF, 69 Or App 527 (1984). As discussed above, because claimant's condition fluctuates with activity, we have concluded that her permanent loss of earning capacity is most accurately reflected by Dr. Scheinberg's report.[1]

Finally, on reconsideration, the insurer challenges the validity of the Department's bulletin (WCD Bulletin No. 242). Specifically, the insurer contends that the bulletin "does not make sense" because it provides a method for testing the validity of lumbar flexion through straight leg raising that should, in the insurer's opinion, apply equally to lumbar extension. So far as the record discloses, the insurer raises the issue for the first time on review. Therefore, we are not inclined to consider whether

[1] Although the insurer argues that the ALJ improperly "presumed" that claimant had experienced increased symptoms since she returned to work, the record supports the ALJ's conclusion, as claimant told Dr. Scheinberg that she had returned to work and was "doing alright," but was taking over-the-counter medication for pain. (Ex. 15-2). Furthermore, as noted above, such a finding is consistent with both of the medical opinions in this case which expressed that claimant's increased activity would lead to increased symptoms.

the Department's Bulletin is valid. See Stevenson v. Blue Cross, 108 Or App 247, 252 (1991); Gunther H. Jacobi, 41 Van Natta 1031, 1032 (1989) (new issues or legal theories presented for the first time on review are not considered where prejudice would result to one of the parties). However, even if we consider the insurer's argument, we have recently approved the application of Bulletin 242, and noted that the bulletin prescribes a specific application of the validity criteria set forth in a validly adopted rule. See Jeana Larson, 48 Van Natta 1278 (1996).

As we noted in Larson, the Director's Bulletin 242 establishes the same method for determining validity of lumbar flexion as is found in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, which are expressly incorporated into the disability rating standards. The AMA Guides explains that the straight leg raising test is "[a]n additional method to test "lumbar spine flexion" because "perceived lumbar flexion is actually a compound movement of both the lumbar spine and the hips" so that "[a] comparison of hip flexion to straight leg raising * * * offers a validation measure independent of reproducibility." AMA Guides, 3rd Ed (revised), p 96. We are in no position to conclude, as the insurer impliedly requests, that the American Medical Association's reasoning concerning the straight leg raising validity test "makes no sense."[2]

Consequently, we continue to adhere to our prior decision that claimant has established an entitlement to an award of unscheduled permanent disability.

Claimant's attorney is entitled to an assessed fee for services on reconsideration. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $200, 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 response to the insurer's request for reconsideration), the complexity of the issue, and the value of the interest involved.

Accordingly, our June 14, 1996 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our June 14, 1996 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] We also decline the insurer's invitation to disregard the "text" of the bulletin and to rely, instead, on the insurer's interpretation of the mathematical calculations provided on the Department's worksheet

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In the Matter of the Compensation of
VOLLINA DRAPER, Claimant
WCB Case No. 94-14143
ORDER OF ABATEMENT
Willner & Associates, Claimant Attorneys
David G. Low, Attorney

On July 10, 1996, we issued an order dismissing claimant's request for Board review of an Administrative Law Judge's (ALJ's) order that had affirmed the Director's determination that claimant was not a subject worker of the employer at the time of her alleged injury. Reasoning that the ALJ's order contained an incorrect notice of appeal rights, we also remanded the case to the ALJ to issue a corrected order (on behalf of the Director) with the proper notice of appeal rights in accordance with ORS 183.482 and Copeland v. Lankford, 141 Or App 138 (1996). Shortly after issuance of our order, we received the Director's motion to dismiss claimant's request for review. Noting our lack of appellate authority, the Director asserts that we are likewise without authority to remand the case (on behalf of the Director) to the ALJ. We treat the Director's motion as a request for reconsideration of our July 10, 1996 order.

In order to further consider this matter, we withdraw our July 10, 1996 order. The parties are granted an opportunity to respond. To be considered, those written responses must be filed within 14

days from the date of this order. The Director's reply(s), if any, must be filed within 14 days from the date of mailing of the parties' response(s). Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRIS G. STILL, Claimant
WCB Case No. 95-09407
ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our July 15, 1996 Order on Review that: (1) reinstated a July 27, 1995 Order on Reconsideration award of unscheduled and scheduled permanent disability, in lieu of the Administrative Law Judge's (ALJ's) award; and (2) reversed the ALJ's approved attorney fee award. Specifically, claimant contends that our reversal of the ALJ's approved attorney fee award could be construed to include other attorney fees awarded in this case. On reconsideration, SAIF agrees claimant's counsel is entitled to the assessed attorney fees awarded by the ALJ for defending against SAIF's request for a reduction of claimant's permanent disability award.

Here, the ALJ awarded an out of compensation fee for increased amounts which resulted from the ALJ's award. Because the increased award included the scheduled permanent disability awards which we reversed, we reiterate that we reverse the ALJ's approved attorney fee award which was based on the increased compensation (i.e., the increased scheduled permanent disability awards) resulting from the ALJ's order.

The ALJ also awarded claimant's counsel separate assessed attorney fee awards for defending against SAIF's request to reduce claimant's unscheduled and scheduled permanent disability awards. Accordingly, because SAIF did not achieve a reduction in the Order on Reconsideration awards, the assessed fees awarded by the ALJ are undisturbed.

Finally, claimant requests an assessed attorney fee for services on review in defending against SAIF's request for a reduction of claimant's scheduled and unscheduled permanent disability awards. SAIF concedes that claimant is entitled to a fee for defending the unscheduled permanent disability award at the Board level.

We agree that claimant is entitled to an assessed attorney fee with respect to the defense of the unscheduled permanent disability award, which was not reduced. However, on review, we did reduce claimant's scheduled permanent disability awards from the amount awarded by the ALJ. See Debra L. Cooksey, 44 Van Natta 2197 (1992) (When the claimant's conditions have been considered separately for purposes of rating permanent disability and the employer has presented separate and distinct arguments regarding each condition which the claimant is required to defend, it is appropriate to award an attorney fee for the specific condition which was not reduced by an employer's appeal.) In other words, because an entitlement to a Board level fee pursuant to ORS 656.382(2) is based on our finding that compensation should not be reduced or disallowed, and we did reduce the ALJ's scheduled permanent disability award, we do not find it appropriate to award an attorney fee related to the scheduled conditions merely because, as claimant argues, SAIF failed to have the scheduled awards reduced to zero.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the unscheduled permanent disability award is $750, to be paid 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.

Accordingly, we withdraw our July 15, 1996 order. On reconsideration, as supplemented herein, we republish our July 15, 1996 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 F. CASSIDY, Claimant
WCB Case Nos. 93-07111, 93-00760, 93-07110 & 93-00761
SECOND ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Priscilla M. Taylor, Defense Attorney

Claimant requests reconsideration of our June 4, 1996 Order on Remand. Specifically, claimant seeks an award of a $3,000 attorney fee under ORS 656.388(1) and 656.382(2) for services before the Court of Appeals.

In order to further consider claimant's motion, we abated our June 4, 1996 order on June 26, 1996. Albertsons, Inc. and Fred Meyer, Inc. were each granted an opportunity to respond. Having received responses from Albertsons, Inc. and Fred Meyer, Inc., as well as claimant's reply, we proceed with our reconsideration.

ORS 656.382(2) allows for a reasonable attorney fee where an appeal to the court is initiated by the employer or insurer and claimant's compensation is not disallowed or reduced. ORS 656.388(1) allows a reasonable attorney fee for services before every prior forum where a claimant finally prevails after remand from the Court of Appeals.

Here, Albertsons requested judicial review of our prior order which set aside its "back-up" denial as improper under the "clear and convincing evidence standard of former ORS 656.262(6), and found it responsible for claimant's low back condition. John F. Cassidy, 46 Van Natta 2254 (1994). The court reversed and remanded for reconsideration of the effectiveness of Albertsons' "back-up" denial under amended ORS 656.262(6)(a). Albertsons, Inc. v. Cassidy, 139 Or App 115 (1996). On remand, we found that Albertsons' "back-up" denial was improper even under the "preponderance of the evidence" standard of amended ORS 656.262(6)(a). John F. Cassidy, 48 Van Natta 1121 (1996).

By virtue of our Order on Remand, claimant has finally prevailed over Albertsons' denial after remand from the Court of Appeals. Moreover, his compensation has not been reduced or disallowed. Under such circumstances, we conclude that claimant is entitled to a reasonable attorney fee for his counsel's services at the court level pursuant to ORS 656.388 and ORS 656.382(2).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services before the Court of Appeals is $2,500, payable by Albertsons, Inc. This fee is in addition to claimant's previous awards. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief and motion for reconsideration), the complexity of the issue, and the value of the interest involved.

Finally, Albertsons argues that the issue in this case was limited to responsibility only, and that under ORS 656.308(2)(d) claimant's attorney fee is limited to $1,000. We disagree. In addition to the responsibility issue, there was a compensability issue involving Albertsons "back-up" denial. On remand, we have found that Albertsons' denial should be set aside. Because this case involves an issue of compensability in addition to responsibility, claimant's fee is not limited by ORS 656.308(2)(d).

Accordingly, as modified herein, we republish our June 4, 1996 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
KIM J. HAYES, Claimant
WCB Case No. TP 95008
THIRD PARTY DISTRIBUTION ORDER
James B. Griswold, Claimant Attorney
William J. Blitz, Attorney
Michael O. Whitty (Saif), Defense Attorney

Claimant has petitioned the Board for resolution of several "third-party" disputes which raise the following issues: (1) a "just and proper" distribution of proceeds from a $512,000 settlement agreement with Northwest Diesel Service and Great Dane Trailers (ORS 656.593(3)); (2) whether the percentage of the proceeds of the settlement with Northwest Diesel allocated to claimant's wife's "loss of consortium" claim (10 percent) should be increased; (3) claimant's entitlement to a portion of the proceeds of a settlement of a legal malpractice claim reached by the non-complying employer (Two D's Trucking, Inc.) and the Oregon State Bar Professional Liability Fund (PLF), on behalf of the employer's attorney (Alderman); (4) whether the paying agency, the SAIF Corporation, is entitled to a portion of the proceeds of a $25,000 settlement of a lawsuit brought by claimant against Alderman; and (5) whether the Board should declare that SAIF/Department has waived its entitlement to share in any of the proceeds that might be recovered by claimant in an action brought by claimant against Northwest Life Assurance Co. and Gerald Derby. Claimant also requests that this matter be set for hearing to allow him to present evidence regarding the value of the loss of consortium claim.

For the following reasons, we reject claimant's request for an evidentiary hearing. In addition, we hold that SAIF is entitled to receive $165,129.52 as its "just and proper" share of the third party recovery from Northwest Diesel and Great Dane Trailers in accordance with ORS 656.593(1). See ORS 656.593(3).

FINDINGS OF FACT

Claimant, a truck driver, sustained extensive injuries to his spinal cord in a motor vehicle accident on August 18, 1992 and has become a paraplegic. On September 21, 1992, the Department issued a Proposed and Final Order declaring claimant's employer, Two D's Trucking, Inc. (Two D's), to be in noncompliance with Oregon workers' compensation law and assessing a civil penalty. On January 19, 1993, SAIF, as the processing agent for the non-complying employer, issued a denial of the claim on the grounds that claimant was not a subject worker at the time of injury.

The alleged non-complying employer requested a hearing regarding the Department's order, while claimant appealed SAIF's denial. The ALJ found that the employer had sought the advice of its insurance agent (Stanley) and its attorney (Alderman) about how workers' compensation insurance costs could be reduced. The ALJ further found that Alderman and Stanley advised the employer that workers' compensation coverage could be eliminated if all employees were made corporate officers; that Alderman drafted the necessary papers to make claimant a corporate officer; and that Stanley placed insurance coverage with Northwest Life Assurance to replace the workers' compensation coverage.

The ALJ determined that claimant was not a legitimate corporate officer and that the employer's scheme to name claimant a corporate officer was a "sham." The ALJ then concluded that the employer was in noncompliance with workers' compensation law and that claimant was a subject worker at the time of injury. Accordingly, the ALJ set aside SAIF's denial and affirmed the Department's noncompliance order. The Board affirmed the ALJ's order. Kim J. Hayes, 46 Van Natta 1034, on recon 46 Van Natta 1182 (1994).

Apart from claimant's workers' compensation claim, there have been several lawsuits involving allegedly negligent third-parties. Claimant elected to seek damages from the non-complying employer, as well as from Northwest Diesel Service, Inc., G S Roofing, Inc., and Great Dane Trailers, Inc. Claimant's wife also pursued a separate claim for "loss of consortium." A settlement was reached with respect to Northwest Diesel for the limits of its $500,000 insurance policy and with Great Dane Trailers for $12,000. SAIF approved a settlement with Northwest Diesel for the sum of $450,000, which in effect allocated 10 percent ($50,000) of the proceeds to the loss of consortium claim, a sum not subject to SAIF's third-party lien. Claimant objected to the amount of SAIF's allocation for the loss of consortium claim, as well as to its distribution of the remaining settlement proceeds according to the statutory

distribution formula in ORS 656.593(1). The parties agreed to present this dispute to the Board for resolution under its authority to determine the "just and proper" distribution of third-party settlement proceeds. ORS 656.593(3).

Claimant's lawsuit against the non-complying employer and G S Roofing went to trial. A judgment was entered in favor of G S Roofing, but claimant obtained a judgment in the amount of $5,741,302 against the non-complying employer. (Ex. 5-3). Of this amount, the jury awarded approximately 11.3 percent ($650,000) to claimant's wife for the loss of consortium claim.

Upon obtaining the judgment against the non-complying employer, claimant signed a "Covenant not to Execute," whereby claimant agreed not to collect the judgment in return for an assignment of the non-complying employer's rights to sue Northwest Life Assurance Co. and Stanley's supervisor, Gerald Derby. Claimant has filed suit against Northwest Life Assurance, but this case has not been settled or gone to trial.

In a separate proceeding, the non-complying employer (Two D's) filed suit against Alderman and Stanley, alleging that they had provided negligent advice on avoiding workers' compensation coverage. Claimant was not a party to this suit, which Two D's settled with the PLF. By terms of this agreement, the PLF agreed to pay $175,000 to Two D's on behalf of Alderman. $100,000 of this settlement was payable to the Department of Consumer and Business Services in reimbursement for claims costs incurred pursuant to ORS 656.054 and ORS 656.735(4).[1] The Department agreed to release the non-complying employers from any further liability, including that under ORS Chapter 656, with the exception of ORS 656.593. (Ex. 10-4).

Finally, claimant filed suit against Alderman, Stanley, Derby and Northwest Life Assurance Co., alleging that the four defendants had worked together on the scheme to write the insurance policies to avoid paying workers' compensation premiums. Claimant alleged that, as result of the scheme, which involved making all employees corporate officers, Two D's had no workers' compensation coverage and would not have safety inspections of its equipment. The claim against Alderman was settled for $25,000. The other defendants were dismissed from the lawsuit.

SAIF asserts a lien for actual claim costs of $519,729.59. SAIF also asserts that, at claim closure, claimant will be entitled to an estimated permanent disability award of $146,025. Claimant does not dispute the amount of SAIF's actual and projected claim costs.

CONCLUSIONS OF LAW AND OPINION

Request for Hearing

Claimant requests that this matter be set for a hearing so that live testimony can be presented regarding his spouse's "loss of consortium" claim. We reject claimant's request.

Board decisions under the third party law must be made on a record sufficient to sustain judicial review. Blackman v. SAIF, 60 Or App 446, 448 (1982). The parties agreed to present the dispute pertaining to the value of claimant's wife's loss of consortium claim to the Board. The parties have had a full opportunity to present their positions, as well as offer documentary evidence. In fact, claimant has submitted substantial documentation regarding the "loss of consortium" issue consisting of affidavits from himself and his wife, a trial transcript of their testimony regarding the effects of claimant's injury, and a videotape depicting a "Day in the Life" of claimant. While referring a "third-party" dispute to a fact-finding hearing is not unprecedented, see Nova Y. Knutzen, 40 Van Natta 1825 (1988), we conclude that the record has been sufficiently developed so that we can decide the issues presented for resolution. Blackman v. SAIF, supra.

"Just and Proper" Distribution

The first issue we address concerns the "just and proper" distribution of the proceeds of the settlement ($512,000) of claimant's third-party suit against Northwest Diesel and Great Dane Trailers. Claimant seeks a portion (50 percent) of this recovery greater than the statutory one-third share under ORS 656.593(1), as well as an increased allocation of the settlement proceeds to his spouse's loss of consortium claim. For the following reasons, we reject claimant's requests.

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[1] The Department was referred to as the "State" in the agreement, to which SAIF was not a signatory.

At the outset, we summarize the applicable law. If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The 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 third persons. The claim was processed by SAIF on behalf of the non-complying employer, and claimant has been provided compensation in the sum of $519,729.59. 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, except the cost of recovering such damages. Norman H. Perkins, 47 Van Natta 488 (1995).

Since claimant has settled his third party claims against Northwest Diesel and Great Dane Trailers, and since SAIF has approved those settlements, 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.

SAIF proposes that the $512,000 settlement be distributed according to the statutory formula in ORS 656.593(1). After deduction of 10 percent for claimant's spouse's loss of consortium claim ($51,200), SAIF proposes that a one-third deduction of the remaining balance of the settlement ($460,800) be allocated for attorney fees ($153,600), which would leave a balance of $307,200. After deduction of litigation costs of $55,000, leaving a balance of $252,000, one-third of the remainder ($84,000) would be distributed to claimant and the remaining $168,133.33 would be allocated to SAIF in partial reimbursement of its undisputed claim costs in the amount of $519,729.59.

On the other hand, claimant argues that a "just and proper" distribution of the settlement proceeds should require that he receive a 50 percent share of the settlement proceeds and that the portion allocated to his spouse's loss of consortium claim be increased from 10 to 25 percent. Based on the following reasoning, we find that a "just and proper" distribution of the settlement proceeds should follow the statutory formula.

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 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, supra, 47 Van Natta at 490 (1995); Jack S. Vogel, 47 Van Natta 406 (1995).

Here, claimant does not contest SAIF's assertion that it incurred the aforementioned $519,729.59 in temporary disability, permanent disability, vocational benefits and medical expenses while processing claimant's injury claim. Instead, claimant argues that SAIF should reduce its share of the settlement proceeds so that he can receive a larger portion of the third party settlement.

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 Santos King, 47 Van Natta 2026, 2027 (1995); Gerald L. Davidson, 42 Van Natta 1211, 1213 (1990). In this case, we likewise find that it is "just and proper" for SAIF to recover most of the balance of settlement proceeds remaining after distribution of claimant's attorney fees, litigation expenses, and statutory one-third share. In reaching this conclusion, we note that SAIF will recover less than one-third of its undisputed costs incurred in processing this claim. In light of such circumstances, we find it "just and proper" for SAIF and claimant to receive reimbursement in accordance with the statutory formula in ORS 656.593.

Claimant argues that the portion of the settlement proceeds allocated to his spouse's loss of consortium claim should be increased. The Board lacks the statutory authority to approve or disapprove a proposed settlement of a claimant's spouse's loss of consortium claim. Weems v. American Intern. Adjustment Co. 123 Or App 83, 86 (1993), aff'd Weems v. American Intern. Adjustment Co., 319 Or 140 (1994); SAIF v. Cowart, 65 Or App 733 (1983). However, the Board can consider the value of such a claim as evidence of the reasonableness of a proposed settlement of claimant's underlying negligence claim. Weems v. American Intern. Adjustment Co., supra, 123 Or App at 86. Claimant argues that the value of his spouse's loss of consortium claim is substantially greater than 10 percent. However, the jury in claimant's lawsuit against Two D's Trucking, considering the same evidence that is available to the Board, awarded claimant's spouse damages which amounted to 11.32 percent of claimant's eventual recovery of $5,741,302. In light of such circumstances, and after considering the parties arguments, we find that 11.32 percent ($57,958.40) of the $512,000 settlement amount is a reasonable allocation of proceeds to the loss of consortium claim.[2]

Alderman Settlement

In its brief, SAIF concedes that it makes no claim regarding the proceeds of this settlement. Therefore, the issue of whether SAIF is entitled to a portion of these proceeds or whether it must approve the settlement is moot.

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[2] Claimant notes that the percentage of the "non-economic" damages of $2,250,000 awarded by the jury to claimant's spouse in the Two D's lawsuit was 22.41 percent of the total award for non-economic damages. However, claimant omits from his calculation his award of "economic" damages of $2,841,302. (Ex. 5-2). It is well-settled that the paying agency's lien attaches to both economic and non-economic damages. See Webster N. White, 45 Van Natta 2068, 2069 (1993); Kenneth Owens, 40 Van Natta 1049, 1050-51 (1988). We, therefore, conclude that our allocation of the settlement proceeds to the loss of consortium claim is more consistent with the jury's verdict than is claimant's.

Claimant also notes that 50 percent of his prayer for non-economic damages was granted, while 100 percent of his wife's loss of consortium claim was awarded by the jury. We do not consider such results to be particularly enlightening. A myriad of reasons (not the least of which being an overestimation of the value of the claim) could account for such an outcome. In any event, we find a ratio based on the actual damages, as ascertained by an unbiased arbiter (a jury) to be eminently more useful in conducting our independent evaluation.

Legal Malpractice Settlement

The issue here is whether Two D's lawsuit against its negligent attorney is a "third-party" action, the proceeds of whose settlement are subject to statutory distribution. The Supreme Court in Toole v. EBI Companies, 314 Or 102 (1992) addressed the issue of whether the statutory lien of a carrier on the proceeds of an injured worker's recovery against a negligent third party extends to the proceeds of a malpractice action against an attorney based on the attorney's mishandling of the worker's third-party negligence action.

The Court agreed with the Court of Appeals that the Board had jurisdiction to resolve whether a claim against an attorney is a third-party claim, whether malpractice settlements are void for lack of approval by the paying agencies or the Board, and whether a paying agency is entitled to a "just and proper" share of the settlement proceeds. ORS 656.593(3). However, reversing the Court of Appeals, the Supreme Court held that, because the claim against the claimant's attorney is derived from the claim against the third party, because the recoverable damages are the damages that the claimant would have recovered from the third party, and because of the clear legislative history, an action for attorney malpractice based on the attorney's negligent failure to recover compensation for an injured worker directly from a responsible third party is a third-party action under ORS 656.593, to which a paying agency's lien extends. The Court reasoned that damages recoverable in a malpractice action would be the damages that the claimant would have recovered in the original third-party action but for his or her attorney's negligence.

We find Toole distinguishable. In contrast to Toole, the non-complying employer's malpractice claim in this case is not derived from any of claimant's third-party claims. The employer's malpractice lawsuit is entirely separate from any of claimant's causes of action against allegedly negligent third-parties. The funds in dispute are the proceeds of an action by the non-complying employer against Alderman, who was allegedly negligent in devising a scheme so that the non-complying employer could evade the mandatory insurance requirements of workers' compensation law. Claimant has not established that these funds are damages to which he would otherwise be entitled.

Accordingly, we conclude that the non-complying employer's settlement with his allegedly negligent attorney did not require notice to claimant or his approval. We further find that the proceeds of this settlement are not subject to distribution according to the third-party statutes.[3]

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[3] We acknowledge that SAIF will ultimately receive the Department's portion of the malpractice settlement in reimbursement of its claim costs, i.e., the Department will use those funds to periodically pay SAIF for any reimbursable costs incurred while processing the claim. ORS 656.054(3). Thus, we have considered this factor in determining the "just and proper" distribution of the proceeds of claimant's third-party suit against Northwest Diesel and Great Dane Trailers. However, inasmuch as SAIF has an uncontested lien for actual claim costs of $519,729.59 and estimates a future permanent disability award of $146,025, its eventual receipt of the Department's portion of the legal malpractice settlement ($100,000), still leaves SAIF with a total recovery ($265,129.52) that falls far short of full reimbursement of its actual and projected claim costs. For this reason, we continue to consider it "just and proper" for SAIF to recover a share of the Northwest Diesel and Great Dane Trailers settlement proceeds commensurate with the statutory formula of ORS 656.593(1).

Claimant argues that he is entitled to the $175,000 settlement, contending that the "State" controlled distribution of the funds knowing that claimant had a lawsuit pending against Two D's. Claimant apparently considers SAIF and the Department to be the same entity. However, as previously noted, SAIF was not a signatory to the settlement of the claim brought by Two D's against Alderman. Moreover, SAIF and the Department are not interchangeable. SAIF appears in this matter as the "assigned claims agent" for processing the non-complying employer claim. ORS 656.054(1). Since it also pays benefits to claimant, SAIF also qualifies as a "paying agency" pursuant to ORS 656.576. It does not, however, represent the Department, which became involved in Two D's suit against Alderman by virtue of its right to reimbursement of claim costs under ORS 656.054(3) and ORS 656.735(4).

Claimant also argues that a hearing is necessary to tell the "complete and full story" regarding how the State "single-handedly and selfishly took and controlled" Two D's primary cash asset. We reject claimant's request. First, other than claimant's unsubstantiated assertion, there is no evidence that the Department accepted an unreasonable sum following its settlement negotiations with the non-complying employer and the PLF (on behalf of Two D's attorney). Had claimant presented evidence from any of the participants to the "Two D's" malpractice settlement which even suggested questionable behavior on the part of the Department, we might have been inclined to refer this matter to hearing to evaluate the conflicting evidence. However, in the absence of such evidence, we do not consider it appropriate to delay resolution of this matter to essentially engage in a fishing expedition. Finally, as previously explained, Two D's lawsuit was a totally separate cause of action from claimant's third-party claims. Thus, as a nonparticipant in that lawsuit, claimant is without standing to challenge the settlement.

Pending Case Against Northwest Life Assurance

As previously noted, there has been no settlement or judgment with regard to this case. Where no third party settlement has been reached, there are no proceeds from which we can determine a "just and proper" distribution. We, therefore, agree with SAIF that it is premature to issue an opinion on how the proceeds of any settlement with respect to the claim against Northwest Life Assurance and Derby should be distributed. See Julio G. Mejia, 44 Van Natta 764, 766 (1992); Delores M. Shute, 41 Van Natta 1028 (1989).

Claimant contends, however, that the "State" is not entitled to share in any recovery that might be obtained in this case and seeks a ruling that any lien that SAIF has against any judgment was extinguished when the "State" signed the settlement agreement resolving Two D's claim against Alderman. Claimant reasons that his rights in the pending lawsuit arise because of his judgment obtained against the non-complying employer. According to claimant, inasmuch as the "State" waived any further claims against the non-complying employer as part of the settlement of the non-complying employer's claim against Alderman, the "State" has "waived" any and all claims against the non-complying employer. Thus, claimant argues that any recovery should not be distributed according to ORS 656.593.

We again emphasize that SAIF was not a signatory to the settlement of Two D's claim against Alderman. It, therefore, did not "waive" its rights under ORS 656.593. To the extent that claimant challenges the validity of SAIF's lien, we once more note that no settlement offer has been made, nor has a judgment been filed. Under these circumstances, we lack authority to resolve any dispute regarding the "just and proper" distribution of proceeds resulting from this action. Julio G. Mejia, supra; Mary E. Bigler, 43 Van Natta 619, 621 (1991). Nevertheless, as we stated in Bigler, should a settlement or judgment subsequently materialize and should the validity of SAIF's lien remain in dispute, the parties may again seek Board resolution.

In summary, we conclude that a distribution of the proceeds of the settlement of claimant's third party action against Northwest Diesel and Great Dane Trailers according to the statutory formula of ORS 656.593(1) is "just and proper." See ORS 656.593(3). The amount allocated to claimant's spouse's "loss of consortium" claim should not exceed 11.32 percent.[4] We further conclude that the proceeds from the non-complying employer's lawsuit against its allegedly negligent attorney (Alderman) are not subject to distribution according to the third-party statutes.

IT IS SO ORDERED.

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[4] 11.32 percent of the $512,000 settlement is 57,958.40. This leaves a balance of $454,041.60 to be distributed according to the statutory formula of ORS 656.593. SAIF's ultimate share of the third-party recovery will be $165,129.52, following deduction of attorney fees (one-third), litigation costs ($55,000) and claimant's one-third share.

Board Chair Hall dissenting.

Citing Urness v. Liberty Northwest, 130 Or App 454 (1994), the majority acknowledges that, in determining a "just and proper" distribution of claimant's settlement of his third-party suit against Northwest Diesel and Great Dane Trailers, it has the authority to judge this case on its own merits. The majority further avers that it does not arbitrarily adhere to the statutory distribution scheme of ORS 656.593(1). Despite its acknowledgment of its broad authority to determine a "just and proper" distribution, the majority, nevertheless, follows the rigid statutory distribution formula. Because the majority's actions belie its own words, I must respectfully dissent.

There is no doubt that the Urness court granted the Board wide latitude in making a "just and proper" distribution. I submit that, in performing our appointed task of apportioning third-party settlement proceeds, our powers are similar to those of a court of equity. That is, we must determine what is fair and equitable whenever we are called upon to determine a "just and proper" distribution under ORS 656.593(3). Unfortunately, the majority fails to fulfill this role by adhering to the statutory distribution formula of ORS 656.593(1).

Reduced to its essence, the majority's justification for following the statutory scheme lies in its conclusion that SAIF will recover less than one-third of its undisputed costs incurred in processing the claim. However, this rationale is unsatisfactory, because the paying agency will never fully recover its lien when a settlement is for less than the full amount of the lien. Is the majority saying that it will not depart from the statutory formula in such cases? I can only conclude that it is. If so, then it violates the Urness court's admonition that we exercise our discretion and judge each case on its own merits.

The majority finds that 11.32 percent ($57,958.40) of the $512,000 settlement is a reasonable allocation to the spouse's loss of consortium claim. I strongly disagree. Such an allocation does not adequately reflect the full extent of the spouse's separate claim for which the jury awarded the spouse $650,000. Furthermore, while the paying agency's lien attaches to both economic and non-economic damages, Webster N. White, 45 Van Natta 2068 (1993), that does not make the majority's allocation "just and proper," when the lien is of an economic nature (medical, time loss and permanent disability) and yet the jury in the "Two D's" lawsuit awarded non-economic damages of $2,250,000, or some 39 percent of the total verdict. The majority's allocation fails to recognize the enormous non-economic (pain and suffering) damages claimant has and will suffer and that these damages are not part of the workers' compensation benefits paid to claimant. The majority fails to explain why their statutory distribution is equitable in light of claimant's non-economic damages and the spouse's independent claim.

Considering the devastating impact of claimant's injury on his and his wife's lives, a "just and proper" distribution requires something much different from the statutory formula that the majority provides. Because the majority fails to properly exercise its statutory role, I must part company from its decision in this case.

August 8, 1996 Cite as 48 Van Natta 1641 (1996)

In the Matter of the Compensation of
DANIEL S. GRIFFITHS, Claimant
WCB Case No. 94-05901
ORDER OF ABATEMENT
Bryant, Emerson, et al, Claimant Attorneys
Howes & Brown, Defense Attorneys

On July 8, 1996, we issued an order dismissing claimant's request for Board review of an Administrative Law Judge's (ALJ's) order that had affirmed the Director's determination that claimant was not a subject worker of the employer at the time of her alleged injury. Reasoning that the ALJ's order contained an incorrect notice of appeal rights, we also remanded the case to the ALJ to issue a corrected order (on behalf of the Director) with the proper notice of appeal rights in accordance with ORS 183.482 and Copeland v. Lankford, 141 Or App 138 (1996).

In reaching our conclusion, we cited Vollina Draper, 48 Van Natta 1505 (1996). We have recently withdrawn our Draper decision to consider the Director's contention that, since we lack appellate review authority, we are likewise without authority to remand a "subjectivity determination" case (on behalf of the Director) to the ALJ.[1] In light of our abatement order in Draper, we also withdraw our July 18, 1996 order in this case. In addition, we implement the following supplemental briefing schedule.

The parties' responses to this order must be filed within 14 days from the date of this order. The Director's reply(s), if any, must be filed within 14 days from the date of mailing of the parties' response(s). Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

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[1] Copies of the Director's motion in Draper have been included with the parties' counsels' copies of this order.

In the Matter of the Compensation of
PATRICK E. KELLY, Claimant
Own Motion No. 96-0308M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant, *pro se*, requests review of the SAIF Corporation's July 1, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from May 3, 1996 through May 29, 1996. SAIF declared claimant medically stationary as of May 30, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 1, 1996 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Even though medical opinion establishes that a claimant required ongoing care for an indefinite period of time, the ongoing care does not necessarily establish that the claimant was not medically stationary. Maarefi v. SAIF, 69 Or App 527, 531 (1984). In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

In a May 30, 1996 letter, Dr. Cronk, claimant's then-treating surgeon, opined that:

> "I think [claimant's] condition has reached the point of maximum improvement and his condition is medically stationary. His claim may be closed at this time. [Claimant] has moderate impairment with respect to the knee based on the articular damage and the absence of his lateral meniscus. Once again, his arthritic involvement is likely to progress with the passage of time; heavy use of the knee might accelerate that."

Dr. Cronk further noted that claimant was examined on May 13, 1996, and "was doing well at that time and was informed that he could resume work activities although he should not climb [telephone] poles." Dr. Cronk reported that:

> "[Claimant] has applied for work with US West. I have reiterated the fact that he has very advanced articular damage in his lateral compartment with moderate damage in the patellofemoral and should avoid high-impact activities. If he is experiencing no giving way and feels the knee is comfortable, then he may climb poles but should do so with caution and with the understanding that the knee will gradually worsen with time because of the arthritic process which is already set in motion."

Dr. Cronk also noted that, two days after his May 13, 1996 examination, claimant had reported "grinding in his knee and transient locking." Dr. Cronk "informed [claimant] that it was likely the knee would periodically catch and might even swell due to the advanced nature of his articular damage." Here, Dr. Cronk provided a clinical diagnosis which persuades us that claimant could expect to experience ongoing symptoms due to the articular damage in his knee. However, ongoing symptoms do not establish that claimant's compensable injury was not medically stationary. Maarefi v. SAIF, supra. Inasmuch as Dr. Cronk performed claimant's most recent surgery, and also performed several post-operative examinations, we find him to be in the best position to evaluate claimant's condition. Moreover, we consider his opinion to be well-reasoned and supported by current medical evidence. Weiland v. SAIF, supra; Somers v. SAIF, supra.

On July 8, 1996, the Board received claimant's request for Board review of SAIF's closure. In his undated letter, claimant asserted:

> "In Ref to Dr. Omera's [sic] letter I don't feel I was stationary. You can't leave a knee in that much pain and swelling. There is always something you can do for it if you want."

Although we do not find a letter from Dr. O'Meara in the record, claimant noted in his letter that:

> "I have a[n] appointment with Doctor Roberts. I think maybe we can do something with this knee so I may work with it or at least [have] no pain."

To support his contention that he was not medically stationary at claim closure, claimant requested that SAIF submit to the Board a July 12, 1996 letter from Dr. Roberts. In an undated letter received by the Board on July 17, 1996, claimant contended that "Dr. Roberts has or is scheduling [an] appointment for knee fusion, [because] it is the only fix possible." SAIF subsequently submitted Dr. Roberts' July 12, 1996 letter to the Board, but contended that the report does not relate to claimant's condition at the time of closure, as "it has been received after closure and does not mention a request for surgery, just a referral to another doctor to consider surgery."

Dr. Roberts had performed operations on claimant's knee in 1990 (arthroscopic surgery, synovectomy and debridement) and 1991 (posterior cruciate repair), and had opined in 1990 that claimant's prognosis was poor and at some point claimant would require a knee replacement. Although Dr. Roberts had performed several operations on claimant's knee, he did not examine claimant at the time of closure, and was not claimant's treating physician at closure. In fact, until the July 12, 1996 examination, there is no evidence in the record that Dr. Roberts had examined claimant since 1991. Weiland v. SAIF, supra; Somers v. SAIF, supra; Scheuning v. J.R. Simplot & Co., supra.

Claimant submitted a copy of a December 14, 1990 letter from Dr. Roberts, in which he opined that "[t]he only operation even close to reasonable for [claimant] would be a knee fusion to make the joint totally stiff and you and I have already talked about that and decided that you wouldn't like it." Six years later, in his July 12, 1996 letter, Dr. Roberts opined that:

> "I still feel [claimant] is too young for a total joint arthroplasty and I do not think his life-style would allow him to successfully have a total joint [replacement]. For that reason, I recommend that his care be transferred to Dr. Rod Beals at the University for consideration for a left knee joint fusion."

Although he recommended that claimant be considered for a left knee joint fusion (as he suggested was "close to reasonable" in 1990), Dr. Roberts did not opine that claimant's knee condition was not medically stationary at closure. Rather, Dr. Roberts notes, because claimant's "life-style" would not allow the total joint arthroplasty, for that reason he recommended consideration of the left knee joint fusion. Such reasoning does not cause us to conclude that material improvement of claimant's condition was reasonably anticipated from medical treatment or the passage of time at the time of claim closure. See ORS 656.005(17).

Neither are we persuaded that Dr. Roberts actually recommended further surgery. Dr. Roberts' July 12, 1996 letter only indicated that he recommended that claimant's "care be transferred to Dr. Rod Beal" for consideration of further surgery. Further, Dr. Roberts stated that the left knee joint fusion was "a procedure I have never done." Thus, we do not consider Dr. Roberts' opinion persuasive regarding claimant's potential need for surgery.

Finally, Dr. Roberts reported that he did not have claimant's "new x-rays from Corvallis," but he had a report of the x-ray reading. Based on that report, Dr. Roberts opined that "there is evidence of further degenerative change including more spurring, further loss of joint space and cyst formation now." However, Dr. Roberts does not indicate when the "new" x-rays were taken. The only x-rays noted in the record are "standing" x-rays taken on April 16, 1996, and reviewed by both Drs. Steele and Cronk before claimant's May 3, 1996 surgery. Such circumstances, in addition to the "post-closure" nature of the opinion, do not persuade us that claimant's condition was not medically stationary at closure.

Based on this record, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that SAIF's closure was proper.[1]

Accordingly, we affirm SAIF's July 1, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

---

[1] In the event that Dr. Roberts or Dr. Beals recommends further surgery for claimant's compensable injury, our decision does not preclude claimant from asking SAIF to reopen his claim. ORS 656.278(1). Should such circumstances arise, and in the event that SAIF declines to reopen the claim, claimant may refer the matter to our attention or to the attention of the Workers' Compensation Ombudsman.

In the Matter of the Compensation of
JAMES M. KING, Claimant
WCB Case No. 93-06873
ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. King v. Building Supply Discount, 138 Or App 519 (1996) (hereinafter King II). The court reversed and remanded our prior order for reconsideration in light of its decision in King v. Building Supply Discount, 133 Or App 179 (1995) (hereinafter King I).

In our prior order, we concluded that claimant failed to establish compensability of a blood clot condition in his left leg. In light of this conclusion, we also found that the SAIF Corporation's denial of this blood clot condition was not unreasonable. James M. King, 46 Van Natta 1281 (1994). In reaching our compensability decision, we found claimant's treating physicians' causation opinions unpersuasive because they were based on an understanding that claimant's coronary artery disease (CAD) was a compensable condition, an opinion which we found against "the law of the case." Subsequently, the court held that SAIF was barred by claim preclusion from denying claimant's CAD. King I, 133 Or App at 183. Consequently, as we found on remand from King I, the CAD is part of the compensable condition. James M. King, 47 Van Natta 1563 (1995). We proceed with our reconsideration.

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact with the following exception and supplementation. We do not adopt the second sentence of the "Ultimate Findings of Fact."

On February 23, 1993, claimant had surgery for a blood clot in his left leg. (Ex. 19). On June 3, 1993, SAIF issued a denial which stated, in relevant part:

> "We have carefully reviewed your claim filed with SAIF Corporation for a myocardial infarction of March 19, 1977 sustained while you were working for Building Supply Discount Center[,] Inc.
>
> "We find we must now delineate our responsibility in the hospitalization and care provided in February of 1993. Based on the information in [sic] file, and without waiving other questions of compensability, we must hereby deny care, treatment and hospitalization for chronic occlusive disease of the left iliac artery, chronic occlusion of the left superficial femoral artery and a fresh thrombus in the deep femoral artery as the exposure of March 19, 1977 is not the major contributing cause of these conditions." (Ex. 22).

At hearing, the parties agreed that the issue was SAIF's June 3, 1993 denial, with claimant contending that the denial should be set aside and SAIF contending that it should be upheld. (Tr. 2, 3). In addition to relying on the language of its June 3, 1993 denial, SAIF also asserted that claimant's left leg blood clot condition was not compensable because the underlying CAD was not compensable. (Tr. 2, 3, 10, 11).

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the relevant facts. In 1977, claimant suffered a myocardial infarction (heart attack), which required double bypass surgery. This heart attack and resulting surgery were found compensable by a prior ALJ. At that time, CAD was also diagnosed. In 1988, claimant suffered a second heart attack for which he filed a claim. SAIF denied claimant's claim for the 1988 heart attack and claimant's preexisting CAD. SAIF's denial was set aside "in its entirety" by a prior ALJ whose order became final.

From June 1990, claimant received treatment from Dr. Semler, treating cardiologist, to stop or slow the progression of claimant's underlying CAD. On September 1, 1992, SAIF denied the treatment, asserting that it was necessitated by claimant's underlying CAD, which SAIF contended was not compensable. Finding that SAIF was precluded from denying claimant's CAD, a prior ALJ set aside SAIF's denial. On review, we concluded that SAIF was not precluded from issuing its denial and on the merits found that claimant's CAD was not compensable. James M. King, 46 Van Natta 1281 (1994). Thereafter, claimant requested judicial review.

Noting that SAIF had failed to appeal the prior ALJ's order relating to its denial of claimant's 1988 heart attack and CAD, the court concluded that SAIF was precluded from contesting the compensability of claimant's CAD. King I, supra, 133 Or App at 183. Consequently, the court reversed and remanded. On remand, we set aside SAIF's partial denial of claimant's CAD. James M. King, 47 Van Natta at 1564.

In the meantime, on February 23, 1993, claimant underwent surgery for a blood clot in his left leg. On June 3, 1993, SAIF issued a partial denial of claimant's treatment for "chronic occlusive disease of the left iliac artery, chronic occlusion of the left superficial femoral artery and a fresh thrombus in the deep femoral artery," contending that the 1977 heart attack was not the major contributing cause of these conditions. (Ex. 22). This denial is the subject of the present litigation. Claimant requested a hearing on this denial. The ALJ set aside SAIF's denial, relying on the prior ALJ's determination that SAIF was precluded from denying claimant's preexisting CAD and, in the alternative, finding that claimant prevailed on the merits.

On review, we concluded that claimant failed to establish compensability of the blood clot condition in his left leg. In reaching this conclusion, we found claimant's treating physicians' causation opinions unpersuasive because they were based on an understanding that claimant's coronary artery disease (CAD) was a compensable condition, an opinion which we found against "the law of the case." 46 Van Natta 1282. Citing King I, supra, the court has reversed and remanded for reconsideration.

On remand, we implemented a supplemental briefing schedule to permit the parties to present their positions in light of the court's decisions in King I and King II. Having received the parties' briefs, we proceed with our reconsideration.

As a preliminary matter, claimant argues that SAIF raised on review and again raises on remand a new issue that it did not raise at hearing. Specifically, claimant argues that, at hearing, SAIF limited its basis for denying the left leg blood clot condition to its contention that claimant's CAD was not compensable. Therefore, claimant argues, SAIF should not be allowed to argue on remand the merits of the compensability of the left leg condition independent of the CAD, a condition SAIF is precluded from denying pursuant to King I.

For the following reasons, we disagree with claimant's underlying premise that, at hearing, SAIF limited the basis of its denial of claimant's left leg blood clot condition. At hearing, the parties agreed that the issue was SAIF's June 3, 1993 denial, with claimant contending that the denial should be set aside and SAIF contending that it should be upheld. (Tr. 2, 3). The June 3, 1993 denial denies "care, treatment and hospitalization for chronic occlusive disease of the left iliac artery, chronic occlusion of the left superficial femoral artery and a fresh thrombus in the deep femoral artery as the exposure of March 19, 1977 is not the major contributing cause of these conditions. " (Ex. 22). The denial is not limited to a contention that the left leg conditions denied are caused by a noncompensable underlying CAD.

In support of his argument that SAIF limited its denial of the left leg condition to its contention that the underlying CAD was not compensable, claimant relies on certain statements made by SAIF's attorney during a discussion regarding admission of various exhibits. The relevant portions of this discussion are as follows:

"REFEREE: Is it SAIF's position that the conditions denied on June 3, 1993 are not compensable because claimant's coronary artery disease is not compensable?

SAIF's ATTORNEY: Right.

CLAIMANT'S ATTORNEY: Your honor --

SAIF's ATTORNEY: And that's our --

REFEREE: You'll have ample opportunity, and Mr. -- I don't think [SAIF's attorney] is done yet, and he'll have ample opportunity.

SAIF's ATTORNEY: And that's our --

REFEREE: I'm just trying to understand what's being argued here.

SAIF's ATTORNEY: That's also one of our positions in this denial today, and I would say with respect to this law of the case statement is that -- when you speak of law of the case, as I understand it, you're talking about claim preclusion. That doctrine cannot apply, with respect, to the Thye O and O because it's on appeal.

REFEREE: Does SAIF have other basis or bases of denial of those conditions that were denied on June 3, 1993, beyond that those conditions are not compensable because claimant's coronary artery disease is not compensable?

SAIF's ATTORNEY: Well, I don't think so.

REFEREE: Okay.

SAIF's ATTORNEY: That denial speaks for itself." (Tr. 10-11 (emphasis added)).

Although SAIF's attorney clearly contended that claimant's left leg condition was not compensable because the underlying CAD was not compensable, the above emphasized language demonstrates that SAIF did not limit its compensability argument to that contention. SAIF also relied on the denial itself, which was not limited to the contention that the underlying CAD was not compensable. (Ex. 22). On this record, we find that issues were raised regarding compensability of the underlying CAD in relationship to the left leg condition and compensability of the left leg condition on the merits. Pursuant to King I, the CAD is a compensable component of claimant's claim; therefore, relitigation of the CAD issue is precluded. However, the issue of the compensability of the left leg condition on the merits remains.

Claimant's compensable conditions include the 1977 heart attack and resulting bypass surgery, the 1988 heart attack, and the CAD. As discussed above, the issue before us is the compensability of the left leg blood clot condition that required surgery in February 1993. Because claimant's left leg condition is related, if at all, to the compensable conditions as an indirect consequence of any or all of the compensable conditions, the major contributing cause standard of ORS 656.005(7)(a)(A) applies. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Claimant must, therefore, prove that the compensable conditions (the 1977 heart attack and bypass surgery, the 1988 heart attack, and/or the CAD) are the major contributing cause of his consequential condition (the left leg blood clot condition).

Given claimant's preexisting arteriosclerotic disease in the left iliac and left superficial femoral arteries, we conclude that expert medical evidence is necessary to establish causation. Uris v. Compensation Department, 247 Or 420, 427 (1967); Barnett v. SAIF, 122 Or App 279, 282 (1993) (when a case involves a medically complex condition, there must be expert medical evidence establishing causation). Four physicians provided opinions regarding the cause of the February 1993 blood clot in claimant's femoral artery. The physicians disagree as to whether claimant's blood clot originated in the left ventricle of his heart or in his femoral artery.

When there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Claimant argues that we should give greater weight to the opinions of Drs. Semler and Donnelly

because they were the treating physicians. See Weiland v. SAIF, 64 Or App 810 (1983). However, we find that this case involves expert analysis rather than expert external observations, and therefore, the status of treating physician confers no special deference in this case. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini Corp., 43 Or App 299 (1979).

Dr. Toren, cardiologist, performed a review of claimant's medical records for SAIF, including reviewing the operative report regarding claimant's February 1993 left leg surgery. (Ex. 23). Dr. Toren noted that the February 1993 surgery revealed a "fresh thrombus in the deep femoral artery" and "severe, chronic arteriosclerotic occlusive disease in the left iliac artery with a chronic occlusion of the left superficial femoral artery." (Ex. 23-1). He noted that there were two potential causes of claimant's "acute thrombotic occlusion of the left profunda femoral artery[:] a thrombus *in situ* superimposed on chronic iliofemoral arteriosclerotic disease; and an embolus from his left ventricle." (Ex. 23-1). Dr. Toren acknowledged that Dr. Semler's opinion that an embolus in claimant's left ventricle caused claimant's femoral thrombosis was a "possibility." However, Dr. Toren opined that it was more likely that the thrombus occurred *in situ* based on the following factors.

First, the thrombotic occlusion occurred at the site of severe occlusive arteriosclerotic disease. (Ex. 23-2). Dr. Toren noted that when the underlying arteriosclerotic peripheral vascular disease is severe enough that removal of the thrombus is not sufficient to restore proper blood flow, requiring reconstructive bypass grafting, it is an indication of thrombus occurring *in situ*. Dr. Toren described the mechanism of this type of thrombus as either: (1) progressive arteriosclerotic disease, leading to slowing of the flow of blood to the point where thrombosis occurs; or (2) plaque disruption in the iliofemoral system may lead to thrombus formation. Id. He noted that claimant's underlying occlusive disease was severe enough that Dr. Donnelly needed to do reconstructive surgery. Id.

Second, because claimant's left ventricular thrombus was of the mural type, he was at the lowest risk for embolization. Dr. Toren explained that a mural thrombus was "an organized clot, more or less plastered against the wall of the left ventricle." Id. In addition, he noted that claimant's thrombus has not been described as demonstrating motion. Considering all of these factors, Dr. Toren concluded that it is medically probable that claimant's "thrombotic femoral occlusion was due to the consequences of arteriosclerotic peripheral vascular disease, unrelated to his prior myocardial infarctions and bypass surgery." Id.

Dr. Porter, professor of vascular surgery at Oregon Health Sciences University, reviewed claimant's medical records for SAIF. (Ex. 25). Noting the surgical findings regarding the condition of claimant's left iliac and femoral arteries, Dr. Porter opined that the cause of claimant left leg symptoms was the formation of an *in situ* thrombus in claimant's left profunda femoris artery. (Ex. 25-2). He opined that there was no reasonable probability that a left ventricular derived embolus caused the need for the left leg surgery. (Ex. 25-2).

Dr. Semler opined that the most likely cause of the blood clot in claimant's left femoral artery was a blood clot traveling to the femoral artery from the left ventricle. (Exs. 21, 26). Dr. Semler stated there was evidence from claimant's echocardiograms that claimant had a blood clot in his left ventricle. He opined that this left ventricle blood clot was related to claimant's CAD in that the clot was present as a result of claimant's previous heart attack which, in turn, was the result of his compensable CAD. (Ex. 26). Dr. Semler also stated that chronic occlusive disease in the arteries of the lower extremities was not the same as coronary artery disease, in that the coronary arteries supply the heart. Id.

Dr. Donnelly performed claimant's femoral artery surgery in February 1993. By letter dated July 29, 1993, claimant's attorney sent copies of Dr. Semler's causation opinions, as summarized above, and asked if Dr. Donnelly concurred with Dr. Semler's assessment. (Ex. 21, 26, 27). Dr. Donnelly checked a box indicating that he concurred and stated "[h]e [Dr. Semler] is absolutely correct." (Ex. 27).

These medical reports indicate that, in addition to the compensable coronary artery disease, claimant suffers from arteriosclerotic peripheral vascular disease.[1] In this regard, Dr. Semler

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[1] Dr. Porter stated that "[b]oth of [claimant's] myocardial infarctions, as well as his left leg symptoms, are all related to the same underlying disease process, namely that of extensive cardiac and peripheral atherosclerosis." (Ex. 25-2). To the extent that this statement implies the cardiac atherosclerosis is not compensable, we find it unpersuasive as being against the "law of the case" in that CAD is part of the compensable claim. However, Dr. Porter's statement does support a finding that the arteriosclerotic peripheral vascular disease is separate from the CAD condition.

acknowledged that the artery disease in the legs and the CAD were not the same condition. As a separate condition, the peripheral vascular disease is necessarily not included in the CAD. In addition, there is no evidence that this peripheral vascular disease is caused or worsened by the compensable CAD. However, although acknowledging that the CAD and the artery disease in claimant's leg are not the same condition, Dr. Semler failed to address the contribution, if any, of the left leg artery disease to the need for the surgery. Likewise, Dr. Donnelly's concurrence with Dr. Semler's opinion fails to address the peripheral vascular disease factor. For this reason, we find the opinions of Drs. Semler and Donnelly unpersuasive.

In contrast, Dr. Toren persuasively explained why it was more likely that the blood clot developed directly in claimant's left leg due to the peripheral vascular disease rather than traveling down from the clot in claimant's left ventricle. Based on Dr. Toren's well-reasoned opinion, we find that claimant's peripheral vascular disease caused the left leg blood clot condition that required surgery in February 1993. Somers v. SAIF, supra. Consequently, we conclude that claimant has failed to prove that his compensable conditions (the 1977 myocardial infarction and coronary bypass surgery, the 1988 myocardial infarction, and the CAD) were the major contributing cause of his surgery and treatment for a blood clot in the left femoral artery in February 1993. See ORS 656.005(7)(a)(A). Accordingly, claimant's left leg blood clot condition is not compensable.

In conclusion, on reconsideration, we continue to conclude that claimant has failed to establish a compensable claim regarding the left leg blood clot condition that required surgery in February 1993. Accordingly, as supplemented and modified herein, we republish our June 30, 1994 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANTONIO RESENDEZ, Claimant
WCB Case Nos. C602113, C602114, C602115 & C602116
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Rasmussen, et al, Claimant Attorneys
David J. Lefkowitz, Defense Attorney

Reviewed by Board Members Moller and Hall.

On July 26, 1996, the Board received the parties' claim disposition agreements (CDAs) in the above-captioned matter. Pursuant to those agreements, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injuries. We disapprove the proposed agreements.

A claim disposition agreement must be set aside if we find that it is unreasonable as a matter of law. ORS 656.236(1)(a). An agreement is "unreasonable as a matter of law" if it exceeds the bounds of applicable administrative rules, or if a reasonable fact-finder could only conclude that the agreement was unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). OAR 438-009-0022(3)(j), and 438-009-0020(1) require that a CDA provide the total amount of consideration to be paid to the claimant.

Here, the parties' CDAs do not provide for a separate consideration to be paid to claimant for each CDA. Instead, each CDA provides that a previously approved July 15, 1996 Disputed Claim Settlement (DCS) and a July 9, 1996 resignation of employment and release shall constitute the consideration for each of the four CDAs. We have previously held that a CDA which does not provide for a separate amount of consideration for each claim exceeds the bounds of the administrative rules. Viola Slover, 46 Van Natta 121 (1994); Jerry H. Foss, 43 Van Natta 48 (1991).

In Slover, we disapproved a CDA which provided that no consideration would be paid to the claimant under the CDA. Instead, the agreement provided that the consideration for the current CDA was consideration already paid in conjunction with a previously approved CDA. Here, as in Slover, the

four CDAs attempt to use consideration previously paid under a DCS and a resignation and employment release. As in Slover, we conclude that the CDAs, which also do not provide for a separate amount of consideration for each claim, exceed the bounds of the rules. In addition, as in Slover, because the DCS and employment release proceeds have already presumably been paid to claimant, the consideration offered for the four CDAs is "illusory."[1]

We find additional problems with the parties' agreements. Where more than one claim is being disposed of, each CDA must contain a separate summary page which contains all the information required by the rule for each separate claim. Julie K. Gasperino, 45 Van Natta 861 (1993). Here, the summary pages of each of the CDAs refer to four different dates of injury and four different claim numbers. Each CDA must have its own summary page with the required information pertaining to that claim only. Id; OAR 438-009-0022(1), (3)(c), (d).

Because the offensive portions of the parties' agreements 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 disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, we decline to approve the agreement and return it to the parties. ORS 656.236(1).

In reaching this conclusion, we further note that three of the parties' separate CDAs lack the postcards which are required by rule to notify all parties of approval of the CDA in each specific claim. See OAR 438-009-0028. Since the CDAs are already being disapproved on other more substantive grounds, the parties are reminded that future revised CDA's must all comply with this procedural requirement.

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 436-060-0150(5)(k), (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

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[1] Likewise, since the consideration flowing from the employment termination agreement pertains to a matter outside of our statutory purview, we would be without authority to approve a CDA containing such a provision. See Sandra Pickett, 48 Van Natta 1495 (1996); Karen A. Vearrier, supra.

In the Matter of the Compensation of
JACQUELYNE M. SCHULTE, Claimant
WCB Case No. 95-05380
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) found that the self-insured employer's denial was not prematurely issued; and (2) upheld the employer's denial. On review, the issue is the propriety of the employer's partial denial and, if the denial is procedurally proper, compensability of claimant's L5-S1 bulging disc. We reverse.

FINDINGS OF FACT

On May 2, 1994, claimant compensably injured her low back. (Ex 1). The employer accepted a disabling lumbar strain. (Ex 9). Dr. Kitchel, orthopedist, became claimant's attending physician. (Ex 12).

On June 30, 1994, claimant reported to Dr. Kitchel "a great increase in her right leg pain." (Ex. 14). Claimant underwent an MRI scan the following day which disclosed a bulging L5-S1 disc. (Ex 16). Dr. Kitchel subsequently diagnosed: (1) a musculoligamentous injury of the lumbar spine; and (2) a herniated L5-S1 disc. On July 5, 1994, Dr. Kitchel opined that, assuming claimant's history to be correct, "the current problem is a work related injury." (Ex. 17). Dr. Kitchel's report was copied to the employer. (Ex 17-2).

Claimant was referred by Dr. Kitchel to Dr. Tearse, neurologist, for a consulting examination. (Ex 23). On September 12, 1994, Dr. Tearse opined that claimant's L5-S1 disc bulge "appears to be the cause of her persistent low back pain." (Ex 24). Dr. Tearse recommended that claimant undergo bilateral L5-S1 nerve root blocks. (Id.). However, Dr. Kitchel reported on January 20, 1995 that claimant declined the recommended treatment. (Ex 29).

On March 27, 1995, Dr. Kitchel concurred with a letter from the employer's attorney reciting the attorney's understanding that Dr. Kitchel felt claimant's L5-S1 disc bulge was an incidental finding that was not related to her compensable injury. (Ex 30).

On April 10, 1995, the employer issued a partial denial of claimant's L5-S1 bulging disc on the basis that the condition was not related to claimant's employment. (Ex 32). Claimant requested a hearing from the denial, alleging that it was prematurely issued because there was no claim for the bulging disc.

CONCLUSIONS OF LAW AND OPINION

Relying on the medical reports from Drs. Kitchel and Tearse, the ALJ found that the employer reasonably concluded there was potential liability for the bulging disc condition. See Weyerhaeuser Co. v. Warrilow, 96 Or App 34, rev den 308 Or 184 (1989). Thus, the ALJ determined that the denial was not premature. Further concluding that claimant had not proved compensability of the low back condition, the ALJ upheld the denial.

We need not resolve the question of whether claimant and/or her attending physician filed a "claim" for a L5-S1 bulging disc ("new medical condition" claim or otherwise) because, even if she did, the "claim" was withdrawn prior to issuance of the employer's April 10, 1995 denial.

Both treating physician Kitchel and consulting physician Tearse reported the existence of the L5-S1 condition. Dr. Kitchel opined that claimant's "current problem is a work related injury." Dr. Tearse opined that the L5-S1 disc bulge "appears to be the cause of her persistent low back pain." Dr. Tearse prescribed treatment for that condition. However, claimant rejected such treatment. Moreover, on March 27, 1995, Dr. Kitchel submitted a report concurring with the proposition that claimant's L5-S1 finding was incidental and unrelated to her compensable lumbar strain.

A denial issued in the absence of a claim is a nullity and has no effect. Altimarano v. Woodburn Nursery, Inc., 133 Or App 16, 19-20 (1995); Larry J. Bergquist, 46 Van Natta 2397; Cindy L. Smith, 44 Van Natta 1660 (1992); William F. Hamilton, 41 Van Natta 2195, 2198 (1989). Likewise, a carrier's denial of a "withdrawn" claim is null and void and has no legal effect. William C. Becker, 47 Van Natta 1933, 1934 (1995).

Arguably, the employer's denial in this case followed the filing of a "claim" on claimant's behalf by Drs. Tearse and Kitchel in 1994. See ORS 656.005(6). ("Claim" means a written request for compensation from a subject worker or someone on the worker's behalf). However, prior to issuance of the employer's denial, Dr. Kitchel had agreed that the L5-S1 disc bulge was an "incidental" finding unrelated to the compensable May 1994 injury, and claimant had declined treatment for the condition. Furthermore, throughout these proceedings claimant has consistently maintained that she is not seeking benefits for the L5-S1 disc pathology. We find that, under these circumstances, any claim filed on claimant's behalf for an L5-S1 disc bulge had been withdrawn before issuance of the employer's April 10, 1995 denial. Therefore, there was no claim outstanding when the employer issued its denial.

Consequently, we disagree with the ALJ's conclusion that the employer's April 10, 1995 denial was not "premature." Therefore, we reverse the ALJ's decision upholding the denial.[1]

[1] We note that, in this proceeding, claimant has requested only that we set aside the denial as premature. Inasmuch as there has been no request for a penalty or attorney fee, we do not address any entitlement to such benefits.

ORDER

The ALJ's order dated August 9, 1995 is reversed. The self-insured employer's denial of claimant's L5-S1 disc condition is set aside as a nullity.

August 8, 1996 Cite as 48 Van Natta 1651 (1996)

In the Matter of the Compensation of
JANET L. SUTTON, Claimant
WCB Case No. 95-06335
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

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 right carpal tunnel syndrome condition. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following changes and supplementation. We delete the first, third, fifth and sixth paragraphs on page 3. In the fourth paragraph on page 3, we change the second sentence to read: "She then worked at SMI for one year, at Rose City Paper Boxes for three months and at Rose City Meat Packers for three months."

The employer argues that the last injurious exposure rule governs disposition of this case. We disagree.

The last injurious exposure rule is applied in situations involving successive employers, where each employment is capable of contributing to the disease and the finder of fact is unable to determine which employment actually caused the condition. Bracke v. Baza'r, 293 Or 239, 248-49 (1982). On the other hand, where actual causation is established with respect to a specific employer, it is not necessary to rely on judicially created rules of assignment pertaining to successive employments in determining responsibility. See Runft v. SAIF, 303 Or 493, 501-02 (1987); Eva R. Billings, 45 Van Natta 2142 (1993).

Here, claimant relies on Dr. Stewart's reports to prove actual causation with the employer. On January 11, 1995, Dr. Stewart reported that claimant had been having right carpal tunnel symptoms for over two years. (Ex. 28-4). Dr. Stewart noted that claimant's symptoms began while she was working at the employer and did not appreciably worsen at later employment. (Id.) Dr. Stewart diagnosed right carpal tunnel syndrome related to employment at the employer. (Ex. 28-5). After electrical studies were performed, Dr. Stewart reported that the "cause and onset was related to her work at [the employer] as her left side had been previously." (Id.) In a later report, Dr. Stewart opined that the onset of claimant's right carpal tunnel syndrome was at the employer and claimant's subsequent work activities did not appreciably affect her right carpal tunnel syndrome. (Ex. 79). Dr. Stewart reported that the development of claimant's carpal tunnel syndrome was a "natural progression" of the condition. (Id.)

On the other hand, Dr. Button did not believe that a cause for carpal tunnel syndrome had been, or could be, identified. (Ex. 78). Since claimant had no preexisting or underlying factors, Dr. Button concluded that claimant's condition was idiopathic. (Id.) Dr. Button acknowledged that claimant's right hand symptoms developed while she was employed at the employer, but he viewed the employment as having no relationship to the carpal tunnel syndrome.

When the medical evidence is divided, we tend to give greater weight to the reports of the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reason not to give greater weight to the reports of Dr. Stewart. Although Dr. Stewart did not expressly state that claimant's work with the employer was the major contributing cause of her right carpal tunnel syndrome, it is well settled that "magic words" are not necessary to establish medical causation. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109

(1991), rev den 312 Or 676 (1992). We agree with the ALJ that Dr. Stewart's opinion establishes that claimant's employment with the employer was the major contributing cause of claimant's right carpal tunnel condition. In other words, claimant has established that her work with the employer is the actual cause of the right carpal tunnel condition.

Citing Spurlock v. International Paper Co., 89 Or App 461, 464-65 (1988), the employer contends that, even if claimant has chosen to prove actual causation, the last injurious exposure rule may be asserted as a defense if the subsequent employment actually contributed to the worsening of an underlying disease. Here, however, there are no medical opinions that establish that claimant's subsequent employment contributed to a worsening of her carpal tunnel syndrome. Dr. Stewart concluded that claimant's subsequent work activities did not appreciably affect her right carpal tunnel syndrome. (Ex. 79). Although Dr. Button found that claimant's right carpal tunnel syndrome had worsened, he could not ascribe the worsening to any particular job activity. (Ex. 77). We are not persuaded that claimant's subsequent employment actually contributed to a worsening of her right carpal tunnel syndrome.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's affidavit), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 17, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the self-insured employer.

In the Matter of the Compensation of
RAMONA ANDREWS, Claimant
WCB Case No. 95-10230
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) admitted Exhibit 8 (a medical report from claimant's attending physician) into the record; and (2) set aside its denial of claimant's injury/occupational disease claim for right foot plantar fasciitis. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant submitted a December 4, 1995 report from Dr. McComb (Exhibit 8) on December 7, 1995, one day before hearing. At hearing, the employer objected to admission of Dr. McComb's report, arguing that claimant had failed to obtain and submit the report timely pursuant to OAR 438-007-0018(2). The employer also contended that claimant had failed to establish that, despite due diligence, she was unable to obtain and submit Dr. McComb's report earlier than one day before hearing. Although the ALJ initially excluded Exhibit 8, the ALJ issued an interim order dated December 12, 1995 admitting Exhibit 8. Subsequently, the ALJ allowed the employer to present rebuttal evidence and admitted Exhibit 9, Dr. Gambee's response to Dr. McComb's report.

On review, the employer contests the ALJ's evidentiary ruling. The employer argues that, despite the fact that it denied the claim in August 1995 based on Dr. Gambee's August 16, 1995 report, claimant waited until November 1995 to obtain rebuttal medical evidence. Citing OAR 438-007-0018(2), the employer acknowledges that the rule does not specifically provide a sanction against the party violating the rule, but the employer argues that substantial justice requires that the late submitted evidence be excluded.

Although the employer argues that claimant should have obtained the report from Dr. McComb earlier, there is no contention that claimant did not furnish Dr. McComb's medical report within seven days of its receipt of the report, as required by OAR 438-007-0015(4).[1] That rule provides that documents acquired after the initial exchanges of discovery materials shall be provided to other parties within seven days after the disclosing party receives the documents. Documents submitted within the seven-day limit may not be excluded. See, e.g., Nancy G. Brown, 48 Van Natta 363 (1996); Phyllis J. Wheeler, 44 Van Natta 970, 971 (1992). We conclude that the ALJ properly admitted Exhibit 8.

Compensability

Arguably claimant had three preexisting conditions: cavus feet (high arches), "tight heel cords" and she was overweight. (Exs. 5, 8). There had been no change in claimant's weight for the past two to three years.[2] (Tr. 9-10). Claimant was diagnosed with right foot plantar fasciitis on June 8, 1995.

The employer argues that the claim must be analyzed as an occupational disease because claimant's condition developed gradually. We disagree.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's plantar fasciitis was an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. Mathel v. Josephine County, 319 Or 235, 240 (1994); James v. SAIF, 290 Or 343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984); Valtinson v. SAIF, supra ("sudden in onset" does not have to be "instanteous").

Claimant has been an emergency room admitting representative for 20 years and her job involved extensive walking between different areas. The employer's job analysis estimated that an admission representative may "easily walk up to 7 to 10 miles per day." (Ex. 4B). Despite claimant's preexisting foot conditions, she never had any pain or soreness in her feet before the end of May 1995. (Tr. 9). Claimant had never sought treatment for any foot problem and did not need to wear any special footwear before the end of May 1995. (Id.)

In 1995, claimant's employer remodeled its emergency facilities and doubled the size of its facilities. (Tr. 12). The expansion "greatly" increased the distances claimant walked. (Tr. 13). The new emergency department opened a few days before Memorial Day weekend in 1995. (Tr. 12). Within three days of working in the new facilities, claimant began to experience pain in her right foot. (Tr. 15). By June 6, 1995, the pain in her foot had increased so that she could hardly walk to her car after work. (Tr. 14-15). On June 8, 1995, claimant sought medical treatment from Dr. McComb and was diagnosed with right foot plantar fasciitis. (Ex. 1).

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[1] At hearing, claimant's attorney said that he received Dr. McComb's report on December 7, 1995, the day before hearing, and he faxed a copy to the employer's attorney within an hour of his receipt of the report. (Tr. 2).

[2] Claimant does not dispute that her cavus feet (high arches), "tight heel cords" and overweight condition are "preexisting conditions" under ORS 656.005(24), in that they constitute an "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[.]" We need not address that issue, because, even if we assume that claimant has three preexisting conditions, we are persuaded that claimant's injury was the major contributing cause of the disability and need for treatment for her right foot plantar fasciitis.

We disagree with the employer's assertion that claimant's plantar fasciitis arose gradually. Rather, we find that claimant's plantar fasciitis condition arose over a discrete time period, shortly after the employer opened the new emergency facilities. The record supports the occurrence of an injury in early June 1995. The injury was unexpected, as claimant had not had previous problems with her feet. Moreover, claimant's foot condition was "sudden in onset" in that it occurred over a discrete, identifiable period of time. The fact that claimant's pain grew progressively worse over a short period of time does not make it "gradual in onset." Donald Drake Co. v. Lundmark, supra (the claimant's back trouble coincided precisely with jolting of the faulty loader; the fact that the claimant's back pain grew worse over his six-week employment did not make it "gradual in onset"); Rickey C. Amburgy, 48 Van Natta 106 (1996). Therefore, we analyze the claim as an accidental injury, rather than an occupational disease.

The medical evidence establishes that claimant's work injury combined with the preexisting conditions.[3] (Exs. 5, 8). Therefore, assuming preexisting conditions, claimant must establish that her work injury was the major contributing cause of the disability or need for treatment of the right foot plantar fasciitis. ORS 656.005(7)(a)(B).

Based on Dr. McComb's reports, the ALJ found that claimant's work activities were the major contributing cause of her plantar fasciitis. The employer argues that the ALJ erred by relying on Dr. McComb's opinion and contends that the opinion of Dr. Gambee is more persuasive. We disagree.

Dr. McComb has been claimant's physician for 32 years. (Tr. 9, Ex. 8). Before June 1995, Dr. McComb had not treated claimant for sore feet. (Ex. 8). On June 8, 1995, Dr. McComb reported that claimant had pain in her right foot and he noted that she "does a lot of walking at work." (Ex. 1). Dr. McComb prescribed medication and recommended "ice, rest, avoid high heels" and stretching. (Id.) On June 12, 1995, Dr. McComb restricted claimant's work to "minimal walking - desk work ok." (Ex. 2).

Claimant was off work for two days and returned to a light duty, sedentary position for two months. (Tr. 15-16). Claimant testified that the sedentary job allowed her to sit and put her foot up and she said that her symptoms got better in time. (Tr. 19). Dr. McComb reported on June 19, 1995 that claimant's foot had improved and she was not walking as much as before and he recommended that claimant gradually increase her walking. (Ex. 1). On July 17, 1995, the employer added tennis shoes to the dress code "[d]ue to the increase in walking in the new ER." (Ex. 4a). In response to the new policy, claimant changed the shoes she wore at work. (Tr. 18). Claimant testified that, after returning to her regular job, her foot was still sore but she did not have any need for treatment. (Tr. 22).

Claimant was examined by Dr. Gambee on August 16, 1995. Dr. Gambee reported that there had been a major remodeling in claimant's department and her walking had increased significantly. (Ex. 5). Dr. Gambee found that claimant was 40 pounds overweight, which he characterized as "modest overweight." Dr. Gambee concluded that the combination of claimant's weight problems, cavus feet and tight heel cords constituted more than 51 percent of her need for treatment. (Id.)

Dr. McComb disagreed with Dr. Gambee's conclusions. Dr. McComb reported that claimant had adapted to her high arches and tight heel cords quite well and he noted that they had given her no problems. (Ex. 8). Dr. McComb commented that, according to a study, claimant was only 11 pounds over the normal weight. Dr. McComb was not sure what percent the contributing factors played in claimant's condition, but he guessed that it was "far under" 49 percent. (Id.) Dr. McComb reported that, in June 1995, claimant had a significant increase in the time on her feet and the distance walked due to the remodeling in her department. Dr. McComb concluded that the change in claimant's walking requirements constituted more than 51 percent of her need for treatment. (Id.)

On January 12, 1996, Dr. Gambee reviewed Dr. McComb's report. Dr. Gambee disagreed with Dr. McComb's conclusion that claimant was only 11 pounds over the normal weight. (Ex. 9). Dr. Gambee concluded that claimant was 30 percent overweight at 170 pounds and he referred to claimant's "significant obesity." Dr. Gambee commented that claimant "became symptomatic a little bit earlier in life because she was asked to do some increased walking." (Id.) Dr. Gambee reported that, without claimant's preexisting conditions, she would not have become significantly symptomatic. (Id.) Dr. Gambee concluded that more than 51 percent of claimant's need for care was due to her foot deformity, heel cord deformity and weight problems.

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[3] See infra note 2.

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). Here, there are no persuasive reasons not to defer to Dr. McComb's opinion. In light of Dr. McComb's opinion that claimant was only 11 pounds over the normal weight, we are not persuaded by Dr. Gambee's conclusion that claimant had "significant obesity." Although Dr. McComb was not sure of the exact percentage that claimant's preexisting conditions contributed to her condition, he thought that they were "far under" 49 percent. (Ex. 8). Moreover, Dr. McComb reported that claimant had adapted to her high arches and tight heel cords and he noted that they had given her no problems until she had a significant increase in the time on her feet and the distance walked due to the remodeling.

The employer argues that Dr. McComb's report is not persuasive because it is based solely on the temporal relationship between the onset of claimant's symptoms and the employer's remodeling. Citing Bronco Cleaners v. Velazquez, 141 Or App 295 (1996), the employer contends that Dr. McComb's report is legally insufficient to meet claimant's burden of proof. We disagree.

In Bronco Cleaners v. Velazquez, supra, the court held that, if the claimant merely demonstrated that before she worked for the employer, she did not have a condition, and now she does, that proof would be legally insufficient under ORS 656.266. However, in Velazquez, the evidence was sufficient because it went beyond that chronological connection and demonstrated a "pattern of diminishment and enhancement of the condition that correlates to the existence of or lack of exposure to the work place." 141 Or App at 299.

Here, contrary to the employer's assertion, Dr. McComb's opinion is not based solely on a temporal relationship between claimant's symptoms and work-related activity. Rather, we find that Dr. McComb's chart notes and claimant's testimony demonstrate "a pattern of diminishment and enhancement" of the plantar fasciitis condition that correlated to claimant's increased walking at work due to the remodeling. See Bronco Cleaners v. Velazquez, supra.

The employer's new facilities opened in late May 1995. Shortly after working in the new facilities, claimant began to experience right foot pain. Before June 1995, Dr. McComb had not treated claimant for sore feet. (Ex. 8). On June 8, 1995, Dr. McComb diagnosed right plantar fasciitis and he noted that claimant did a lot of walking at work. (Ex. 1). On June 12, 1995, Dr. McComb restricted claimant's work to "minimal walking - desk work ok." (Ex. 2). Claimant was off work for two days and returned to a light duty, sedentary position for two months. (Tr. 15-16). Claimant testified that the sedentary job allowed her to sit and put her foot up and she said that her symptoms got better in time. (Tr. 19). Dr. McComb reported on June 19, 1995 that claimant's foot had improved and she was not walking as much as before and he recommended that claimant gradually increase her walking. Dr. McComb pointed out that claimant had no foot problems until she had a significant increase in the time on her feet and the distance walked due to the remodeling. (Ex. 8). Dr. McComb concluded that the change in claimant's walking requirements constituted more than 51 percent of her need for treatment. (Id.) Based on Dr. McComb's report, we conclude that claimant's work injury was the major contributing cause of the disability and need for treatment for her right foot plantar fasciitis.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,300, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 8, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,300, payable by the self-insured employer.

In the Matter of the Compensation of
ANITA M. BARRON, Claimant
WCB Case No. 95-11704
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall, Christian and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the insurer's denial of her low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

In the second paragraph of the findings of fact, we change the first sentence to the following: "On August 27, 1995, claimant worked as a 'fire person.' (Tr. 45)."

We change the fifth sentence in the third paragraph to the following:

"Claimant testified that her 'bottom kind of hurt' (Tr. 39), but she did not realize she had any pain in her lower back until she got home that evening. (Tr. 40). Claimant was able to stand up and proceed out the back door."

We change the fourth paragraph to the following:

"Claimant testified that taking out the trash was the duty for the 'fire person' or the 'grill person.' (Tr. 45). The routine was to take out the trash between 12:00 and 12:30 after the restaurant closed. (Tr. 46). Dan was the 'grill person' on August 27, 1995. (Id.) Claimant was working as the 'fire person' on August 27, 1995 (Tr. 45), and she testified that dumping the garbage was part of her job duty that evening. (Tr. 38). Claimant did not regularly dump the garbage. (Tr. 45). Claimant testified that generally two people were not required to dump the garbage, but she had never dumped the garbage before so she was walking out with Shauna to dump the garbage. (Tr. 38). Claimant testified that her primary purpose in taking out the trash with Shauna was to see Shauna's reaction to the 'toilet paper' prank. (Tr. 45, 46)."

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant injured her back on August 27, 1995, when she slipped on a wet floor on the employer's premises as she approached the back door to dump a garbage can with Shauna, one of her co-workers. Claimant had not dumped the garbage prior to August 27, 1995. Claimant had asked Shauna to assist her in dumping the garbage that night so that claimant could see Shauna's reaction when Shauna saw her car, which claimant and a co-worker had "toilet-papered" as a prank earlier that night.

After claimant slipped, she testified that her "bottom kind of hurt" (Tr. 39), but she did not realize she was in any pain and she was able to stand up and proceed out the back door. Claimant and Shauna dumped the garbage into the dumpster, and claimant showed Shauna her car. Claimant had a lot of pain in her lower back at home that evening. (Tr. 40). A day or two after the accident, claimant reported her back injury to the employer. On August 31, 1995, claimant sought treatment for low back pain. Claimant was diagnosed with acute thoracolumbar/lumbosacral strain.

The ALJ found that claimant was assigned to be the counter clerk/cashier on August 27, 1995 and concluded that claimant had overstepped the boundaries defining the ultimate work she was assigned to perform. The ALJ reasoned that claimant dumped the garbage at about 10:30 p.m., although she knew that it was the grill cook's responsibility to dump the garbage after midnight. The ALJ referred to claimant's testimony that her primary purpose in dumping the garbage was to show Shauna her car and to witness her reaction.

The ALJ also found that, although claimant was aware of the employer's policy that the restaurant's back door was to be used only for deliveries and dumping the garbage, she used the back door in pursuit of a personal mission, i.e., to witness Shauna's reaction to the prank.

The ALJ concluded that claimant's activity in dumping the garbage, and the injury she sustained while doing so, was outside the course and scope of her employment. The ALJ reasoned that claimant's regular duties were defined by her counter clerk/cashier job and, by performing a task outside those regular duties, she departed from the course of her employment.

Claimant argues that the ALJ erred by concluding that dumping the garbage was a task outside of claimant's regular duties. Claimant argues that helping to take out the garbage was not "misconduct" and was not "prohibited." We agree.

In Andrews v. Tektronix, Inc., 323 Or 154, 166 (1996), the court rejected the view that an employee's violation of an employment rule rendered his or her claim per se noncompensable. The court commented that the Board's focus on "misconduct" carries with it a connotation of fault, which has no place in our workers' compensation scheme. Id. at 159. Rather, the initial inquiry is whether claimant was engaged in an activity that was within the boundaries of his or her ultimate work. Id. at 166. That determination is made by evaluating all the factors that are pertinent to the question of work-connectedness and weighing those factors in light of the policy underlying the Workers' Compensation Act. Id.

Thus, our first inquiry is whether claimant was engaged in an activity that was within the boundaries of her ultimate work. Although the ALJ found that claimant was assigned to be the counter clerk/cashier on August 27, 1995, claimant testified that she was the "fire person" on August 27, 1995. (Tr. 45). Claimant testified that taking out the trash was the duty for the "fire person" or the "grill person." (Id.) Dan was the "grill person" on August 27, 1995. (Tr. 46). Thus, on August 27, 1995, taking out the trash was the responsibility of either claimant or Dan. The routine was to take out the trash between 12:00 and 12:30 after closing. (Tr. 46). Claimant testified that dumping the garbage was part of her job duty on August 27, 1995, (Tr. 38), although she did not regularly dump the garbage. (Tr. 45). Claimant said that generally two people were not required to dump the garbage, but she had never dumped the garbage before so she was walking out with Shauna to dump the garbage. (Tr. 38). Claimant testified that her primary purpose in taking out the trash with Shauna was to see Shauna's reaction to the "toilet paper" prank. (Tr. 45, 46).

Based on claimant's testimony, we find that taking out the trash was part of her job duties on August 27, 1995. There is no contradictory evidence. Although claimant testified that the routine was to take out the trash between 12:00 and 12:30 a.m., there is no evidence that it was a violation of the employer's policies to take out the trash at an earlier time. Thus, we disagree with the ALJ's conclusion that claimant was assigned to be the counter clerk/cashier on August 27, 1995 and that she overstepped the boundaries defining the ultimate work she was assigned to perform.[1] Rather, we conclude that claimant was injured when she was engaged in an activity within the boundaries of her ultimate work. See Andrews v. Tektronix, Inc., supra.

The insurer contends that the claim is not compensable under ORS 656.005(7)(b)(B) because claimant's primary goal for rushing through the door was the personal pleasure derived from her prank. Claimant argues that we should not address this argument because the insurer raised this argument for the first time on review. Since there is no evidence that the insurer raised this issue at hearing,[2] we are not inclined to consider it on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Cynthia A. Watson, 48 Van Natta 609 (1996).

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[1] We also disagree with the ALJ's finding that claimant used the back door for a personal mission, even though she was aware of the employer's policy that the restaurant's back door was to be used only for deliveries and dumping the garbage. Since claimant used the back door for dumping the garbage, we find that she did not violate the employer's policy. Claimant did not use the back door only to witness Shauna's reaction to the prank.

[2] We note that opening statements were waived by the parties and closing arguments were not recorded.

In any event, we conclude that ORS 656.005(7)(b)(B) does not apply in this case. ORS 656.005(7)(b)(B) provides that a "compensable injury" does not include "[i]njury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure." Here, claimant suffered a low back injury when she slipped on the wet floor while taking out the trash. Claimant was not injured while she was involved in the toilet paper prank. Since claimant's injury was not incurred while engaging in or performing any recreational or social activities, we need not examine whether those activities were "primarily for the worker's personal pleasure."

The insurer also argues that claimant's active participation in the "toilet paper" prank was a voluntary stepping aside from the scope of her employment. The insurer's argument misses the mark. Once again, the insurer focuses on claimant's participation in the "toilet paper" prank, not the act of taking out the trash. Claimant was not injured while she was participating in the "toilet paper" prank and we do not address that issue on review. In contrast, as discussed earlier, claimant's actions in taking out the trash were part of her job duties on August 27, 1995.

We also disagree with the insurer's characterization of claimant's injury as a "horseplay injury." In Mark Hoyt, 47 Van Natta 1046, 1047 (1995), we defined "horseplay" as "[r]owdy or unruly behavior." Even if we assume that claimant's participation in the "toilet paper" prank was "horseplay," we find no evidence that her actions in taking out the trash consisted of rowdy or unruly behavior.

For an injury to be compensable under workers' compensation law, it must "aris[e] out of and in the course of employment." ORS 656.005(7)(a). The requirement that the injury occur "in the course of employment" concerns the time, place and circumstances of the injury. Norpac Foods, Inc., v. Gilmore, 318 Or 363, 366 (1993). The requirement that the injury "arise out of" the employment tests the causal connection between the injury and the employment. Id. In assessing the compensability of an injury, neither element is dispositive. Id.

The insurer concedes that the "course of employment" prong was not disputed and the only issue is the causal connection between claimant's employment and her injury.[3] To analyze the "arising out of employment" prong of the work-connection test, we must determine 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). Considering all the circumstances, we conclude that they did.

In assessing whether there is a sufficient link between claimant's injury and employment, the connection between claimant's work and what happened must be evaluated. Id. at 338. Part of that inquiry is whether what occurred was an anticipated risk of employment. As explained by Larson:

> "All risks causing injury to a claimant can be brought within three categories: risks distinctly associated with the employment, risks personal to the claimant, and 'neutral' risks--i.e., risks having no particular employment or personal character. Harms from the first are universally compensable. Those from the second are universally noncompensable. It is within the third category that most controversy in modern compensation law occurs. The view that the injury should be deemed to arise out of employment if the conditions of employment put claimant in a position to be injured by the neutral risk is gaining increased acceptance." Id. (quoting 1 Larson, Workmen's Compensation Law § 7.00, 3-12 (1993)).

We must first categorize the nature of the risk that caused claimant's injury. SAIF v. Marin, 139 Or App 518, 523 (1996). Claimant injured her back on August 27, 1995, when she slipped on the wet floor on the employer's premises as she approached the back door. There is no evidence that the risk of

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[3] The dissent apparently does not accept the insurer's concession that the "course of employment" prong was not disputed. By concluding that claimant failed to establish that her injury occurred while in the course of an activity whose purpose was related to her employment, we respectfully submit the dissent overfocuses on claimant's alleged "misconduct" in the "TP" prank. As the court said in Andrews v. Tektronix, Inc., supra, 323 Or at 159, the focus on "misconduct" carries with it a connotation of fault, which has no place in workers' compensation law. Rather, the focus should be on the employment risk/hazard that caused claimant to fall.

slipping on a wet floor was personal to claimant. Rather, we conclude that the risk of slipping on a wet floor was an employment-related risk.[4] See id. at 524.

In taking out the trash, claimant was engaged in an activity within the boundaries of her ultimate work and was not disobeying the employer's instructions. Compare Andrews v. Tektronix, Inc., supra (addressing the work-connectedness test when an employee is injured while disobeying an employer's instructions; an employee's violation of an employment rule does not render his or her claim per se noncompensable). Although claimant's motive for taking out the trash at the particular time was primarily to show Shauna the car, that does not negate the fact that claimant was performing a work activity for the employer. Since claimant's injury was caused by a wet floor on the employer's premises, we conclude that claimant's conditions of employment put her in a position to be injured. Accordingly, claimant has established a causal link between the injury and her employment, thus satisfying the "arising out of employment" element of the work-connection test.

Finally, we reject the ALJ's conclusion that claimant's personal motive in taking the garbage out the back door distracted her from using appropriate care in walking toward the door. We agree with claimant that her alleged contributory negligence is not relevant to the analysis. See Andrews v. Tektronix, Inc., supra ("fault" is irrelevant in determining a worker's entitlement to compensation).

In sum, we find that claimant's low back injury arose out of and occurred in the course of her employment.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 16, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $4,000, payable by the insurer.

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[4] We note that, even if claimant had clocked out and was leaving through the back door to go home, the risk hazard in this case, i.e., the slippery floor, would bring claimant within the scope of her employment.

Board Member Moller dissenting.

According to the majority, because claimant's injury involved slipping on a wet floor on the employer's premises while performing a work activity, her injury arose out of her employment. I do not agree. I am unable to find a sufficient connection between claimant's employment and her injury to support her claim for workers' compensation benefits. Therefore, I respectfully dissent.

My first disagreement is with the majority's factual findings. The majority concludes that claimant was performing a work activity for the employer -- taking out the trash -- at the time of her injury. My review of the record persuades me otherwise. The only evidence supporting the majority's finding was claimant's testimony that it was her job to dump the garbage the night of the injury. However, she also testified that she had never dumped the garbage before, even though she had worked for the employer for six months. (Tr. 26, 45). In addition, although the trash was not normally removed until closure of the business at 12:00 a.m., claimant's injury occurred at approximately 10:30 p.m. Neither claimant's 801 claim form nor her First Medical Report make any mention of her injury having occurred in the process of dumping the garbage or, for that matter, performing any other work task.

Rather, the record contains abundant evidence that "dumping the trash" was merely a pretense for getting Shauna outside. Claimant asked for Shauna's help in emptying the garbage, although that task was ordinarily performed by one person. (Tr. 38). Both Dan, the grill person, and Shauna were already outside when claimant slipped. (Tr. 37). Although claimant stated that she and Shauna were going to empty the garbage, someone else had moved the garbage can outside earlier, (Tr. 38), and Shauna already "had the garbage can in her hand" when claimant slipped while still inside the building. (Tr. 37). Claimant said that the primary reason she was taking out the trash was so that she could see Shauna's reaction to the "TP" prank and that "[t]hat was how we could get her outside." (Tr. 45, 46).

Additional undisputed facts further refute the majority's conclusion that claimant's injury is sufficiently work-related to support compensability. The prank was initiated by a co-worker who was not on duty the day of the incident. (Tr. 33). The employer's shift manager was not aware of the prank until after the incident. (Tr. 17-18, 37). Had he been aware of the prank, he would not have approved of it. (Tr. 21). Claimant could not recall whether she had "clocked out" from work before or after the incident. (Tr. 40). Claimant testified that she hurt herself "when we were walking out to show Shauna her car." (Tr. 35).

Whether an injury is sufficiently related to work to support compensability is tested by the "arising out of" and "in the course of" statutory elements set forth in ORS 656.005(7)(a). As recently reiterated by the Oregon Supreme Court, "the work-connection test may be satisfied if the factors supporting one prong are minimal while the factors supporting the other prong are many." Krushwitz v. McDonald's Restaurants of Oregon, 323 Or 520 (1996). Here, however, the factors supporting both prongs are exceedingly weak. In terms of time, place and circumstances (*i.e.*, the course of employment prong), claimant has failed to establish that her injury occurred while in the course of an activity whose purpose was related to her employment. Instead, the accident clearly occurred while claimant was engaged in unapproved horseplay. Claimant had completed all of her assigned duties and was engaged in a personal matter at the time of the incident. Moreover, claimant, whose burden it is to establish compensability, could not establish whether the injury occurred on paid time or after she had clocked out for the day.

In terms of the causal relationship between claimant's employment and her injury (*i.e.*, the arising out of prong), claimant has similarly failed to establish the requisite connection between her injury and her employment. In this regard, there is no evidence in the record to explain the wet spot on the floor that contributed to claimant's fall. It may well be that the wet spot was related to a risk of claimant's employment. However, absent any evidence to that effect, the arising out of prong is just as unproven as is the course of employment prong.

In sum, because the majority erroneously concludes that there is a sufficient nexus between claimant's injury and her employment, I dissent.

In the Matter of the Compensation of
WILBERTH A. ALEJOS, Claimant
WCB Case No. 95-08825
ORDER ON REVIEW
H. Galaviz Stoller, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that increased claimant's unscheduled permanent disability award from 25 percent (80 degrees), as awarded by an Order on Reconsideration, to 39 percent (124.8 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and summarize the pertinent facts as follows:

Claimant compensably injured his low back on June 16, 1994. He underwent a lumbar laminectomy at L5-S1, left side, in August 1994. He became medically stationary on December 27, 1994.

Claimant's claim was closed by Determination Order on March 17, 1995, awarding claimant 34 percent (108.8 degrees) unscheduled permanent disability for his low back condition and 9 percent (13.50 degrees) scheduled disability for loss of use or function of the left leg. The insurer requested reconsideration, and a July 26, 1995 Order on Reconsideration reduced claimant's unscheduled permanent disability award to 25 percent and his scheduled permanent disability award to 4 percent. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

With regard to claimant's unscheduled permanent disability award,[1] the ALJ found that claimant was entitled to a value of 1 for formal education, a value of 4 for skills and a value of 4 for adaptability. The ALJ then assembled the factors, multiplying claimant's age and education value (5) by the adaptability value (4), for a total of 20 which, when added to the value for impairment (19), equaled a total unscheduled permanent disability award of 39 percent.

On review, the insurer contends that claimant's formal education value should be zero (rather than 1) because claimant represented that he has a high school diploma. In addition, the insurer argues that claimant's adaptability value should be 2 (rather than 4) because the DOT Code best describing claimant's work over the past five years has a physical strength requirement of medium.[2] We address each issue in turn.

Formal Education

The insurer argues that the ALJ engaged in speculation in finding that claimant did not have a high school diploma, especially in light of claimant's signed representation that he obtained a high school diploma in 1973. We agree.

Claimant bears the burden of proving the extent of his disability. See ORS 656.266. The only evidence in the record[3] concerning claimant's education is a form signed by claimant indicating that he completed 12 years of schooling and received a diploma in 1973 (Ex. 9); a report from the examining

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[1] The extent of claimant's scheduled permanent disability is not an issue on review.

[2] The ALJ found that claimant's base functional capacity was heavy, based on DOT Code 405.687.014 (nursery worker).

[3] Because this is an "extent" case, the evidentiary record is limited to the evidence submitted on reconsideration and made part of the reconsideration record. Amended ORS 656.283(7).

doctors that claimant indicated, through an interpreter, that he completed one year of high school (Ex. 5-2) and the unsubstantiated assessment of the Department evaluator that claimant could not have had 12 years of education by age 16 because high school in Mexico is not 12 years. (Ex. 10-2).

Based on this record, we are most persuaded by what claimant himself has signed regarding his education. In the absence of any evidence concerning the structure of the educational system in Mexico, we rely on the written representation that claimant completed 12 years of education and acquired a high school diploma in 1973, at age 16 or 17. We therefore give claimant a value of zero for formal education under OAR 436-35-300(2).

Adaptability

Claimant's adaptability factor is determined by comparing claimant's base functional capacity (BFC) with his residual functional capacity (RFC). OAR 436-35-310. The parties agree that claimant's RFC is "medium/light." The insurer argues on review that claimant's base functional capacity is "medium" because none of claimant's jobs in the past five years involve the heavy physical duties described in DOT Code 405.687-014 (nursery worker). Specifically, the insurer contends that the DOT Code that comes closest to describing claimant's past jobs is 403.687.018 (harvest worker, fruit), with a physical requirement of medium.

In his "Work/Educational History" form, claimant reported that in the prior five years, he had worked as a tree splicer, berry picker and berry sorter. His 801 form indicates that he was working as a berry inspector, sorting berries from foreign materials, at the time of his injury. Although claimant reported to his examining doctors that he worked one year seasonally in a nursery, there is no evidence in the record concerning any heavy strength job duties at the nursery.

Accordingly, we find that the most physically demanding job that claimant has performed in the last five years is a combination of fruit harvest worker (DOT 403.687-018) and fruit farm worker (DOT 403.683-010), both of which have a strength requirement of medium. Based on the matrix set forth in OAR 436-35-310(6) and comparing claimant's BFC of medium to his RFC of medium/light, claimant's adaptability value is 2.

In reassembling the factors based on our findings above, the total value of claimant's age (0), education (0) and skills (4) is multiplied by the adaptability factor of (2) for a total of 8. When this value is added to the value for impairment (19), the result is 27, entitling claimant to a total unscheduled permanent disability award of 27 percent. The ALJ's order is modified accordingly.

ORDER

The ALJ's order dated January 25, 1996 and republished March 15, 1996 is modified in part. In lieu of the ALJ's award of 39 percent (124.8 degrees) and in addition to the Order on Reconsideration award of 25 percent (80 degrees) unscheduled permanent disability, claimant is awarded an additional 2 percent (64 degrees) for a total award of 27 percent (86.4 degrees) unscheduled permanent disability for his low back condition. Claimant's attorney fee award is likewise modified. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
LARENE E. WAGGONER, Claimant
WCB Case No. 95-12809
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order which upheld the self-insured employer's denial of claimant's occupational disease claim for a low back condition. In its brief, the employer asserts that the ALJ improperly admitted an exhibit. On review, the issues are the ALJ's evidentiary ruling and compensability.

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

The ALJ inadvertently stated in her "findings of fact" that claimant's prior low back injury was in June 1964. However, the previous injury was in June 1994. The ALJ's factual findings are modified accordingly.

With respect to the ALJ's evidentiary ruling, the employer contends that the ALJ abused her discretion in reopening the record after closing argument and admitting Exhibit 9A, which consisted of chart notes from claimant's chiropractor, Dr. Conklin.[1] We disagree.

We review an ALJ's evidentiary ruling for abuse of discretion. See Mary J. Richards, 48 Van Natta 390, 391 (1996) (citing James D. Brusseau II, 43 Van Natta 541 (1991)). In this case, however, we find no abuse of discretion when the ALJ reopened the record to admit chart notes that were apparently inadvertently omitted from the record. We agree with the ALJ's reasoning that, under these circumstances, fairness to all parties required that a decision be rendered based on a complete record. (Tr. 28). Accordingly, we do not disturb the ALJ's evidentiary ruling.

Claimant also contends that the ALJ should have found the opinion of Dr. Conklin persuasive and determined that her low back occupational disease claim was compensable. However, for the reasons noted by the ALJ, we agree that Dr. Conklin's opinion is not persuasive. Therefore, we agree with the ALJ that claimant failed to sustain her burden of proving that her occupational disease claim is compensable.

ORDER

The ALJ's order dated February 22, 1996 is affirmed.

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[1] The employer avers that it has not filed a "cross-appeal," but rather a "cross-assignment of error." While we agree that the employer did not "cross-request" review, we reach this conclusion not because we accept the employer's distinction between a "cross-appeal" and a "cross-assignment of error." Rather, it is because the employer did not file a "cross-request" for review within 30 days of the ALJ's order or within 10 days of claimant's request for review. ORS 656.289(3). Notwithstanding the lack of a timely filed cross-request for review, we have considered the employer's challenge to the ALJ's evidentiary ruling because it may contest any portion of the ALJ's order in the absence of a cross-request for review, provided claimant's request for review has not been withdrawn. See Catherine E. Wood, 47 Van Natta 2272, 2274 n. 1 (1995); Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983). Finally, had the ALJ's order awarded compensation, and had we affirmed such an order, claimant's attorney would have been entitled to an attorney fee for services on review under ORS 656.382(2). See Kordon v. Mercer Industries, 308 Or 290 (1989); Stanley H. Randolph, 44 Van Natta 2308 (1992). However, claimant's counsel is not entitled to an attorney fee under that statute since the ALJ's order did not award any compensation.

In the Matter of the Compensation of
ARLIE B. TOMPKINS, Claimant
WCB Case No. 95-07663
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to admit evidence at hearing that was not part of the record on reconsideration; (2) found that claimant's claim was not prematurely closed; and (3) affirmed the Order on Reconsideration awarding no unscheduled permanent disability for a cervical strain. On review, the issues are evidence, premature closure, and extent of permanent disability.

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

The ALJ found that the SB 369 amendments to ORS 656.283(7) prohibited claimant from submitting additional evidence at hearing that was not part of the record presented to the Department of Consumer and Business Services on reconsideration of the self-insured employer's Notice of Closure. In addition, based on the reconsideration record, the ALJ found that claimant was medically stationary when the employer closed the claim and that claimant had not proven any permanent loss of earning capacity as a result of his compensable injury.

Claimant contends on review that the ALJ erred in not allowing claimant to testify on his own behalf at the hearing, and also that amended ORS 656.283(7) violates Article I, Section 10 of the Oregon Constitution[1] and the Due Process Clause of the United States Constitution. Specifically, claimant argues that amended ORS 656.283(7) unconstitutionally deprived him of the right to present evidence that he was not medically stationary when the employer closed his claim and that he suffered chronic headaches due to his compensable injury, entitling him to compensation for unscheduled permanent disability.

Subsequent to the ALJ's order, we held that, under amended ORS 656.283(7), evidence that was not submitted at reconsideration and not made part of the reconsideration record is statutorily inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996).[2] We also found that the amended statute did not violate the claimant's procedural due process rights, and that the claimant's testimony at the hearing regarding the extent of his permanent disability was inadmissible.[3]

Claimant's argument focuses on his inability to testify at hearing concerning a factual error in the Order on Reconsideration,[4] his chronic headaches and his failure to appear for a medical arbiter's

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[1] Article I, Section 10 guarantees that "every man shall have a remedy by due course of law for injury done him in his person, property, or reputation."

[2] In Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996), the Court of Appeals overruled Joe R. Ray to the extent we held that ORS 656.283(7) applies retroactively to cases in which "post-reconsideration" evidence was properly admitted under the former law. In this case, however, the hearing took place after the June 7, 1995 enactment of SB 369. Therefore, the prohibition of subsequent evidence set forth in amended ORS 656.283(7) is applicable. See Dean J. Evans, 48 Van Natta 1092 (May 30, 1996) (adhering to the holding of Joe R. Ray where the hearing was held after June 7, 1995).

[3] Although a signatory to this order, Chair Hall directs the parties to the dissenting opinions in Joe R. Ray, supra.

[4] The Department found that claimant was under the care of both Dr. Chau and Dr. Washington, but that there was no documentation as to which was the attending physician. Claimant sought to testify concerning which of the two was his attending physician, because Dr. Washington concurred with the report of Drs. Wilson and Duff, declaring claimant medically stationary on August 16, 1994, whereas Dr. Chau did not. (Ex. 75-4).

exam. As we did in Joe R. Ray, supra, we reject claimant's constitutional challenges to amended ORS 656.283(7) in this case.[5] The reconsideration process provided claimant with the opportunity to correct any erroneous information in the record and to submit additional medical information by his attending physician. In addition, even after the Department issued the Order on Reconsideration, until he requested a hearing, claimant could have asked the Director to abate, withdraw and/or amend the order to correct any errors in the reconsideration order itself. See Joe R. Ray, supra; see also Duane B. Onstott, 48 Van Natta 753 (1996).

Accordingly, we affirm the ALJ's decision rejecting claimant's request to present evidence at hearing about the identity of his attending physician or the extent of his disability which was not submitted at reconsideration and made part of the reconsideration record. We also agree with the ALJ's determination that claimant's claim closure was not premature and that claimant did not establish his entitlement to a permanent disability award.

ORDER

The ALJ's order dated October 19, 1995 is affirmed.

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[5] In Joe R. Ray, supra, we held that the procedures afforded during the reconsideration process were sufficient to protect claimant's procedural due process rights under the Fourteenth Amendment to the United States Constitution. We did not analyze the Oregon Constitution because it does not contain a due process clause. See, e.g. State v. Clark, 291 Or 231, 235 n 4, cert den 454 U.S. 1084 (1981). In this case, we reject claimant's challenge to amended ORS 656.283(7) under Article I, Section 10 of the Oregon Constitution because the procedural limitation on evidence set forth in the statute is not the kind of "injury" contemplated by that constitutional guarantee. See Cole v. Dept. of Revenue, 294 Or 188, 191 (1982).

In the Matter of the Compensation of
PAMELA M. AHLSTROM, Claimant
WCB Case No. 95-05230
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's left knee condition. On review, the issue is compensability.

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

Relying on James D. Johnson, 48 Van Natta 303 (1996), the employer argues that there is insufficient evidence of a causal connection between claimant's knee condition and her work activities. According to the employer, there was no accidental injury because claimant only "began to bend down" when she felt pain and tightness.

In James D. Johnson, supra, the claimant's left knee buckled with a popping feeling while taking a step at work on the level floor of the plant. There was no evidence that the claimant slipped, twisted, or tripped over anything on the floor. The claimant was later diagnosed with a left medial meniscus tear. We found that the "course of employment" element was met because the claimant's injury occurred on the employer's premises during working hours. However, we found no evidence of the requisite causal connection to satisfy the "arising out of employment" element since the claimant did not stumble or trip over anything on the plant floor. Rather, the claimant's knee went out as he was taking a step. In addition, we concluded that the medical evidence established no causal connection other than the fact that claimant's knee went out at work, which was insufficient to meet the claimant's burden.

For an injury to be compensable under workers' compensation law, it must "aris[e] out of and in the course of employment." ORS 656.005(7)(a). The requirement that the injury occur "in the course of

employment" concerns the time, place and circumstances of the injury. Norpac Foods, Inc., v. Gilmore, 318 Or 363, 366 (1993). The requirement that the injury "arise out of" the employment tests the causal connection between the injury and the employment. Id. In assessing the compensability of an injury, neither element is dispositive. Id.

Based on claimant's credible testimony,[1] we find that claimant's knee injury occurred while she was at work, and, therefore, occurred in the course of her employment. To analyze the "arising out of employment" prong of the work-connection test, we must determine 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).

Claimant, an assistant manager in apparel, testified that part of her job involved "recovering" the store at night and picking up merchandise off the floor that has fallen. (Tr. 19). Claimant testified that, on March 30, 1995, some wallets were laying around one of the fixtures and she was squatting down to pick them up when she felt tightness and discomfort in her left knee. (Tr. 19, Exs. 2, 3, 3A, 3B). Claimant subsequently sought medical treatment for her left knee.

We find that the task of picking up wallets off the floor was directly connected to claimant's work duties, and, at the time she was injured, claimant was engaged in an activity that was within the boundaries of her ultimate work. See Andrews v. Tektronix, Inc., 323 Or 154, 166 (1996). Claimant did not have any preexisting left knee conditions and there is no evidence that the risk of injury was personal to claimant. See SAIF v. Marin, 139 Or App 518, 523-24 (1996). Rather, we find that the nature of the risk of harm that befell claimant was an employment-related risk because it was directly connected to her work duties. See id. at 524.[2] Unlike James D. Johnson, supra, claimant's knee was not injured while she was merely taking a step at work. We agree with the ALJ that claimant's left knee injury arose out of and in the course of her employment with the employer.

Next, the employer contends that Dr. Freeman's opinion on causation is entitled to little weight because it was premised on an inaccurate history of claimant's work activities. The employer asserts that Dr. Freeman's opinion is premised on the erroneous medical history that claimant had a "sustained position of the knee" in an abnormal position. (Ex. 8).

Claimant contends that this case does not involve a complex medical situation that requires expert medical opinion to resolve. We need not address that issue because, even if we assume that this case involves a complex medical causation question, we would still find that claimant has satisfied her burden of proof.

Although Dr. Freeman referred to claimant's "sustained position," (Ex. 8), and "sustained hyperflexed position" (Ex. 11), in his written reports, it is clear from Dr. Freeman's deposition testimony that he had an accurate history of claimant's work injury. Dr. Freeman testified that claimant told him that "she had bent down, had some pain in the knee, the knee started swelling some, and it was still giving her trouble the next day." (Ex. 9-9). Dr. Freeman also relied on claimant's written explanation of the injury.[3] (Ex. 9-25, -26). The employer's attorney asked Dr. Freeman how long the bending would have needed to take place in order to cause effusion. Dr. Freeman replied that it "could have happened

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[1] The ALJ found that claimant's testimony was credible as to demeanor and substance. Since the ALJ's credibility finding was based in part upon the observation of claimant's demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990). When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our de novo review of the record, we agree with the ALJ that claimant was a credible witness.

[2] In SAIF v. Marin, supra, 139 Or App at 524, the court explained that employment-related risks are those that are inherent to the claimant's job and that either produce injury while the claimant is engaged in his or her usual employment or that become manifest later in the form of occupational diseases.

[3] Dr. Freeman referred to a workers' compensation questionnaire ("deposition exhibit 1") in which claimant reported: "I was recovering ladies' wallets and I was bending down to pick them up, and I noticed I could not bend my left knee. As the evening went on, my knee increased with the swelling." (Ex. 9-33).

with just an initial bending or it could have happened over a period of time." (Ex. 9-27). Dr. Freeman relied on claimant's history to determine which way it happened. (Id.) Contrary to the employer's assertion, we conclude that Dr. Freeman had an accurate history of claimant's work injury.

The employer asserts that Dr. Freeman testified that he noted no swelling of claimant's left knee on April 1, 1995, and the employer argues that it is improbable that Dr. Freeman would have missed claimant's swelling at that time. As the ALJ pointed out, when Dr. Freeman examined claimant on April 1, 1995, Dr. Freeman assumed that claimant's leg discomfort was radicular in nature and he did not consider any potential left knee problems. (Exs. A, 9-8, -11). Moreover, Dr. Freeman testified that he did not examine claimant's knee on April 1 because he attributed her complaints to sciatic pain. (Ex. 9-11). Dr. Freeman did not examine claimant's knee until April 13, 1995. (Ex. 9-25).

We conclude that Dr. Freeman's opinion on causation is persuasive because it is well-reasoned and based on an accurate history of claimant's work injury. We agree with the ALJ's reasoning and conclusion that Dr. Woolpert's opinion is wholly unpersuasive. Claimant has established that her left knee injury is compensable.

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

ORDER

The ALJ's order dated March 1, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
JAMES M. BARNUM, Claimant
WCB Case No. 95-11264
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Schultz's order that 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 except for the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. On May 12, 1995, claimant injured his right knee at work while he was loading broken pieces of concrete into a front-end loader. Claimant's right knee was stiff and swollen the following morning. Claimant did not seek medical attention and his symptoms subsided. Shortly thereafter, claimant spent three to four days on a backpacking trip and experienced renewed swelling in his right knee. Claimant sought treatment from Dr. Phillips on June 13, 1995. Claimant was subsequently diagnosed with a popliteal cyst, synovitis, degenerative joint disease and degenerative medial meniscus, as well as degenerative arthritis. (Exs. 10, 13).

The ALJ concluded that, as a result of his work activities on May 12, 1995, claimant experienced a temporary pathological worsening of his preexisting knee condition. The ALJ found that the most persuasive medical opinion was from Dr. Linder.

SAIF argues that the ALJ misconstrued Dr. Linder's opinion and erred in concluding that Dr. Linder's opinion established the compensability of claimant's right knee condition.

On December 1, 1995, Dr. Linder examined claimant on behalf of SAIF. Dr. Linder diagnosed "mild but significant pre-existing degenerative arthritis and popliteal cyst of the right knee, aggravated by industrial work activities of May 12, 1995, with possibly some additional aggravation by subsequent personal activities." (Ex. 13-6, -7). Dr. Linder believed that the work-related activities and subsequent personal activities "aggravated the arthritis and synovitis to the point of becoming symptomatic." (Ex. 13-7). Dr. Linder reported that claimant's preexisting conditions "historically were quiescent" until May 12, 1995 and the conditions then became irritated on a temporary basis. (Id.) Dr. Linder commented that there may have been some additional aggravation with hiking, but the "main precipitating event was the work activities of May 12, 1995." (Id.)

Regarding the major contributing cause of claimant's condition, Dr. Linder concluded:

> "The pre-existing degenerative joint disease and popliteal cyst constitute the major contributing cause of his current condition requiring treatment. I regard his industrial injury as being a temporary aggravation of the underlying condition. I believe the treatment he has required up to the present time is specifically related to the industrial injury possibly slightly additionally affected by his hiking activities but there really is no way of quantifying what portion was due to his hiking and what due to working. It is noteworthy that hiking is a form of leisure enjoyment for him, and that this type of hiking he has done frequently and never previously had associated knee problems. This is an additional reason why I tend to feel the major contributing cause was his work activities." (Ex. 13-7; emphasis in original).

On the one hand, Dr. Linder opined that "[t]he pre-existing degenerative joint disease and popliteal cyst constitute the major contributing cause of his current condition requiring treatment." (Ex. 13-7). On the other hand, Dr. Linder concluded that "the major contributing cause was his work activities." (Id.) Because Dr. Linder's opinion is, at best, inconsistent and confusing, we do not find it persuasive. Furthermore, Dr. Linder commented that there was "no way of quantifying" what portion of claimant's treatment was due to hiking and what portion was due to work activities. We conclude that Dr. Linder's opinion is entitled to little weight.

The only other medical opinion in the record is from Dr. Bills. On September 6, 1995, Dr. Bills reported that the synovitis and degenerative joint disease were the primary cause for claimant's need for treatment. (Ex. 10). On November 14, 1995, Dr. Bills agreed that the preexisting degenerative joint disease and degenerative medial meniscus constituted the major contributing cause of claimant's condition. (Ex. 12).

In sum, there is no persuasive medical opinion that establishes that claimant's work activities were the major contributing cause of the disability or need for treatment for his right knee condition. Therefore, we conclude that claimant has failed to meet his burden of proof. See ORS 656.266.

ORDER

The ALJ's order dated February 15, 1996 is reversed. The SAIF Corporation's September 8, 1995 denial is reinstated and upheld. The ALJ's award of a $2,500 assessed attorney fee is also reversed.

Board Chair Hall dissenting.

I disagree with the majority's conclusion that Dr. Linder's opinion is not sufficient to establish that claimant's work activities were the major contributing cause of the disability or need for treatment for the right knee condition. The majority confuses claimant's original, temporary condition, for which his work activities were the major contributing cause, with claimant's subsequent ("current") knee condition, which is not at issue in this case.

Dr. Linder opined that claimant's preexisting right knee conditions were quiescent until the stress of his May 12, 1995 work activities. (Ex. 13). Dr. Linder reported that the "main precipitating event" and the "major contributing cause" of claimant's right knee condition was the work activities. (Ex. 13-7). Dr. Linder believed that claimant's industrial injury caused a temporary aggravation of the underlying condition and he concluded that claimant's treatment up to the present time was specifically related to the industrial injury with a possibility of a slight additional effect on his right knee as a result of post-injury hiking. (Id.) Dr. Linder noted that claimant had hiked frequently and never previously had any associated knee problems.

Based on Dr. Linder's persuasive and well-reasoned opinion, claimant has established that his work activities on May 12, 1995 were the major contributing cause of his need for medical care and treatment.[1] I agree with the ALJ's comment that whether claimant's continued need for treatment is related to the May 12, 1995 injury on a major contributing cause basis is not at issue here. Because the majority confuses claimant's original, temporary condition with a later ("current") condition, which is not being litigated, and in doing so relies on that portion of Dr. Linder's opinion that addresses claimant's "current condition", I respectfully dissent.

[1] The majority finds Dr. Linder's opinion inconsistent and confusing. It is respectfully submitted that the majority's conclusion, in that regard, results from the majority confusing Dr. Linder's opinion on the original-temporary condition with his opinion on the current condition.

August 14, 1996 Cite as 48 Van Natta 1669 (1996)

In the Matter of the Compensation of
ROBERT A. CLIBBON, Claimant
WCB Case No. 95-03404
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that upheld the self-insured employer's denial of his occupational disease claim for right hemidiaphragmatic paralysis. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the ultimate findings of fact. We summarize the pertinent facts as follows:

Claimant, age 53 at the time of hearing, works as a truck driver. In early 1994, he was partnered with another driver as part of a two-man sleeper long haul truck driving team. On these long trips, the partners pushed themselves hard and got little rest. What little sleep claimant did get was in the truck's sleeper compartment while his partner drove.

On March 17, 1994, the morning after he returned home from a long trip, claimant awoke with a painful and stiff neck. He was eventually diagnosed with a cervical strain.[1] On April 11, 1994, while reclining in a chair at home, claimant experienced the acute onset of pain in the right side of his rib cage. He also felt a heavy weight in his chest and short of breath. He sought treatment, and was diagnosed with right hemidiaphragmatic paralysis.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to prove by a preponderance of the evidence that his right hemidiaphragmatic paralysis (RHP) was caused in major part by his employment activities as a long haul truck driver. We find to the contrary.

[1] Claimant's cervical strain was found compensable by a previous Opinion and Order.

The medical evidence establishes that RHP is a relatively unusual condition resulting from an injury to the phrenic nerve. The phrenic nerve roots originate in the cervical spinal cord. From the cervical spine, the nerve travels through the anterior portion of the neck and into the chest, where it innervates the diaphragm. (Ex. 23-9). The three known causes of RHP are trauma to the spinal cord or chest, lesions affecting the phrenic nerve or peripheral nerve disease. (Exs. 21, 23-10).

Because the causation issue in this case presents a medically complex question, our resolution of the issue turns on an analysis of the expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Four physicians have offered opinions concerning the cause of claimant's RHP:[2] Drs. Taylor, Tara, Heitsch, each of whom have treated claimant, and Dr. Olmscheid, who examined claimant one time at the insurer's request.

Dr. Taylor, a neurologist who saw claimant on several occasions beginning in June 1994, opined that, based on a reasonable medical probability, claimant's job activities (particularly the bouncing in the truck on long drives) were the major cause of injury to the nerve roots in the cervical region or the phrenic nerve, which was the cause of claimant's RHP. (Ex. 26). Dr. Tara, of the Portland Lung Institute, also concluded that claimant's job-related activities immediately prior to March 17, 1994 were the major contributing cause of his RHP, although she provided no explanation for this opinion. (Ex. 19B). Dr. Heitsch, of Electronic Medical Systems, Inc., determined that the likely cause of claimant's RHP was an injury to the phrenic nerve associated with the pain and swelling of his neck from the cervical strain injury. (Ex. 19A).

Dr. Olmscheid, on the other hand, reported that he could not identify the specific cause of claimant's condition within a reasonable medical probability. Dr. Olmscheid testified that, from a statistical standpoint, it would be unlikely for claimant's cervical strain to be the cause of his RHP. (Ex. 23-12, 23-21). Dr. Olmscheid explained that the most common cause of RHP is trauma to the cervical spine or chest. The second most common cause is a lesion or tumor on, or adjacent to, the phrenic nerve, and the least common cause, by far, is a peripheral nerve abnormality. (Ex. 23-12). Dr. Olmscheid determined that, in claimant's case, his RHP was probably not caused by peripheral neuropathy or an obvious phrenic nerve disorder, but could be the result of trauma or perhaps a small abnormality on the phrenic nerve which did not show on the imaging studies. (Ex. 23-30).

In resolving complex medical causation issues, such as those 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). In this case, we find the medical opinion of Dr. Taylor to be the most persuasive.

Dr. Taylor reported that, although it is impossible to know precisely why claimant developed RHP, the most likely cause was the repetitive trauma of bouncing around in the truck on long drives. Dr. Taylor explained that testing showed no lesions or masses compressing against the phrenic nerve which supplies the right diaphragm. Dr. Taylor also explained that because claimant also presented with symptoms of radiculopathy into the right arm, the trauma likely occurred at the nerve roots in the cervical region rather than the phrenic nerve itself. (Exs. 24, 26). Dr. Taylor's well-reasoned opinion is supported by the opinion of Dr. Tara and is not rebutted by the testimony of the employer's expert, Dr. Olmscheid. Although Dr. Olmscheid questioned the relationship between claimant's cervical strain and the RHP, he did not specifically address the repetitive trauma caused by claimant's work activities, particularly the bouncing in the truck. Further, Dr. Olmscheid admitted it was possible that claimant's RHP was related to his cervical strain.

Accordingly, in light of Dr. Taylor's thorough and well-reasoned opinion, we conclude that it is more likely than not that claimant's RHP was caused in major part by his work activities as a long haul truck driver during March and April 1994. We therefore set aside the employer's denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for prevailing over the employer's denial of claimant's RHP. ORS 656.386(1). After considering the factors

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[2] Dr. Nelson, who treated claimant's cervical symptoms and diagnosed his RHP, did not form an opinion on causation. (Ex. 22).

set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 12, 1996 is reversed. The self-insured employer's denial of claimant's right hemidiaphragmatic paralysis is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $4,000, payable by the employer.

In the Matter of the Compensation of
BERKLEY R. CONNER, Claimant
WCB Case No. 95-01484
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order which upheld Liberty Northwest Insurance Corporation's denial of his current left knee condition. On review, claimant contends that Liberty is responsible for his claim.

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

Claimant initially injured his left knee on December 3, 1985 while working for Liberty's insured. Claimant filed a claim for a "strained, twisted knee" that Liberty accepted by checking the acceptance box on a form 801. The claim was closed without permanent disability by Notice of Closure issued on April 24, 1986.

Claimant sustained a second compensable left knee injury on December 2, 1991, while working for an employer insured by Kemper Insurance Company. Kemper accepted the claim as a left knee strain. The claim was closed without an award of permanent disability by a Notice of Closure issued on March 26, 1992.

Claimant subsequently experienced a recurrence of left knee pain and instability that prompted him to seek treatment from Dr. Rabie in May 1994. A July 1994 MRI scan demonstrated left anterior cruciate insufficiency and degenerative change over the left lateral femoral condyle.

Claimant filed a claim for his current left knee condition with Kemper and Liberty. Both claims were denied. Claimant entered into a Disputed Claim Settlement (DCS) with Kemper, but litigated Liberty's denial at hearing.[1]

The ALJ determined that Liberty was not responsible for claimant's current left knee condition, consisting of anterior cruciate ligament (ACL) instability and lateral femoral condyle degeneration. The ALJ reasoned that the medical opinion of an examining physician, Dr. Farris, established that claimant's 1991 Kemper injury was the major contributing cause of claimant's ACL condition. The ALJ also found that claimant failed to establish that his lateral femoral condyle condition was related to the compensable 1985 left knee injury with Liberty.

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[1] By entering into this settlement, claimant is deemed to have accepted the possible consequence that he will not receive compensation from the only other potentially causal carrier. See Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71, 78 (1994); E.C.D., Inc. v. Snider, 105 Or App 416 (1991); Lola M. Springer, 46 Van Natta 2213 (1994).

On review, claimant contends that the ALJ should have assigned responsibility to Liberty. We disagree.

ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

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. See 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 371-72, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993). Conversely, ORS 656.308(1) does not apply when a claimant's further disability or need for treatment involves a condition different than that which has already been processed as part of a compensable claim. See Armand J. DeRosset, supra.

We have held that, in the context of successive accepted injuries involving the same condition, ORS 656.308(1) governs the determination of responsibility for further compensable disability or need for treatment involving that condition. Bonni J. Mead, 46 Van Natta 1185 (1994). However, 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, Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984) is applicable. Raymond H. Timmel, 47 Van Natta 31 (1995)

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.

We conclude that, regardless of whether we apply ORS 656.308 or Kearns, Kemper was responsible for claimant's current left knee conditions In other words, if claimant's current left knee condition involved the "same condition" as that previously processed as part of the prior accepted injuries, then Kemper would be responsible as the last carrier with the most recent claim for the accepted conditions. Armand J. DeRosset, supra. If, however, claimant's current left knee condition is different from what was processed as part of the prior accepted claims, but instead concerns the same body part (left knee), Kemper would still be responsible. Kearns, supra. We reach this conclusion because, based on our de novo review of the medical record, we find that neither the medical opinion of Dr. Farris nor that of Dr. Rabie preclude a causal connection between claimant's current left knee condition and his last accepted injury for Kemper's insured in 1991. (Exs. 28-10, 34).

Accordingly, we agree with the ALJ that Liberty is not responsible for claimant's current left knee conditions. Thus, we affirm the ALJ's decision upholding Liberty's denial.

ORDER

The ALJ's order dated January 16, 1996 is affirmed.

In the Matter of the Compensation of
WILLIAM J. DELOREY, Claimant
WCB Case No. 95-06144
ORDER ON REVIEW (REMANDING)
Ernest M. Jenks, Claimant Attorney
G. Joseph Gorciak III, Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) set aside its denial of claimant's injury claim for sensory neuritis; and (2) awarded an assessed attorney fee. The insurer also moves for remand for admission of additional evidence. On review, the issues are compensability, attorney fees, and remand. The motion for remand is granted.

The ALJ found that claimant had established traumatic neuritis by medical evidence supported by objective findings and concluded that claimant's work incident was the major contributing cause of the neuritis.

The insurer argues that claimant was not credible and asserts that claimant provided an inaccurate history of work activities, lifting activities and symptom complex to the various physicians. The insurer also moves to remand this case to the ALJ for the taking of additional evidence because claimant failed to disclose the name of Dr. O'Neill, a physician involved in the care of his disputed condition.

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983) (Board has no authority to consider newly discovered evidence). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

The insurer wrote to claimant's attorney on June 2, 1995, asking for information "concerning any and all injuries" to claimant's right lower extremity. The insurer's attorney also asked for information related to claimant's prior injuries and requested copies of "all other discovery to which I am entitled under Oregon Administrative Rules." On the same date, the insurer submitted its "Response to Issues," which requested copies of all medical reports and all other documents pertaining to the claim.

The insurer asserts that claimant did not provide information before the record was closed that he had conferred with and received medications from Dr. O'Neill. According to the insurer, it was not aware of Dr. O'Neill's involvement until claimant submitted an "Affidavit for Expedited Remedy for Failure to Pay Temporary Disability" on April 16, 1996, stating that Dr. O'Neill had been his attending physician for his workers' compensation injury since August 1995. The insurer contends that claimant's affidavit is inconsistent with his testimony at the August 18, 1995 hearing. At the hearing, claimant was asked how many physicians or health providers of any kind that he had been to since March 8, 1995. (Tr. 71). Claimant did not mention Dr. O'Neill's name.

Claimant argues that remand is not appropriate because the insurer did not use due diligence to obtain information regarding Dr. O'Neill's treatments. Claimant asserts that the insurer was on notice of Dr. O'Neill's treatment as early as March 5, 1996. However, claimant does not explain how, if the insurer did not receive notice of Dr. O'Neill's involvement until March 1996, the insurer could have made efforts to obtain Dr. O'Neill's reports before the August 1995 hearing or before the record closed on January 16, 1996.

Claimant also contends that the insurer never asked claimant to provide information on his most recent medical treatment. Rather, claimant asserts that the insurer requested information relating to prior injuries. Contrary to claimant's assertion, the insurer's request for medical information was not limited to prior injuries. In the insurer's June 2, 1995 "Response to Issues" letter, the insurer requested "copies of all medical reports and all other documents pertaining to this claim, whether or not the claimant intends to rely upon them at hearing." The insurer also requested copies of "all other discovery" to which the insurer was entitled under Oregon Administrative Rules in another June 2, 1995 letter.

Claimant had an ongoing duty to furnish the insurer with copies of all medical reports and other documents pertaining to the claim. Under former OAR 438-07-015(3), upon written demand by the carrier, the claimant shall furnish to the carrier copies of "all medical and vocational reports and other documents pertaining to the claim" which the claimant did not receive from the carrier making the demand. Documents acquired after the initial exchanges are to be provided to the other party within seven days after the disclosing party's receipt. Former OAR 438-07-015(4). Under former OAR 438-07-017(1), "[a]ll medical or vocational material, whether created or existing before, on, or after the date of injury or exposure shall be disclosed under OAR 438-07-015[.]"

Claimant argues that Dr. O'Neill's treatment for claimant's "disputed condition" did not begin until after the date of the August 18, 1995 hearing. Although claimant acknowledges that he discussed his work injury with Dr. O'Neill on July 5, 1995, he asserts that Dr. O'Neill's involvement with his condition at that time was limited to that discussion. Claimant's argument ignores the fact that the insurer had requested "copies of all medical reports and all other documents pertaining to this claim, whether or not the claimant intends to rely upon them at hearing." It is not clear whether claimant actually had any reports or documents from Dr. O'Neill. Nevertheless, claimant failed to disclose Dr. O'Neill's involvement when the insurer's attorney asked him at hearing how many different physicians he had been to "since March 8th of 1995, physicians or health providers of any kind[.]" (Tr. 71; emphasis added). Claimant's argument also ignores the fact that the record did not close until January 16, 1996.

We find that the insurer exercised due diligence by initially requesting all medical reports and other documents from claimant and by questioning claimant at hearing about his physicians and health providers. See Penny S. Orcutt, 47 Van Natta 1057, on recon 47 Van Natta 1330 (1995) (carrier exercised due diligence in trying to obtain the claimant's past medical history before hearing, but was unable to do so until the claimant, for the first time, provided the information in her testimony); Penni L. Mumm, 42 Van Natta 1615 (1990) (the claimant exercised due diligence by making a standard request for claims information and by asking the carrier about the apparent incompleteness of the records).

Despite the insurer's due diligence in requesting all documents pertaining to the claim and questioning him regarding prior treatment, Dr. O'Neill's involvement in the case was unknown before the ALJ issued the Opinion and Order. Claimant's credibility was a central consideration in the insurer's defense and the ALJ's conclusions. Claimant's failure to disclose the existence of Dr. O'Neill may affect the ALJ's determination of claimant's credibility. Furthermore, we find that Dr. O'Neill's opinion is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., supra.

Having found that the insurer proved a compelling reason, we grant its motion to remand for the admission of additional evidence regarding claimant's treatment with Dr. O'Neill. In addition, the ALJ shall allow claimant an opportunity to cross-examine or rebut the proffered evidence. The submission of this additional evidence shall be made in any manner that the ALJ determines will achieve substantial justice. Following these further proceedings, the ALJ shall issue a final, appealable order concerning the issues raised in this case.

Accordingly, the ALJ's order dated February 15, 1996 is vacated. This matter is remanded to ALJ Davis for further proceedings consistent with this order. Following these further proceedings, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

Board Chair Hall specially concurring.

Although I agree that this case should be remanded to the ALJ, I am troubled by the majority's focus on claimant's alleged failure to produce documents. The record before us does not establish whether claimant had any documents that were subject to the insurer's request for medical reports and other documents, even assuming that the insurer's request was ongoing. Because the moving party has not established a failure to comply with the request for documents, remand on that basis is not appropriate.

Nevertheless, I agree with the majority that claimant should have more fully answered the insurer's questions at hearing concerning his physicians and health providers. On that basis, I agree that remand to the ALJ is appropriate.

August 14, 1996 Cite as 48 Van Natta 1675 (1996)

In the Matter of the Compensation of
MARTHA L. GARRISON, Claimant
WCB Case Nos. 95-13285 & 95-11758
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
SAFECO Legal, Defense Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that: (1) upheld the SAIF Corporation's denial (on behalf of the People's Market) of claimant's claim for right carpal tunnel syndrome; and (2) upheld SAFECO Insurance Company's denial (on behalf of Special T Shoppe) of claimant's claim for the same condition. On review, the issues are compensability and, potentially, responsibility.

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

The ALJ found that the opinion of Dr. Gill, who examined claimant on behalf of SAFECO, did not support compensability. On review, claimant argues that the ALJ should not have relied on Dr. Gill's opinion.

First, we note that the ALJ concluded only that Dr. Gill's opinion did not establish a causal relationship. We agree with that conclusion. Furthermore, inasmuch as claimant does not rely on Dr. Gill's opinion, we do not find it necessary to determine the adequacy, or inadequacy, of his opinion.

Claimant does, however, rely on the opinion of Dr. Tesar. The ALJ discounted Dr. Tesar's opinion, as Dr. Tesar reported that claimant's first carpal tunnel symptoms occurred in 1994, while the record indicated that carpal tunnel had been diagnosed as early as 1992. On review, claimant essentially argues that it is not dispositive whether or not Dr. Tesar was aware of Dr. Cumming's reports documenting carpal tunnel syndrome symptoms in 1992, as Dr. Tesar understood claimant's work activities and had a complete description of her past medical history.

Regardless of Dr. Tesar's understanding of claimant's work activities and her medical history, the fact remains that Dr. Tesar based his conclusion on an erroneous assumption that claimant had not had carpal tunnel symptoms during her employment with SAIF's insured. Specifically, Dr. Tesar reported that, "[s]ince there is no documentation in the chart of symptoms of carpal tunnel syndrome while (claimant) was working at People's Market, I certainly do not think that the work there is the major contributing cause for her current condition and need for treatment." Rather, Dr. Tesar concluded that the work activities at SAFECO's insured were the major contributing cause of her condition. (Ex. 11-10).

Accordingly, in light of Dr. Tesar's mistaken assumption, we are unable to speculate that Dr. Tesar would have reached the same conclusion, had he known about claimant's carpal tunnel symptoms during her employment with SAIF's insured. Consequently, because we find that Dr. Tesar did not have a complete or accurate history, we agree with the ALJ that his opinion is not persuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

Because none of the remaining medical opinions in the record support compensability, we conclude that claimant has failed to meet her burden of proof. The ALJ's order is, therefore, affirmed.

ORDER

The ALJ's order dated February 15, 1996 is affirmed.

In the Matter of the Compensation of
PAUL E. HARGREAVES, Claimant
WCB Case No. 95-01401
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed Board Members Hall and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order which: (1) set aside its denial of claimant's lumbar disc conditions; and (2) awarded penalties for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability and penalties.

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

The ALJ set aside the insurer's denial of claimant's low back condition and related surgery, finding that claimant's compensable low back injury on July 25, 1994 was the major contributing cause of his need for surgery. On review, the insurer contends that the medical evidence fails to satisfy the requirements of both ORS 656.005(7)(a)(B) and ORS 656.225. We disagree with the insurer's contentions.

We first determine whether ORS 656.005(7)(a)(B) is applicable.[1] The record establishes that claimant has long-standing degenerative disc disease which preexisted claimant's compensable July 25, 1995 low back injury, which the insurer accepted as a lumbar strain. (Exs. 44-2, 50-7). An examining physician, Dr. Geist, opined in his April 4, 1995 medical report that claimant's compensable 1994 low back injury was "superimposed" on preexisting degenerative disc disease. (Ex. 50-7). However, Dr. Geist never clarified how he used the term "superimposed." Thus, we are unable to conclude, based only on Dr. Geist's report, that there was a "combined condition." See Sanford v. Balteau Standard, 140 Or App 177, 183 (1996) (case remanded to Board for clarification of its decision when nothing in the record or in Board order indicated how the term "superimposed" was used).

Dr. Mawk, claimant's attending surgeon, opined that degenerative disc disease is considered a fairly common condition, but that most people remain asymptomatic unless there is an injury that causes a disc to bulge. (Ex. 54-1). According to Dr. Mawk, claimant's compensable injury was responsible for the bulging of claimant's L4-5 disc and the symptoms for which Dr. Mawk ultimately performed surgery. Id. Based on this opinion, we conclude that claimant's compensable injury did "combine" with his preexisting degenerative disc disease and that, therefore, ORS 656.005(7)(a)(B) is applicable. Thus, claimant must establish that his compensable injury is the major contributing cause of his need for medical treatment of the "combined condition." Rickey C. Amburgy, 48 Van Natta 106 (1996).

Dr. Mawk opined that claimant 's compensable injury was the major contributing cause of claimant's need for surgery, consisting of a hemilaminectomy at L4-5 and a foraminotomy at L5-S1. (Exs. 56A, 59). Dr. Mawk's operative report confirmed that claimant did have a disc herniation at L4-5, a finding consistent with that made by an associate, Dr. Obukhov. (Exs. 41, 59). Inasmuch as Dr. Mawk performed claimant's surgery, his opinion is entitled to considerable weight. Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988) (opinion of worker's treating surgeon entitled to particular deference). Moreover, in light of Dr. Geist's testimony that claimant's compensable injury was the major contributing cause of claimant's need for surgery, (Ex. 55a-26), we agree with the ALJ that claimant has sustained his burden of proving that his "combined condition" is compensable under ORS 656.005(7)(a)(B).

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[1] ORS 656.005(7)(a)(B) provides:

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

The insurer contends, however, that ORS 656.225 requires that claimant prove that the compensable injury is the major contributing cause of a pathological worsening of the preexisting degenerative condition.[2] The insurer asserts that claimant has failed to do so. For the following reasons, we find that the above statute does not defeat this claim.

Given our finding that claimant's current low back condition is a "combined condition," ORS 656.225 is not germane because claimant's medical treatment is not solely directed to the preexisting condition. Sally A. Niebuhr, 47 Van Natta 2259, 2260 n. 2 (1995). Even if ORS 656.225 was applicable, we would find, based on Dr. Mawk's persuasive opinion, that the compensable injury pathologically worsened claimant's preexisting degenerative disc disease.

We now turn to the penalty issues. The ALJ found that claimant's temporary disability benefits were unreasonably terminated by the insurer's issuance of its July 5, 1995 Notice of Closure. The insurer contends that its closure was reasonable based on its June 14, 1995 notice to claimant that, pursuant to OAR 436-30-035(7), it would close the claim if it did not hear from claimant or his attending physician within two weeks of the date of the letter. (Ex. 54D). We disagree.

Claimant's unrebutted and credible testimony is that, upon receipt of the insurer's letter, he immediately arranged the first available appointment with Dr. Mawk. (Trs. 21, 22). Claimant also provided unrebutted testimony that he called the insurer's claims adjuster and informed her that he was unable to obtain an appointment until June 30, 1995. (Tr. 34). Under these circumstances, we agree with the ALJ that the insurer's administrative closure on July 5, 1995 was unreasonable, given claimant's response to the insurer's June 14, 1995 letter advising that it would close the claim if he was not under active treatment.

The insurer also contests the ALJ's determination that the insurer acted unreasonably in delaying payment of temporary disability benefits based on claimant's credible testimony that, on five occasions, his temporary disability benefits did not arrive on time. (Tr. 25). Considering claimant's credible testimony, as well as the fact that the insurer produced no documentary or lay testimony to contradict claimant's allegations, we agree with the ALJ that claimant sustained his burden of proving that the insurer unreasonably delayed payment of temporary disability benefits. We, thus, affirm the ALJ's assessment of a 25 percent penalty.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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. 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 issues. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated December 13, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

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[2] ORS 656.225 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."

In the Matter of the Compensation of
MADALINE M. MURPHY, Claimant
WCB Case No. 95-07333
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its partial denial of claimant's C5-6 spondylosis and degenerative disc disease. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We change the first paragraph on page 2 to read: "X-rays of the cervical spine in October of 1994 disclosed osteoarthritic problems at the C5-6 and C6-7 levels with some foraminal encroachment. (Ex. 25)." We do not adopt the last paragraph of the findings of fact or the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. On March 14, 1994, claimant tripped on a floor mat at work, but did not fall to the ground. Claimant experienced pain in her back, neck and right shoulder. The insurer accepted a right sacroiliac and right trapezius strain. (Ex. 9). Claimant was treated primarily with physical therapy.

Claimant continued to have problems with her neck and was referred to Dr. Kitchel, orthopedic surgeon. On November 7, 1994, Dr. Kitchel diagnosed a musculoligamentous injury of the cervical spine and degenerative disc disease at multiple levels. (Ex. 28). An MRI showed degenerative disc disease at C5-6 and C6-7 and a large spur at C5-6 projecting into the spinal foramen resulting in moderate narrowing. (Ex. 29). A CT myelogram showed "cervical spondylosis with central spondylotic bar and right lateral spur formation at C5-6." (Ex. 38). Dr. Kitchel subsequently performed cervical surgery.

There is no dispute that claimant had preexisting cervical spondylosis and degenerative disc disease. Furthermore, the medical evidence establishes that claimant's March 1994 work injury combined with her preexisting conditions to cause or prolong the disability or need for treatment. (Exs. 51-12). Therefore, claimant must prove that the work injury was the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. ORS 656.005(7)(a)(B). Based on Dr. Kitchel's opinion, the ALJ concluded that claimant's March 14, 1994 injury was the major contributing cause of her cervical condition.

The insurer argues that the ALJ erred in relying on Dr. Kitchel's opinion to prove compensability. The insurer contends that Dr. Kitchel's reports establish that claimant's preexisting conditions were the major contributing cause of claimant's condition and need for surgery.

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 of claimant's current need for treatment. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995). An event which precipitates symptoms of a preexisting condition is not necessarily the major contributing cause of those symptoms.

On February 20, 1995, Dr. Kitchel reported that claimant's underlying problem was a combination of the spondylitic bar and bone spur and he thought that was causing the compression of the nerve. (Ex. 42). However, Dr. Kitchel believed that the underlying condition was made symptomatic by the March 14, 1994 injury. (Id.) Dr. Kitchel reported on April 20, 1995 that the "major underlying need for [claimant's] surgery is the cervical degenerative disease." (Ex. 43). Once again, Dr. Kitchel commented that claimant's condition was made symptomatic as a result of the March 14, 1994 work injury.

On July 21, 1995, Dr. Kitchel reported that, if surgery was done on claimant, the "primary diagnosis to lead to that surgery would be the underlying spondylosis or degenerative condition." (Ex. 49). On August 15, 1995, Dr. Kitchel opined that he could not tell if the March 1994 accident caused any pathological change in her neck, but he believed that it irritated her cervical nerve roots and was responsible for the symptoms which she was currently having. (Ex. 50). Dr. Kitchel reported further:

> "At this time, I believe the injury does continue to be the precipitating cause of her need for treatment. However, I believe that if any surgery were to be done it would be for the underlying cervical degenerative disease and subsequent nerve root compression." (Id.)

Dr. Kitchel was deposed after he had performed cervical surgery on claimant. At surgery, Dr. Kitchel found some compression of the sixth cervical nerve root on the right. (Ex. 51-5). Dr. Kitchel testified that claimant's injury precipitated her symptoms and her symptoms precipitated her need for surgery. (Ex. 51-7). Dr. Kitchel explained:

> "I think that it was the initial pinch or the initial event that made the nerve symptomatic. And then, with the fact that the bone spur was there and the fact that the canal -- where the nerve root went through was already narrowed, it didn't allow the inflammation and the irritation of the nerve to subside without giving the nerve some more room.
>
> "But the sort of underlying cervical degenerative disease maintained and continued the inflammation and irritation of the nerve and didn't allow it to quiet down." (Ex. 51-9, -10).

Dr. Kitchel agreed that the work incident was the major contributing cause of the "initial irritation" of the nerve root. (Ex. 51-10). However, Dr. Kitchel said that "the major contributing cause of the need for surgery was the fact that the symptoms had been exacerbated or brought on by the industrial injury, but that the surgery itself was done primarily to treat the underlying degenerative disease." (Ex. 51-12). Dr. Kitchel said that it was speculative to say whether the nerve had any underlying pathological change. (Ex. 51-13). Later in the deposition, Dr. Kitchel agreed that the surgery was entirely addressed to remove the bone spur and he agreed that, if the spur had not been there, it was likely that claimant's condition would have resolved in the normal course as a result of conservative treatment. (Ex. 51-22, -25). Dr. Kitchel testified that he continued to stand by his opinion letters. (Ex. 51-27).

We conclude that Dr. Kitchel's opinions fail to establish a compensable claim under ORS 656.005(7)(a)(B). At most, Dr. Kitchel's opinions establish that claimant's work injury was the precipitating cause of her symptoms, but the work injury was not the major cause of her need for treatment. See Dietz v. Ramuda, supra. Rather, Dr. Kitchel's reports and deposition testimony establish that claimant's preexisting cervical conditions were the major contributing cause of her need for treatment.

The other medical opinions do not support claimant's claim. Dr. Weller reported that claimant's bone spur was causing her continued neck complaints rather than the cervical strain condition. (Ex. 40). Dr. Rosenbaum reported that claimant had underlying cervical spondylosis with degenerative changes and spur formation, but they were not pathologically changed by the work injury. (Ex. 48). Dr. Rosenbaum opined that surgery would be directed to the bone spur and spondylosis, but not the industrial injury. (Id.) We conclude that claimant has failed to establish the compensability of her C5-6 spondylosis and degenerative disc disease.

ORDER

The ALJ's order dated March 28, 1996 is reversed. The Insurer's denial is reinstated and upheld. The attorney fee award is also reversed.

In the Matter of the Compensation of
THOMAS M. SAVELICH, Claimant
WCB Case No. 95-09940
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Odell's orders that: (1) upheld the insurer's denials of claimant's occupational disease/aggravation claim for a low back condition; and (2) declined to reopen the record to admit a medical report. On review, the issues are evidence and compensability.

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

Evidence Issue

The ALJ declined to reopen the record to admit a supplemental report of claimant's consulting physician, Dr. Hacker, which was prepared two days before the hearing, but not received by the parties until after the record closed. The ALJ found that the substance of Dr. Hacker's December 4, 1995 opinion was obtainable prior to the closing of the record, and that this supplemental report constituted a late report from a physician whose medical reports were already in evidence.

On review, claimant argues that the ALJ should have admitted Dr. Hacker's December 4, 1995 report as a remedy for the carrier's failure to timely disclose the report to claimant.[1] The insurer acknowledges that it received Dr. Hacker's December 4, 1995 report a day after the record closed and did not disclose it to claimant until approximately one month later. However, the insurer notes that, regardless of this belated disclosure, the same standard would be used for determining whether reopening of the record was warranted, i.e., whether the substance of the report was obtainable prior to the closing of the record. See Renia Boyles, 42 Van Natta 1203 (1992). In addition, the insurer contends that Dr. Hacker's December 4, 1995 report is essentially a restatement of his October 25, 1995 opinion (Ex. 22), and would add nothing new to the record.

An ALJ may reopen the record to admit new material evidence. The party seeking to admit late evidence must explain why the evidence could not reasonably have been discovered and produced at the hearing. OAR 438-007-0025. Here, as the ALJ found, although claimant could not have produced this particular report of Dr. Hacker at the hearing because he was not aware of it, he could have obtained a similar report from Dr. Hacker (commenting on Dr. White's report) prior to the hearing. We find no abuse of discretion in the ALJ's decision not to reopen the record to admit this report.

Compensability

We adopt and affirm the ALJ's conclusion that the opinions of Drs. Hacker and Reeves are unpersuasive because these physicians changed their opinion without adequate explanation.[2] See Kelso v. City of Salem, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive). We also note that neither Dr. Reeves nor Dr. Hacker opined that claimant's work exposure resulted in a pathological worsening of claimant's preexisting degenerative disc disease (as is required to prove an occupational disease under ORS 656.802(2)(b)) or that claimant's 1992 accepted low

[1] The insurer received the report on December 7, 1995, the day after the record closed, but did not disclose it to claimant until January 10, 1996.

[2] The ALJ also rejected Dr. Hacker's October 25, 1995 report, finding that it was couched in terms of possibility. Dr. Hacker stated that claimant's limitation of range of motion was "most likely" attributable to his 1992 fall and chronic back pain. Unlike the ALJ, we do not consider this opinion to suggest possibility rather than probability. We nevertheless agree with the ALJ that the opinion is unpersuasive because it is lacking in explanation and analysis.

back strain was the major cause of her worsened "combined" condition (as is required to prove an aggravation under ORS 656.273(1), ORS 656.005(7)(a)(B), and Gloria T. Olson, 47 Van Natta 2348 (1995)).

ORDER

The ALJ's order dated January 5, 1996, as amended and reconsidered February 16, 1996, is affirmed.

August 14, 1996 Cite as 48 Van Natta 1681 (1996)

In the Matter of the Compensation of
RICHARD UHING, Claimant
Own Motion No. 94-0078M
OWN MOTION ORDER OF DISMISSAL
Benjamin W. Ross, Claimant Attorney
Saif Legal Department, Defense Attorney

On March 16, 1995, we issued our Own Motion Order, in which we authorized the reopening of claimant's 1986 injury claim for the payment of temporary disability benefits commencing the date claimant was hospitalized for proposed surgery. On February 26, 1996, we issued an Own Motion Order Reviewing Carrier Closure, which set aside the SAIF Corporation's November 27, 1995 closure as premature, because claimant had not undergone the proposed surgery.

In a June 20, 1996 letter, stating that it reinstated claimant's temporary disability benefits shortly after our February 26, 1996 order that set aside its Notice of Closure, SAIF reports that claimant has not yet scheduled surgery but has continued to receive time loss. Under such circumstances, SAIF requested that we indicate a "timeframe which the Workers' Compensation Board wants to allow timeloss benefits [while claimant] decides whether or not to proceed with the proposed surgery." On July 2, 1996, we acknowledged SAIF's request and implemented a briefing schedule to clarify the parties' respective positions.

On July 8, 1996, SAIF responded that it was "not taking a position on this matter." Instead, SAIF asked the Board to indicate whether it wished to impose a "timeframe" regarding claimant's receipt of timeloss benefits pending his decision regarding the proposed surgery.

In a July 10, 1996 letter, claimant responded that Dr. Paltrow, claimant's treating physician, opined that claimant could not yet proceed with surgery. Reporting that claimant was not psychiatrically stable, Dr. Paltrow advised that he would render his opinion as to when claimant could undergo surgery by the first week of November 1996.

Among its powers under ORS 656.278(1), the Board has the authority to review closures of claims reopened under its own motion jurisdiction, as well as to consider requests for suspension of temporary disability compensation in those claims. See OAR 438-012-0060; 438-012-0035(5). Since SAIF has not closed the claim, nor is it seeking suspension of temporary disability compensation, it is essentially requesting us to offer an advisory opinion regarding claimant's continuing entitlement to timeloss. Because we do not issue advisory opinions, we conclude that there are presently no contested issues for our resolution.

Accordingly, because we find no current justifiable controversy for our resolution, the matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD L. HERZOG, Claimant
WCB Case No. C6-02012
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Nancy F.A. Chapman, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

On July 17, 1996, 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 worker's compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On July 22, 1996, we wrote to the parties regarding a provision in the CDA which released claimant's eligibility for preferred worker status for the claim. We noted that the provision was in conflict with ORS 656.622(4)(c) which provides that a worker may not waive eligibility for preferred worker status by agreement pursuant to ORS 656.236. We requested that the parties correct this matter by submitting an addendum.

The parties have now submitted an addendum to the CDA specifying that claimant does not and cannot waive eligibility for preferred worker status in the CDA. Inasmuch as the CDA, as amended, is in accordance with ORS 656.622 and the terms and conditions prescribed by the Board, we approve the amended CDA.[1]

IT IS SO ORDERED.

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[1] In their addendum, the parties have included language suggesting that former OAR 436-110-280(6)(e) allows a waiver of preferred worker status in claim disposition agreements and is, therefore, in conflict with ORS 656.622(4)(c). However, former OAR 436-110-280(6)(e) pertains to disputed claim settlements under ORS 656.289 and does not apply to CDAs. Consequently, the language in the amended CDA concerning the administrative rule is not relevant and is superfluous. Thus, our approval of this agreement should not be construed as an agreement with the parties' understanding or interpretation of the administrative rule.

In the Matter of the Compensation of
VICTOR MAGDALENO-GONZALEZ, Claimant
WCB Case Nos. 95-10360 & 95-02884
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that: (1) found that claimant's claim was not prematurely closed by a December 8, 1994 Notice of Closure; (2) affirmed a March 1, 1995 Order on Reconsideration that awarded no unscheduled permanent disability; (3) found that claimant's claim was not prematurely closed by a June 9, 1995 Notice of Closure; and (4) affirmed a September 5, 1995 Order on Reconsideration that awarded no unscheduled permanent disability. On review, the issues are premature closure and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

On January 22, 1994, claimant, who works in a chicken processing plant, experienced a compensable injury to his left shoulder, neck and upper back when he slipped and fell into a 20-inch deep concrete gutter. Dr. Crawford, claimant's attending physician, diagnosed a cervical sprain, thoracic sprain, and a left shoulder strain. (Ex. 1-2). Claimant subsequently complained of low back and bilateral leg pain, for which he was evaluated by Dr. Rosenbaum, neurologist, who found no evidence of radiculopathy. (Ex. 8). On April 4, 1994, Dr. Crawford released claimant to regular work. (Ex. 10). On April 15, 1994, the insurer accepted disabling cervical and thoracic strains. (Ex. 11).

Dr. Crawford continued to treat claimant for complaints of pain and weakness in the low back and both legs. (Exs. 12, 13, 14, 15, 16, 19-3, 19-8). A May 28, 1994 MRI revealed a small, central herniated disc at L5-S1. (Exs. 13, 16). On June 29, 1994, Dr. Crawford restricted claimant to modified work and continued conservative treatment. (Ex. 16).

On October 5, 1994, claimant requested a hearing on "de facto" partial denials of a left shoulder strain, a lumbar strain and a herniated disc at L5-S1. (Ex. 17).

On October 21, 1994, Dr. Robert Rosenbaum again evaluated claimant's condition. He reported that claimant's symptoms and posture suggested a left L5-S1 radiculopathy, but, finding no muscle weakness, atrophy, fasciculations, or reflex changes, he recommended further electrophysiologic testing. (Ex. 18).

On November 16, 1994, claimant was examined for the insurer by Drs. Strum and Wilson. They opined that claimant had not experienced a significant disc herniation as a result of the industrial injury and concluded that claimant was medically stationary. (Ex. 19). Dr. Crawford disagreed with Drs. Strum and Wilson's report. (Exs. 21, 22).

On December 1, 1994, the insurer formally accepted cervical, thoracic and lumbar strains. (Ex. 20).

The insurer issued a December 8, 1994 Notice of Closure, finding claimant medically stationary as of November 28, 1994 and awarding no permanent disability. (Ex. 23). Claimant requested reconsideration, raising the issues of premature closure and unscheduled permanent disability.

On February 24, 1995, a prior ALJ found that claimant's left shoulder strain and herniated disc were compensable components of the claim. (Ex. 26A).

A March 1, 1995 Order on Reconsideration affirmed the Notice of Closure. Claimant requested a hearing.

On March 18, 1995, the insurer amended its Notice of Acceptance to include claimant's herniated disc. (Ex. 28).

The insurer issued a June 9, 1995 Notice of Closure, finding claimant medically stationary on November 16, 1994 and awarding no permanent disability. (Ex. 35). Claimant requested reconsideration, raising the issues of premature closure, medically stationary date and unscheduled permanent disability. A September 5, 1995 Order on Reconsideration affirmed the Notice of Closure in all respects. (Ex. 40). Claimant requested a hearing. Claimant's hearing requests on the two Orders on Reconsideration were consolidated.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant was medically stationary at the time of the December 8, 1994 and June 9, 1995[1] Notices of Closure. Claimant contends that he was not medically stationary on either November 28, 1994,[2] or November 16, 1994, and that the insurer's closures of his claim were premature. We agree.

December 8, 1994 Notice of 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 claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the December 8, 1994 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

When the medical evidence is divided, greater weight is usually given to the opinion of claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no such reasons.

There are two opinions regarding claimant's medically stationary status, one by Drs. Strum and Wilson, who examined claimant for the insurer, and the other by Dr. Crawford, claimant's treating physician. Drs. Strum and Wilson diagnosed three conditions related to the January 1994 injury: a cervicothoracic strain, a left shoulder strain, and a lumbosacral strain. Based on their interpretation of the MRI report (they did not have the films for review), they opined that claimant had not experienced a significant disc herniation, but only a minimal disc bulge. They further opined that the disc bulge was solely related to degenerative disc disease and not to the January 22, 1994 injury. (Ex. 19-8). Finally, they found claimant medically stationary and without any work restrictions as to those specific conditions they related to the January 1994 injury. (Ex. 19-9).

Dr. Crawford, in contrast, disagreed with Drs. Strum and Wilson's opinion that claimant was medically stationary. Dr. Crawford, who continued to treat claimant through October 1994, and who had referred claimant for evaluation of his low back and leg symptoms by Dr. Robert Rosenbaum, reported that claimant continued to have painful episodes due to the disc herniation and continued to benefit from physical therapy. Dr. Rosenbaum found that claimant had symptoms suggesting a left L5 or S1 radiculopathy and had recommended EMG testing to establish whether claimant had some localized denervation. (Ex. 18). Dr. Crawford had also restricted claimant from lifting more than 10 pounds at work because of his low back and leg symptoms. (Exs. 21, 22, 25).

We give greater weight to Dr. Crawford's opinion than that of Drs. Strum and Wilson for the following reasons. First, a claimant must be medically stationary from all compensable conditions before the claim is properly closed. See Rogers v. Tri-Met, 75 Or App 470 (1985); see also Cheryl A. Trask, 47 Van Natta 322 (1995). Claimant has the following conditions that arose out of his January 22, 1994 injury claim: cervical strain, thoracic strain, lumbar strain, left shoulder strain and an L5-S1 herniated disc. All of these compensable conditions arose out of the same industrial injury, and should therefore be processed to closure. Lynda J. Zeller, 47 Van Natta 1926 (1995).

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[1] The ALJ referred to the second closure as a "September 5, 1995 closure." September 5, 1995 is the date of the second Order on Reconsideration.

[2] It is unclear to us why the December 8, 1994 Notice of Closure establishes the medically stationary date as November 28, 1994, as claimant was examined by Drs. Strum and Wilson on August 16, 1994.

Here, however, Drs. Strum and Wilson concluded that claimant's disc bulge was related to early degenerative disc disease and not to the January 1994 injury or claimant's low back and leg pain complaints. As a result, the doctors identified claimant's low back condition as a lumbosacral soft tissue contusion/strain. They found claimant medically stationary only as to his left shoulder, neck and upper back, and the low back strain. Second, Drs. Strum and Wilson's opinion regarding the non-compensability of claimant's herniated disc is contrary to the law of the case, i.e., claimant's L5-S1 herniated disc is compensably related to the 1994 compensable injury. See Kuhn v. SAIF, 73 Or App 768 (1985). Finally, Dr. Crawford, as the treating physician, is in a better position to declare claimant medically stationary than Drs. Strum and Wilson, who examined claimant on only one occasion and who based their opinion regarding claimant's herniated disc condition on an MRI report, rather than the films themselves.

In sum, the record persuades us that claimant's compensable herniated disc condition was not medically stationary at the time of the December 8, 1994 Notice of Closure. Therefore, we conclude that the insurer's December 8, 1994 closure was improper.

June 9, 1995 Notice of Closure

Subsequent to the first claim closure and the insurer's acceptance of claimant's herniated disc, claimant was examined by Dr. Thomas Rosenbaum, on referral from Dr. Crawford. On March 21, 1995, Dr. Thomas Rosenbaum opined that claimant's current conditions were limited to musculoskeletal symptomatology, without neurologic signs or symptoms. He recommended conservative care. (Ex. 30).

On April 19, 1995, Drs. Strum and Wilson reexamined claimant for the insurer.[3] They continued to opine that claimant's central disc bulge preexisted and was unrelated to his January 1994 injury. (Ex. 32-7). They also opined that claimant remained medically stationary in regard to his neck, shoulders and low back strains. (Id.).

On April 25, 1995, Dr. Thomas Rosenbaum responded to the insurer's queries regarding whether claimant's condition was the same as it was in November 1994, whether claimant's condition is medically stationary, and whether the treatment program he recommended was palliative care. After reviewing Drs. Strum and Wilson's November 16, 1994 report diagnosing chronic cervical, thoracic and lumbar strains, Dr. Thomas Rosenbaum opined that claimant's diagnoses had not changed, that claimant's condition was unchanged, and that claimant was medically stationary. (Ex. 33). Dr. Rosenbaum also concurred with Drs. Strum and Wilson's April 25, 1995 opinion.

For the following reasons, we do not find that a preponderance of medical opinion establishes that all of claimant's conditions were medically stationary at the time of the June 1995 closure.

First, the attending physician's concurrence or comments are required when the insurer refers a worker for an insurer medical examination. See OAR 436-030-0035(1) through (5). Dr. Crawford, not Dr. Thomas Rosenbaum, is claimant's attending physician. Thus, Dr. Thomas Rosenbaum's concurrences with Drs. Strum and Wilson's reports are not persuasive. Second, Dr. Rosenbaum's concurrence with Drs. Strum and Wilson's November 16, 1994 opinion does not serve to rehabilitate the lack of persuasiveness of that opinion. Moreover, for the same reasons that we found Drs. Strum and Wilson's November 16, 1994 opinion unpersuasive, we find their April 25, 1995 opinion, which is virtually identical to their November 1994 opinion, unpersuasive. Kuhn v. SAIF, supra; Rogers v. Tri-Met, supra; Cheryl A. Trask, supra. Finally, the insurer did not seek a closing examination from the attending physician, nor did the insurer submit Dr. Thomas Rosenbaum's or Drs. Strum and Wilson's 1995 opinions to Dr. Crawford for concurrence or comment, as required under OAR 436-30-0035(5). Consequently, we find the insurer's June 9, 1995 claim closure was procedurally improper. See David M. Chandler, 48 Van Natta 1500 (1996) (when carrier failed to strictly comply with Director's rules in closing claim, closure set aside as procedurally improper). Accordingly, we set the insurer's closure aside.

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[3] Claimant was also examined by Dr. Morris, on referral from Dr. Crawford, and by Dr. Dineen, medical arbiter. Neither offered an opinion on claimant's medically stationary status.

Because claimant's claim has been prematurely closed, we do not address the extent of scheduled or unscheduled permanent disability.

ORDER

The ALJ's order dated January 17, 1996 is reversed. The December 8, 1994 Notice of Closure and March 1, 1995 Order on Reconsideration are set aside as prematurely issued. The June 9, 1995 Notice of Closure and September 5, 1995 Order on Reconsideration are set aside as prematurely issued. The claim is remanded to the insurer for further processing according to law. Claimant's attorney is awarded 25 percent of the increased temporary disability benefits created by the Board's order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
GREG H. BOOTH, Claimant
WCB Case No. 95-04876
THIRD ORDER ON RECONSIDERATION
Karl Goodwin (Saif), Defense Attorney

Pursuant to our July 17, 1996 Second Order on Reconsideration, we republished our May 23, 1996 order in which we affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for his sinus and upper respiratory condition. Claimant has now submitted additional letters to the ALJ and to the Director, which indicate that he does not agree with our decision. Interpreting claimant's letters as another motion for reconsideration, we withdraw our prior orders.[1]

After considering claimant's submissions to the ALJ and the Director, we find that we have nothing further to add to our prior orders. Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our prior orders. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Inasmuch as it does not appear that SAIF has received copies of claimant's most recent letters, copies of those letters have been included with SAIF's counsel's copy of this order. We have also forwarded a copy of claimant's letter to the Director. Finally, a copy has been distributed to the ALJ. However, since we have affirmed the ALJ's order, the ALJ is without authority to alter either his or our decision.

In the Matter of the Compensation of
ORFAN A. BABURY, Claimant
WCB Case No. 95-07660
ORDER ON REVIEW
Benjamin W. Ross, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that increased claimant's unscheduled permanent disability award for a low back condition from 10 percent (32 degrees), as awarded by an Order on Reconsideration, to 14 percent (44.8 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We delete the last sentence of the first paragraph on page 2 and we delete the first sentence of the third paragraph on page 2.[1] We do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The issue on review is adaptability, specifically claimant's residual functional capacity. The ALJ concluded that claimant's residual functional capacity was medium/light.

Claimant relies on the opinion of his attending physician, Dr. Gulick. Claimant argues that the only credible and persuasive evidence of his physical restrictions is the July 26, 1994 physical capacities evaluation by Dr. Gulick. We disagree.

On reconsideration, impairment is determined by a medical arbiter, "except where a preponderance of medical opinion establishes a different level of impairment." Former OAR 436-35-007(9) (WCD Admin. Order No. 6-1992).[2] We do not automatically rely on a medical arbiter's opinion in evaluating a claimant's permanent impairment. Instead, we rely on the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994).

Dr. Gulick performed a closing examination on July 21, 1994. Dr. Gulick commented that "[m]easurements were taken X 3 and recorded due to a suggestion in the past examinations that this pt has exaggerated pain behaviors and inconsistancies [sic] in exam. I found less inconsistancy [sic] in measured ROM's than anticipated, though there is some and is reported." (Ex. 74). Dr. Gulick concluded that claimant was capable of light work. (Id.) Dr. Gulick stated that claimant showed severe deconditioning and commented:

> "I cannot explain this pt's pain. I cannot explain his absence of reflexes to my exam, asymmetrical to other examiners, all of which shows some inconsistancies [sic] on to the other. In my opinion, the extent of the pt's restrictions cannot be entirely attributed to the injury for which tx was given. Certainly in the pt's mind, he makes frequent mention of his shoulder pain from 14 years ago, his herniated disc from 11 years ago, and his MVA from 1987. To the extent that these injuries have contributed to a decline in his body habitus they cannot be isolated from this current injury. I do feel that the majority of the tx was due to the injury, since the pt had not had any tx fr 6 months prior to this injury." (Ex. 74-75).

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[1] We note that the certified reconsideration record does not include evidence to support those findings.

[2] Because the claim closed with an October 7, 1994 Determination Order, the applicable standards for determining claimant's entitlement to unscheduled permanent disability are contained in WCD Admin. Orders Nos. 6-1992 and 93-056 apply to claimant's claim. Former OAR 436-35-003(2).

On July 26, 1994, Dr. Gulick performed a physical capacity evaluation and found that claimant could occasionally carry 21 to 25 pounds. (Ex. 71). Dr. Gulick also found that claimant was limited as to the frequency he could sit, stand and walk at one time. (Id.) Dr. Gulick again concluded that claimant was capable of light work.

In light of Dr. Gulick's comments on July 21, 1994 that she was unable to explain claimant's pain or his absence of reflexes, as well as her comments that the extent of claimant's restrictions could not be entirely attributed to the work injury, we are not persuaded by Dr. Gulick's opinion that claimant's residual functional capacity (RFC) is light.

Instead, we are persuaded by Dr. Martens' opinion that claimant's RFC is medium. Dr. Martens performed a medical arbiter examination on May 24, 1995. Dr. Martens reported that claimant had chronic back pain, with no objective orthopedic neurologic findings, and many signs of pain behavior. (Ex. 17). Dr. Martens concluded that claimant was capable of medium work, i.e., lifting and carrying 35 to 50 pounds. (Id.) Dr. Martens also found that claimant was not restricted in his work activities. Since Dr. Martens' opinion is well-reasoned and closer in time to the June 22, 1995 Order on Reconsideration, we find it persuasive and we rely on Dr. Martens' conclusion that claimant's RFC was medium.

On review, the parties do not contest the age value of 1, formal education value of 0, education/skills value of 1 or the impairment value of 10. The parties also agree that claimant's base functional capacity (BFC) was medium. Former OAR 436-35-280(1)(a) (WCD Admin. Order No. 93-056) provided for an adaptability value of zero when a worker's RFC is equal to or greater than the BFC. However, in Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996), the court held that the Director's rules that give a zero adaptability value when a worker had returned to regular work conflict with ORS 656.214(5) and 656.726(3)(f)(A) and are, therefore, invalid.

In Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), we applied the reasoning used by the Carroll court in concluding that former OAR 436-35-280(1) was inconsistent with ORS 656.726(3)(f)(A). We concluded that the rule could not be used in determining the extent of a worker's unscheduled permanent disability. Rather, we found that, pursuant to former OAR 436-35-280(7), the value for the other societal factors should be added to the value for impairment to arrive at the percentage of unscheduled permanent disability to be awarded. We concluded that this analysis was essentially the same as assigning an adaptability value of one.

Applying this formula here, the value of claimant's age (1), formal education (0) and skills (1) are added for a total of 2, which is multiplied by the adaptability value of (1) for a total of 2. Former OAR 436-35-280(6). When this value is added to the value for impairment (10), the result is 12. Former OAR 436-35-280(7). Accordingly, we modify the ALJ's order and find that claimant is entitled to 12 percent unscheduled permanent disability for his low back condition.

ORDER

The ALJ's order dated April 2, 1996 is modified. In lieu of the ALJ's award and in addition to the Order on Reconsideration award of 10 percent (32 degrees), claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability for a total award of 12 percent (38.4 degrees) unscheduled permanent disability for the low back. Claimant's counsel's out-of-compensation attorney fee from this award shall be modified accordingly.

In the Matter of the Compensation of
PATRICK E. KELLY, Claimant
Own Motion No. 96-0308M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 8, 1996 Own Motion Order Reviewing Carrier Closure, in which we affirmed the SAIF Corporation's July 1, 1996 Notice of Closure in this claim. With his request for reconsideration, claimant submits pre-closure medical information from his treating physician not previously submitted into the record.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF 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.

August 21, 1996 Cite as 48 Van Natta 1689 (1996)

In the Matter of the Compensation of
SAMANTHA M. FITZSIMMONS, Claimant
WCB Case Nos. 95-02119, 95-02118 & 94-10110
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
William J. Blitz, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Holtan's order that: (1) upheld the self-insured employer's partial denial of her current lumbar and thoracic strain conditions; (2) upheld the employer's "de facto" denial of claimant's aggravation claim for her current condition; (3) declined to award a penalty for an allegedly unreasonable denial; (4) declined to award interim compensation benefits; (5) upheld the employer's partial denial of claimant's thoracic outlet syndrome; (6) declined to award temporary disability benefits related to an accepted right wrist strain; (7) declined to reclassify claimant's right wrist strain claim as disabling; (8) upheld the employer's denial of claimant's occupational disease claim for a thoracic outlet and overuse syndrome; (9) declined to award a penalty for an allegedly unreasonable denial; (10) declined to award interim compensation benefits related to claimant's occupational disease claim; and (11) declined to award a penalty for an allegedly unreasonable failure to pay interim compensation. On review, the issues are compensability, aggravation, interim compensation benefits, claim reclassification, and penalties and attorney fees.

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

On review, claimant argues that, with respect to the causation of her sacroiliac dysfunction, thoracic outlet syndrome and lumbar/thoracic strain conditions, the ALJ should have relied on the opinion of claimant's treating doctor, Dr. Peterson. Specifically, claimant argues that this case requires medical expertise in the aforementioned conditions. Claimant contends that, as a physician who specializes in sports medicine and has training in osteopathy, Dr. Peterson is more qualified to render an opinion than the orthopedic surgeons and neurologists who provided opinions which did not support causation or compensability. We are not persuaded by claimant's argument because it which provides no reasons for deferring to a sports medicine doctor in a case such as this. Furthermore, for the additional reasons provided by the ALJ, we agree that Dr. Peterson's opinion is not persuasive. Accordingly, because the remaining medical opinions do not establish compensability of the above-referenced conditions, we affirm the ALJ on this issue.

ORDER

The ALJ's order dated February 23, 1996 is affirmed.

In the Matter of the Compensation of
CAROLYN A. MORRISON, Claimant
WCB Case No. 95-11545
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denials of claimant's current cervical spine condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Findings of Ultimate Fact," as modified and supplemented.

Claimant compensably injured her neck at work in April 1983. The claim was closed by Determination Order in August 1985.

In August 1987, claimant sought treatment from Dr. Brett, neurosurgeon, for further neck pain. After reviewing MRI and CT scans, Dr. Brett diagnosed disc bulging at C4-5, C5-6, and C6-7, "consistent with [claimant's] age and mild degenerative disc disease." Drs. Dinneen, Snodgrass, and Tilden examined claimant on behalf of the employer. Based on the MRI and CT scans, those physicians opined that claimant had osteoarthritic degenerative disc disease with disc protrusions at C4-5, C5-6, and C6-7, "probably preexisting."

By an October 1988 stipulation and order, the employer accepted an aggravation of claimant's compensable April 1983 (rather than "1993") injury. The claim was reclosed by an April 1990 Determination Order that awarded claimant unscheduled permanent disability, based in part upon the degenerative disc bulges at C4-5, C5-6, and C6-7. The employer paid claimant benefits pursuant to, and did not appeal, that Determination Order.

In 1995, claimant again experienced neck pain, and was referred to Dr. Brett. A June 1995 MRI revealed a broad disc herniation at the C4-5 level, and lesser protrusions at the C5-6 and C6-7 levels. Dr. Brett opined that claimant's ongoing complaints are "mainly a result of progressive degenerative change and osteoarthritis rather than related to her previous work injury."

CONCLUSIONS OF LAW AND OPINION

Based on Dr. Brett's report, the ALJ found that claimant's current cervical symptoms are not related to any accepted condition. Thus, the ALJ upheld the employer's denials. For the reasons that follow, we disagree.

Subsequent to the ALJ's order, the court issued its decision in Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996). In light of amended ORS 656.262(10), the court reexamined its decision in Deluxe Cabinet Works v. Messmer, 130 Or App 254 (1994), rev den 320 Or 507 (1995).[1]

In Messmer I, an employer failed to appeal a Determination Order which had awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease. The court held that, although an employer's payment of compensation, by itself, did not constitute acceptance of the degenerative condition, the employer's failure to challenge the award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that the condition was not part of the compensable claim. In Messmer I, the court reasoned that the result was not that the degenerative condition had been accepted, it was that the employer was barred by claim preclusion from denying that it was part of the compensable claim. 130 Or App at 258.

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[1] For the sake of clarity, we refer to the court's first decision as Messmer I. We refer to the court's most recent decision as Messmer II.

In Messmer II, the court concluded that amended ORS 656.262(10) did not require a change in the result of Messmer I. The court found that, if the legislature had intended to enact a statute that had the effect of overruling the court's prior decision, it had failed to do so. Specifically, the court concluded that the amended statute said nothing about the preclusive consequences of an employer's failure to appeal a determination order. Rather, the court reasoned that the statute, as amended, provides only that payment of permanent disability benefits does not preclude an employer from subsequently contesting compensability. Accordingly, the court held that, because the legislature had not successfully changed the law, the court could not rewrite the statute to give effect to what the legislature may have intended. Consequently, the court determined that amended ORS 656.262(10) did not effectively overrule its prior decision in Messmer I. 140 Or App at 556.

Messmer II controls this case. The condition at issue is claimant's cervical degenerative osteoarthritis. Although the employer never formally accepted that condition, it did not challenge the April 1990 Determination Order that awarded claimant unscheduled permanent disability for disc bulges at C4-5, C5-6, and C6-7. In light of the medical evidence relating claimant's cervical disc bulges to her degenerative osteoarthritic condition, we conclude that the Determination Order was based, at least in part, on that condition. The order became final by operation of law. Because the uncontroverted evidence establishes that claimant's current problems arise from "progressive degenerative change and osteoarthritis" at the C4-5, C5-6, and C6-7 levels, the employer is precluded from contending that claimant's current cervical condition is not part of her compensable condition.

The employer's payment of compensation did not, by itself, constitute an acceptance of claimant's cervical degenerative condition. ORS 656.262(9). Nevertheless, in light of the court's most recent ruling in Messmer II, we conclude that the employer's failure to challenge the April 1990 award on the ground that it included an award for a noncompensable condition precludes it from denying that claimant's osteoarthritic degenerative cervical condition was part of the compensable claim. The result is not that the employer has accepted claimant's degenerative osteoarthritis; rather, it is that the employer is barred by claim preclusion from denying that it is part of claimant's 1980 claim. 130 Or App at 258. Accordingly, we reverse that portion of the ALJ's order which upheld the employer's denials of claimant's current cervical condition and claim for treatment.[2]

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by the 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 13, 1996 is affirmed in part and reversed in part. The self-insured employer's denials are set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, payable by the employer. The remainder of the order is affirmed.

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[2] Inasmuch as we conclude that this case is controlled by Messmer II, we need not address claimant's argument that the ALJ erred in declining to take administrative notice of the definition of "spondylosis" in Stedman's Medical Dictionary. Similarly, we do not reach the issue of whether the employer accepted claimant's degenerative osteoarthritic condition by reason of the 1988 stipulated settlement.

In the Matter of the Compensation of
MICHAEL C. DAVIS, Claimant
WCB Case No. 95-13167
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that declined to award an attorney fee for an alleged "de facto" denial of a herniated disc condition. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his back on January 3, 1995. On March 31, 1995, the insurer accepted a lumbosacral strain. On November 30, 1995, the insurer amended its acceptance to include a lumbosacral strain, mild disc bulge at L4-5 and disc protrusion, left, at L5-S1. (Ex. 11). Claimant requested a hearing, asserting that his attorney was entitled to a fee for obtaining acceptance of the herniated disc claim.

The ALJ found no evidence in the record that the insurer had refused to pay any compensation. No written denial of the herniated disc condition was issued. The ALJ concluded that since there was no denial of the claim, no attorney fee was authorized under amended ORS 656.386(1).

Claimant argues that the action of the insurer in refusing to issue a written denial is an action which "otherwise does not give rise to an entitlement to any compensation" under amended ORS 656.386(1), and, therefore, constitutes a denial.[1] We disagree.

We agree with the ALJ that claimant is not entitled to an attorney fee for the alleged "de facto" denial. Under amended ORS 656.386(1), which is applicable in this case, a claimant's attorney is entitled to an attorney fee "in cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial. A "denied claim" is defined 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." In Michael J. Galbraith, 48 Van Natta 351 (1996), we held that there was no "denied claim" under amended ORS 656.386(1) where the carrier paid all benefits for the compensable condition and did not expressly contend that the allegedly "de facto" denied condition was not compensable.

In this case, as in Michael J. Galbraith, supra, there is no contention that any benefits for the herniated disc condition have been unpaid. In addition, the record does not establish that the insurer refused to pay compensation on the express ground that the additional conditions were not compensable or did not give rise to an entitlement to compensation. Under such circumstances, we conclude that a "denied claim" has not been established and no attorney fee may be awarded under amended ORS 656.386(1). See James W. Vullo, 48 Van Natta 1061 (1996).

ORDER

The ALJ's order dated March 19, 1996 is affirmed.

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[1] Claimant also contends that the February 8, 1995 report of Dr. Dickson diagnosing a herniated disc was a "claim" for compensation on behalf of claimant. We need not resolve that issue because, for the reasons expressed in this decision, there is no "denied claim" upon which to award an attorney fee under amended ORS 656.386(1). See David Gonzalez, 48 Van Natta 376, 378 (1996) (rather than determining when the claimant made a "claim," we look to whether this claim constitutes a "denied claim" under amended ORS 656.386(1)).

In the Matter of the Compensation of
DAN A. EDWARDS, Claimant
WCB Case Nos. 94-12034 & 94-08644
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Karl Goodwin (Saif), Defense Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The noncomplying employer (All-Star Satellite, "All-Star") requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside the SAIF Corporation's denial, on All-Star's behalf, of claimant's "new injury" claim for an L4-5 disc condition; and (2) upheld Sedgwick James' (Sedgwick's) denial of claimant's aggravation claim for the same condition. On review, the issues are compensability[1] and, potentially, responsibility. We reverse in part and affirm in part.

PRELIMINARY MATTER

With his respondent's brief, claimant has submitted a copy of a forgery conviction order involving a witness at the hearing, in addition to other materials not in the record. Claimant contends that these materials undermine the credibility of one of the witnesses who testified at hearing. We decline to consider claimant's post-hearing submissions. Claimant has provided no reason for failing to present the documents at hearing at the time of cross-examination of the witness. Consequently, we do not consider the submitted materials on review.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last paragraph (finding number 29, O&O p. 6) and the section entitled "Discussion of Findings." We add the following supplementation.

Claimant initially injured his low back on July 26, 1991, while working as a certified nurse's aide for Segwick's insured, Emerald Nursing Center. On June 29, 1992, Sedgwick accepted claimant's low back "symptoms of muscular strain." Claimant's claim was closed and reopened again several times for surgery and treatment of the L5-S1 condition.

On approximately February 21, 1994, claimant began working for All-Star as a satellite antenna installer. In March 1994, claimant began to work in the field installing satellite dishes. Claimant's work required some standing, digging, climbing and lifting. Claimant's back symptoms worsened during his employment with All-Star. On April 19, 1994, claimant sought treatment for low back, right leg pain, and mental stress. On May 18, 1995, claimant underwent surgery, which included a foraminatomy at L4-5 for tightness of the left L5 nerve root.

CONCLUSIONS OF LAW AND OPINION

Compensability/L4-5 disc condition

The ALJ found that claimant had established the compensability of his L4-5 disc condition. We disagree.

On review, we first address All-Star's contention that, by accepting claimant's low back symptoms, Sedgwick also accepted his L4-5 degenerative condition. All-Star relies on Georgia-Pacific v. Piwowar, 305 Or 494 (1988). However, we do not find Piwowar to be on point. In Piwowar, the carrier accepted a "sore back." Consequently, because the claimant's symptoms were caused by a degenerative condition, the court held that acceptance of the claim for a condition (sore back) included acceptance of the disease causing that condition. Piwowar, supra.

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[1] We note claimant's contention that Sedgwick is contesting compensability of claimant's L5-S1 condition. However, as explained in its June 17, 1996 letter, Sedgwick has clarified that its reference to claimant's L5-S1 was a typographical error, and Sedgwick contests only compensability of claimant's L4-5 disc condition.

However, in the present case, Sedgwick specifically accepted claimant's symptoms of a muscular strain of the low back. Here, unlike in Piwowar, Sedgwick did not accept claimant's symptoms without qualification. Rather, it accepted claimant's symptoms resulting from muscle strain. Consequently, because Sedwick's acceptance does not equate to an acceptance of the degenerative disease, or symptoms of a degenerative disease, we reject All-Star's argument that Sedgwick accepted claimant's L4-5 condition.

Consequently, because we find that claimant's L4-5 condition was not previously accepted, claimant must establish the compensability of that condition.

Claimant's treating surgeon, Dr. Golden, has rendered an opinion regarding causation. However, for the following reasons, we do not find his opinion to be persuasive. Prior to performing claimant's May 1995 surgery involving the disputed L4-5 condition, Dr. Golden believed that claimant's recent low back problems were primarily related to a herniated disc or fissure at L4-5. However, Dr. Golden's theory of causation was not borne out by surgical findings. Specifically, following surgery, Dr. Golden reported that there was "no evidence of a disc herniation or significant degeneration at L4-5." (Ex. 128-1). Accordingly, because Dr. Golden's theory is not supported by the surgical findings, we do not find his opinion to be persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

Additionally, Dr. Golden provided an opinion in which he eventually concluded that claimant's combined work activities at both Emerald and All Star were the major cause of the L4-5 problems. However, we note that claimant suffered the sudden onset of extreme left-sided low back pain (which prompted his most recent surgery) upon rolling over in bed on June 8, 1994, seven weeks after he stopped working for All Star. Dr. Golden could not say whether claimant's "herniation" on that date was spontaneous "or whether the rolling over in bed incident was the predominant factor." (Ex. 119-34). Under the circumstances, we find no explanation for the inconsistency between this theory of causation and the doctor's eventual conclusion that claimant's work exposure was the major cause of the L4-5 condition. See Moe v. Ceiling Systems, supra. Moreover, even if the ultimate conclusion was otherwise consistent with the remainder of the opinion, we would not find it particularly persuasive because the doctor failed to explain why he believes the condition is work related even though seven weeks passed between claimant's last work exposure and the sudden onset of L4-5-related symptoms.

Accordingly, we cannot say that Dr. Golden's opinion persuasively supports a conclusion that claimant's L4-5 condition is work-related. Furthermore, there is no other medical opinion in the record which supports compensability of the L4-5 condition. Accordingly, we reverse the ALJ's compensability decision concerning claimant's L4-5 condition. The ALJ's attorney fee award of $2,950, assessed against SAIF for its "de facto" denial of the L4-5 condition, is also reversed.

ORDER

The ALJ's order dated October 25, 1995, as reconsidered December 21, 1995, is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's "de facto" denial, on behalf of All-Star Satellite, of claimant's L4-5 condition is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award of $2,950, assessed against SAIF, is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
ANTHONY J. McGEE, Claimant
WCB Case No. 94-14260
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Johnstone's order that set aside its denial of claimant's current psychological and psychiatric conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and summarize the pertinent facts as follows:

Claimant compensably injured his low back on February 16, 1985, when the chair he was sitting in came apart and he fell to the floor. He was originally diagnosed with a contusion of the lumbosacral junction. Claimant's low back and radiating left leg pain continued, and on March 3, 1986 he underwent a laminectomy at L5-S1. The surgeon found a large, bulging herniated disc underneath the S1 nerve root. Claimant's pain continued post-operatively.

Physicians who examined claimant during September and October 1986 noted severe pain behavior and psychological factors impeding claimant's recovery. A Determination Order closed the claim on February 24, 1987, finding claimant medically stationary as of December 22, 1986.

Claimant continued to seek treatment for low back pain. Examining physicians diagnosed low back pain syndrome, but again noted strong functional disturbance. On November 18, 1987, the employer issued a denial of claimant's claim for aggravation of his low back injury. On December 20, 1987, claimant was diagnosed by a clinical psychologist with "adjustment disorder with depressed mood, no personality disorder."

By an Opinion and Order issued March 18, 1988, an ALJ (formerly Referee) found that claimant had proved a compensable aggravation, based upon a physical and emotional worsening of his condition. Following claim reopening, claimant was examined by a number of psychologists and psychiatrists. Claimant's treating doctors diagnosed Major Depressive Disorder related to claimant's compensable back injury, whereas Dr. Parvaresh concluded that claimant's greatest impairment was due to personality make-up and traits.

The claim was again closed by Determination Order issued on August 8, 1988. In a January 9, 1989 Opinion and Order addressing the extent of claimant's unscheduled permanent disability, an ALJ (then Referee) found that claimant's psychological conditions prevented him from returning to gainful employment and rendered him permanently and totally disabled.

Claimant continued to treat with a psychologist, Dr. Burns, and a psychiatrist, Dr. Maletzky for his psychological conditions. Both doctors continued to diagnose depression related to his compensable injury. Claimant also continued to seek treatment for his physical condition and was ultimately diagnosed with a recurrent herniated disc at L5-S1 with S1 nerve root impingement. He underwent a diskectomy at L5-S1 and foraminotomy of the left S1 nerve root on October 19, 1989.

Following the 1989 surgery, claimant continued to suffer left S1 radiculopathy. Claimant also continued to obtain psychological care related to his chronic low back pain condition. In 1990, claimant developed stasis dermatitis and varicose veins in his left leg, as a result of a reflex sympathetic dystrophy of the left lower extremity with swelling and weepy dermatitis of the foot.

In April 1993, claimant was reevaluated by Dr. Parvaresh, who concluded that claimant's condition had not changed since 1986. He also reported that claimant did not have an Axis I diagnosis, but instead a preexisting personality make up problem, an Axis II diagnosis.

On November 21, 1994, the insurer issued a denial of claimant's "current psychological and psychiatric conditions." Claimant then requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's current psychological condition, diagnosed by his treating physicians as major depressive disorder, is the same condition the employer was previously ordered to accept in conjunction with claimant's aggravation claim, and therefore the doctrine of res judicata (issue preclusion) prevented the insurer from relitigating the compensability of claimant's psychological condition. In addition, the ALJ determined that, because there has been no change in claimant's condition, amended ORS 656.262(6)(c) did not apply.[1] Alternatively, the ALJ found that even if the insurer was not precluded from litigating the compensability of claimant's current condition, a preponderance of the medical evidence demonstrated that claimant's 1985 industrial back injury remained the major contributing cause of his current psychological condition.

On review, the insurer argues that, under amended ORS 656.262(6)(c), a carrier may deny the continuing compensability of a combined or consequential condition notwithstanding a previous litigation order finding the condition compensable at an earlier point in time. The insurer also contends that, to the extent claimant currently has a diagnosed mental disorder, his 1985 compensable back injury has ceased to be the major contributing cause of that condition. We disagree with the latter contention.

Under amended ORS 656.262(6)(c),[2] an insurer that has accepted a combined or consequential condition may later deny that combined or consequential condition if the "otherwise compensable injury ceases to be the major contributing cause." The word "cease" in the new statute presumes a change in the claimant's condition or a change of circumstances so that the compensable condition is not the major contributing cause. See Harry L. Lyda, 48 Van Natta 1300 (1996); Elsa S. Wong, 48 Van Natta 444, 445 n. 1 (1996). Like the ALJ, we are not persuaded that there has been such a change in the cause of claimant's psychological condition since the employer was directed to accept it in 1988. We base our conclusion on the following reasoning.

Where, as here, 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). In addition, absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

Dr. Burns, the clinical psychologist who first treated claimant in 1987 and last saw him in October 1994, opined that claimant continued to suffer from a chronic depressive disorder that was directly related to his 1985 industrial injury. In August 1995, Dr. Burns reported that he had considered the possibility that claimant was malingering or exaggerating his back pain, but found no support for that conclusion. (Ex. 348-4) Rather, Dr. Burns believed, based on his seven years of intermittent treatment of claimant, that as a result of his 1985 injury, claimant had severe physical limitations and chronic pain which, in turn, caused his ongoing bouts of major depression. (Exs. 348, 349).

Dr. Klecan, on the other hand, opined that claimant was likely malingering but had no diagnosable mental or personality disorder. Dr. Klecan examined claimant one time in May 1995 at the insurer's request. Because he found no evidence of a mental or personality disorder during his examination, and there were references to functional overlay in claimant's prior medical treatment records, Dr. Klecan did not consider claimant's physical condition to be a relevant factor. (Ex. 347-27). He also opined that if claimant was suffering from depression or other disabling mental disorder, such condition is no longer present.

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[1] ORS 656.262(6)(c) provides:

"An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

[2] As set forth in Section 66(5)(b) of SB 369, amended ORS 656.262(6)(c) applies retroactively "to all claims without regard to any previous order or closure."

Dr. Parvaresh, a psychiatrist who examined claimant in April 1988 and again in April 1993, also concluded that claimant did not have any diagnosable mental disorder. Instead, Dr. Parvaresh found that claimant had long-standing personality problems (an Axis II diagnosis) that had nothing to do with his 1985 industrial injury.[3] (Exs. 119, 337, 340). In April 1993, Dr. Parvaresh opined that clinically, claimant's condition had not changed since 1988. He further reported that claimant's underlying psychological make-up "tends to camouflage a variety of physical and so called psychosomatic problems, so much so, that a person in clinical examination may manifest a great deal of subjective complaints and not much objective findings to support them." (Ex. 340-1).

Although both Dr. Klecan and Parvaresh concluded that claimant had no diagnosable mental disorder related to his industrial injury, both doctors based their opinion on the supposed lack of objective evidence supporting claimant's subjective pain complaints. As the ALJ found, however, there were objective findings of continuing physical limitations related to claimant's 1985 industrial injury.

For example, in October 1989, claimant underwent a second surgery related to his industrial injury, a diskectomy at L5-S1 and a foraminotomy of the S1 nerve root. Post-operatively, claimant treated with Dr. Long until February 1992. Claimant continued to suffer left S1 radiculopathy, and Dr. Long noted in 1991 that it may take years for the radiculopathy to resolve. (Ex. 287). Dr. Long did not question claimant's diagnosis or presentation. Then, in September 1992, claimant returned to Dr. Aversano, whom he had not seen since March 1989. Dr. Aversano reported that claimant remained "completely disabled" as a result of his chronic pain in the low back and left leg. Dr. Aversano found claimant's back range of motion "quite limited" and weakness and vascular changes in the left leg. (Ex. 327). On February 12, 1993, Dr. Aversano reported no change in claimant's chronic pain condition. (Ex. 336).

In February 1993, claimant was also evaluated by Dr. Rosenbaum, a neurosurgeon, at the insurer's request. Although Dr. Rosenbaum noted the presence of functional overlay, he also confirmed that claimant continued to have physical limitation and symptoms related to his 1985 injury. Dr. Rosenbaum opined that claimant was not capable of repetitive lifting and would be employable only in a sedentary or light capacity. (Ex. 338-7). In May 1993, claimant was reevaluated by Dr. Baum, an orthopedic surgeon. Dr. Baum diagnosed, among other things, lumbar radiculopathy and chronic lymphoedema with stasis ulceration secondary to a sciatic nerve injury. On examination, Dr. Baum found that claimant had painful, restricted range of motion in the lumbar spine, mild restricted motion in the hip and a stiff left knee. (Ex. 339).

After considering the medical evidence, we, like the ALJ, find no persuasive reason not to rely on the complete, well-reasoned opinion of claimant's long-time treating psychologist, Dr. Burns. See Weiland v. SAIF, supra. As noted above, of the three mental health experts who rendered opinions concerning the cause of claimant's current psychological condition,[4] only Dr. Burns had a complete understanding of claimant's physical condition. Dr. Burns explained that claimant's 1985 industrial injury has had "enduring consequences" and that his physical limitations and chronic pain continue to be the major contributing cause of his chronic depression and/or adjustment disorder. (Ex. 348). Conversely, in concluding that claimant had no diagnosable mental disorder, neither Dr. Klecan nor Dr. Parvaresh considered the objective findings of Drs. Long, Aversano, Rosenbaum and Baum supporting claimant's ongoing subjective complaints of pain. Rather, it appears that both psychiatrists relied on older (1989 and earlier) medical treatment records noting functional overlay and symptom magnification and assumed that claimant had little or no actual physical impairment or pain as a result of his 1985 injury. Moreover, unlike Dr. Burns, neither Dr. Klecan or Dr. Parvaresh had the opportunity to observe claimant over an extended period of time.

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[3] In the January 9, 1989 Opinion and Order, which declared claimant permanently and totally disabled as of July 21, 1988, the ALJ (then Referee) specifically rejected Dr. Parvaresh's opinion that claimant's emotional problems related to a long-standing, preexisting personality disorder. (Ex. 152-4).

[4] Although Dr. Maletzky, a psychiatrist, treated claimant for depression related to his 1985 compensable injury during 1989 and 1990, Dr. Maletzky does not provide an opinion concerning the cause of claimant's "current" psychological condition.

Accordingly, on this record, we find that a preponderance of the evidence establishes that claimant's 1985 compensable back injury remains the major contributing cause of his current psychological condition.[5] We therefore affirm the ALJ's decision to set aside the insurer's denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,900, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief 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 5, 1996 is affirmed. For services on review, claimant's counsel is awarded $1,900, payable by the insurer.

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[5] Although claimant's consequential condition was found compensable prior to 1990, when the standard for such conditions was material contributing cause (see, e.g., Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985)), we are persuaded by the medical evidence in this case that claimant's compensable back injury was (and still is) the major contributing cause of his consequential psychological condition.

In the Matter of the Compensation of
STEVEN L. REEVES, Claimant
WCB Case Nos. 95-01816, 95-00684 & 95-00683
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys
Brian L. Pocock, Defense Attorney

The self-insured employer, Roseburg Forest Products, requests reconsideration of our July 24, 1996 Order on Review that adopted and affirmed the Administrative Law Judge's (ALJ's) order setting aside the employer's denial and disclaimer of claimant's low back injury claim. As it did in its briefs on review, the employer asserts that the opinion of Dr. Golden is legally insufficient because it provides only the "precipitating cause" or "but for" analysis disapproved in Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995). The employer further argues that our decision in Cody Lambert, 48 Van Natta 115 (1996), in which we rejected the opinion of Dr. Golden regarding causation of a back condition, is "exactly on point to this case." We do not agree. To the contrary, a comparison of Lambert and this case illustrates the basis for our decision here.

In Lambert, the claimant had experienced three prior work-related low back strains superimposed on spondylolysis/spondylolisthesis at L5-S1. Following the last of these strains, claimant's low back symptoms completely resolved. Claimant subsequently experienced a work-related knee injury that resulted in an altered gait. Thereafter, claimant reported the recurrence of low back pain which he contended was caused in major part by the altered gait resulting from his knee injury. Dr. Golden supported that claim. As noted by the employer here, we rejected Dr. Golden's opinion on causation in Lambert, in part, because it was solely based on the appearance of symptoms coincidental with claimant's altered gait.

Rather than dictating a similar result here, our decision in Lambert is based on facts that differ dispositively from those present in this case. Here, claimant experienced a traumatic accident at work that resulted in claimant seeking hospital emergency room treatment within two days. In Lambert, the claimant reported no specific incident but, rather, he attributed the onset of his symptoms to an extended period of altered gait. Moreover, as we noted in our decision in Lambert, although the

claimant reported back pain allegedly due to altered gait in early 1993, he also subsequently failed to report any back complaints in early 1994, prior to his first visit to Dr. Golden. In fact, Dr. Golden did not first examine the claimant in Lambert until two years after his knee injury; whereas here Dr. Golden began treating claimant approximately two weeks after the work incident.

In addition, a comparison of repeat x-rays of the claimant's low back in Lambert disclosed an absence of any interim change in his preexisting condition. Here, by contrast, we have found that post-injury radiological testing disclosed a distinct change in claimant's preexisting condition. We acknowledge that this issue was strongly contested by the employer. Nevertheless, we continue to rely on the opinion of Dr. Golden on this point, particularly in light of his opportunity to view claimant's back pathology on a first-hand basis during surgery.

Although the employer focuses on Dr. Golden's discussion concerning the post-injury onset of symptoms of claimant's previously asymptomatic condition, we are unwilling to separate out Dr. Golden's repeated reference to the pathological changes in claimant's condition. Therefore, we do not interpret Dr. Golden's opinion to be based solely on the appearance of symptoms where there previously were none.

Accordingly, we withdraw our July 24, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our July 24, 1996 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
JOANN S. ROBISON, Claimant
WCB Case Nos. 95-08286 & 95-08259
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
James B. Northrop (Saif), Defense Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Herman's order which awarded claimant a $3,500 carrier-paid attorney fee pursuant to ORS 656.307(5) for prevailing against SAIF's denial of her occupational disease claim for a bilateral wrist condition. In her respondent's brief, claimant contends that SAIF must process her claim as a "new condition." On review, the issues are attorney fees and claim processing.

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

Citing Dan J. Anderson, 47 Van Natta 1929 (1995), the ALJ awarded claimant's counsel a $3,500 attorney fee in accordance with ORS 656.307(5) for services rendered on claimant's behalf regarding the responsibility issue. On review, SAIF requests that we reconsider our decision in Anderson, contending that claimant's counsel's attorney fee should be limited to $1,000 pursuant to ORS 656.308(2)(d). Noting that amended ORS 656.307(2) now provides that a ".307" proceeding is to be conducted in the same manner as any other responsibility hearing, SAIF asserts that Anderson is not controlling because it concerned a "307" arbitration proceeding under the former statute. Alternatively, SAIF argues that, even if Anderson is controlling, the ALJ's attorney fee award was excessive and should be limited to $2,000. We disagree with SAIF's contentions.

In Dan J. Anderson, supra, we held that amended ORS 656.308(2)(d) applies retroactively to cases pending on Board review, but that it does not 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). After considering SAIF's arguments, we reaffirm our holding in Anderson.[1]

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that the ALJ's assessed fee award of $3,500 for claimant's attorney's services at the responsibility proceeding was reasonable. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue and the value of the interest involved.

The ALJ set aside SAIF's responsibility denial with respect to claimant's bilateral wrist condition and remanded the claim for processing in accordance with law. Claimant contends that her claim should be processed as a "new condition" claim. We agree with SAIF that this claim processing issue is premature. See Richard L. Elsea, 47 Van Natta 61, on recon 47 Van Natta 262 (1995) (premature to address claim processing obligations which naturally flow from compensability/responsibility determination).[2]

Finally, we do not award an attorney fee for claimant's counsel's services on Board review regarding the attorney fee issues. 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 March 29, 1996 is affirmed.

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[1] In reaching this conclusion, we emphasize that our decision in Anderson relied on amended ORS 656.307(5) which 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."

Amended ORS 656.307(5) is essentially the same as the former version of the statute, except that Administrative Law Judge has been inserted in place of "arbitrator." Thus, while ORS 656.307(2) was altered by the 1995 legislative amendments, the portion of the statute that controlled our decision in Anderson (ORS 656.307(5)) was not. Under these circumstances, we again conclude that our reasoning in Anderson is valid. See Gary L. Brenner, 48 Van Natta 361 (1996) (declining to reconsider Anderson rationale).

[2] In any event, it appears that claimant's concerns about how SAIF will process the claim are unfounded. The ALJ found that claimant had sustained a "new occupational disease" for which SAIF was responsible. (Opinion and Order p. 5).

In the Matter of the Compensation of
FLORENCE G. SELVIDGE, Claimant
WCB Case No. 95-13524
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order which reversed an Order on Reconsideration that awarded 23 percent (73.6 degrees) unscheduled permanent disability for a low back condition and assessed a penalty pursuant to former ORS 656.268(4)(g). In its brief, the SAIF Corporation contends that the ALJ improperly excluded an exhibit. On review, the issues are extent of unscheduled permanent disability, penalties and evidence. We reverse and affirm the Order on Reconsideration.

FINDINGS OF FACT

Claimant compensably injured her low back on May 2, 1994, a claim that SAIF accepted for a lumbar strain and symptomatic worsening of a preexisting L4-5 disc herniation. Dr. Feldstein, claimant's attending physician, declared claimant medically stationary on January 13, 1995, but requested that a consulting physician, Dr. Corrigan, perform the closing examination because she was unable to determine how much of claimant's disability was due to the compensable injury versus the preexisting low back condition.

Dr. Corrigan performed the closing examination on January 23, 1995 and stated that he was "inclined to agree" with a prior panel of examining physicians who concluded that claimant had no permanent impairment due to the compensable injury. (Ex. 17-3). Dr. Corrigan noted that claimant's "minor" reductions in lumbar range of motion were consistent with her age, body habitus and preexisting low back findings.

SAIF forwarded Dr. Corrigan's report to Dr. Feldstein for review. Dr. Feldstein replied "yes" when asked if claimant was released for regular work with respect to her compensable injury. (Ex. 20). Dr. Feldstein also replied "yes" when asked whether Dr. Corrigan's range of motion findings were the result of claimant's "natural aging process" or the injury of May 2, 1994. Id.

SAIF closed the claim by March 30, 1995 Notice of Closure, which awarded no permanent disability. Claimant requested reconsideration and appointment of a medical arbiter.

Dr. Martens performed the arbiter's examination on November 7, 1995 and diagnosed a lumbar strain and symptomatic worsening of a preexisting L4-5 disc herniation. Dr. Martens reported claimant's range of motion findings and noted that claimant had a limited or partial loss of ability to repetitively use her lumbar spine, in part due to preexisting, recurrent lumbosacral strain and herniated nucleus pulposus. (Ex. 27-4).

An Order on Reconsideration issued on December 6, 1995, which awarded 23 percent unscheduled permanent disability. (Ex. 28). The award was based on the product of age and education times adaptability (18) and a rating of 5 for permanent impairment. The evaluator's worksheet stated that the impairment award was based on a "chronic and permanent" condition. (Ex. 18-28-4). The reconsideration order also assessed a 25 percent penalty pursuant to former ORS 656.268(4)(g). SAIF requested a hearing from the Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

The ALJ reduced claimant's permanent disability award to zero, reasoning that the medical evidence did not establish that claimant suffered permanent impairment as a result of the compensable May 2, 1994 injury. In reaching this conclusion, the ALJ noted Dr. Corrigan's opinion that claimant's permanent impairment was not due to the compensable injury and Dr. Feldstein's "concurrence" with Dr. Corrigan's report. The ALJ also concluded that Dr. Martens did not identify whether claimant's range of motion findings were due to accepted conditions and noted that Dr. Martens attributed repetitive use limitations to claimant's preexisting conditions.

On review, claimant contends that the reconsideration order should be reinstated, asserting that she is entitled to a 5 percent impairment rating for a "chronic condition" based on the arbiter's report. SAIF contends that the ALJ improperly excluded a proposed exhibit consisting of a January 22, 1996 Opinion and Order issued by another ALJ, who upheld SAIF's denial of claimant's L4-5 disc herniation and current disability. For the following reasons, we find that the reconsideration order should be reinstated.

We acknowledge that we recently reversed the other ALJ's order upholding SAIF's denial of claimant's L4-5 disc herniation and current disability. Florence G. Selvidge, 48 Van Natta 1466 (1996). We may take administrative notice of our own orders. Groshong v. Montgomery Ward Co., 73 Or App 103 (1985); Lloyd G. Crowley, 43 Van Natta 1416 (1991). Accordingly, the "law of the case" is that claimant's L4-5 herniated disc and current disability are compensable.[1]

In evaluating claimant's permanent disability, we do not automatically rely on a medical arbiter's opinion in evaluating permanent impairment. See Raymond L. Owen, 45 Van Natta 1528 (1993), aff'd Roseburg Forest Products v. Owen 129 Or App 442 (1995) (Impairment is established by a preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. See Carlos S. Cobian, 45 Van Natta 1582 (1993). In 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, Dr. Feldstein, claimant's attending physician, did not rate claimant's permanent impairment and, instead, referred the closing examination to Dr. Corrigan, who concluded that claimant had no impairment due to her compensable injury. Dr. Corrigan's findings could be used to rate claimant's impairment if Dr. Feldstein had concurred with them. See Tektronix, Inc. v. Watson, 132 Or App 483, 487 (1995) (consulting physician's impairment findings admissible for purposes of evaluating impairment when ratified by attending physician).

Although the ALJ considered Dr. Feldstein to have concurred with Dr. Corrigan's evaluation, in Dr. Feldstein's response to Dr. Corrigan's closing examination she only confirmed that claimant was released to regular work. Dr. Feldstein's affirmative response to the compound question of whether claimant's impairment was due to the aging process or the compensable injury, does not constitute a persuasive concurrence. See Brown v. Weyerhauser Company, 77 Or App 182, 183 (1985) (the claimant's physician's answer of " yes" to a compound question, only one part of which would support the claim, was too ambiguous to support a finding that the claimant carried his burden of proving compensability). Since Dr. Feldstein did not concur with Dr. Corrigan's report, and we can not consider Dr. Corrigan's impairment findings in the absence of such a concurrence, this leaves only Dr. Martens' medical arbiter's report.

Dr. Martens concluded that claimant had limitations on repetitive use of the lumbar spine, but attributed it primarily to a recurrent lumbar strain and herniated L4-5 disc. Inasmuch as we have determined that claimant's current disability, including the herniated disc condition, is compensable, Florence G. Selvidge, supra, we conclude that Dr. Martens' arbiter's report establishes that claimant is entitled to a 5 percent "chronic condition" award.

Consequently, we conclude that claimant has permanent impairment due to the compensable injury. Inasmuch as the parties do not dispute the Department's calculation of claimant's other disability factors, we affirm the Order on Reconsideration's 23 percent unscheduled permanent disability award. Moreover, SAIF does not contest the Department's assessment of a 25 percent penalty pursuant to former ORS 656.268(4)(g). Therefore, we affirm that portion of the Order on Reconsideration as well.

Because we have affirmed the unscheduled permanent disability awarded by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation created by this order

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[1] SAIF challenges the ALJ's evidentiary ruling that excluded admission of the other ALJ's order upholding SAIF's denial. We need not decide whether the ALJ abused his discretion in excluding the order since we have taken judicial notice of our recent order reversing the other ALJ's order.

(the 23 percent "increase" between the ALJ's order and our 23 percent award), not to exceed $3,800. See ORS 656.386(2); OAR 438-015-0055(1). In the event that all or any portion of this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), aff'd Volk v. America West Airlines, 135 Or App 565 (1995). We do not award an attorney fee for claimant's counsel's services regarding the penalty issue. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The ALJ's order dated April 5, 1996 is reversed. The Order on Reconsideration, including the 23 percent unscheduled permanent disability award, and penalty pursuant to ORS 656.268 (4)(g) is reinstated and affirmed. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order (23 percent), not to exceed $3,800. In the event that all or any portion of this "increased" unscheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk, supra.

In the Matter of the Compensation of
CAMILLA R. BLANCO, Claimant
WCB Case No. 95-10109
ORDER ON RECONSIDERATION
Shelley K. Edling, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

The self-insured employer requests reconsideration of our June 5, 1996 order that affirmed an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's occupational disease claim for a left leg condition. Specifically, the employer contends that: (1) this case should be remanded to the Hearings Division for further development of the record in light of Andrews v. Tektronix, Inc., 323 Or 154 (1996); (2) the Board should review this case en banc; and (3) its denial should be reinstated and upheld.

On July 5, 1996, we withdrew our June 5, 1996 order for reconsideration and granted claimant an opportunity to respond to the employer's motion. Having received claimant's response and the employer's reply, we proceed with our reconsideration.

We first address the employer's request for an en banc review of this case. Although the Board may sit en banc in rendering a decision, the act or decision of any two members shall be deemed the act or decision of the Board. ORS 656.718(2). Whether a case is reviewed en banc is a matter solely within our own discretion. See Ralph L. Witt, 45 Van Natta 449 (1993); Kurt D. Cutlip, 45 Van Natta 79 (1993). Here, our initial decision was rendered by a panel. Furthermore, that decision addressed the case holding on which the employer's request for en banc review is based. Under such circumstances, we find no persuasive reason to refer this case to en banc review. Consequently, the employer's request for an en banc review is denied. See Mark Ostermiller, 46 Van Natta 1785 (1994).

The employer seeks remand of this matter for further development of the record in light of Andrews v. Tektronix, Inc., supra. For the following reasons, we find the record sufficiently developed and we deny the motion for remand.

We may remand a case 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). We have previously found a compelling basis to remand where the record was devoid of evidence regarding a legal standard which had changed while Board review was pending. See, e.g., Troy Shoopman, 46 Van Natta 21 (1994); Betty S. Tee, 45 Van Natta 289 (1993). However, where the record is sufficiently developed to make a determination under the new standard, we have declined to remand. See Solio C. Diaz, 48 Van Natta 371, 373 n. 2 (1996); Clifford E. Clark, 47 Van Natta 2310 (1995).

Citing the Court's decision in Andrews, the employer asserts that this matter must be remanded for additional evidence. The employer contends that Andrews created new standards, but did not set forth any precedent for application of the new standard. We disagree with the employer's argument to the extent that we do not read Andrews as significantly changing the method for analyzing "course and scope" cases. In Andrews, the Court stated:

> "We previously have described ORS 656.005(7)(a) as setting out 'two elements of a single inquiry[.]' Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366, 867 P2d 1373 (1994). One element, the requirement that the injury occur 'in the course of employment,' concerns the time, place and circumstances of the injury. Id. The other requirement, that the injury 'arise out of' the worker's employment, examines the causal connection between the injury and employment. Id. Although both elements must be evaluated, neither is dispositive: Ultimately, they merely serve as analytical tools for determining whether, 'in light of the policy for which [that] determination is to be made[,]' the connections between the injury and employment is sufficient to warrant compensation. Rogers v. SAIF, 289 Or 633, 642, 616 P2d 485 (1980)." (Footnote omitted).

The Andrews Court went on to hold that the fact that the employer has instructed the worker to avoid certain work, and that the worker's injury occurred when he or she disregarded that instruction, are only two of many factors that must be considered in the overall calculation of work-connectedness. Although the Court clarified the law in cases where the worker fails to follow the employer's rules, the Court did not make any substantial change in the way cases are analyzed under ORS 656.005(7)(a). Thus, we disagree with the employer's contention that Andrews created "new standards." We believe that the standards for determining work-connectedness are the same now as they were before the Andrews decision. Thus, we do not find that this is a case where remand is warranted due to a change in legal standards pending Board review. See Clifford E. Clark, supra.

In any case, we find the record sufficiently developed concerning the additional factors listed by the Court. Although we are not persuaded that all of the listed factors are relevant to this particular case, we have separately addressed each of them.

Among the additional factors listed by the Court to be considered in determining work-connectedness, are the degree of connection between what the worker is authorized to do and is forbidden to do, the degree of judgment and latitude normally given the worker, workplace customs and practices, the relative risk to the worker when compared to the benefit to the employer, and the like. The Court further indicated that when a worker's failure to follow a work-defining instruction is taken into consideration, the manner in which the instruction was conveyed, and the worker's consequent perception of the instruction's purpose and scope, also must be considered.

Here, claimant's injuries were sustained during the time, place and under the circumstances in which she normally worked. Moreover, the injuries occurred while she was performing her regular job duties as a teller. Although claimant was directed to use her crutches while working, she testified that she was unable to perform her duties (walking back and forth between the drive up window and her regular counter while carrying things) with crutches. Considering that claimant's performance of her teller duties benefited the employer in that her work assignments were being completed, we do not find her failure to use her crutches to be a significant departure from her employer's expectations.

We do not find the degree of judgment or latitude given to the worker to be a particularly relevant factor in this case. However, the record indicates that claimant was subject to the instructions of her supervisor, including the instruction to use her crutches. As stated above, we do not find that claimant's failure to use her crutches is, by itself, sufficient to render her injuries noncompensable. This is only one of many factors we have considered.

Based on this record, the relative risk to claimant of using her crutches was small. However, because claimant credibly testified that she could not perform her duties with the crutches, we do not find either that the employer would have benefited significantly by claimant using her crutches or that it was possible for claimant to comply with such an instruction. (We recognize that the employer would have benefited to the extent that claimant would not have been injured; however, we note that claimant testified she could not do her job with the crutches). Thus, this factor is not especially helpful in this case.

To the extent that employment practices are relevant in this case, claimant's testimony indicates that it was the practice for tellers to cover the drive up window when no one was scheduled to work at the drive up. (Tr. 17-18). Claimant's leg began hurting after she covered the drive up window. (Tr. 18). She had difficulty using her crutches while going back and forth between her counter and the drive up window. (Tr. 18). Claimant's supervisor did not challenge claimant's assertion that she covered the drive up window. Thus, we find the record sufficiently developed on this factor to the extent it is relevant.

The record was also sufficiently developed concerning how the employer's instruction to use the crutches was conveyed, and claimant's consequent perception of the instruction's purpose and scope. This was the major issue at hearing and has been more than adequately developed. The record reveals that claimant understood her supervisor's admonishments to use her crutches, but was unable to perform her regular duties with the crutches.

It may be that the precise factors raised by Andrews were not raised at hearing. However, each of those factors is already encompassed in the pivotal question of whether claimant's failure to follow the employer's instructions to use her crutches severed the connection between claimant's injury and work. Consequently, we find that all of the factors which are relevant in this case to the issue of the work-connectedness of claimant's injuries have been thoroughly and completely developed. Thus, we find no compelling reason to remand.

Turning to the merits, the employer argues that claimant has not established that her injuries arose out of employment. This issue was thoroughly addressed in the ALJ's order and was decided against the employer. We adopted the ALJ's order and we decline to address the employer's contention further.

Finally, the employer argues that the medical evidence does not establish that claimant's work activities were the major contributing cause of the combined condition. See ORS 656.802(2)(b), 656.005(7)(a)(B). The employer further argues that the "combined condition" is the preexisting fracture as well as the increased angulation and the new fracture. We disagree. Based on the medical evidence in this record, we find that the preexisting tibia fracture combined with claimant's work activities to cause a new fibula fracture and increased angulation of the preexisting tibia fracture. The new fracture and increased angulation are the "combined condition" for purposes of ORS 656.005(7)(a)(B). As we previously concluded, Dr. Buuck's opinion establishes that claimant's work activities between July 10 and July 24, 1995 are the major contributing cause of the combined condition.

The employer argues that our conclusion regarding what constitutes the combined condition in this case is somehow inconsistent with our conclusion regarding what the combined condition was in our decision in Dan D. Cone, 47 Van Natta 2220, on recon 47 Van Natta 2343 (1995). Specifically, the employer asserts that the "combined condition" must include the preexisting condition. The employer further argues that the medical evidence does not support compensability of the "combined condition" if that condition includes the preexisting fracture. We disagree with the employer's interpretation of our holding in Cone.

In Cone, the claimant contended that a 1985 accepted low back strain injury was worsened by subsequent repetitive trauma at work and amounted to a compensable occupational disease claim. We found that the 1985 injury was the preexisting condition for purposes of ORS 656.005(24). In order to establish compensability, the claimant had to show that his employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. The "combined condition" in Cone was a herniated disc condition which resulted from a combination of the 1985 low back strain injury and the repetitive microtrauma from subsequent work conditions. Thus, the "combined condition" (herniated disc) was a separate condition from the preexisting condition (1985 strain).

The preexisting condition in this case was a tibia fracture, and the increased angulation of the tibia fracture and the new fibia fracture are the "combined condition." In this case, as in Cone, the "combined condition" is a separate entity from the preexisting condition. Thus, we do not find this case to be inconsistent with Cone.

We conclude that claimant is entitled to an attorney fee for services on reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $500, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved. This award is in addition to claimant's previous attorney fee awards.

As supplemented herein, we republish our June 5, 1996 order in its entirety. For services on reconsideration, claimant's attorney is awarded $500, to be paid by the employer. 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
CHARLES W. FRAZIER, Claimant
WCB Case No. 95-03970
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the SAIF Corporation's denial of his occupational disease claim for toxic exposure and contact dermatitis. On review, the issue is compensability.

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

Claimant is a heating, ventilation, and air conditioning technician for OHSU. On November 30, 1994, he was required to do repair work in the fan room of a building where experimental work is done and toxic chemicals are used. When claimant entered the room, the central fan was not working and he noted a faint odor.

The next morning, claimant's face, eyes and throat were burning and swollen and his head itched. He sought treatment with Dr. Richards, who diagnosed contact dermatitis, most likely secondary to exposure to unknown irritants at work.

The ALJ found that claimant failed to sustain his burden of proof under ORS 656.266 and 656.802, because there was no direct evidence of toxic fumes in the fan room or, if there were such fumes, they were present at a level sufficient to cause claimant's condition. The ALJ further noted that there was no medical evidence identifying which chemical or chemicals caused claimant's reaction or why. Based on Fred W. Hodgen, 47 Van Natta 413 (1995),[1] the ALJ found Dr. Richards' opinion insufficient to prove that claimant's work exposure caused his medical condition. We agree.

Unlike the dissent, we do not consider the fact that chemicals were being used in the building on the day claimant made repairs in the fan room to be sufficient evidence that claimant's condition is work related. Claimant testified he noticed a "faint" or "mild" odor when he entered the fan room on the seventh floor, but there is no evidence in the record identifying the source of this odor, or its toxicity.[2] Dr. Richards could not identify the irritant, other than to speculate that claimant was exposed to something in the fan room that caused his symptoms.

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[1] In Fred W. Hodgen, supra, we held that the claimant failed to affirmatively establish that he acquired his tuberculosis infection as a result of a work exposure.

[2] Claimant testified that thiamine or some kind of acidic acid was being used in one of the research labs in the building that day (Tr. 13), but there is no evidence that this chemical was present at all, let alone at a toxic level, in the fan room where he was working.

On this record, we find that claimant has not affirmatively proven that he was exposed to toxic substances at work, or that his work exposure caused his medical condition.

ORDER

The ALJ's order dated January 19, 1996 is affirmed.

Board Chair Hall dissenting.

In adopting and affirming the ALJ's order, the majority has found that claimant failed to sustain his burden of proof under ORS 656.266 and 656.802, because there was no "direct" evidence of toxic fumes in the fan room or, if there were toxic fumes, which chemicals were present. Because the law does not require "direct" evidence of exposure,[1] or that the claimant specifically identify the chemical or chemicals that caused his reaction, I respectfully dissent.

As the Court of Appeals recently held, a claimant need not prove the specific agent at work that caused his or her condition, as long as the persuasive evidence indicated that the condition is work related. Bronco Cleaners v. Velazquez, 141 Or App 295 (1996). Here, claimant testified he noticed a faint odor when he entered the fan room. It is undisputed that acids and other chemicals were being used in the building's reseach labs that day. Further, the undisputed medical opinion indicates that claimant's work exposure caused his reaction. Based on this evidence, I would find that claimant has sustained his burden, and that his toxic exposure claim is compensable.

[1] As triers of fact, we are entitled to draw reasonable inferences from the evidence as a whole. See, e.g., Skeeters v. Skeeters, 237 Or 204, 214 (1964) (while the jury cannot be permitted to speculate, the jurors can draw reasonable inferences from the evidence submitted by the litigants); Law v. Kemp, 276 Or 581, 585-86 (1976) (same).

August 23, 1996 Cite as 48 Van Natta 1707 (1996)

In the Matter of the Compensation of
PATRICIA L. HODGES, Claimant
WCB Case No. 95-12789
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that declined to award an attorney fee for the SAIF Corporation's rescission of its denial of claimant's claim for a low back strain. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We do not adopt the "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not entitled to an assessed attorney fee pursuant to amended ORS 656.386(1). We agree, however, we base our conclusion on the following reasoning.

Under amended ORS 656.386(1), claimant's attorney is entitled to an attorney fee "in cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge." We have previously held that the crucial inquiry under the amended statute is whether there was a "denied claim" and whether there was a "rescission." Vicki M. Emerson, 48 Van Natta 821 (1996).

Here, claimant's low back strain was accepted prior to claimant's counsel filing a request for hearing. Accordingly, there was no longer a denied claim for purposes of a fee pursuant to amended ORS 656.386(1). Consequently, we find this case distinguishable from cases in which a claimant's claim was accepted only after the claimant requested a hearing. See, e.g., Emily M. Bowman, 48 Van Natta 1199 (1996). Therefore, we agree with the ALJ that claimant's counsel has not established entitlement to an assessed attorney fee in this case.[1]

ORDER

The ALJ's order dated March 1, 1996 is affirmed.

[1] We disagree with the dissent's conclusion that SAIF's actions should result in an attorney fee under the statute. The dissent does not dispute that the claim was accepted prior to the request for hearing being filed. Additionally, in light of the prior acceptance, it cannot be said that claimant's counsel was instrumental in obtaining the rescission of the denial, which is a prerequisite under the statute.

Board Chair Hall dissenting.

I disagree with the majority's conclusion that claimant has not proven an entitlement to an attorney fee pursuant to amended ORS 656.386(1). Although SAIF accepted the low back claim, it had previously issued a denial/disclaimer of the claim. That denial/disclaimer was not "rescinded" until after claimant's counsel requested a hearing. Consequently, SAIF's mishandling of the claim resulted in claimant's counsel being required to request a hearing, in order to preclude a denial from becoming final. Regardless of the "acceptance" occurring before the request for hearing was filed, the fact remains that the carrier did not rescind its denial until claimant's counsel requested a hearing. By the very terms of the amended statute, claimant is entitled to an attorney fee for obtaining the rescission.

In the Matter of the Compensation of
JEFFREY T. KNUDSON, Claimant
Own Motion No. 94-0439M
OWN MOTION ORDER
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant contends that the SAIF Corporation has failed to comply with our March 8, 1996 Own Motion Order, and requests that we enforce our order by requiring the SAIF Corporation to resume payment of temporary disability compensation (TTD or "time loss") commencing February 1, 1995. In addition, claimant seeks penalties and attorney fees for SAIF's allegedly unreasonable refusal to pay temporary disability compensation. Finally, claimant requests a 25 percent approved attorney fee, as well as a "separate fee for [his attorney's] services rendered for enforcing the Board's Own Motion Order of March 8, 1996." In the alternative, claimant requests that the Board refer the matter to the Hearings Division for an evidentiary hearing.

FINDINGS OF FACT

Claimant requested that his 1982 injury claim be reopened for own motion relief. Claimant's treating physician performed a laminectomy and disc excision at L4-5 on July 11, 1994. On September 20, 1994, SAIF issued a denial of the compensability of claimant's current L4-5 disc herniation condition, on which claimant requested a hearing with the Hearings Division. (WCB Case No. 94-12084).

On October 27, 1995, Administrative Law Judge (ALJ) Poland issued an Opinion and Order which set aside SAIF's denial and remanded the claim to SAIF for processing. SAIF requested Board review of the ALJ's order. On March 8, 1996, the Board issued an Order on Review, which affirmed ALJ Poland's order.

On March 8, 1996, we also issued our own motion order, which authorized the reopening of claimant's 1982 low back injury claim for the payment of temporary disability compensation commencing July 11, 1994, the date claimant underwent surgery for the compensable injury. Our order advised SAIF that, when claimant became medically stationary, it should close the claim pursuant to OAR 438-012-0055. Our order was not appealed.

On March 29, 1996, SAIF requested that claimant provide information on his current wages. On April 1, 1996, SAIF directed a payment of temporary disability compensation to claimant, covering the period from July 11, 1994 to February 1, 1995. On April 2, 1996, claimant returned the completed wage-request form to SAIF.

On April 8, 1996, claimant forwarded to SAIF Dr. Bardolph's authorization for temporary disability compensation, which authorized TTD beginning July 11, 1994 through March 14, 1995.

On April 12, 1996, claimant forwarded to SAIF Dr. Salib's TTD authorization. That authorization covered the period from March 15, 1995 through the "present" (April 11, 1996).

In a July 17, 1996 letter directed to Dr. Salib, SAIF acknowledged receipt of the physician's time loss authorizations beginning March 15, 1995. SAIF advised Dr. Salib that "Oregon law now states that a physician cannot retroactively authorize disability more than 14 days (ORS 656.262(4)(f)."

Claimant has not received any additional payments of temporary disability after SAIF's April 1, 1996 payment of time loss covering the period of July 11, 1994 to February 1, 1995.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Hearing

With respect to claimant's request to refer this matter for a hearing, we acknowledge our authority to refer disputes to the Hearings Division for fact finding. See OAR 438-012-0040(3). Such actions are normally taken when the disputes are directly attributable to a witness' credibility or reliability (there is a need to develop testimonial and documentary evidence), or when the factual record is insufficiently developed to permit the Board adequate and proper review. See e.g. Charles Tedrow, 48 Van Natta 616 (1996).

Here, the matter in dispute is not contingent upon an appraisal of a witness' credibility or reliability, nor is the factual record incomplete. Rather, the issue pertains to SAIF's refusal to pay temporary disability compensation in an open own motion claim. Because we consider the record to be adequately developed, we need not refer this matter to another forum for taking of further evidence. See Frank L. Bush, 48 Van Natta 1293 (1996); Gary A. Toedtemeier, 48 Van Natta 1014 (1996).

Entitlement to Temporary Disability Compensation

Claimant contends that, pursuant to our March 8, 1996 Own Motion Order reopening his claim, he is entitled to further temporary disability compensation. Further, claimant contends that, because his treating physicians have authorized TTD commencing July 11, 1994 through April 11, 1996, SAIF had no authority to cease the payment of temporary disability on February 1, 1995. Relying on ORS 656.262(4)(f), SAIF contends that claimant's treating physicians cannot authorize time loss retroactively more than 14 days, and it properly terminated temporary disability compensation on February 1, 1995.

Because TTD has been authorized in this claim under ORS 656.278 and the claim is reopened, the issue is whether SAIF could lawfully terminate temporary disability compensation pursuant to ORS 656.278 or our "own motion" rules (i.e., OAR Chapter 438, Division 012). We conclude that SAIF could not "terminate" payment of TTD pursuant to ORS 656.262(4)(f) because that provision does not apply in "own motion" claims where the claim has been reopened for payment of benefits, either voluntarily or by Board order. We base our conclusion on the following reasoning.

The Board has exclusive "own motion" jurisdiction to authorize the reopening of a claim under ORS 656.278 and OAR Chapter 438, Division 012, of the Board's rules. See Miltenberger v. Howard's

Plumbing, 93 Or App 475 (1988). Moreover, the Board's jurisdiction includes the authority to enforce the Board's own motion orders. See Thomas L. Abel, 45 Van Natta 1768 (1993); Darlene M. Welfl, 44 Van Natta 235 (1992); Ivan Davis, 40 Van Natta 1752 (1988); David L. Waasdorp, 38 Van Natta 81 (1986).

Here, pursuant to ORS 656.278, we authorized the reopening of claimant's 1982 low back injury claim for payment of TTD, commencing July 11, 1994, the date claimant underwent surgery for the compensable condition. Thereafter, SAIF was required to pay temporary disability benefits until one of the following events occurred: (1) the claim was closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement was submitted to the Board pursuant to ORS 656.236(1), unless the claim disposition agreement provided for the continued payment of temporary disability benefits; or (3) termination of such benefits was authorized by the terms of ORS 656.268. OAR 438-012-0035(4).

ORS 656.268 provides that payment of TTD shall continue until whichever of the following events first occurs: (a) the worker returns to regular or modified employment; (b) the attending physician gives the worker a written release to return to regular employment; (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; or (d) any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4) or other provisions of this chapter. ORS 656.262(4)(f), which was added to Chapter 656 by the 1995 Legislature, provides:

> "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."

As is clear from the text of ORS 656.262(4)(f), this subsection applies to temporary disability benefits payable "under ORS 656.268." However, temporary disability in "own motion" cases is payable pursuant to ORS 656.278. Unlike temporary disability benefits under ORS 656.262 or 656.268, temporary disability benefits under ORS 656.278 arise by means of voluntary reopening by the carrier or authorization from the Board and will be authorized only if a claimant has met multiple statutory criteria, i. e., the claimant's condition has worsened requiring surgery or inpatient hospitalization. See also OAR 438-012-0035(1). Our authority to award temporary disability under ORS 656.278 is not conditional on an attending physician's time loss authorization. See Pamela Vinyard, 48 Van Natta 1442 (1996) (Because the Board has sole authority to reopen a claim for the payment of temporary disability under ORS 656.278, an attending physician's time loss authorization is not necessary for the reopening of an own motion claim).

Since an attending physician's time loss authorization is not required for commencement of temporary disability benefits pursuant to ORS 656.278, we conclude the lack of such authorization is not a basis for terminating such benefits. In other words, the "attending physician authorization" requirement of ORS 656.262(4)(f) does not apply to the processing of claims reopened under ORS 656.278.

In reaching this conclusion, we note that OAR 438-012-0035 provides that a carrier's payment of temporary disability in "own motion" cases must continue until "termination" of such benefits is authorized by ORS 656.268. In contrast to the circumstances which allow termination of temporary disability benefits pursuant to the precise "pre-closure" situations described in ORS 656.268(3)(a-c), ORS 656.268(3)(d) provides a general statement that "[a]ny other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4)" or other provision of that chapter is sufficient to stop the payment of such benefits. (Emphasis supplied). By its terms, ORS 656.268(3)(d) provides not only for termination of benefits, but also the suspension and withholding of benefits payable pursuant to ORS 656.268. However, in "own motion" cases where benefits are payable pursuant to ORS 656.278, OAR 438-012-0035(4)(c) authorizes only "termination" of benefits by the terms of ORS 656.268. Thus, only those events listed in ORS 656.268(3) which would permit termination of temporary disability benefits paid pursuant to ORS 656.278 are applicable to "own motion" cases.

In this case, by refusing to pay temporary disability benefits beyond February 1, 1995, despite our March 8, 1996 order authorizing payment of benefits, SAIF has essentially withheld benefits for lack of effective "time loss" authorization by an attending physician. Because our rules do not permit the unilateral withholding of benefits payable pursuant to ORS 656.278, we conclude that claimant is entitled to reinstatement of the payment of TTD in this claim, recommencing on February 2, 1995, until such benefits can be lawfully terminated. See OAR 438-012-0035.

Penalties/Attorney Fees

Claimant requests penalties for SAIF's allegedly unreasonable failure to pay compensation. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount of 25 percent of the amounts "then due."

SAIF's refusal to pay compensation is not unreasonable if it has a legitimate doubt about its liability. Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990). Once our March 8, 1996 order authorizing temporary disability compensation became final, all "pre-order" temporary disability was due and payable up to the date of our order, absent grounds to terminate that payment pursuant to ORS 656.268(3)(a-c). Thus, "retroactive" time loss was due claimant within 14 days of our final March 8, 1996 own motion order (by April 22, 1996).

Without our express consent, SAIF ceased payment of TTD on February 1, 1995. Citing ORS 656.262(4)(f), SAIF argues that it was not required to pay temporary disability compensation more than 14 days retroactive of a physician's authorization. Until our decision today, there was no point or authority finding ORS 656.262(4)(f) inconsistent with the principles of ORS 656.278 for the "termination" of temporary disability benefits under own motion claims. Under such circumstances, we find that SAIF had a reasonable doubt as to its obligation and liability pursuant to its reliance on ORS 656.262(4)(f). This is particularly true because OAR 438-012-0035 refers to ORS 656.268 generally in allowing a carrier to terminate benefits, and it does not specifically exclude ORS 656.262(4)(f). Therefore, until the date of this order which finds the application of ORS 656.262(4)(f) inappropriate for terminating benefits in own motion claims, SAIF had a legitimate doubt regarding its responsibility for the payment of "retroactive" temporary disability benefits.

However, "prospective" temporary disability compensation was due within 14 days after the issuance of our March 8, 1996 order (by March 22, 1996). See OAR 436-60-150(4)(h). In addition, on its receipt of Dr. Salib's authorization for TTD, SAIF did not recommence temporary disability even though that authorization authorized timeloss beginning March 15, 1995 through April 11, 1996. SAIF offers no explanation for its failure to recommence TTD on March 28, 1996, pursuant to Dr. Salib's contemporary authorization (14 days prior to April 11, 1996). Since the provisions of ORS 656.268(3)(d) and ORS 656.262(4)(f) do not provide a basis for its failure to begin paying TTD effective March 28, 1996, we find that SAIF did not have a legitimate doubt for this claim processing decision.

On this record, we find that, effective March 28, 1996, SAIF unreasonably refused to pay compensation in claimant's 1982 low back claim. Therefore, under ORS 656.262(11)(a), we find that claimant is entitled to a 25 percent penalty of the "post-March 28, 1996" compensation "then due" claimant as a result of our March 8, 1996 order. This penalty is assessed and payable from March 28, 1996 (14 days before Dr. Salib's April 11, 1996 timeloss authorization) through the date of this order (unless said compensation could be lawfully terminated under OAR 438-012-0035 prior to this order), and is payable in equal shares to claimant and his attorney. See Frank L. Bush, supra; John R. Woods, 48 Van Natta 1016 (1996); Jeffrey D. Dennis, 43 Van Natta 857 (1991).

Claimant requests a "separate fee" for services rendered for enforcing the Board's Own Motion Order of March 8, 1996," in addition to an out-of-compensation fee of 25 percent of additional benefits awarded by this order.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Claimant does not cite, nor do we find, authority to award an assessed fee for his attorney's efforts in securing enforcement and penalties in this case. See ORS 656.386(1); Forney v. Western States Plywood, 297 Or 628 (1984). Therefore, we are unable to grant claimant's request for a "separate fee" or an assessed fee in this matter.

However, by this order, we have directed SAIF to pay claimant one-half of our penalty assessment, as well as one-half payable to claimant's attorney. Further, claimant's attorney is herein allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080.

ORDER

SAIF is directed to process this claim to closure pursuant to OAR 438-012-0055 and our March 8, 1996 Own Motion Order. SAIF shall recommence temporary disability compensation beginning February 2, 1995, until it is authorized to terminate temporary disability compensation. The penalty assigned herein shall be based on the unpaid temporary disability compensation between March 28, 1996 and the date of this order. The approved attorney fee shall be based on the increased compensation awarded under this order, from February 2, 1995 through the date of this order.

IT IS SO ORDERED.

August 23, 1996 Cite as 48 Van Natta 1712 (1996)

In the Matter of the Compensation of
LANA L. RUNKEL, Claimant
WCB Case No. 93-14247
ORDER ON RECONSIDERATION (REMANDING)
William H. Skalak, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

On April 11, 1996, we abated our March 12, 1996 order in which we: (1) reversed the Administrative Law Judge's (ALJ's) decision not to award claimant interim compensation from June 29, 1993 to August 20, 1993; and (2) affirmed the ALJ's finding that SAIF had accepted claimant's psychological condition, including a preexisting personality disorder. We took this action to consider the SAIF Corporation's motion for reconsideration. SAIF contends that claimant is not entitled to interim compensation because she had withdrawn from the work force at the time of her June 1993 aggravation claim. SAIF also asserts that we incorrectly determined that it accepted claimant's personality disorder. Having received and considered claimant's response, we now proceed with our reconsideration.

In our order, we determined that claimant had satisfied at least the third prong of the criteria listed in Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989).[1] Therefore, we concluded that claimant was in the work force at the time of her aggravation claim and was, accordingly, entitled to interim compensation. SAIF contends that we failed to make a finding that claimant was willing to work at the time of her June 1993 aggravation claim and that there is no evidence to support such a finding.

We disagree. Our finding that claimant satisfied the third prong of the Dawkins test necessarily included a finding that claimant was willing to work. In addition, such a finding is supported by the record.

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[1] To receive temporary total disability upon aggravation of a work-related injury, the claimant must be in the work force at the time of the aggravation. Dawkins v. Pacific Motor Trucking, supra. A claimant is deemed to be in the work force under the Dawkins criteria if:

a. The claimant is engaged in regular gainful employment; or

b. The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or

c. The claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile. 308 Or at 258.

For example, claimant has demonstrated her willingness to work through her participation in vocational rehabilitation. Although SAIF notes the ALJ's finding that claimant's participation was motivated by her desire to maintain benefits, rather than by a desire to return to work, claimant's inability to work was due to her personality disorder, which we have determined to be compensable (see discussion below), and not due to a voluntary withdrawal from the work force. See Gilbert R. Brown, 43 Van Natta 585 (1991) (where the claimant's inability to work was due to his injury-related physical and psychological problems, the claimant was a member of the work force at the time of the aggravation of his prior work-related injury). Therefore, we conclude that claimant satisfied the willingness-to-work aspect of the Dawkins test.

SAIF also contends that it did not accept claimant's personality disorder. SAIF first asserts that there is no evidence that it notified claimant that her psychological conditions were accepted, and, thus, should not be considered to have accepted the personality disorder. However, claimant correctly observes that acceptance is a question of fact and that a notice of acceptance is not a prerequisite to acceptance. SAIF v. Tull, 113 Or App 449, 454 (1992). Accordingly, the fact that SAIF may not have formally notified claimant that it accepted her psychological condition does not mean that SAIF did not accept that component of the claim.[2]

SAIF contends that it never accepted a preexisting personality disorder because no treatment was sought or given for that component of claimant's psychological condition. Moreover, SAIF argues that no treating physician ever advised that claimant's preexisting personality disorder was a part of the claim. Therefore, SAIF reasons that there was no claim made for that condition. We disagree.

Dr. Klein, claimant's treating psychiatrist, concurred with the medical report of an examining psychiatrist, Dr. Turco, who diagnosed a passive-aggressive and passive-dependent personality disorder. (Exs. 25-3, 26). In addition, Dr. Klein herself confirmed that claimant has an underlying personality disorder. (Ex. 83). Based on this record, we conclude that claimant did receive treatment for her preexisting personality disorder (a condition acknowledged by the attending psychiatrist) and that this condition was part and parcel of the psychological condition that SAIF processed for six years prior to issuing its August 20, 1993 denial. This processing included payment of all medical treatment for claimant's psychological condition and eight independent medical evaluations of claimant's psychological condition.

Under these circumstances, we reiterate our agreement with the ALJ that SAIF's acceptance of claimant's psychological condition should be broadly construed to encompass all causes of claimant's psychological condition, including the personality disorder. Accordingly, we once again reject SAIF's arguments that it never accepted claimant's personality disorder.

Claimant's attorney is entitled to an additional assessed fee for time spent responding to SAIF's reconsideration request and finally prevailing over its denial. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that an additional reasonable fee for claimant's attorney's services regarding SAIF's request for reconsideration is $750, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the request (as represented by counsel's statement of services and by claimant's response to the reconsideration request), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our March 12, 1996 order including that portion which remanded the aggravation issue to ALJ Herman for further development of the record. The parties' right of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] SAIF also attacks the ALJ's reliance on SAIF's adjuster's agreement to pay medical bills as a basis for concluding that SAIF accepted claimant's psychological condition. See ORS 656.262(10) (merely paying or providing compensation shall not be considered acceptance of a claim or admission of liability). While payment of compensation alone does not make claimant s personality disorder compensable, we agree with the ALJ that, as a factual matter, SAIF's claim processing, including payment of all medical bills related to claimant's psychological condition, transcended mere payment of compensation and is evidence that SAIF accepted claimant's personality disorder.

In the Matter of the Compensation of
JAMES E. SURDAM, Claimant
WCB Case Nos. 95-12202, 95-06843 & 95-06630
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Garaventa's order that: (1) declined to admit a medical report into evidence because the physician had been suspended from practicing medicine when the report was written; (2) upheld Liberty Northwest Insurance Corporation's denial, on behalf of Zeida Painting Co., Inc., of claimant's occupational disease claim for a right knee degenerative condition; and (3) upheld Liberty's denial, on behalf of Rak Renovations, Inc., of claimant's occupational disease claim for the same condition. On review, the issues are evidence, compensability and, potentially, responsibility.

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

In the third paragraph on page 3, we change the second sentence to read: "Claimant reported that the knee pain was so severe that it caused the fall off the ladder which resulted in the multiple rib fractures." We also change the second sentence in the fifth paragraph on page 3 to read: "Based on a history that claimant had sought medical attention in March 1995 following a March 1, 1995 fall, they opined that claimant's work as a painter was not the major contributing cause of degenerative joint disease or of a worsening of the condition and that the need for a total knee replacement is not caused by work activities as a painter or by any specific injurious incident."

Evidence

Claimant argues that Exhibit 21, a December 15, 1995 report from Dr. Beck (a physician who had been suspended from practicing medicine when the report was written), should have been admitted into the record. According to claimant, the fact that Dr. Beck did not meet the qualifications of an attending physician under ORS 656.005(12)(a) or (12)(b) does not affect his ability to render an expert opinion as to causation in this case.

The ALJ excluded Exhibit 21 from consideration at hearing because, at the time the report was written, Dr. Beck was not duly licensed under Oregon Workers' Compensation law. In addition, the ALJ found that, because Exhibit 21 was not received into evidence, Exhibit 22 was irrelevant and would not be admitted. (Both exhibits remained in the file for purposes of appeal).

An ALJ is 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 matter that will achieve substantial justice. ORS 656.283(7). We review the ALJ's evidentiary ruling for abuse of discretion. James D. Brusseau II, 43 Van Natta 541 (1991).

Although claimant argues that the ALJ erred in excluding Dr. Beck's December 15, 1995 report, he does not explain why the ALJ's decision to exclude the report constitutes an abuse of discretion. See Brown v. SAIF, 51 Or App 389, 394 (1991) (the ALJ's decision to admit or exclude evidence is limited only by the consideration that the hearing as a whole achieve substantial justice). In any event, we need not resolve the evidentiary issue because, even if we considered Dr. Beck's later report and Exhibit 22, we would reach the same conclusion regarding compensability. Accordingly, we decline to resolve the question of whether it was an abuse of discretion to exclude Exhibit 21.[1]

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[1] We note that, although the court and Board require expert medical opinion on causation in some situations, there is no requirement in the statutes or rules that mandates that the expert must be licensed. See Aetna Casualty Co. v. Robinson, 115 Or App 154, 158 (1991) (psychologist was not required to be licensed in order to render an opinion on the claimant's mental condition). The expert's qualifications affect the weight to be given to the opinion, not its admissibility. Id.; Tammy G. Dodson, 46 Van Natta 1895 (1994). OEC 702 provides: "If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise."

Compensability

In March 1995, claimant was examined by Dr. Gaskell for chronic right knee pain that had worsened over the years. Dr. Gaskell commented that a 1987 x-ray indicated that claimant had degenerative arthritis of the knee. (Exs. 4, 19). Dr. Gaskell referred claimant to Dr. Hanley, orthopedist. (Ex. 4).

Dr. Hanley diagnosed advanced bicompartmental arthritis, probably involving the lateral compartment, and recommended a right total knee arthroplasty. (Ex. 5). In his October 2, 1995 chart note, Dr. Hanley indicated that he could not support a conclusion that the unequal nature of claimant's knee degeneration was due to repetitive microtrauma. (Ex. 5A). Dr. Hanley commented on October 13, 1995 that it was "very difficult, if not impossible, to conclude that [claimant's] work was the primary cause of this degeneration." (Id.) Dr. Hanley concluded that the cause of claimant's degeneration in both knees was multifactorial, including genetic factors, the aging process, daily and work activities, weight and nutritional status. (Ex. 20). Regarding claimant's asymmetrical knee degeneration, Dr. Hanley reported:

> "I have been performing knee surgery and total knee replacements on patients now for over eight years. Throughout those years, virtually all of my patients have had one knee more affected than the other. I do not believe it can be stated with any reasonable scientific basis that [claimant's] work activities are the primary reason that he has experienced degeneration in his right knee at a somewhat faster rate than on his left." (Id.)

Dr. Gaskell did not believe that claimant's work activities were the major contributing cause of the degenerative condition in either knee. (Ex. 19). Rather, he concluded that the major contributing cause of the degenerative condition was the natural aging process. (Id.) Dr. Logan, who examined claimant on behalf of the insurer, also concluded that claimant's work was not the major contributing cause of his degenerative joint disease. (Ex. 16).

Dr. Beck examined claimant in May 1995 and diagnosed knee pain, consistent with degenerative joint disease. (Ex. 13). On August 23, 1995, Dr. Beck agreed with Dr. Hanley that osteoarthritis of the knees can occur before age 52, as in claimant's case, as part of the natural aging process, albeit on an infrequent basis. (Ex. 18). However, Dr. Beck opined that the advanced degree of degenerative joint disease in claimant's right knee was secondary to the repetitive microtrauma claimant sustained in his work activities.[2] (Id.) In contrast, Dr. Beck attributed the degenerative arthritis in claimant's left knee to an underlying congenital cause. (Id.)

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). We agree with the ALJ that Dr. Hanley's opinion is more persuasive than that of Dr. Beck, particularly since Dr. Beck agreed with Dr. Hanley that osteoarthritis of the knees can occur at an early age, as in claimant's case, as part of the aging process. Dr. Hanley's opinion was based on an accurate history and was well reasoned. Furthermore, Dr. Hanley's opinion is supported by the opinions of Drs. Gaskell and Logan that claimant's work was not the major contributing cause of his degenerative joint disease. (Exs. 16, 19).

ORDER

The ALJ's order dated February 23, 1996 is affirmed.

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[2] We note that, even if we considered Dr. Beck's subsequent report, we would reach the same conclusion regarding compensability. Dr. Beck issued a later report on December 15, 1995, at which time his medical license had been suspended. (Exs. 21, 22). Dr. Beck referred to medical literature and described claimant's right knee as having "secondary degenerative joint disease," which frequently results from gross trauma or repetitive microtrauma. (Ex. 21). According to Dr. Beck, the amount of claimant's asymmetrical degeneration was quite unusual and he concluded that the major contributing cause of claimant's right knee condition was occupational exposure. (Id.)

In the Matter of the Compensation of
ALAN T. SPAETH, Claimant
WCB Case Nos. 95-10954 & 95-08437
ORDER OF ABATEMENT
Popick & Merkel, Claimant Attorneys
Roberts, et al, Defense Attorneys
Sather, Byerly, et al, Defense Attorneys

The Cigna Insurance Company requests abatement and reconsideration of our July 25, 1996 Order on Review in which we assessed an attorney fee against it under ORS 656.382(2). Geisy Greer & Gunn also requests reconsideration of that portion of our order that affirmed the ALJ's award of an attorney fee under ORS 656.386(1).

In order to consider this matter, we withdraw our July 25, 1996 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
LOIS F. BARTON, Claimant
WCB Case No. 95-11774
ORDER ON RECONSIDERATION
Whitehead & Klosterman, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our July 30, 1996 Order on Review that set aside its denial of claimant's right ankle injury claim. SAIF contends that the Board made two factual findings not supported by the record. Considering these two "factual corrections," SAIF asks the Board to reevaluate its finding that claimant did not act unreasonably in choosing to walk down a grassy slope in the employee parking lot.

Specifically, SAIF contends that: (1) rather than two graveled paths with grass growing through the gravel, a portion of one of the paths was paved with asphalt, providing a safer alternative route; and (2) although the nursing home's administrator occasionally walks down the grassy slope, she usually walks down a route she considers "safer," establishing that claimant's choice of route was unreasonable. Citing Sumner v. Coe, 40 Or App 815 (1979) (riding on the hood of a co-worker's car to leave work) and Lane v. Gleaves Volkswagen, 39 Or App 5 (1979) (climbing over a seven-foot fence to exit work), SAIF renews its contention that because there was a safer alternative route for claimant to get from the uneven, multi-level, grassy upper employee parking lot to the rear entrance of the employer's building, claimant's decision to traverse the grassy slope was unreasonable, such that the claim is not compensable.

After our review of the record, we cannot disagree with the "factual corrections" proposed by SAIF. Nonetheless, SAIF's argument misses the mark. As we explained in our prior order, while there may have been an alternative route through the parking lot to the building entrance, and that route may have been "safer," that, in and of itself, does not establish that claimant's decision to walk down the uneven incline was per se unreasonable, thus rendering an otherwise compensable injury noncompensable. See Andrews v. Tektronix, Inc., 323 Or 154 (1996) (the Oregon Workers' Compensation system is a "no-fault" system). Thus, even considering SAIF's "corrected" facts, we find that claimant's conduct in the present case -- merely walking over the natural terrain that comprised the employee parking lot -- does not rise to the level the court found unreasonable in Sumner and Lane.

Consequently, we continue to find that claimant's injuries "arose out of" her employment. Therefore, we continue to conclude that claimant has established a sufficient causal connection between her conditions of employment and the injury to establish compensability. Norpac Foods v. Gilmore, 318 Or 363 (1994).

Accordingly, we withdraw our July 30, 1996 order. On reconsideration, as modified and supplemented herein, we adhere to and republish our July 30, 1996 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 E. KNIGHT, JR., Claimant
WCB Case No. 95-13512
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Menashe's order which awarded an assessed fee pursuant to ORS 656.386(1) for claimant's counsel's efforts in obtaining rescission of an alleged "de facto" denial of a thoracic strain. Claimant cross-requests review of those portions of the ALJ's order which: (1) determined that his request for hearing regarding an alleged "de facto" denial of a right shoulder strain was premature; and (2) upheld SAIF's denial of claimant's cervical injury claim. In his brief, claimant also requests an award of penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are attorney fees, compensability, penalties and validity of the hearing request. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Hearing Request

We adopt and affirm the ALJ's reasoning and conclusion.

Compensability

We adopt and affirm the ALJ's reasoning and conclusion.

Penalties and Attorney Fees

The ALJ concluded that claimant's attorney was entitled to an attorney fee under ORS 656.386(1) for obtaining rescission of a "de facto" denial of a thoracic strain. In reaching this conclusion, the ALJ found that a thoracic strain claim had been presented in February 1995 (after claimant's compensable February 8, 1995 injury) and was not accepted until January 30, 1996, after claimant's counsel had satisfied the requirements of ORS 656.262(6)(d)[1] by writing to SAIF on November 6, 1995 and requesting formal acceptance of a "compensable injury to [claimant's] back." (Ex. 20).

On review, SAIF contends that the ALJ incorrectly awarded an assessed fee under ORS 656.386(1) because: (1) there was no "denied claim" within the meaning of that statute; and (2) the November 6, 1995 letter did not trigger the claim processing requirements of ORS 656.262(6)(d). We need not address the latter contention, for even if we assume that claimant's counsel's November 6, 1995 letter sufficiently communicated claimant's objections to SAIF's Notice of Acceptance, we agree with SAIF that there was no "denied claim" within the meaning of ORS 656.386(1).

Under ORS 656.386(1), a claimant's attorney is entitled to an attorney fee in cases involving "denied claims" where the attorney is instrumental in obtaining a rescission of the denial. A "denied claim" is defined under the statute 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 compensation." We

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

held in Michael J. Galbraith, 48 Van Natta 351 (1996), that there was no "denied claim" under ORS 656.386(1) where the carrier paid all benefits for the compensable condition and did not expressly contend that the allegedly "de facto" denied condition was not compensable.

In this case, as in Michael J. Galbraith, supra, there is no contention that any benefits for the compensable condition have been unpaid. In fact, the record contains an affidavit from SAIF's claims adjuster that all benefits for claimant's compensable injury have been paid. (Ex. 30). In addition, the record does not establish that SAIF refused to pay compensation on the "express ground" that the thoracic condition was not compensable or did not give rise to an entitlement to compensation. (Exs. 21A, 22, 24, 25, 26, 27). Under such circumstances, we conclude that a "denied claim" has not been established and that no attorney fee may be awarded under amended ORS 656.386(1). See Jerry L. Jones, 48 Van Natta 833 (1996).[2]

Finally, claimant contends that SAIF's "de facto" denials of his thoracic and right shoulder claims and its express denial of his cervical claim were unreasonable, thus entitling him to an award of penalties and attorney fees.[3] We disagree.

We have affirmed the ALJ's order upholding SAIF's denial of claimant's cervical claim, and we have also affirmed the ALJ's determination that claimant's hearing request regarding an alleged "de facto" denial of his right shoulder claim was premature. Moreover, even if claimant could allege a "de facto" denial pursuant to ORS 656.262(6)(d) with respect to his thoracic condition, no benefits have gone unpaid. Therefore, there are no amounts "then due" upon which to base a penalty under ORS 656.262(11)(a) and no unreasonable resistance to the payment of compensation under ORS 656.382(1). See Jerry L. Jones, supra. Consequently, we decline to award penalties and attorney fees for SAIF's allegedly unreasonable claim processing.

ORDER

The ALJ's order dated March 22, 1996 is reversed in part and affirmed in part. That portion that awarded an assessed fee for a "de facto" denial is reversed. The remainder of the ALJ's order is affirmed.

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[2] Claimant asserts that SAIF's response to his request for hearing that the "Administrative Law Judge lacks jurisdiction to provide any relief" satisfies the requirement of a "denied claim." We disagree. We find SAIF's response to claimant's hearing request similar to the carrier's response to the claimant's hearing request in Michael J. Galbraith, supra. In Galbraith, the carrier responded to the claimant's request for hearing by asserting that the worker was "entitled to no relief." Because we determined that there was no refusal to pay compensation on the express ground that the condition was not compensable or that the claimant was not otherwise entitled to compensation, we held that there was no "denied claim" as required by ORS 656.386(1). Here, SAIF's response to the request for hearing also did not constitute an express refusal to pay compensation on the ground that claimant's condition was not compensable or otherwise did not give rise to an entitlement to compensation. Cf. Emily M. Bowman, 48 Van Natta 1199 (1996) (distinguishing Galbraith and finding a "denied claim" where the carrier's response to the claimant's hearing request denied that the claimant had sustained a work-related injury or disease). Given that this record does not establish an express refusal to pay compensation, we conclude that there is no "denied claim" within the meaning of ORS 656.386(1).

[3] Although SAIF contends that we should decline to address the penalty issues because claimant failed to raise them before the ALJ, claimant's hearing request did raise penalty and fee issues. See Liberty Northwest v. Alonzo, 105 Or App 458 (1991) (issues raised in a request for hearing are ripe for resolution, even if they are not raised or argued at hearing).

Board Chair Hall Specially Concurring.

Although compelled by the doctrine of stare decisis to follow our holding in Michael J. Galbraith, 48 Van Natta 351 (1996) (Board Chair Hall dissenting), I continue to believe that Galbraith was wrongly decided. In my view, a carrier's responsive pleading that the claimant is not entitled to relief (as was the case in Galbraith) or (as in this case) that the ALJ lacks jurisdiction to provide relief constitutes an express refusal to pay compensation on the ground that the injury or condition "otherwise does not give rise to an entitlement to compensation." In my view, the requirement of a "denied claim" under ORS 656.386(1) is satisfied in both instances.

In the Matter of the Compensation of
PATRICIA A. LANDERS, Claimant
WCB Case No. 95-12560
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its partial denial of claimant's left knee chondromalacia patella condition; and (2) set aside its denial of claimant's aggravation claim for a left knee condition. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of finding No. 28, and with the following supplementation:

Claimant began working for the employer in June 1981. In December 1983, she sought treatment in connection with a long history of left knee complaints. She was diagnosed with, among other things, patellar chondromalacia and an unstable patella. Claimant underwent arthroscopic surgery with debridement on December 20, 1983.

On April 19, 1986, claimant twisted her left knee at work, and developed pain and popping in the knee. She was diagnosed with a medial collateral ligament strain. In August 1986, claimant underwent a second arthroscopic surgery, debridement and excision of medical synovial plica, left knee. The surgeon, Dr. Witney, noted chondromalacia of the patella.

On August 4, 1987, claimant's left knee popped when she stood up at work. She was initially diagnosed with a subluxing patella and chondromalacia. Dr. Whitney then diagnosed an acute injury (possible torn meniscus) along with "well known" chondromalacia of the medial femoral condylar patella. Claimant filed a left knee injury claim, which the employer accepted as disabling on September 4, 1987.

Claimant developed increasing left knee pain. In early January 1988, she sought treatment after her knee again popped while walking at work. On about August 28, 1988, while at work, claimant's left knee gave out and she fell on her right knee. She was diagnosed with a right knee contusion and sprain of the medial collateral ligament.

Claimant filed a workers' compensation claim for an injury to both knees arising out of her fall on August 28, 1988. The employer accepted a disabling injury claim on September 28, 1988.

Claimant underwent a third arthroscopic surgery on her left knee in November 1988, and subsequently continued to experience chronic symptoms. She underwent a fourth arthroscopic surgery on her left knee in October 1989, but still continued to have symptoms.

On March 26, 1990, Dr. Bert reported that claimant's left knee was medically stationary "with moderate impairment based upon recurrent chondromalacia." On June 22, 1990, Dr. Bert noted that claimant continued to complain about both knees from the chondromalacia patellae. He confirmed her medically stationary status on October 30, 1990.

Claimant's 1988 injury claim was closed by a Determination Order issued November 20, 1990, awarding 7 percent scheduled permanent disability for loss of use or function of the right knee. Claimant's 1987 injury claim was closed by a Determination Order issued November 21, 1990, awarding 12 percent scheduled permanent disability for loss of use or function of her left knee.

Claimant appealed the Determination Orders seeking, among other things, to increase her scheduled permanent disability awards. An Opinion and Order issued December 3, 1991, which

increased claimant's award of scheduled permanent disability for the left leg (knee) to 17 percent.[1]

Meanwhile, claimant participated in an authorized training program, which she completed in October 1991. On November 6, 1991, her 1987 left knee injury claim was reclosed by a Determination Order, which awarded no additional permanent disability. Claimant requested reconsideration. A June 17, 1992 Order on Reconsideration reduced claimant's left leg scheduled permanent disability to 9 percent. Claimant then requested a hearing, seeking to increase the permanent disability award by 8 percent, for a total of 17 percent.

By Opinion and Order dated March 16, 1993, a prior ALJ (then Referee) found that because claimant's prior 17 percent permanent disability award for the left leg (as granted in the December 3, 1991 Opinion and Order) had become final, that award could not be reduced by the Appellate Unit on reconsideration. In modifying the June 17, 1992 Order on Reconsideration, the ALJ specifically noted that the parties had stipulated that claimant had a 17 percent permanent loss of use or function in her left knee.

Claimant's left patellar chondromalacia condition progressively worsened. On August 28, 1995, claimant made an aggravation claim arising out of her accepted 1987 left knee injury. The insurer denied the claim on September 22, 1995, and claimant requested a hearing.

At hearing, the parties stipulated to litigate, as part of the aggravation denial, the compensability of the chondromalacia of claimant's left patella.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that the employer's acceptance of claimant's 1987 left knee injury included the chondromalacia patella. In addition, the ALJ found that claimant's 1987 knee injury, her subsequent work injuries and her treatment for those injuries remain the major contributing cause of her current chondromalacia condition, and set aside the employer's partial denial.

On review, the employer contends that the ALJ erred in finding that it accepted claimant's preexisting chondromalacia condition as part of her 1987 left knee injury claim. In addition, the employer argues that claimant's 1987 left knee injury is no longer the major contributing cause of her current chondromalacia condition, and therefore it may deny her current condition under ORS 656.262(6)(c).

We agree with the employer that it did not accept claimant's preexisting chondromalacia condition when it accepted a disabling "injury sustained August 4, 1987."[2] Based on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (Messmer II), however, we nevertheless conclude that the

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[1] The ALJ (then Referee) awarded claimant an additional 5 percent for a chronic condition limiting repetitive use of the left knee/leg. Although the employer sought review of the Opinion and Order, it did not challenge the extent of claimant's permanent disability. The employer's request for review concerned only the rate of scheduled permanent disability and offset. (Ex. 165; see also Ex. 173).

[2] Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). When the carrier accepts the symptoms of a disease, however, it also accepts the disease causing that symptom. Georgia Pacific v. Piwowar, 305 Or 494, 501 (1988).

Here, the employer's September 4, 1987 acceptance did not identify a specific condition, but advised claimant that her claim for an "injury sustained August 4, 1987" had been accepted as a compensable disabling injury. (Ex. 30). The contemporaneous medical records identify two conditions, an injury and a degenerative disease. The emergency room report sets forth a history of a "pop" in claimant's left knee, with a diagnosis of "subluxing patella/chondromalacia." (Ex. 24). Dr. Whitney, who saw claimant six days later, also recorded a history of claimant having had "intermittent mild trouble with her knee" and feeling a "loud pop in her knee joint" with acute pain when she stood up from a squatting position at work. He diagnosed an "acute injury, possible torn meniscus" and "chondromalacia of the medial femoral condylar patella, well know[n]." (Ex. 27).

Considering the contemporaneous medical reports (particularly Dr. Whitney's description of a "possible meniscus tear" when referring to an "acute injury"), we conclude that the employer's acceptance of a disabling "injury" occurring on a specific date, did not encompass the known underlying, preexisting disease, chondromalacia of the left patella. Further, the employer's payment of compensation relating to the chondromalacia condition does not enlarge the scope of its acceptance. ORS 656.262(10).

employer is precluded from contesting the compensability of claimant's chondromalacia patella condition because it did not appeal the orders which awarded permanent disability based, in part, on the chondromalacia of the left patella.

In Messmer II, the court essentially affirmed its earlier decision, Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995) (Messmer I) under the amended version of ORS 656.262(10).[3] In Messmer I, an employer failed to appeal a Determination Order which had awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease. The court held that the employer's failure to challenge the permanent disability award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that the condition was not part of the compensable claim. The Messmer I court reasoned that although the employer had not accepted the degenerative condition,[4] it was barred by the doctrine of claim preclusion from denying that the degenerative condition was part of the compensable claim.

In Messmer II, the court held that the amendments to ORS 656.262(10) did not overrule its prior decision in Messmer I. Specifically, the Messmer II court found that because the amended statute provides only that payment of permanent disability benefits does not preclude an employer from subsequently contesting compensability and says nothing about the preclusive consequences of an employer's failure to appeal a determination order, the new law did not affect the reasoning or holding of Messmer I. The court further explained that even if the legislature had intended to overrule Messmer I, the court could not rewrite the statute to give effect to what the legislature may have intended.

In this case, the employer failed to contest the November 21, 1990 Determination Order as well as that portion of the December 3, 1991 Opinion and Order which awarded permanent disability benefits based on claimant's left patella chondromalacia condition. In finding claimant medically stationary on March 26, 1990, Dr. Bert specifically attributed "moderate impairment" to claimant's recurrent chondromalacia. (Ex. 76). The November 21, 1990 Determination Order awarded claimant 12 percent scheduled permanent disability for surgery and lost range of motion of the left knee. On claimant's appeal, that award was later increased to 17 percent by the December 3, 1991 Opinion and Order. The employer could have appealed the Determination Order and challenged the rating of claimant's left patella chondromalacia as a noncompensable, preexisting condition, but it did not do so. The employer instead subsequently stipulated that claimant was entitled a 17 percent permanent disability award for her left knee. (Ex. 173).

Accordingly, because the employer failed to contest the orders which awarded permanent disability benefits for claimant's left patella chondromalacia condition, it is now precluded from denying the compensability of that condition under Messmer II, supra. See also Roger L. Wolff, 48 Van Natta 1197 (1996).

Although ORS 656.262(6)(c) allows an employer to deny the compensability of a combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition, that section is premised on the insurer's or employer's "acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order." In this case, as discussed in footnote 2, supra, the employer never voluntarily accepted claimant's chondromalacia condition, nor was it directed to do so by litigation order. Therefore, ORS 656.262(6)(c) is not applicable.

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[3] In 1995, the legislature added the following sentence to ORS 656.262(10):

"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."

Like most of the 1995 amendments to Chapter 656, the amendments to ORS 656.262(10) apply retroactively. See Messmer II, supra, 140 Or App at 551, n 2.

[4] Like the ALJ and the Board, the court found that the employer had accepted a strain injury but not the underlying degenerative condition. Messmer I, supra, 130 Or App at 258.

For the reasons set forth above, we affirm that portion of the ALJ's order which set aside the employer's partial denial of claimant's chondromalacia condition.

Aggravation

The ALJ found that, since claimant's last arrangement of compensation for her left knee condition in 1991, she has experienced new synovial thickening, greater tenderness at the medial facet of the patella, reduced range of motion, a markedly positive inhibition sign, and additional patellar degeneration and roughness. The ALJ further determined that this worsening constituted an "actual worsening" under ORS 656.273(1) because it was pathological as well as symptomatic, and involved more than the waxing and waning of symptoms contemplated by claimant's prior award of 17 percent scheduled permanent disability.

On review, employer contends that the worsening of claimant's left knee condition is due to the progression of her preexisting chondromalacia of the left patella, which it asserts is not a compensable condition, rather than her accepted industrial injuries or subsequent work exposure. Since we have already concluded that the employer is precluded from contesting the compensability of claimant's left knee chondromalacia condition, we reject the employer's contention.

Under the aggravation statute, 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." ORS 656.273(1) (emphasis added).

In this case, as explained above, claimant's chondromalacia of the left patella has become a "compensable condition" by operation of law. Messmer II, supra. Because there is medical evidence supported by objective findings establishing an actual worsening of this condition, we adopt the ALJ's conclusion to set aside the employer's denial of claimant's aggravation claim.

Attorney Fee 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 8, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the employer.

August 26, 1996 Cite as 48 Van Natta 1723 (1996)

In the Matter of the Compensation of
DAVID L. REED, Claimant
WCB Case Nos. 95-12495 & 95-03760
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition; and (2) upheld the employer's denial of claimant's current low back condition. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. On page 2, we change the second paragraph to read: "On January 11, 1994, the claim was accepted for a lumbar strain." We do not adopt the last two paragraphs.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant compensably injured his low back on October 1, 1993. Dr. Peterson examined claimant on October 3, 1993 in the emergency department and diagnosed "[a]cute lumbosacral strain with right lower extremity radiation." (Ex. 3-3). Dr. Peterson reported that the "LS-spine" films showed "spondylolisthesis L4-5 with some extra calcifications noted, posterior elements, also some degenerative joint disease, but no acute changes." (Ex. 3-2).

Claimant was examined by Dr. Bowman, orthopedist, on October 7, 1993. Dr. Bowman reviewed claimant's x-rays and diagnosed a right sacroiliac strain and lumbar strain, "in the setting of a degenerative grade I retrolisthesis of L3 on L4, i.e., degenerative spondylolisthesis." (Ex. 7).

On January 11, 1994, the employer accepted a lumbar strain. (Ex. 25).

Claimant experienced increased low back symptoms on February 24, 1994, following snow shoveling activity. Dr. Bowman diagnosed an exacerbation of the previous lumbar strain. (Ex. 34). On March 23, 1994, Dr. Bowman released claimant to light duty. (Ex. 41).

On April 14, 1994, claimant was examined by Dr. Powell on behalf of the employer. Dr. Powell diagnosed "[l]umbosacral strain, acute, related, healed" and "[p]re-existing degenerative arthritis of L4-5, not aggravated." (Ex. 42). Dr. Powell reported that claimant had 4 % total body impairment. (Id.) Dr. Bowman concurred with Dr. Powell's report. (Ex. 46).

On May 4, 1994, Dr. Bowman reported that claimant had right hip pain, which was related to his degenerative spondylolisthesis. (Ex. 45).

A June 14, 1994 Determination Order awarded claimant 25 percent unscheduled permanent disability for his low back. (Ex. 49).

Claimant returned to Dr. Bowman in November 1994 for increased low back symptoms that occurred after he operated a forklift over a rough floor and was bounced around. (Tr. 9, Ex. 52). A myelogram and CT scan were performed on January 19, 1995. (Ex. 65). Dr. Bowman reported that the myelogram showed mild stenosis at L4-5 and central stenosis with some lateral recess stenosis. (Ex. 69). Dr. Bowman commented that claimant would need a fusion at some point and he referred claimant to Dr. Flemming. (Id.)

Dr. Flemming diagnosed chronic lumbar radicular syndrome associated with degenerative spondylolisthesis of L4 on 5 with L-4 and L-5 nerve root compromise. (Ex. 71). Dr. Flemming recommended a total decompressive laminectomy of L4 and L5 with a fusion of L4 to 5.

The employer denied claimant's aggravation claim on March 24, 1995 on the basis that claimant's October 1, 1993 work injury was not the major contributing cause of his current condition.

On October 12, 1995, claimant filed a claim for increased low back pain that occurred when he reached up over his head and lifted a box from a stack of boxes. (Ex. 84). On November 7, 1995, the employer denied claimant's current condition on the basis that the October 12, 1995 incident was not the major contributing cause of his current condition. (Ex. 88). Claimant requested a hearing on both denials.

The ALJ rejected claimant's argument that the acceptance of the October 1, 1993 injury encompassed degenerative joint disease and spondylolisthesis. The ALJ concluded that claimant's lumbar strain had not worsened since the last arrangement of compensation and claimant's compensable lumbar strain was not the major cause of his current need for treatment or disability.

Claimant argues that the degenerative joint disease and spondylolisthesis were part of his accepted industrial injury. According to claimant, since the preexisting degenerative joint disease and spondylolisthesis were identified before claim closure, were not denied and were "probably" rated in the June 14, 1994 Determination Order, those conditions must have been accepted as part of his low back injury. Claimant asserts that, by failing to appeal the Determination Order, the employer accepted the underlying degenerative conditions.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Here, the only condition that the employer specifically accepted in writing was a "[l]umbar strain." (Ex.25).

In Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995) ("Messmer I"), an employer failed to appeal a Determination Order which had awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease. The court held that, although an employer's payment of compensation, by itself, did not constitute acceptance of the degenerative condition, the employer's failure to challenge the award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that the condition was not part of the compensable claim. In Messmer I, the court reasoned that the result was not that the degenerative condition had been accepted; it was that the employer was barred by claim preclusion from denying that it was part of the compensable claim. Id at 258.

In Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) ("Messmer II"), the court reexamined the Messmer case in light of Senate Bill 369. The court found that amended ORS 656.262(10) said nothing about the preclusive consequences of an employer's failure to appeal a determination order. Rather, the court noted that the amended statute provides only that payment of permanent disability benefits does not preclude an employer from subsequently contesting compensability. Consequently, the court held that the amended statute, ORS 656.262(10), did not overrule its prior decision in Messmer I. Deluxe Cabinet Works v. Messmer, supra; Roger L. Wolff, 48 Van Natta 1197 (1996).

In Olson v. Safeway Stores, Inc., 132 Or App 424, 428 n.1 (1995), the court distinguished that case from Messmer I because the Board had not made a finding that the Determination Orders awarded compensation for a degenerative condition. The court found that "it [was] not obvious from [the] review of the determination orders and the evaluators' worksheets that the award included any compensation related to the degenerative condition." Id.

We agree with claimant that the preexisting degenerative joint disease and spondylolisthesis were identified before claim closure and the employer did not deny either of those conditions. However, unlike Messmer I, neither the June 14, 1994 Determination Order nor the evaluator's worksheet indicated that the unscheduled permanent disability award included any compensation related to the degenerative joint disease or spondylolisthesis.

The June 14, 1994 Determination Order awarded claimant 25 percent unscheduled permanent disability. (Ex. 49). The evaluator's worksheet referred to the accepted condition as lumbar strain. (Ex. 48). The worksheet indicated that 5 percent of the award was for claimant's "R.O.M." (range of motion) impairment and 20 percent was related to age, education and adaptability. The worksheet referred to the "R.O.M." as of April 14, 1994, which correlates with Dr. Powell's April 14, 1994 examination of claimant.

On April 14, 1994, Dr. Powell diagnosed "[l]umbosacral strain, acute, related, healed" and "[p]re-existing degenerative arthritis of L4-5, not aggravated." (Ex. 42). Dr. Powell commented that claimant had sustained a lumbosacral strain as the result of the October 1, 1993 injury that was superimposed on preexisting degenerative arthritic changes of L4-5. (Id.) Dr. Powell reported that claimant had "impairment of function from the range of motion studies and according to the *AMA Guides to the Evaluation of Permanent Impairment, Third Edition (Revised)*, this comes to 4% total body impairment, and this is related." (Id.) Dr. Bowman concurred with Dr. Powell's report. (Ex. 46).

Although claimant contends that the preexisting degenerative joint disease and spondylolisthesis were "probably" rated in the June 14, 1994 Determination Order, there is nothing in the evaluator's worksheet or Dr. Powell's April 14, 1994 report to indicate that claimant's permanent impairment was due to the preexisting conditions. To the contrary, Dr. Powell concluded that claimant's preexisting degenerative arthritis of L4-5 was not aggravated. (Ex. 42). Moreover, since Dr. Powell did not attribute claimant's back findings to causes other than the compensable low back injury, we construe the findings as showing that claimant's impairment was due to his compensable injury, not to the preexisting conditions. See Kim E. Danboise, 47 Van Natta 2163, on recon 47 Van Natta 2281 (1995).

Unlike Messmer I, this record is insufficient to establish that claimant's June 14, 1994 Determination Order awarded compensation for degenerative joint disease or spondylolisthesis. See Olson v. Safeway Stores, Inc., supra, 132 Or App at 428 n.1; Glow I. Meissner, 47 Van Natta 1486 (1995). Therefore, Messmer v. Deluxe Cabinet Works, supra, is not controlling.

Next, claimant contends that he suffered a symptomatic worsening of his compensable condition greater than that contemplated by the previous disability award.

ORS 656.273(1) requires proof of two elements in order to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." Peter J. LaFreniere, 48 Van Natta 988 (1996); Gloria T. Olson, 47 Van Natta 2348 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under amended ORS 656.005(7)(a). Id.

Claimant's compensable 1993 injury was accepted as a lumbar strain. (Ex. 25). Claimant's current condition following the June 14, 1994 Determination Order has been variously diagnosed as "an exacerbation of the same problem," "L-S strain with nerve root irritation," grade I degenerative spondylolisthesis of L4-5, mild stenosis at L4-5 and central stenosis with some lateral recess stenosis, and chronic lumbar radicular syndrome associated with degenerative spondylolisthesis of L4 on 5 with L-4 and L-5 nerve root compromise. (Exs. 52, 54-2, 69, 71). Since the current diagnoses contain elements of spondylolisthesis and stenosis as well as a lumbar strain, we conclude that claimant's current condition is not the same as his accepted 1993 condition. Therefore, claimant must first establish the compensability of his current condition. See Peter J. LaFreniere, supra; Gloria T. Olson, supra.

Claimant has degenerative joint disease and spondylolisthesis that preexisted his 1993 work injury. The opinions of Drs. Bowman, Flemming and Jessen establish that claimant's preexisting conditions combined with his compensable 1993 injury to cause or prolong his current disability and need for treatment. (Exs. 73, 76, 77, 79, 80, 82, 83). Therefore, in order to establish the compensability of his current low back condition, claimant must prove that the compensable 1993 injury is the major contributing cause of his current disability or need for treatment. ORS 656.005(7)(a)(B). Claimant relies on the opinions of his treating physicians, Drs. Flemming and Bowman.

According to Dr. Flemming, claimant's industrial injury was the "precipitating event" that caused him to seek medical attention and the industrial injury made the spondylolisthesis more symptomatic. At most, Dr. Flemming's opinions establish that claimant's work injury was the precipitating cause of his current back condition. That is insufficient to meet claimant's burden of proof. See Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995) (precipitating cause of worker's condition not necessarily major or primary cause of condition). Moreover, Dr. Flemming believed that the spondylolisthesis was the cause of claimant's symptoms that required medical treatment and he said that the surgery was required to treat the symptomatic spondylolisthesis. (Ex. 80-1). Dr. Flemming's opinions do not establish a compensable claim under ORS 656.005(7)(a)(B).

On June 12, 1995, Dr. Bowman reported that the major contributing cause of claimant's need for treatment was the industrial injury and the work activities that exacerbated his symptoms during his recovery. (Ex. 79). Dr. Bowman's deposition testimony, however, is inconsistent with that opinion. At a later deposition, Dr. Bowman agreed that the proposed surgery was directed at claimant's degenerative condition. (Ex. 83-6). Although Dr. Bowman initially reported that the industrial strain worsened the underlying condition, (Ex. 79), Dr. Bowman later testified that claimant's injury did not accelerate the degenerative process, but the injury made it more symptomatic and it accelerated claimant's need for medical treatment. (Ex. 83-6). Dr. Bowman testified that claimant's work injury did not increase any "slippage" and he commented that the degenerative condition probably would have continued, "irregardless." (Ex. 83-6, -7). Since Dr. Bowman did not explain the inconsistencies in his apparent change of opinion regarding causation of claimant's current low back condition, we attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987).

There are no other medical opinions that support compensability. Dr. Jessen did not agree that the major contributing cause of claimant's further need for treatment was due to the work injury. (Ex. 73-2). Rather, Dr. Jessen believed that claimant's later episodes were due to the natural progression of the degenerative process rather than the work-related injury. (Id.) Therefore, we conclude that claimant has failed to meet his burden of proving that his work activities were the major contributing cause of his current low back condition, and we affirm the ALJ's order.

ORDER

The ALJ's order dated February 8, 1996 is affirmed.

In the Matter of the Compensation of
ANTHONY J. McKENNA, Claimant
WCB Case Nos. 95-07570, 95-02480 & 94-07262
ORDER DENYING MOTION TO DISMISS
William E. Brickey (Saif), Defense Attorney
Bottini, et al, Defense Attorneys

Claimant has moved for an order dismissing Safeco Insurance Company's cross-request for Board review of Administrative Law Judge (ALJ) Thye's order. Contending that he received untimely notice of Safeco's request, claimant seeks dismissal of the cross-appeal, as well as sanctions under ORS 656.390. We deny the motion to dismiss.

FINDINGS OF FACT

On May 22, 1996, ALJ Thye issued an order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a L4-5 disc condition; (2) upheld Safeco's denials of claimant's aggravation and occupational disease claims for his low back condition; (3) set aside Safeco's denial of claimant's L4-5 disc condition; (4) declined to assess Safeco and SAIF penalties for alleged discovery violations; (5) declined to assess penalties for unreasonable denials; and (6) assessed Safeco a penalty for an untimely paid medical bill and travel expense reimbursement claim.

On June 14, 1996, claimant, pro se, mailed, by certified mail, a request for review of the ALJ's order to the Board. Claimant challenged the ALJ's May 22, 1996 order, as well as procedural rulings rendered by the ALJ in an April 18, 1996 Interim Order. Enclosed with claimant's request was a certificate of service attesting that claimant had mailed copies of his appeal to all parties and their representatives. On June 18, 1996, the Board mailed a computer-generated letter to the parties and their representatives acknowledging the request for review.

On June 21, 1996, the Board received Safeco's cross-request for review of the ALJ's order. Safeco challenged the ALJ's finding that its payment of a prior permanent disability award constituted acceptance of the L4-5 condition. Safeco's cross-request indicated that copies had been sent to claimant and to Safeco's claims examiner. Claimant received a copy of Safeco's cross-request on June 22, 1996.

On June 24, 1996, the Board mailed a letter to Safeco's counsel acknowledging the cross-request. Copies of the acknowledgment letter were also mailed to claimant, SAIF, and Safeco.

Thereafter, claimant moved for dismissal of Safeco's cross-request. Asserting that Safeco neglected to include a certificate of service by mailing along with its request and contending that Safeco's reason for seeking review was inadequately stated, claimant requests dismissal of the appeal, as well as sanctions under ORS 656.390.

CONCLUSIONS OF LAW

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). When one party timely requests Board review, the other parties have at least the remainder of the 30-day period and, in any event, no less than 10 days within which to cross-request review. ORS 656.289(3); Robert Casperson, 38 Van Natta 420 (1986). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice received within the statutory period. Argonaut Insurance v. King, 63 Or App 847, 852 (1983).

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

Here, the 30th day after the ALJ's May 22, 1996 order was June 21, 1996. Furthermore, the tenth day following claimant's June 14, 1996 request for Board review was June 24, 1996. Since Safeco's cross-request was filed with the Board on June 21, 1996 and because claimant acknowledges actual notice

of Safeco's appeal on June 22, 1996, we conclude that Safeco's appeal satisfied the filing and notice requirements of ORS 656.289(3) and 656.295(2).[1]

We also reject claimant's motion for dismissal of Safeco's cross-request based on an alleged "non-reason." To begin, since the requirement for a stated reason for requesting Board review is not jurisdictional, but rather prescribed as an informational aid, the failure to comply with OAR 438-011-0005(3) does not result in dismissal of a party's appeal. See Kimberly L. Murphy, 41 Van Natta 847 (1989). Likewise, the alleged merits of an appealing party's argument, or lack thereof, is of no relevance in determining our jurisdiction to consider the request for review. See Mike D. Sullivan, 45 Van Natta 990 (1993). Consequently, since Safeco has filed a valid cross-request for review of the ALJ's order, we are authorized to conduct our appellate review.

Finally, we acknowledge claimant's motion for sanctions under ORS 656.390 against Safeco for an allegedly frivolous appeal. Since consideration of that issue would be best left until such time as we conduct our review of the substantive record, we shall defer ruling on that motion.

Accordingly, claimant's motion to dismiss is denied. In light of these circumstances, the briefing schedule shall be revised as follows. Claimant's appellant's brief shall be due 21 days from the date of this order. Safeco's respondent's/cross-appellant's brief and SAIF's respondent's brief shall be due 21 days from the date of mailing of claimant's brief. Claimant's reply brief(s)/cross-respondent's brief shall be due 14 days from the date of mailing of Safeco's respondent's/cross-appellant's brief and 14 days from the date of mailing of SAIF's respondent's brief. Safeco's cross-appellant's reply brief shall be due 14 days from the date of mailing of claimant's cross-respondent's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] Had we found Safeco's cross-appeal statutorily defective, such a conclusion would not preclude it from contesting any portion of the ALJ's order to which it alleged it had been aggrieved. It is well-settled that, pursuant to our de novo review authority, 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). Thus, as long as claimant maintains his request for review of any portion of the ALJ's order, any other party can raise any issue even without a formal cross-request for review. Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983).

In the Matter of the Compensation of
TREVOR E. SHAW, Claimant
WCB Case No. 95-01654
ORDER ON RECONSIDERATION
Schneider, Hooton, Claimant Attorneys
Scheminske, et al, Defense Attorneys

The insurer requests reconsideration of our July 30, 1996 order that required the payment of a penalty due as a result of its alleged failure to pay temporary disability benefits on an open, accepted claim through the date of claim closure, where there was a final order finding no basis for the insurer to unilaterally terminate the payment of such benefits and awarding a penalty. The insurer contends that, because no amounts were due at the time our prior order became final, no penalty may be assessed. The insurer also points out that our order incorrectly stated that the claim was closed on February 17, 1995, rather than January 17, 1995.

We have nothing further to add to our prior order in regard to the penalty matter. However, the insurer is correct that the claim was closed on January 17, 1995. We therefore modify our order to indicate that the date of claim closure is January 17, 1995.

Accordingly, we withdraw our July 30, 1996 order in its entirety. On reconsideration, as modified herein, we republish our July 30, 1996 order. The parties' 30-day rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRADLEY H. BISHOP, Claimant
WCB Case No. 96-04028
ORDER OF DISMISSAL (REMANDING)
Galton, Scott & Colett, Claimant Attorneys
Scheminske, et al, Defense Attorneys

The Board has received the insurer's request for review of Administrative Law Judge (ALJ) Otto's July 22, 1996 "Order Denying Motion for Suspension of Hearing." Because we conclude that the ALJ's order is not a final order, we dismiss the request for review.

FINDINGS OF FACT

Claimant requested a hearing to appeal the insurer's April 15, 1996 denial of his bilateral wrist condition. The hearing was set for July 24, 1996. On June 12, 1996, the insurer notified claimant that he was scheduled to be examined by its consulting physician, Dr. Radecki, on June 22, 1996. Claimant did not attend that examination.

On June 19, 1996, the insurer moved for suspension of the scheduled hearing on the ground that claimant refused to cooperate with its investigation of the claim by refusing to appear for the examination by Dr. Radecki.

On July 22, 1996, ALJ Otto issued his order denying suspension of the scheduled hearing. Citing ORS 656.262(14) and OAR 436-060-0140, the ALJ ordered that claimant was not required to cooperate with the insurer's preparation for litigation following issuance of its compensability denial. The order contained a statement explaining the parties' rights of appeal. The hearing was postponed and is currently awaiting docket assignment.

On August 21, 1996, the insurer requested review of the ALJ's July 22, 1996 order. On August 23, 1996, the Board issued a computer-generated letter to the parties acknowledging the request for review.

CONCLUSIONS OF LAW

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 which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Here, the ALJ's July 22, 1996 order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, notwithstanding the inclusion of a statement explaining the parties' rights of appeal, the order was interim in nature. Specifically, the ALJ's order merely denied suspension of the hearing.

As a result of the ALJ's July 22, 1996 order, further proceedings will be required to determine claimant's entitlement to and/or the amount of compensation. Inasmuch as further action before the Hearings Division is required as a result of the ALJ's order, we conclude that the order is not a final order. Allen H. Howard, 42 Van Natta 2706 (1990). Consequently, notwithstanding the statement regarding the parties' rights of appeal, we hold that jurisdiction to consider this matter continues to rest with the ALJ. Review of the procedural and substantive decisions reached by the ALJ in this case must await issuance of the ALJ's eventual final order (assuming that a party timely seeks Board review).

Accordingly, since jurisdiction to consider this matter continues to rest with the Hearings Division, the request for review is dismissed and this case is returned to the docketing unit for docket assignment and further action consistent with ALJ Otto's July 22, 1996 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TAMMY L. BLAKESLEE, Claimant
WCB Case Nos. 96-01359 & 95-08998
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Judy C. Lucas, (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) T. Lavere Johnson's order that upheld the SAIF Corporation's denial of her occupational disease claim for bilateral brachial plexopathies with thoracic outlet syndrome on the left and de Quervain's syndrome on the right. On review, the issue is compensability.

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

In 1988, while working at Smoke Craft as a laborer, claimant developed pain, swelling, cramping and numbness in both forearms. Smoke Craft's carrier accepted a claim for bursitis/arthritis of the right forearm, wrist and thumb, and bilateral carpal tunnel syndrome. Claimant underwent several release surgeries, and her claim was finally closed in October 1992.

In September 1991, claimant began working for SAIF's insured, Driver and Motor Vehicles Services (DMV), as an office assistant. From September 1991 until mid-1995, claimant's job duties primarily involved sorting, microfilming and shredding of documents. Claimant also lifted and carried boxes of paper and plastic tubs which, when filled with shredded material, weighed up to 20 lbs. In mid-1995, claimant transferred to the DMV warehouse, where she worked until her employment terminated on September 7, 1995. The warehouse position required lifting and carrying of storage boxes weighing up to 50 lbs, and overhead reaching and lifting.

Meanwhile, claimant's bilateral forearm symptoms continued. She sought treatment in April 1993 from Dr. Neuburg and in May 1995 from Dr. Warren, although neither doctor diagnosed her symptoms or made treatment recommendations.

On June 16, 1995, claimant made a claim with the DMV for her bilateral arm and hand pain. She contended that her symptoms were caused by her duties microfilming documents, which involved fast, repetitive use of her hands and arms.

On August 28, 1995, claimant began treating with Dr. Knox, who ultimately diagnosed her condition as bilateral brachial plexopathies with thoracic outlet syndrome on the left and de Quervain's syndrome on the right, based on EMG and nerve conduction studies done September 15, 1995.

The ALJ found that claimant failed to establish the compensability of her condition by a preponderance of the evidence. On review, claimant contends that Dr. Knox's opinion concerning the cause of claimant's current condition is sufficient to establish compensability under ORS 656.802. We disagree.

Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time. See Weiland v. SAIF, 64 Or App 810, 814 (1983). 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). Medical opinions that are not based on a complete and inaccurate history are not persuasive. Miller v. Granite Construction, 28 Or App 473, 476 (1977).

Like the ALJ, we find persuasive reasons not to rely on Dr. Knox's opinion in this case. First, although Dr. Knox is claimant's treating physician (for her arm and hand symptoms), he did not begin treating claimant until August 1995, years after her symptoms progressed. Therefore, Dr. Knox's opinion is not necessarily entitled to the deference ordinarily given to long-term attending physician's opinions. See, e.g., Cody L. Lambert, 46 Van Natta 115 (1996).

Second, it appears that Dr. Knox did not have an accurate understanding of claimant's history or her job duties at DMV. Dr. Knox reported that claimant's job entailed moving boxes weighing about 30-50 pounds for a ten hour shift 40 hours per week, whereas claimant testified that for all but the last three months of her employment, her duties involved mostly sorting, shredding and microfilming, with minimal lifting.[1] (Tr. 13, 29-32). Dr. Knox also believed that claimant had a history of "trauma" to her upper extremities and hands as a result of an on-the-job accident or injury occurring on or about December 2, 1988 (Exs. 36, 37-1, 37B). Yet, there is no evidence in the record that claimant's 1988 claim arose out of an accident or traumatic event. On the contrary, the evidence suggests that her compensable arm condition developed gradually, due to the repetitive motion required by her laborer job. (See Exs. 1, 2, 3).

Third, Dr. Knox determined that claimant experienced a work-related worsening of her preexisting condition.[2] (Ex. 37B). If that is so, then claimant's claim implicates the provisions of ORS 656.802(2)(b), and she must prove that her employment conditions were the major contributing cause of the combined condition as well as of a pathological worsening of the disease. See SAIF v. Jones, 138 Or App 484 (1996). Although Dr. Knox uses the "magic words" to attribute claimant's current condition to her work activity (Ex. 37-2), the record does not establish that claimant's work activity was the major contributing cause of a pathological worsening of her underlying, preexisting condition.[3] At best, therefore, Dr. Knox's opinion indicates that claimant's work caused a symptomatic worsening of a preexisting condition, which does not satisfy the statutory standard.

For the above reasons, we find Dr. Knox's opinion insufficient to carry claimant's burden of proof. We therefore uphold SAIF's denial.

ORDER

The ALJ's order dated March 29, 1996 is affirmed.

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[1] As is apparent from claimant's 801 form, her current symptoms developed while she was performing the microfilming duties, well before she transferred to the warehouse. (Ex. 29; See also Exs. 27, 28, 35).

[2] In fact, Dr. Knox referred to claimant's preexisting condition as "a major player" in terms of her current diagnosis, thereby undermining his opinion that claimant's work activity was the major contributing cause. (Ex. 37-2).

[3] On the contrary, Dr. Warren, who treated claimant between 1988 and 1992 (in connection with her 1988 claim) and saw her again in May 1995, reported no objective worsening of claimant's condition as a result of her microfilming activities at work. (Ex. 31).

In the Matter of the Compensation of
KENNETH G. ABEL, Claimant
WCB Case No. 95-09264
ORDER OF ABATEMENT
Myrick, Seagraves, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests abatement of our July 30, 1996 Order on Review which affirmed the Administrative Law Judge's (ALJ's) order that: (1) set aside its denial of claimant's psychological condition claim; and (2) awarded an assessed attorney fee of $7,000. Announcing that the parties have reached a settlement of their dispute, SAIF requests abatement of this matter pending submission of the proposed settlement. SAIF represents that claimant agrees that this matter should be abated.

Based on the representations in SAIF's motion, we withdraw our July 30, 1996 order. On receipt of the parties' proposed settlement, we will proceed with our review. In the meantime, the parties are requested to keep the Board fully apprised of any further developments in this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID S. LIVESAY, Claimant
WCB Case No. 95-04576
ORDER DENYING MOTION TO DISMISS
Roberts, et al, Defense Attorneys

Claimant, pro se, has requested review of Administrative Law Judge (ALJ) McKean's June 11, 1996 Opinion and Order. Questioning whether claimant's request was untimely filed, the self-insured employer seeks dismissal of the appeal. The motion for dismissal is denied.

FINDINGS OF FACT

The ALJ's Opinion and Order issued on June 11, 1996. Copies of the ALJ's order were mailed to claimant, the employer, its claims administrator, and their attorney. On July 31, 1996, the Board received claimant's undated 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, its claims administrator or their attorney. The envelope in which claimant's request was mailed carried a postmark date of July 10, 1996.

A computer-generated acknowledgment of claimant's request for review was mailed by the Board on August 1, 1996. Copies were mailed to all parties to the proceeding and their representatives.

Thereafter, the employer's counsel moved for dismissal of claimant's request for review. Counsel acknowledged that he and the claims administrator had received a copy of claimant's request on July 12, 1996 and July 11, 1996 respectively. (Counsel further represented that the envelope received by the claims administrator carried a July 10, 1996 postmark date.) Questioning whether claimant's request had been timely filed with the Board, the employer sought dismissal of the appeal, if appropriate.

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). The failure to timely file and serve all parties with a request for Board review requires dismissal. Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992). "Party" means 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(21). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986).

Here, noting that the Board received claimant's request for review more than 30 days after the ALJ's June 11, 1996 order, the employer questions our authority to review this appeal. We hold that claimant's request satisfies the statutory requirements of ORS 656.289(3) and 656.295(2). We base this conclusion on the following reasoning.

The 30th day after the ALJ's June 11, 1996 order was July 11, 1996. The Board did not receive claimant's request for review until July 31, 1996. Nevertheless, the envelope which contained claimant's request bears a postmark date of July 10, 1996. This date coincides with the date marked on the envelope received by the claims administrator. Such circumstances persuade us that claimant's request was mailed to the Board on July 10, 1996. Since that date is within 30 days of the ALJ's June 11, 1996 order, we conclude that the request was timely filed. ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(a); Patrick L. Oswalt, 48 Van Natta 1556 (1996).

We apply similar reasoning in determining that notice of claimant's appeal was timely provided to the employer. Based on the employer's counsel's acknowledgment that the employer's claims administrator received a copy of claimant's request on July 11, 1996, which was contained in an envelope with a postmark date of July 10, 1996, we are persuaded that a copy of claimant's request for review was mailed to and received by the employer prior to expiration of the aforementioned 30-day period. Harold E. Smith, 47 Van Natta 703 (1995). Consequently, claimant provided timely notice of his appeal to the other party to the proceeding. ORS 656.289(3); 656.295(2).

Accordingly, the employer'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.

August 28, 1996 Cite as 48 Van Natta 1733 (1996)

In the Matter of the Compensation of
ANDREW D. KIRKPATRICK, Claimant
WCB Case No. 95-00554
ORDER ON RECONSIDERATION
Coons, Cole, et al, Claimant Attorneys
Lundeen, et al, Defense Attorney

Claimant requests reconsideration of our July 3, 1996 order which upheld the insurer's denial of claimant's aggravation claim. Specifically, claimant objects to our conclusion that he did not establish an "actual worsening" under ORS 656.273(1). In addition, claimant seeks en banc review by the Board.

On July 29, 1996, we abated our July 3, 1996 order and granted the insurer an opportunity to respond to claimant's motion. Having received the insurer's response, we proceed with our reconsideration.

Claimant asserts that our order improperly relied on the physicians' failure to use "magic words" as the basis for finding that claimant's biceps weakness did not represent a pathological worsening of his compensable cervical condition. It is not required that medical evidence consist of a specific incantation or that it mimic statutory language. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991). However, the medical evidence must otherwise support the conclusion that the legal standard has been met. Id.

Here, we are not persuaded, based on Dr. Boespflug's opinion or any of the other medical evidence, that claimant's compensable condition has pathologically worsened. As we found in our previous order, the record establishes that claimant had "questionable" biceps weakness prior to claim closure. Thus, Dr. Boespflug's finding of biceps weakness does not, without more, persuade us that claimant's condition has pathologically worsened. Under the circumstances, we find a failure of proof.

Claimant's other contentions were adequately addressed in our July 3, 1996 order.

With respect to claimant's request for "en banc" review by the Board, we deny that request. Although the Board may sit en banc in rendering a decision, the act or decision of any two members shall be deemed the act or decision of the Board. ORS 656.718(2). Whether a case is reviewed en banc is a matter that the Board decides on its own motion. After reviewing this case, claimant's request for an en banc review is denied. See Mark Ostermiller, 46 Van Natta 1785 (1994) (on reconsideration).

On reconsideration, as supplemented herein, we republish our July 3, 1996 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
TRICIA R. POWELL, Claimant
WCB Case No. 95-09597
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Moller and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of claimant's occupational disease claim for her hearing loss condition. On review, the issue is compensability.

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

On review, claimant argues that the ALJ should have relied on the opinion of audiologist Croly, rather than the opinion of Dr. Ediger. Claimant argues that Dr. Ediger's opinion does not take into account claimant's actual work exposure and the fact that she had to adjust her ear plugs during the workday. Claimant also argues that there are no other medical or non-work factors which have been identified that could have caused her hearing loss condition.

After reviewing the medical records, we agree with the ALJ that claimant has failed to meet her burden of proof. First, we find that, through his written report and his deposition, Dr. Ediger provided a persuasive, well-reasoned opinion that discusses claimant's hearing loss. Dr. Ediger testified that claimant's hearing loss had some features which differed substantially from noise-induced hearing loss. (Ex. 7B-6). Although Dr. Ediger was not certain of the cause of claimant's condition, he noted that claimant's hearing loss was asymmetrical, which is not typical for a noise-induced pattern. (Ex. 7B-52). Finally, after considering claimant's work conditions and the type of hearing protection claimant wore during work, Dr. Ediger was unable to conclude that work was the major contributing cause of claimant's condition.

Mr. Croly acknowledged Dr. Ediger's expertise in the field. Mr. Croly reviewed claimant's records and listened to her testimony, but did not examine claimant personally. Although Mr. Croly believed that claimant's condition was work-related, he did not discuss or rebut Dr. Ediger's findings regarding atypical hearing loss features. Finally, Mr. Croly testified that, with the noise levels and hearing protection described, claimant would not have had hearing loss unless it was due to some unique susceptibility or unknown cause. (Tr. 55).

As we have found Dr. Ediger's opinion to be the most persuasive medical opinion in the record, we agree with the ALJ that claimant has not met her burden of proof. Alternatively, we conclude that Mr. Croly's opinion does not establish compensability. Mr. Croly based his opinion on his understanding that claimant had not been subjected to any other source of noise exposure, other than at work. (Tr. 32). However, in the absence of affirmative proof that claimant's condition is caused by work exposure, her claim is not compensable. See, e.g., Ruben G. Rothe, 45 Van Natta 369 (1993); ORS 656.266.

ORDER

The ALJ's order dated February 9, 1996 is affirmed.

Board Chair Hall Specially Concurring.

Although compelled by the doctrine of stare decisis to follow our holding in Michael J. Galbraith, 48 Van Natta 351 (1996) (Board Chair Hall dissenting), I continue to believe that Galbraith was wrongly decided. In my view, a carrier's responsive pleading that the claimant is not entitled to relief (as was the case in Galbraith) or (as in this case) that the ALJ lacks jurisdiction to provide relief constitutes an express refusal to pay compensation on the ground that the injury or condition "otherwise does not give rise to an entitlement to compensation." In my view, the requirement of a "denied claim" under ORS 656.386(1) is satisfied in both instances.

In the Matter of the Compensation of
JENNIFER W. STOVER, Claimant
WCB Case No. 95-05436
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of claimant's upper respiratory condition claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for his finding that claimant saw Dr. Stiger on February 6, 1995.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked as a waitress for the last seven years in the same restaurant. Every month, the restaurant is sprayed to control cockroaches; apparently, the spray contains the chemical Dursban. Claimant normally was present during the application of the spray.

During the morning of February 6, 1995, the restaurant was sprayed in claimant's presence. Later that day, claimant began experiencing symptoms, feeling warm and light headed, with a strange feeling in her throat. The next day, claimant returned to work with increasing symptoms, including shortness of breath, loss of voice, and swelling in the neck; claimant sought treatment later that day.[1] Eventually, on February 9, 1995, claimant was admitted to the hospital, where she was treated by osteopath Dr. Rambousek and Dr. Kendregan, a pulmonary specialist.

Claimant asserts the spraying at work caused her condition that was treated in February 1995. Claimant relies on Dr. Kendregan's chartnotes that claimant "developed upper airway obstruction with probable laryngeal and pharyngeal swelling secondary to exposure," (Ex. 2AAA-1), as well as a report from osteopath Dr. Stiger, who previously treated claimant. According to Dr. Stiger, claimant's condition was an allergic reaction due to her chronic repeated exposure to the chemical sprayed at work; a "local irritation from the chemical"; or a combination of a viral infection and the irritation from the chemical. (Ex. 5).

Dr. Burton, toxicology specialist, examined claimant in April 1995 on behalf of SAIF. Dr. Burton found no causal relationship between claimant's symptoms and exposure to Dursban. (Ex. 3-8). First, according to Dr. Burton, claimant's symptoms were not consistent with exposure to Dursban, which typically consists of nausea, vomiting, diarrhea, abdominal cramping, salivation and bronchorrhea. (Id.) Furthermore, Dr. Burton indicated that substantial direct dermal exposure or ingestion would have been necessary to produce symptoms, and symptoms would have occurred immediately following exposure. (Id.) Instead, Dr. Burton found that claimant experienced a viral upper respiratory infection which resulted primarily in the symptom of laryngitis. (Id. at 9).

Dr. Burton later reviewed and responded to Dr. Stiger's report. According to Dr. Burton, none of the substances identified in the case are known to create sensitization or allergic response. (Ex. 6-2). Dr. Burton also disagreed with Dr. Stiger that claimant sustained laryngeal and pharyngeal irritation from chemical exposure, explaining that such a response "requires a relatively massive direct exposure," which did not occur, and the chemical to which claimant was exposed was not the type to cause such a response. (Ex. 6-2).

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[1] The record is confused concerning any treatment before February 9, 1995. The record contains no documentation that any physician examined claimant before she saw Dr. Rambousek on February 9, 1995. Claimant testified, however, that she first saw Dr. Rambousek on February 7. (Tr. 12). Chartnotes and documents in the record also refer to examinations on February 7 and February 8 (although the physician is not identified). (Exs. 2A-1, 2AA-1, 3-5). Based on this evidence, we find that claimant first sought treatment on February 7, 1995, from Dr. Rambousek.

We disagree with claimant that the evidence from Dr. Kendregan and Dr. Stiger is sufficiently persuasive to carry claimant's burden of proof. First, Dr. Kendregan's chartnote refers only to a "spray" used at claimant's work; there is no proof that he was aware of the particular chemical at issue in this case. In view of Dr. Burton's opinion that claimant's condition was not consistent with exposure to Dursban and that any exposure was not sufficiently extensive to cause a reaction, we find Dr. Kendregan's statement that claimant's condition was "secondary to exposure" inadequate to prove causation.

With regard to Dr. Stiger, as an osteopath, he lacks the expertise of Dr. Burton. Furthermore, there is no proof that he examined claimant. (See fn 1). Finally, we find Dr. Stiger's various theories of causation to have been persuasively rebutted by Dr. Burton.

Lacking persuasive medical opinion proving causation, we agree with the ALJ that the claim fails. ORS 656.005(7)(a); ORS 656.802(2).

ORDER

The ALJ's order dated March 1, 1996 is affirmed.

August 28, 1996 Cite as 48 Van Natta 1736 (1996)

In the Matter of the Compensation of
KENNETH E. MYERS, Claimant
WCB Case No. 96-00933
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that affirmed an Order on Reconsideration award of 8 percent (15.36 degrees) scheduled permanent disability for loss of use or function of each arm. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation.[1] Because the medical arbiter's examination was conducted closer in time to the reconsideration order and his report is a thorough and well-reasoned evaluation of claimant's permanent impairment, we rely on the arbiter's findings over those of Dr. McKinstry. See David Gonzalez, 48 Van Natta 376, 377 (1996).

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

ORDER

The ALJ's order dated May 3, 1996 is affirmed. For services on review, claimant is awarded an assessed fee of $1,000, payable by the insurer.

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[1] On July 29, 1996, claimant's attorney filed a "Reply Brief" with the Board. However, because claimant is the respondent on Board review, and he did not cross-request review of the ALJ's order, claimant is not authorized to file a Cross-reply Brief in this matter. Accordingly, we have not considered claimant's "Reply Brief" on review. See OAR 438-011-0020(2); Rosalie Naer, 47 Van Natta 2033 (1995).

In the Matter of the Compensation of
CHRISTOPHER C. CARSON, Claimant
WCB Case No. 96-00641
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Moscato, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that increased claimant's scheduled permanent disability award for loss of use or function of the right leg (knee) from 26 percent (39 degrees), as awarded by an Order on Reconsideration, to 33 percent (49.5 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the last sentence of finding No. 5 and finding No. 8.

CONCLUSIONS OF LAW AND OPINION

In 1985, claimant injured his right knee and underwent a partial medial menisectomy. Claimant also experienced a disruption of the anterior cruciate ligament (ACL), as a result of this noncompensable incident.

In October 1994, claimant compensably injured his right knee. The employer accepted a disabling torn lateral and medial menisci, and right calf hematoma. In 1995, he underwent a second surgery, in which the remainder of his medial meniscus and his entire lateral meniscus were removed. The claim was closed by a Notice of Closure issued June 20, 1995, awarding claimant 24 percent scheduled permanent disability for loss of use or function of the knee.

Claimant requested reconsideration, and a December 14, 1995 Order on Reconsideration increased his scheduled permanent disability award to 26 percent. Claimant requested a hearing, and the ALJ increased the award to 33 percent based on the combination of the following impairment factors: 20 percent for knee surgery; 10 percent for knee joint instability; 5 percent for a chronic condition; and 2 percent for lost range of motion.

On review, the employer challenges that portion of the ALJ's order awarding 10 percent for knee joint instability. Specifically, the employer argues that the mild mediolateral laxity of the right knee noted by the medical arbiter, Dr. DeWitt, is not ratable under the applicable standards. We agree.

The applicable rules provide that a worker is only entitled to a value for impairment that is caused by the accepted injury and/or its accepted conditions. Former OAR 436-35-007(1) (WCD Admin. Order 6-1992). To the extent the worker's impairment findings are partially due to the accepted injury and also due to unrelated and noncompensable causes, only the accepted compensable condition and worsenings, as defined by ORS 656.005(7)(a) and 656.273, are ratable. Former OAR 46-35-007(2). In addition, with regard to knee laxity, former OAR 436-35-230(3) (WCD Admin. Order 17-1992) provides in pertinent part that: "Knee joint instability, due to specific ligamentous injuries, is valued based on a preponderance of the medical opinion utilizing the following table: * * * ." (Emphasis added).

In this case, the medical arbiter diagnosed claimant's right knee instability as follows: "Mild mediolateral instability of the right knee, secondary to old anterior cruciate ligament tear and medically more probably than not mildly increased by the requirement for a total lateral and total medial meniscectomy, giving a degree of mediolateral instability due to the loss of these space occupying structures no longer present." (Ex. 67-8).

We understand from this report that claimant's knee joint instability is due to the preexisting, noncompensable ACL tear, "mildly increased" by the compensable loss of claimant's menisci. Although the medical arbiter's report indicates that claimant's current instability results from a combination of the

preexisting anterior cruciate insufficiency and the compensable injury, there is no medical evidence indicating that the accepted injury or its direct medical sequelae is the major contributing cause of the instability.[1] See ORS 656.005(7)(a)(B) (combined condition is compensable only if the otherwise compensable injury is the major contributing cause of the disability). In addition, there is no medical evidence indicating that claimant's knee joint instability is due to a specific, compensable ligamentous injury.[2] See former OAR 436-35-230(3). Therefore, on this record, we conclude that claimant is not entitled to a value for his right knee joint instability.

The employer does not request that the award be reduced below the 26 percent awarded by the Order on Reconsideration. Accordingly, we reverse the ALJ's order awarding 33 percent scheduled permanent disability for the right leg (knee) and reinstate and affirm the Order on Reconsideration award of 26 percent.

ORDER

The ALJ's order dated April 23, 1996 as amended May 8, 1996 is reversed. The Order on Reconsideration award of 26 percent (39 degrees) scheduled permanent disability for loss of use or function of the right leg (knee) is affirmed. The ALJ's "out of compensation" attorney fee award is also reversed.

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[1] Indeed, claimant's treating doctor, Dr. Harris, noted a positive anterior drawer sign and a positive pivot shift sign, resulting from the anterior cruciate insufficiency, as well as mildly increased valgas play, also due to the anterior cruciate insufficiency. (Ex. 47-3).

[2] The evidence establishes that the instability results in significant part from the noncompensable, preexisting ACL disruption. (Exs. 47-3, 67-8).

In the Matter of the Compensation of
JAMES M. KING, Claimant
WCB Case No. 93-06873
ORDER OF ABATEMENT
Ransom & Gilbertson, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of our August 8, 1996 Order on Remand. In our order, we continued to conclude that claimant failed to establish a compensable claim regarding the left leg blood clot condition that required surgery in February 1993. On reconsideration, claimant contends that our order failed to address an "on-the-record concession" made by the SAIF Corporation in closing argument. Claimant contends that the "concession" is dispositive of this case.

In order to allow sufficient time to consider the motion, we withdraw our August 8, 1996 order. SAIF is granted an opportunity to respond. To be considered, SAIF's response should be submitted within 14 days of the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
AYRIC F. DIERENFELD, Claimant
WCB Case No. 95-12703
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that affirmed an Order on Reconsideration which awarded claimant 26 percent (83.2 degrees) unscheduled permanent disability for his cervical condition. On review, the issue is extent of unscheduled permanent disability.

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

Relying on our decision in Joe R. Ray, 48 Van Natta 325 (1996), the ALJ declined to consider evidence presented at hearing, including testimony, which had not been made part of the reconsideration record. On review, claimant argues that he should be permitted, through testimony and other evidence, to establish his lost earning capacity and an accurate description of his prior job.

Subsequent to our decision in Ray, the court held that amended ORS 656.283(7) does not apply to exclude evidence that was previously and properly admitted at hearing, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996). Consequently, in light of the court's decision in Plummer, our holding in Ray has been overruled to the extent that evidence concerning the extent of an injured worker's permanent partial disability, that was properly admitted, can be considered on review.

Nevertheless, we have concluded that, where a hearing concerning extent of permanent disability was held after June 7, 1995, the prohibition on subsequent evidence set forth in amended ORS 656.283(7) is applicable. Dean J. Evans, 48 Van Natta 1092 (1996). Thus, we have continued to adhere to our holding in Ray in those cases where the hearing was held after June 7, 1995.

Here, the hearing was held on February 12, 1996. Because claimant's testimony was not submitted during the reconsideration process, we conclude that the ALJ did not err by declining to consider claimant's hearing testimony.

Claimant also challenges the validity of former OAR 436-35-007(3), which sets forth the method for calculating extent of disability whereby an offset is taken for prior awards of permanent disability. Claimant argues that the administrative rule is invalid because it conflicts with the applicable statutory provisions found in ORS 656.214(5). Specifically, claimant argues that the rule is inconsistent with the statute, because the rule allows the carrier an offset unless the workers' condition has "returned to a normal state" immediately prior to the more recent injury. Claimant contends that, pursuant to ORS 656.214(5), he is not required to establish that he has "fully recovered" in order to avoid the carrier taking an offset for a prior award. Rather, claimant argues that no offset should be allowed when his condition is "nearly normal" prior to the latest injury.

Having reviewed the rule in question, we conclude that it meets the concern raised by claimant and that it is not inconsistent with the statute. In this regard, the rule does not require that a claimant fully recover from the prior injury or disease before an offset of a prior award will be denied. Rather, the rule permits an offset unless the "condition or finding of impairment * * * has returned to a normal state." The term "returned to a normal state" does not mean the claimant has "fully recovered." Instead, the term means that "the condition or finding would not be recognized as an impairment under these rules."

Therefore, under the former rule, "full recovery" is not the standard for defeating an offset. Instead, an offset is not available if, prior to the most recent claim, the claimant's "condition or finding of impairment" has improved to the extent that "the condition or finding" would not give rise to ratable impairment under the standards. In this regard, the statute mandates application of the rating standards to determine loss of earning capacity, which, in turn, is the measure of disability.

We conclude that the requirement of the administrative rule is fully consistent with the statutory mandate of ORS 656.214(5), that the worker's degrees of post-injury disability be compared to the extent of the worker's disability before such injury and without such disability. See Buddenberg v. Southcoast Lumber, 316 Or 180 (1993) (application of rating standards not invalid even though claimant's condition has worsened, where extent of claimant's disability, as determined under the standards, was less than the extent of the disability for which claimant previously had been compensated under a former claim); see also Offill v. Greenberry Tank and Iron Co., 142 Or App 351 (1996)(OAR 436-35-007(3) is consistent with mandate of ORS 656.222 to consider prior permanent disability for which the claimant received an award and which had not resolved at time of second injury).

Finally, claimant disagrees with the ALJ's reliance on the DOT (Dictionary of Occupational Titles) category assigned by the Order on Reconsideration. The ALJ found that there was no evidence in the record regarding the job duties involved in claimant's self-employment. We disagree with that conclusion, as claimant's affidavit, which was part of the reconsideration record, constitutes some evidence of those job duties. In his affidavit, claimant proposed that his job duties are most accurately described by DOT 638.261-030 (machine repairer, maintenance).

However, after reviewing the remainder of the record, we do not find that claimant has established that the proposed DOT more accurately describes his computer consulting and repair duties in either his self-employed position or his work with the employer than the assigned DOT 828.261-022 (electronics, mechanic apprentice). See, e.g., Mary Hoffman, 48 Van Natta 730 (1986).

Consequently, we affirm the ALJ on the issue of extent of unscheduled permanent disability.

ORDER

The ALJ's order dated March 13, 1996 is affirmed.

In the Matter of the Compensation of
JAMES H. EISELE, Claimant
WCB Case No. 95-13371
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Galton's order that upheld the insurer's denial of his occupational disease claim for bilateral hearing loss. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the second paragraph, we change the first sentence to the following:

> Claimant started working for the employer in June 1984 as an engine mechanic, where he was exposed to loud noises. (Ex. 4-1). In approximately 1991, claimant began working in quality control, where he had "less intense noise exposure." (Id.)

Claimant argues that the ALJ erred in failing to apply the last injurious exposure rule to determine whether all of claimant's work activities, including past employment, were the major contributing cause of claimant's bilateral hearing loss. The insurer asserts that claimant failed to raise issues of the last injurious exposure rule and responsibility at hearing, and it argues that claimant may not raise those issues for the first time on review. Claimant responds that he is not raising a new issue by arguing the last injurious exposure rule applies, because that rule is only a method of proving that claimant's hearing loss was compensable as an occupational disease. We disagree.

In Manuel Garibay, 48 Van Natta 1476 (1996), the claimant litigated his case based solely on the theory that he proved an occupational disease claim against only the employer. Since the last injurious exposure rule was not raised, cited, or referenced at any time during the proceeding, we rejected the

argument that we should decide the case on such a theory. We held that, because the claimant joined only the employer, he had to prove that employment conditions with the employer were the major contributing cause of his carpal tunnel syndrome or its worsening.

We reach the same conclusion here. On December 5, 1995, the insurer denied compensability of claimant's bilateral hearing loss condition on the basis that his work exposure at the employer was not the major contributing cause of the overall hearing loss. (Ex. 6A). Claimant's request for hearing referred to the insurer's denial and raised issues of compensability and attorney fees. At hearing, claimant's attorney protested the insurer's December 5, 1995 denial and framed the issue as an occupational disease claim. (Tr. 3, 4). Claimant's attorney specifically said that there were no other issues. (Tr. 4).

In opening argument, claimant's attorney acknowledged that the record established that claimant had bilateral noise-induced hearing loss before he started working for the employer. (Tr. 5). Claimant's attorney argued that claimant suffered a progression of his hearing loss during his employment with the employer. (Id.) The insurer's attorney asserted that the case involved a "legal question concerning the test involving an occupational disease and a preexisting condition hurdle that we feel exists in [ORS] 656.005(7)." (Tr. 6). Consistent with this approach, the ALJ's Opinion and Order characterized the case as an "occupational disease claim based upon a worsening of claimant's pre-existing hearing loss condition[.]"

Claimant did not refer to the last injurious exposure rule at any time during the hearing, nor did he refer to any issues of responsibility. Since claimant raises these issues for the first time on review, we decline to address them. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). As in Manuel Garibay, supra, we resolve the issue on review as it has been characterized and litigated by the parties.[1] We agree with the ALJ that the medical evidence fails to establish that claimant's work exposure with the employer was the major contributing cause of his current hearing loss condition.

ORDER

The ALJ's order dated March 8, 1996 is affirmed.

[1] Although a signatory to this order, Chair Hall calls attention to his dissenting opinion in Manuel Garibay, supra, 48 Van Natta at 1478-82.

August 29, 1996 Cite as 48 Van Natta 1741 (1996)

In the Matter of the Compensation of
SANDRA E. POST, Claimant
WCB Case No. 95-07198
ORDER ON REVIEW (REMANDING)
Susak, Dean & Powell, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) upheld the self-insured employer's denial of claimant's bilateral upper extremity conditions; (2) declined to award penalties and attorney fees for an allegedly unreasonable denial; (3) declined to award penalties and attorney fees for allegedly unreasonable discovery violations. In her appellant's brief, claimant contends that the ALJ erred by declining to direct the employer to turn over surveillance tapes to claimant. On review, the issues are evidence, compensability, and penalties and attorney fees. We remand.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We do not adopt his Ultimate Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Prior to hearing, claimant requested a copy of any videotapes that the employer had made which showed claimant performing her work. (Ex. 11B). At hearing, claimant renewed her request. (Tr. 123, 131). The employer conceded that such a tape existed; however, the employer contended that it was not required to provide the tape, as the tape was "impeachment" evidence that was not offered at hearing.

In ruling that the tape did not need to be provided to claimant, the ALJ relied on OAR 438-007-0017(3). That rule provides:

> "Impeachment evidence consisting of medical or vocational reports not used during the course of the hearing must be provided to any opposing party at the conclusion of the presentation of evidence and before closing arguments are presented. Any other withheld impeachment evidence is not subject to disclosure."

The ALJ held that, because the videotape was withheld as impeachment evidence and was not a medical or vocational report, it was not subject to disclosure.

Subsequent to the ALJ's order, we issued our decision in Kenneth D. Legore, 48 Van Natta 1577 (1996). In Legore, the ALJ had concluded that surveillance videotapes were not subject to disclosure under amended ORS 656.283(7) because they constituted impeachment evidence other than medical or vocational reports. However, we noted that under OAR 438-007-0015(5), it is our express policy to promote full and complete disclosure, with the only exception being the withholding of "impeachment evidence." Additionally, we held that the court's decision in SAIF v. Cruz, 120 Or App 65 (1993), was still good law.

In Cruz, the carrier had argued that a taped interview was relevant only for purposes of impeachment. The court held that the Board erred in relying on the carrier's representations as to its intentions for using the claimant's statement. Consequently, the court held that the Board was required to make an independent evaluation to determine whether the evidence was relevant only for impeachment purposes. SAIF v. Cruz, supra.

Because the ALJ in Legore had not viewed the withheld videotapes in camera before ruling that they were impeachment evidence[1] and, therefore, not discoverable, we remanded the case to the ALJ to determine whether the tapes were "impeachment evidence" only, or relevant and material for other purposes.

In the present case, the ALJ similarly did not view the tape. Rather, the ALJ relied on the employer's representation that the tape was impeachment evidence. (Tr. 133). Accordingly, as in Legore, we conclude that this matter must be remanded to the ALJ.[2]

Because we are remanding the case to the ALJ with instructions to view the videotape to determine whether it constitutes "impeachment" evidence only, or is relevant and material for other purposes, we do not address the other issues raised on review. Therefore, we vacate the ALJ's order and remand the case to ALJ Thye for further proceedings consistent with this order. Those proceedings may be conducted in any manner the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] In Legore, we noted that case law defines "impeachment" of a witness as attacking or discrediting the witness, or evidence that tends to destroy a witness or claimant's credibility in the estimation of the trier of fact. Simpson v. Sisters of Charity of Providence, 284 Or 547 (1978); State v. Johanesen, 319 Or 128, 130 n.2 (1994).

[2] We acknowledge that the Legore case involved the application of Board rules that are no longer in effect. However, the employer concedes, and we agree, that the Board's current rule, OAR 438-007-0017(3) incorporates language similar to the amended statute, ORS 656.283(7), which we relied upon in Legore. Accordingly, our decision remains the same under either version of the rules.

In the Matter of the Compensation of
SALLY M. SHINKLE, Claimant
WCB Case No. 94-14542
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of her claim for a L4-5 disc herniation. 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 paragraph (page 3 of the order) and the Findings of Ultimate Fact. We briefly summarize the pertinent facts as follows:

Claimant, a hotel employee, compensably injured her low back at work on March 1, 1987, while pulling a bed away from a wall. An April 1987 CT scan of the lumbar spine showed a moderate degenerative response and slight central bulging of the L4-5 and L5-S1 intervertebral discs. On May 22, 1987, SAIF accepted a "mild central annular bulge at L4-5 and L5-S1, without herniation."

Despite conservative treatment, claimant's low back symptoms continued. In the fall of 1987, claimant decided to withdraw from the work force. A Determination Order issued January 14, 1988, awarding claimant 30 percent unscheduled permanent disability for her bulging disc condition. A stipulated order entered June 14, 1988 increased claimant's unscheduled award to 40 percent.

Claimant continued to experience intermittent low back pain over the next few years. In 1992, she was treated with Prednisone, which provided relief from her symptoms. In February 1993, her doctor substituted Lodine for the cortisone, which also provided relief.

On July 23, 1994, claimant awoke with severe lumbar pain and was unable to walk or lay comfortably. She sought treatment and was diagnosed with a herniation at L4-5. Dr. Purtzer performed fusion surgery on July 28, 1994.

CONCLUSIONS OF LAW AND OPINION

Relying primarily on the opinion Dr. Woolpert,[1] the ALJ determined that claimant's preexisting degenerative condition was the major cause of her subsequent disc herniation at L4-5 and need for surgery in 1994 and upheld SAIF's denial of medical treatment. On review, claimant argues that Dr. Woolpert's opinion is entitled to little weight because it is contrary to the law of the case. Claimant urges us to rely instead on the opinion of her long-term treating physician, Dr. Purtzer, that her 1987 accepted injury is the major cause of her disc herniation. As explained below, we conclude that claimant has sustained her burden of proof and that her disc herniation treatment is compensable.

Dr. Purtzer, who has treated claimant's low back symptoms since August 1987 and performed the fusion surgery in 1994, has identified the work injury as a "significant contributory factor" to claimant's need for surgery. (Ex. 40). Dr. Purtzer reported that although claimant had preexisting, underlying degenerative disc disease, she suffered an injury to her L4-5 disc in her March 1, 1987 industrial accident. He further explained that this damage to the disc eventuated in the rupture that occurred in July 1994. Dr. Woolpert, on the other hand, reported that the major contributing cause of claimant's 1994 disc herniation was the progression of her preexisting degenerative disc disease. Unlike Dr. Purtzer, Dr. Woolpert reported that the bulging discs diagnosed in 1987 were secondary to claimant's preexisting degenerative disease rather than her on-the-job injury.

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[1] Dr. Woolpert examined claimant at SAIF's request in December 1987, and performed a records review in September 1994.

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). However, absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician because of his or her opportunity to observe the claimant over an extended period of time. Weiland v. SAIF, 64 Or App 810 (1983).

In this case, we give the most weight to Dr. Purtzer's opinion because it is well-explained and based on an accurate history. In the same regard, we reject Dr. Woolpert's opinion because it is contrary to the law of the case.[2] See Kuhn v. SAIF, 73 Or App 768 (1992) (when the claimant had previously established that permanent disability arose out of industrial accident, doctor's opinion in subsequent aggravation proceeding that disability was result of congenital condition was held contrary to the law of the case). Based on Dr. Purtzer's expert medical opinion, we conclude that claimant's 1987 accepted injury is the major contributing cause of her L4-5 disc herniation and need for surgical treatment.[3] We therefore set aside SAIF's denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated November 21, 1995 as reconsidered March 22, 1996, is reversed. SAIF's November 15, 1994 denial is set aside, and the medical services claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,200, payable by SAIF.

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[2] Dr. Woolpert has opined that claimant's bulging discs were secondary to her disc deterioration in spite of the fact that SAIF specifically accepted the bulging discs as arising from the March 1, 1987 incident. (See Exs. 6, 19). In his deposition, Dr. Woolpert acknowledged that if he assumed that the accepted 1987 work injury caused claimant's disc bulges, then the major cause of claimant's subsequent disc herniation and need for treatment would be the 1987 work injury, since the disc herniation is a progression of the disc bulge at L4-5. (Ex. 46-16).

[3] Because we are persuaded by Dr. Purtzer's causation opinion, we do not address claimant's alternative argument based on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), and Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995).

In the Matter of the Compensation
FRANK L. BUSH, Claimant
Own Motion No. 93-0149M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

The self-insured employer requests reconsideration of our June 27, 1996 Own Motion Order (as reconsidered on July 10, 1996), which: (1) directed the employer to pay temporary disability compensation recommencing November 17, 1995 until such compensation could be lawfully terminated; and (2) assessed a penalty for unreasonable claims processing, payable in equal shares to claimant and his attorney. The employer requests that we vacate those portions of our June 27, 1996 order which: (1) allow temporary disability from November 17, 1995 forward (on a procedural basis); and (2) order a penalty to be paid for improper claims processing. On reconsideration, we adhere to the conclusions reached in our June 27, 1996 order that claimant is entitled to additional procedural time loss in his 1982

neck claim, and that the employer was unreasonable in its claim processing. However, we modify the temporary disability award and penalty assessment in this matter.[1]

On March 25, 1993, we authorized the reopening of claimant's 1982 left shoulder/cervical injury claim, beginning the date claimant was hospitalized for proposed surgery. The employer points out that, in our June 27, 1996 order, we erred in our Finding of Fact which stated that it terminated temporary disability compensation in the 1982 claim.

On reconsideration, in lieu of that finding, we find temporary disability compensation was being paid to claimant under a pending 1995 low back claim. See *Exhibit 119-5*. When the employer denied the low back claim, it terminated time loss in that claim. Although that fact affects our findings relative to termination of time loss in the neck claim (because the employer had not reinstituted time loss in the neck claim following its 1995 low back denial), it does not alter our finding that claimant is entitled to procedural temporary disability compensation in the still-reopened and unclosed neck claim, nor does it persuade us that the employer reasonably processed this claim. We base these conclusions on the following reasoning.

In our prior order, we noted that, pursuant to ORS 656.268 and our rules, a carrier may not terminate temporary disability in an open claim until a claimant has satisfied one or more criteria in ORS 656.268(3). Here, claimant did return to regular work during the time his claim was still reopened. Therefore, the employer was initially justified in terminating time loss at the time claimant returned to regular work.

However, prior to closure of the claim, claimant was subsequently released from work due, in part, to the neck condition. Thus, even though claimant had returned to work and his temporary disability properly terminated, because the neck claim had not been closed when he was again taken off work due to his neck condition, we hold that the employer was obligated to reinstate his temporary disability compensation.

We distinguish the circumstances in this case from those in Pamela Vinyard, 48 Van Natta 1442 (1996) In Vinyard, we held that, because claimant had met the requirements for own motion reopening set forth in ORS 656.278 and our rules (including the requirement that her compensable condition worsened requiring surgery or hospitalization), her entitlement to temporary disability compensation flows from our statutory authority to reopen a claim under ORS 656.278, rather than by means of an attending physician's work release under ORS 656.262(4).

Here, claimant's neck claim was already reopened, and, as a result of our order reopening the claim, temporary disability was being paid on that claim until claimant returned to work. However, the employer did not close the claim pursuant to our rules and our March 25, 1993 order when claimant was subsequently again restricted from work due to the 1982 compensable neck injury. As the claim was in reopened status, the employer was obligated to reinstate time loss payments until the claimant again meets one or more of the criteria in ORS 656.268(3). OAR 438-012-0035.

In other words, the present issue is not whether the claim should be "reopened." Were that the case, claimant would be required to satisfy the requirements of ORS 656.278(1). Instead, at issue in this case is claimant's procedural entitlement to temporary disability in an already reopened and unclosed claim. Resolution of that issue is dependent on a carrier's "pre-closure" compliance with statutory and administrative claim processing requirements.

The employer contends that, because it did not pay time loss under the neck claim (from September 8, 1995 through November 17, 1995), "there was no procedural error in stopping temporary disability benefits on the low back claim." We have no quarrel with the employer's contention insofar as it concerns the back claim (which we have no authority to address pursuant to our Own Motion jurisdiction). However, in the absence of a Notice of Closure closing claimant's neck claim at that time, we disagree with the employer's assumption that it was not procedurally bound to then commence time loss payments in the open neck claim after it terminated the benefits in the back claim if the events which authorized the termination of benefits under the reopened neck claim no longer existed, i.e.,

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[1] Claimant also seeks review of the employer's July 3, 1996 Notice of Closure contending that his claim was prematurely closed. Inasmuch as the present case pertains to "pre-closure" issues, we have continued with our review of this dispute. Claimant's appeal of the Notice of Closure (and any accompanying issues) will be considered in a separate order issued this date, as the parties have submitted evidence and argument regarding claimant's appeal of that closure.

when the employer stopped paying temporary disability under the low back claim in November 1995, claimant was not released nor had he returned to regular or modified employment.

Further, the employer asserts that "[t]ime loss benefits were not reinstituted in the 1982 claim, and it is the employer's contention that substantive time loss would not be due again unless the claimant went in for surgery or was due time loss through some other lawful entitlement." Yet, because this own motion claim was already in reopened status, claimant would not be required to "re-prove" entitlement to reopening under ORS 656.278 in order to trigger the resumption of temporary disability. See Rodgers v. Weyerhaeuser, 88 Or App 458 (1987) (the claimant need not prove a new worsening when he became "non-medically stationary" prior to claim closure). Instead, consistent with the Rodgers rationale, the circumstances which prompted the prior termination of temporary disability under the neck claim in accordance with our 1993 order no longer existed. See OAR 438-012-0035.

Our conclusion is based on the following facts. Noting claimant's worsening cervical, thoracic and lumbar pain, Dr. Altrocchi released him from working August 17 and 18, 1995. *(Exhibit 85)*. On August 28, 1995, Dr. Altrocchi released claimant to light duty for the indefinite future. *(Exhibit 93)*.

Claimant filed a claim for lower back injury on August 22, 1995. The employer completed a 1502 form on September 27, 1995, noting that claimant had not returned to work since September 8, 1995. On October 5, 1995, Dr. Altrocchi took claimant off work because of neck and back pain until November 15, 1995.

On November 6, 1995, Dr. Maloney became claimant's treating physician. Based on claimant's lumbar and cervical pain, Dr. Maloney released him to sedentary / modified work (four to eight hours per day). *(Exhibit 103)*. Throughout November 1995, Dr. Maloney continued to monitor claimant's condition and to institute restricted work limitations for claimant's neck and lower back pain.

On December 15, 1995, claimant returned to Dr. Newby, who opined that "[a]t the present time, [claimant] is not working and is not medically stationary." Diagnosing "cervical spondylosis," Dr. Newby prescribed a home cervical traction device. Dr. Newby also noted that claimant exhibited "suboccipital tenderness and markedly restricted range of motion of [claimant's] neck and low back."

On January 22, 1996, Dr. Maloney addressed claimant's neck condition, and opined that:

> "Work restrictions I would place this claimant on as a result of the neck condition alone include release within a sedentary/light work range. I have not release[d] the claimant to return to regular work in so far as the neck condition is concerned."

In a January 29, 1996 chart note, Dr. Newby opined that "we have released him to sedentary / light-duty work at the mill as it relates to his neck." On February 26, 1996, Dr. Newby opined that claimant "may not return to work." (See February 26, 1996 Work Release)

Dr. Altrocchi released claimant from work from October 5, 1995 through November 15, 1995. Claimant was released to modified work by Dr. Maloney, his then-attending physician, on November 16, 1995, but was held off all work until November 21, 1995. Dr. Newby declared claimant non-medically stationary on December 15, 1995.

As in our prior order, we continue to rely on the opinions of Drs. Altrocchi, Maloney and Newby, who opined, through objective assessment, that claimant's current conditions included neck and back pain, and that claimant's neck condition was responsible for work releases commencing October 5, 1995.[2] Claimant was paid temporary disability compensation under the back claim through November 17, 1995, when the employer denied the back claim and terminated time loss for claimant's back condition.

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[2] The employer raises the "concern" that Dr. Altrocchi's "decision to disassociate himself from the claimant and further treatment" should affect our decision to rely on his opinion regarding claimant's medical status. Dr. Altrocchi began treating claimant in March 1995 for "headaches." He continued treating claimant for seven months. In the absence of an express reason for this disassociation, we decline to infer from the record that Dr. Altrocchi's medical opinions should be discounted.

It appears that the employer chose to pay time loss for claimant's cervical, thoracic and lumbar conditions under the "new injury" back claim from September 8 through November 17, 1995. On November 17, 1995, it terminated temporary disability in the back claim because it issued a denial of claimant's current back condition. However, the attending physician (now Dr. Maloney) continued to restrict claimant's work activities because claimant continued to suffer from the neck condition. In other words, based on the Rodgers rationale, the employer should have commenced payment of temporary disability compensation in the still-reopened neck claim on November 18, 1995. Although the termination of such benefits was initially warranted under our 1993 "reopening" order when claimant returned to work in 1993, those payments should have recommenced under the still-unclosed neck claim when the events which justified the prior termination no longer existed. See OAR 438-012-0035.

In light of such circumstances, we modify our June 27, 1996 order as follows. Our Findings of Fact should indicate that the employer paid time loss benefits under the 1995 back claim through November 17, 1995, when such payments were terminated. Thereafter, the employer was required to recommence the payment of temporary disability under the neck claim.

However, the payment of "pre-closure" (or "procedural") temporary disability may not be ordered beyond claimant's substantive entitlement to temporary disability, which is determined upon closure of the claim. See Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992); Dan D. Cone, 48 Van Natta 520, 523 (1996). The employer closed claimant's neck claim by Notice of Closure dated July 3, 1996. By order issued this date, we modified the employer's Notice of Closure to award temporary disability from August 17, 1995 until June 19, 1996 (claimant's medically stationary date), with an offset allowed for any payment for time worked and any concurrent payment of temporary disability under the "new injury" claim involving the low back. Thus, as a result of our order, claimant's substantive entitlement to temporary disability ended as of June 19, 1996. We are not authorized to impose a "procedural" overpayment by ordering the employer to pay temporary disability beyond the date that claimant is substantively entitled to such benefits. See Lebanon Plywood v. Seiber, supra; Dan D. Cone, supra. Accordingly, we modify our prior orders to direct the employer to pay temporary disability due and owing from November 18, 1995 until June 19, 1996.

We turn to a reassessment of the penalty award made in our prior order. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier is liable for an additional amount of 25 percent of the amounts "then due." 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); 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 carrier at the time of its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 12, 126 n. 3 (1985). Although we may not impose a "procedural" overpayment of temporary disability, we may assess a penalty based on amounts of "procedural" temporary disability due and owing through the date of claim closure. See Lebanon Plywood v. Seiber, supra.

When the employer terminated claimant's temporary disability under the "new injury" claim on November 17, 1995, claimant remained released from work by Dr. Maloney due to his lumbar and cervical pain. Under such circumstances, we do not find that the employer had a "legitimate doubt" as to its liability to recommence temporary disability in the still-reopened neck claim when it terminated temporary disability in the back claim.[3]

Therefore, the penalty assessed in our prior order is reinstated and shall be based on amounts of temporary disability due and payable from November 18, 1995 until the date of claim closure (July 3, 1996). ORS 656.262(11)(a). Finally, we republish that portion of our prior orders that allowed claimant's attorney an approved fee payable out of the increased compensation created by our orders, not to exceed $1,050, payable directly to claimant's counsel. OAR 438-015-0010(4); 438-015-0080.

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[3] Because claimant was released to modified work during several periods of this open claim, if claimant did not return to regular work, he is entitled to temporary partial disability during those times. ORS 656.212. During those times that claimant was released from all work, he is entitled to temporary total disability until he is released to modified work or satisfies one of the criteria in ORS 656.268(3).

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our June 27, 1996 and July 10, 1996 orders in their entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

August 30, 1996 Cite as 48 Van Natta 1748 (1996)

In the Matter of the Compensation of
FRANK L. BUSH, Claimant
Own Motion No. 93-0149M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Claimant requests review of the self-insured employer's July 3, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from April 7, 1993 through September 1, 1993. The employer declared claimant medically stationary as of June 19, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. In the alternative, claimant contends that he is entitled to additional temporary disability benefits from November 17, 1995 through the medically stationary date.[1]

FINDINGS OF FACT

On March 25, 1993, the Board reopened claimant's 1982 injury claim for the payment of temporary disability compensation commencing the date claimant underwent surgery for the compensable injury.

Claimant underwent cervical surgery on April 7, 1993. On August 11, 1994, Dr. Newby, claimant's treating physician, declared claimant medically stationary. Claimant returned to work. The employer paid temporary disability compensation from April 7, 1993 through September 1, 1993, but it did not close the claim.

Claimant began treating for his cervical, thoracic and lumbar conditions in March 1995. Claimant filed a "new injury" back claim with the employer. The employer paid temporary disability on the new injury claim until November 17, 1995, when it denied claimant's back claim. The employer did not close the 1982 neck claim, nor did it commence the payment of temporary disability compensation in the 1982 claim.

From March 1995 through July 1996, claimant's treating physicians opined that he was disabled due to cervical, thoracic and lumbar pain. However, claimant continued to work until August 17, 1995, when Dr. Altrocchi took him off work for two days.

In a June 11, 1996 chart note, Dr. Newby, claimant's treating physician, diagnosed claimant with cervical and lumbar spondylosis, and opined that claimant "is medically disabled, not working and not medically stationary." Dr. Newby further opined that surgical intervention was not warranted at that time.

In a June 19, 1996 response to an April 3, 1996 letter from the employer, Dr. Newby indicated that he agreed that, without additional surgery, claimant's condition would be considered medically stationary, as no material improvement would be expected without additional treatment. The employer's letter advised Dr. Newby that the employer was "concerned that [claimant] could simply

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[1] On a preliminary matter, in an order issued this date, we corrected our "misstatement" that claimant was receiving temporary disability compensation in the 1982 claim until November 17, 1995, and acknowledged that claimant was receiving those benefits under the "new injury" claim. However, notwithstanding that modification, we adhered to our June 27, 1996 decision that claimant was entitled to procedural temporary disability compensation under the 1982 claim commencing November 18, 1995 until those benefits could be lawfully terminated. In addition, we affirmed our penalty assessed for unreasonable claims processing, and ordered that the penalty be assessed and payable from November 17, 1995 until the date of our second reconsideration order. Finally, we republished that portion of our order that allowed claimant's attorney an approved fee payable out of the increased compensation ordered by our July 10, 1996 order, not to exceed $1,050.

defer any potential treatment for the neck condition and claim entitlement to time loss benefits while he is thinking [about additional surgery]." That letter further advised Dr. Newby that, if he signed the "opinion," he agreed that "in respect to [claimant's] cervical spine condition, it may be considered medically stationary pending any change in his condition or renewed request for potential surgical treatment."

In a July 1, 1996 chart note, Dr. Newby summarized a telephone conversation with the employer as follows:

> "I spoke with [the employer's counsel], and he received my letter from June 19 stating that [claimant] was medically stationary at that point since more active medical treatment, i.e. surgery, was not being planned. I concur with this plan and feel that declaring [claimant] medically stationary as of June 19, 1996, is appropriate."

On July 1, 1996, claimant filed a disability claim with the employer. In his statement, claimant contended that he had been continuously disabled since September 8, 1995 with spine degeneration and cervical pain as a result of his employment.

On July 3, 1996, the employer closed the claim, declaring claimant medically stationary as of June 19, 1996. Claimant requested Board review of the employer's claim closure notice.

On July 8, 1996, Dr. Newby again diagnosed cervical spondylosis at C3-4 and neck pain. Dr. Newby opined that claimant ceased work because of this disability on March 12, 1996, and was now totally disabled from any work. Noting that claimant's condition was "unchanged," Dr. Newby did not recommend surgery for claimant's current condition, and opined that he did not expect a fundamental or marked change in the future.

CONCLUSIONS OF LAW AND OPINION

Premature Claim 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 claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 3, 1996 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

Pursuant to his June 11, 1996 chart note, Dr. Newby diagnosed cervical and lumbar spondylosis. In addition, Dr. Newby opined that claimant was "medically disabled, not working and not medically stationary." However, Dr. Newby did not believe further surgical intervention was warranted.

On the other hand, on June 19, 1996, Dr. Newby agreed with the employer's statement that, without additional surgery at that time, no material improvement would be expected in claimant's neck condition. Furthermore, in a July 1, 1996 chart note, Dr. Newby confirmed that claimant was medically stationary with respect to his neck condition as of June 19, 1996.

After examining this series of opinions, we reach the following conclusion. Although Dr. Newby considered claimant "not medically stationary" on June 11, 1996, his subsequent opinions clarify that, in the absence of further surgery (which Dr. Newby concluded was not warranted), claimant's condition is medically stationary. Therefore, we find that claimant's condition was medically stationary when the claim was closed on July 3, 1996.

Entitlement to Temporary Disability

The employer contends that:

> "[T]his matter being in Board's Own Motion jurisdiction, and claimant having returned to work for a long period of time following the initial reopening under Board's Own Motion jurisdiction, claimant should have to show entitlement under ORS 656.278(1), i.e. temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery, until the worker's condition becomes medically stationary. The worker became medically stationary per Dr. Newby on August 11, 1994 (see Dr.

> Newby letter from February 26, 1996). The claimant then requested additional treatment relating to a new condition at C3-4. No hospitalization or surgery has occurred."

The employer further argues that, because claimant was declared medically stationary on August 11, 1994 and he returned to regular work for some period of time following surgery, he is not entitled to further benefits after that date because he did not undergo more surgery before claim closure. Yet, as explained in our Second Own Motion Order on Reconsideration issued this date, the employer did not close the claim after claimant's August 11, 1994 medically stationary date. Instead, while the claim remained reopened, Dr. Newby declared claimant "not medically stationary" with respect to his cervical condition on December 15, 1995. See ORS 656.005(17); Larry R. Comer, 47 Van Natta 1574 (1995). Therefore, because the 1982 claim remained reopened, claimant must prove that he was disabled due to the compensable injury prior to claim closure, but before June 19, 1996, when Dr. Newby declared him medically stationary. Further, because the claim remained reopened, claimant need not again meet the requirements for "reopening" under ORS 656.278(1) to trigger the resumption of temporary disability. See Rodgers v. Weyerhaeuser, 88 Or App 458 (1987); Larry R. Comer, supra.

Although the employer contends that claimant's current cervical condition is a "new condition at C3-4," it did not deny that condition, nor did it close the claim when claimant began treating for that condition. Dr. Newby opined that:

> "[Claimant] subsequently [after August 11, 1994] became non[-]medically stationary on December 15, 1995 with regard to further aggravation and worsening of his prior work injury. There has been no new injury but further progression of his prior cervical injury which has moved up a level from his prior cervical fusions to the current C3-4 level."

Therefore, claimant did not remain medically stationary with respect to his accepted "cervical/left shoulder condition" after August 11, 1994. Dr. Newby did opine that claimant was medically stationary with respect to the cervical condition on June 19, 1996.[2] The employer properly closed the claim on July 3, 1996.

Based on the medical opinions, we find sufficient evidence in the record to show that claimant was disabled due to the compensable "cervical spine" or "neck" injury until he again became medically stationary on June 19, 1996. Further, we find insufficient evidence that claimant's cervical condition was not related to the compensable injury, or that claimant's cervical complaints were not due to the compensable injury. Under these circumstances, we are persuaded that claimant's disability was due to a compensable "new" neck condition. We conclude that claimant became disabled and unable to work due, in part, to this compensable neck condition on August 17, 1995, when Dr. Altrocchi took him off work for "[c]ervical, thoracic, and lumbar sprain due to overuse at work, plus pre-existing cervical arthritis changes and two cervical operations in the past." (*Exhibit 85*). On September 7, 1995, Dr. Altrocchi opined that claimant continued to have "significant back & neck pain & I have taken [claimant] off [work] completely from the afternoon until Oct. 7, 1995." (*Exhibit 95*). Dr. Maloney agreed that claimant was disabled due to "neck & lbp," and "lumbar & cervical pain," until Dr. Newby opined on December 15, 1995 that his "impression" of claimant's current condition was "cervical spondylosis." (*Exhibits 102, 103, 108, 109, and 110A*).

Accordingly, we modify the employer's July 3, 1996 Notice of Closure to award claimant temporary disability compensation in his 1982 neck claim beginning August 17, 1995 until June 19, 1996, when he was declared medically stationary. The payment of this compensation shall be offset by any payment for time worked, and any concurrent payment of TTD under the "new injury" claim. ORS 656.210; 656.212; Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $1,050, payable directly to claimant's counsel. OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[2] Pursuant to the employer's March 18, 1993 recommendation, the accepted conditions in this claim are claimant's "left shoulder/cervical" conditions. Based on the employer's recommendation, our March 25, 1993 order authorized the reopening of claimant's compensable left shoulder/cervical claim for the payment of temporary disability compensation. Further, in the employer's April 3, 1996 letter to Dr. Newby in which it requested the physician's confirmation that claimant was medically stationary, the employer identifies claimant's current condition only as "neck" and "cervical spine."

In the Matter of the Compensation of
BRIAN GETTMAN, Claimant
WCB Case No. 96-00178
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Christian and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the SAIF Corporation's denial of his injury claim. On review, the issue is course and scope of employment.

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

On review, claimant contends that the ALJ erred in finding that he was not a traveling employee. We disagree.

As a general rule, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987). However, where travel is a necessary part of employment, risks incidental to travel are covered by the Workers' Compensation Law even though the employee may not actually be working at the time of the injury. Proctor v. SAIF, 123 Or App 326, 329 (1993). The first question to be answered is whether travel was a "necessary incident" of claimant's employment.

Here, we find the facts of the case to be similar to the facts in Kevin G. Robare, 47 Van Natta 318 (1995). In Robare, we concluded that the claimant, who traveled daily to different construction sites to work for the employer, was not a traveling employee. We reasoned that the claimant's work activities did not involve traveling for the employer and there was no evidence that the claimant was compensated for any travel time. Rather, we found that the claimant's commuting was not work-related business and was not an integral part of his employment. Robare, supra.

In the present case, claimant similarly commuted to various worksites, and there is no evidence that he was compensated for his travel time. Claimant only occasionally drove one of the employer's trucks and only occasionally took a truck home for his own convenience. Under the circumstances, we find that travel was not an integral part of claimant's employment and we agree with the ALJ that claimant is not a traveling employee.

Accordingly, we proceed to analyze whether the claim is compensable under general principles of workers' compensation law. To establish compensability of an injury, claimant must prove 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 App 363, 366 (1994).

Here, we do not find that claimant's injury occurred in the course of his employment. There is no evidence that claimant was being paid a salary at the time of his injury on that Saturday, which was claimant's day off. Additionally, the injury did not take place at or near a worksite.

Alternatively, we do not find that claimant's injury "arose out of" his employment. In determining whether a causal connection existed between the injury and the employment, we consider 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). Here, we find no causal connection between claimant's employment as a roofer, and his injury which occurred as he crossed the street to visit a yard sale. Even assuming that the employer required claimant to return the sprayer that was in the truck claimant had taken home that night, he was not injured while returning the sprayer or while cleaning the sprayer for the volunteer project being undertaken by his employer. Rather, claimant was injured by a car which struck him after he left the volunteer project and was walking across the street to shop at a yard sale. Under the circumstances, we do not find that the conditions of claimant's employment put him in a position to be injured. Accordingly, we find that claimant's injury did not result from an act which was an ordinary risk of, or incidental to, his employment.

Therefore, we conclude that claimant's injury did not occur in the course of his employment. Additionally, even assuming that the injury had occurred in the course of employment, we are unable to find that the injury arose out of claimant's employment. Consequently, we agree with the ALJ that claimant has failed to establish compensability.

ORDER

The ALJ's order dated April 5, 1996 is affirmed.

In the Matter of the Compensation of
SUSAN A. MICHL, Claimant
WCB Case No. 93-04959
ORDER ON REMAND
David C. Force, Claimant Attorney
Roberts, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Beverly Enterprises v. Michl, 138 Or App 486 (1996). In our prior orders, Susan A. Michl, 47 Van Natta 20, recon 47 Van Natta 162 (1995), we reversed the Administrative Law Judge's (ALJ's) order and set aside the self-insured employer's denial of claimant's left knee injury claim. The court has remanded for reconsideration in light of amended ORS 656.005(7)(a)(B).

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of his "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the relevant facts. On March 8, 1993, claimant slipped and twisted her left knee at work. She sought treatment and was diagnosed with patellar subluxation/dislocation. Claimant had a prior history of patellar subluxation and patellar tracking problems. She came under the care of orthopedic surgeon, Dr. Nagel, who requested authorization for surgery. Claimant filed a claim for the left knee injury, which was denied by the employer. At hearing, the ALJ upheld the denial. Reasoning that the March 8, 1993 work incident "combined" with a preexisting knee condition to cause disability and the need for treatment, the ALJ applied the "major contributing cause" standard in former ORS 656.005(7)(a)(B) and concluded that claimant did not carry her burden of proof under that standard.[1]

On Board review, we disagreed with the ALJ's application of former ORS 656.005(7)(a)(B). Finding no persuasive evidence to prove that the work incident "combined" with a preexisting knee condition, we concluded the "major contributing cause" standard did not apply. Instead, we applied the "material contributing cause" standard and, concluding that claimant carried her burden of proof under that standard, set aside the denial.

Stating that the primary dispute in this case is whether claimant's current condition is the result of a "combination of a work injury and a preexisting condition," the court found that resolution of the dispute involves an interpretation of amended ORS 656.005(7)(a)(B) and, therefore, remanded the case to the Board for reconsideration in light of the amended statute. The parties have submitted memoranda on remand. Pursuant to the court's mandate, and after considering the parties' memoranda, we now proceed with our reconsideration.

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[1] Former ORS 656.005(7)(a)(B) provided:

"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."

Amended ORS 656.005(7)(a)(B) provides:

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

It is apparent from the text of the statute that a condition precedent to application of the "major contributing cause" standard is a factual finding that an otherwise compensable injury "combined" with a preexisting condition to cause or prolong disability or a need for treatment. As we stated in our prior orders, there is no persuasive medical evidence to support a finding that claimant's preexisting knee condition and the work incident "combined" to cause disability or a need for treatment. However, we found persuasive medical evidence, specifically the unrebutted opinion of Dr. Nagel, which established that the work incident was the "sole cause" of claimant's current knee condition. (Ex. 13).

On remand, the employer again points to medical evidence that claimant had preexisting left knee (patellar tracking) problems before the March 1993 work incident. It also points to Dr. Anderson's diagnosis of the current condition as "recurrent" patellar subluxation. (Ex. 8). In addition, it notes that Dr. Nagel prescribed surgery "so that the patella does not dislocate again." (Ex. 11). We agree those medical reports suggest that the preexisting patellar condition contributed to some degree to the current patellar dislocation.

However, we adhere to our prior conclusion that the greater weight of the medical evidence preponderates against that finding. In particular, we again rely on the following unrebutted medical opinion by Dr. Nagel: "It is apparent to me, based on the history, that the dislocated patella from two or three years ago was entirely stabilized and the current injury is the sole result of the 3/8/93 accident." (Ex. 13). Contrary to the dissent, we find that Dr. Nagel's opinion directly addresses the relevant legal issue in this case. By opining that the current injury (patellar dislocation) was the sole result of the industrial accident, Dr. Nagel has necessarily ruled out any contribution from preexisting patellar problems, including the previous patellar tracking problem. In the face of such direct, expert medical evidence, we are not inclined to agree that the existence of a prior history of patellar tracking problems proves that such problems actually contributed to the current dislocation and resultant need for treatment, nor do we believe that the mere "recurrence" of patellar dislocation proves there was a causal connection between the prior and current dislocations. There is simply no persuasive medical evidence to prove these facts. Therefore, we conclude there is no "combined condition" within the meaning of amended ORS 656.005(7)(a)(B), and the "major contributing cause" standard does not apply.[2] In addition, because the current treatment is not "solely directed" to the preexisting condition, ORS 656.225 does not apply.

For the reasons discussed in our prior orders, we adhere to our conclusion that claimant has carried her burden of proving compensability of her current left knee condition under the "material contributing cause" standard. The employer's denial is set aside.

Because claimant has finally prevailed after remand, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. In our prior orders, we awarded claimant's counsel assessed fees of $3,500 for services at hearing, on review and on reconsideration in prevailing over the employer's denial. ORS 656.386(1). We reinstate those awards. Inasmuch as, following remand, we have not disallowed or reduced the compensation awarded to claimant, her counsel is also entitled to an assessed attorney fee under ORS 656.382(2) for services before the Court of Appeals.

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[2] The employer argues that the change in wording of ORS 656.005(7)(a)(B) "now clarifies that two otherwise independent conditions that do not merge (for example, do not affect the same body part) might still 'combine' in their effects to produce the overall disability or need for treatment." In this case, however, based on our finding that the preexisting knee condition did not contribute in any way to claimant's current knee condition, we do not find that the preexisting condition had any "effect" on her current disability or need for treatment. Therefore, we do not need to address the employer's proposed construction of the amended statute.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services before the Court of Appeals and before the Board on remand is $2,485, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief, memorandum on remand, and her counsel'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.

Accordingly, on remand, as supplemented herein, we republish our January 11, 1995 order, as reconsidered on January 31, 1995.

IT IS SO ORDERED.

Board Member Moller dissenting.

The issue before us on remand first requires us to determine "whether claimant's condition is the result of a combination of a work injury and a preexisting condition" for purposes of applying amended ORS 656.005(7)(a)(B) [1995]. Beverly Enterprises v. Michl, 138 Or App 486 (1996). In our prior order, which we decided before the 1995 revisions to ORS 656.005(7)(a)(B), we acknowledged that claimant had "prior left knee problems." However, we concluded that there was no persuasive evidence that claimant's preexisting condition and the March 1994 work incident combined to cause disability or a need for medical treatment. Today, the majority again reaches the same conclusion. I am uncertain whether I would have reached this conclusion under the prior law. However, I am certain that I would not reach the same conclusion under the amended statutes. Therefore, I respectfully dissent.

ORS 656.005(7)(a)(B) was just one of many workers' compensation provisions amended in 1995 by Senate Bill 369. Another statutory change that is applicable to this dispute is the adoption of new ORS 656.005(25). See Or Laws 1995, ch. 332 s. 66. This new provision defines a "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[.]" By contrast, prior to adoption of ORS 656.005(24)[1995], those "causes" that could be considered for purposes of determining compensability under ORS 656.005(7) did not include "predispositions." Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991), rev den 313 Or 210 (1992). Because claimant suffers from just such a predisposition, I would find this statutory change to be significant in this case.

The majority relies on the opinion of Dr. Nagel that "the dislocated patella from two or three years ago was entirely stabilized and the current injury is the sole result of the 3/8/93 accident." The majority's reliance on Dr. Nagel's opinion is misplaced. Dr. Nagel's reasoning is essentially irrelevant to the legal issue we must decide. In this regard, the preexisting condition in this case is not claimant's prior episode of patellar dislocation, and the employer is not arguing that the previous subluxation caused claimant's current subluxation. Rather, the prior episode was merely a symptom of claimant's preexisting patellar tracking problems. The fact that the prior dislocation entirely stabilized is, therefore, equally irrelevant.

Instead, the employer argues that claimant has a predisposition to recurrent subluxations due to a "patellar tracking problem." The evidence of this preexisting condition -- and its contribution to claimant's current episode of subluxation -- is overwhelming. Dr. Anderson, who unlike Dr. Nagel treated claimant for both subluxations, has previously diagnosed "a patellar tracking problem with secondary chondromalacia." Following claimant's work incident, Dr. Anderson diagnosed "recurrent patellar subluxation." Rather than refuting this diagnosis, Dr. Nagel supports this diagnosis as evidenced by his request to perform surgery in order to "prevent further dislocations." In light of this evidence, I am unable to agree with the majority's conclusion that there is no persuasive evidence to support a finding that claimant's preexisting knee condition and the work incident "combined" to cause disability or a need for treatment. To the contrary, all of the persuasive evidence supports this conclusion.

Consequently, in this order we should have proceeded to address the question whether the otherwise compensable work incident was the major contributing cause -- when weighed against claimant's preexisting patellar tracking problems -- of the disability and need for medical treatment related to claimant's subluxation. Because Dr. Nagel weighed the wrong factors to reach his conclusion concerning "sole" causation, that opinion is useless. Absent a remand to further develop the record concerning the correct causal relationship determination, I would conclude that claimant has failed to establish compensability of her claim.

Finally, I note the employer's argument that a portion of the employer's denial in this case is subject to application of the new provisions set forth in ORS 656.225. Specifically, the employer argues that the portion of the employer's denial pertaining to claimant's surgery should be reinstated because that surgery is solely directed to claimant's preexisting condition. I would reject this argument because the statute only applies when the dispute involves an accepted injury or occupational disease claim. Here, as framed by the employer's denial, the sole issue litigated by the parties was whether claimant, in fact, experienced an initially compensable injury. No separate issue was litigated concerning compensability of claimant's surgery.

Nevertheless, for the reason stated above, I do not agree with the majority's conclusion that claimant's preexisting condition did not combine with her work incident to cause the patellar subluxation for which she has sought medical treatment. Nor can I conclude on this record that the work incident was the major contributing cause of claimant's need for treatment for her subluxed patella. Therefore, I dissent.

In the Matter of the Compensation of
JAYMIE K. REYNOLDS, Claimant
WCB Case No. 96-00280
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Yturri, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for "compartment syndrome, right upper extremity, multiple, with myositis, lateral epicondylitis, and deQuervain's" conditions; and (2) declined to assess penalties and attorney fees for an allegedly late and unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

On May 23, 1994, Dr. German, treating orthopedist, first examined claimant regarding her upper extremity complaints, which primarily involved the right upper extremity. (Ex. 8). On May 31, 1994, Dr. German provided the following assessment of claimant's condition: "[c]ompartment syndrome, right upper extremity, multiple, with myositis, lateral epicondylitis, deQuervain's, but I think the primary area is carpal tunnel. * * * Assessment is carpal tunnel syndrome, right." Id. Subsequently, claimant underwent nerve conduction tests, which were normal. (Exs. 10, 11). However, based on claimant's clinical presentation, Dr. German continued to diagnose acute right carpal tunnel syndrome and, ultimately, performed a right carpal tunnel release. (Exs. 12, 13, 14, 15). In June 1994, the employer accepted right wrist tendinitis and right carpal tunnel syndrome. (Exs. 17, 18).

On December 20, 1995, based on Dr. German's May 31, 1994 chart note, claimant requested the employer to amend its acceptance to include "compartment syndrome, right upper extremity, multiple, with myositis, lateral epicondylitis, and deQuervain's" conditions. (Ex. 60). By letter dated December 28, 1995, the employer responded to claimant's request, characterizing Dr. German's May 31, 1994 assessment as "initial speculative diagnoses" and asserting that there was no "definitive clinical evidence" that claimant sustained any injury due to her employment other than the conditions accepted by the employer. (Ex. 62). On March 18, 1996, the employer issued a formal denial of the "compartment syndrome, right upper extremity, multiple, with myositis, lateral epicondylitis, and deQuervain's" conditions. (Ex. 68).

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that the conditions of "compartment syndrome, right upper extremity, multiple, with myositis, lateral epicondylitis, and deQuervain's" are compensable components of her occupational disease claim. Claimant has the burden of proving the compensability of these conditions and must prove that the work activities were the major contributing cause of these conditions. ORS 656.266; 656.802(1)(a)(C) and (2).

While Dr. German's initial assessment included "[c]ompartment syndrome, right upper extremity, multiple, with myositis, lateral epicondylitis, deQuervain's," he also concluded that the assessment was "carpal tunnel syndrome, right." (Ex. 8). There is no further mention of "compartment syndrome, right upper extremity, multiple, with myositis, lateral epicondylitis, and deQuervain's" conditions following Dr. German's May 31, 1994 chart note until a completed check-the-box opinion, addressed to Dr. German, indicating that these conditions were caused in major part by claimant's work activities.[1] (Ex. 64). We do not find this unexplained, unsigned opinion persuasive. Marta I. Gomez, 46 Van Natta 1654 (1994) (the Board gives little, if any, weight to conclusory, poorly reasoned opinions, such as unexplained "check-the-box" reports).

Consequently, we conclude that ALJ was correct in upholding the employer's denial of "compartment syndrome, right upper extremity, multiple, with myositis, lateral epicondylitis, and deQuervain's" conditions.

Finally, we adopt that portion of the ALJ's order concerning the penalty and attorney fee issues.

ORDER

The ALJ's order dated April 5, 1996 is affirmed.

[1] We note that the only mention of "myositis" following Dr. German's May 31, 1994 chart note is contained in the opinion of Dr. Isaacs, consulting physician, who opines that claimant has no myopathy or myositis. (Ex. 34-5).

In the Matter of the Compensation of
CLAY O. VARNEY, Claimant
WCB Case No. 95-06890
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the SAIF Corporation's denial of claimant's injury claim for a right femur fracture and right foot abscess; and (2) declined to assess a penalty and attorney fee for an allegedly unreasonable denial. In his brief, claimant also contends that the higher standard of proof for claimants with preexisting conditions under ORS 656.007(a)(B) is invalid under the Americans with Disabilities Act (ADA). On review, the issues are compensability, penalties, and the applicability of the ADA.

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

We briefly recap the relevant facts. Claimant experienced a non-work-related motor vehicle accident in 1960 that left him a quadriplegic. He also fractured his femur. In order to stabilize his fractured femur, an intermedullary rod had been inserted into the bone. (Exs. 11, 24). This rod no longer remained tight. (Ex. 11). Claimant's quadriplegia caused him to develop osteoporosis, a thinning of his bone tissue. Claimant had experienced several fractures prior to the accident. (Id.).

On or about March 2, 1995, claimant used the restroom at work. As he was transferring himself to the toilet seat, he heard a "pop" in his right leg-hip area. He did not feel pain or other accompanying symptoms. A day or two later, he experienced shaking and sweating, which caused him to visit a hospital emergency room. X-rays revealed a fracture of claimant's right femur at its upper end involving the right trochanteric area, which was surgically repaired on March 6, 1995. Claimant subsequently developed an abscess of the right foot. Dr. Boyd is claimant's attending physician.

Dr. Boyd opined that claimant's quadriplegia, osteoporosis and the rod in his leg (which may have acted as a stress riser) contributed to claimant's femur fracture. (Ex. 11). Therefore, because claimant had preexisting conditions that predisposed him to fractures, he must establish that his work-related activity was the major contributing cause of his March 1995 right femur fracture. ORS 656.005(7)(a)(B); 656.005(24).

Due to the number of potential causes for claimant's fracture, the causation issue is a complex medical question, the resolution of which requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). We ordinarily give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons to do otherwise.

Dr. Boyd initially opined that it was the force with which claimant came down upon the toilet that was the major contributing cause of his femur fracture. (Ex. 21). In contrast, both Dr. McKillop and Dr. Wilson, who each reviewed claimant's medical file for SAIF, concluded that, given the severely osteoporitic condition of claimant's bones, any minor force, such as being turned in bed or transferring from a chair to bed would be capable of breaking claimant's bone. We agree with the ALJ's analysis of the medical opinions, being more persuaded by the unequivocal opinions of Dr. McKillop and Dr. Wilson that the major contributing cause of claimant's fracture was his preexisting osteoporosis (Exs. 24, 25), rather than Dr. Boyd's subsequent statement that he had no way of stating for sure that claimant's lowering himself on the toilet was the injurious event, or that the occurrence of the fracture at that time was simply the result of claimant's 30-year development of osteoporosis with the intermedullary rod in place, altered by mechanics (Ex. 26).

Finally, we adopt and affirm the ALJ's conclusion that claimant's ADA challenge to ORS 656.005(7)(a)(B) in combination with subsection (24) falls outside the Board's jurisdiction. See Rex Brink, 48 Van Natta 916, 917 (1996); Gary W. Benson, 48 Van Natta 1161, 1163 (1996) (citing Sandra I. Way, 45 Van Natta 876 (1993), aff'd on other grounds Way v. Fred Meyers, Inc., 126 Or App 343 (1994)).

ORDER

The ALJ's order dated February 13, 1996 is affirmed.

In the Matter of the Compensation of
WANDA L. BOONE, Claimant
WCB Case No. 96-00538
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Christian and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Daughtry's order that upheld the SAIF Corporation's denial of her occupational disease claim for a bilateral arm condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found the existence of claimant's bilateral arm condition was established by medical evidence supported by objective findings. He relied on findings by Dr. Dunn, claimant's attending physician, of tenderness in both arms and decreased ranges of motion in both wrists. (Ex. 14). Reasoning that those findings were measurable and reproducible, the ALJ concluded the findings constituted "objective findings" of disease within the meaning of ORS 656.005(19). We agree with and adopt this portion of the ALJ's conclusions and opinion.

On the causation issue, however, the ALJ concluded that claimant did not carry the burden of proving her occupational disease claim is compensable, i.e., that work activities were the major contributing cause of her bilateral arm condition. On review, claimant contends the medical record sufficiently carried her burden of proof. We agree and reverse.

To establish her occupational disease claim, claimant must prove by a preponderance of the evidence that employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). Determining "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994). The doctors in this case have reached different conclusions about whether work activities were the major contributing cause of claimant's bilateral arm condition.

Claimant has been employed as laborer for the employer since November 1992. It is undisputed that claimant's employment required physical and repetitive use of both upper extremities. She began developing numbness in the left hand in late 1993 and, a few months later, numbness in the right hand as well. By October 1995, she was experiencing pain in both hands and forearms and in the right shoulder.

She sought treatment with Dr. Dunn who diagnosed bilateral forearm tendinitis and myofascial pain syndrome in the arms and shoulders. He took claimant off work and treated conservatively. Her condition subsequently improved. (Exs. 0, 3). Dr. Gilsdorf also examined her and diagnosed chronic overuse syndrome. He recommended against her return to the repetitive activities of her regular job. (Ex. 6).

Claimant was subsequently examined by Dr. Dickerman at SAIF's request. At that time, she reported 50 percent improvement in her symptoms. He diagnosed a chronic pain syndrome which "could very well" be an overuse syndrome. However, suggesting the possibility that her condition is due to depression and/or a connective tissue disorder, he concluded that the major contributing cause of her condition is "not well established." (Ex. 7-8). Dr. Gilsdorf concurred with Dr. Dickerman's report. (Ex. 12). Dr. Sullivan, who had performed nerve conduction studies on claimant, also concurred. (Ex. 9).

Dr. Dunn, however, disagreed with Dr. Dickerman's report. Dr. Dunn reported observing no evidence of depression during three prior visits with claimant. (Ex. 8). He clarified his diagnoses as overuse tenosynovitis of the wrists, epicondylitis of the elbows, and myofascial pain in the upper arms and shoulders. He opined that the major contributing cause of her condition was the repetitive work activities for the employer, reasoning that there were no off-work activities which subjected her to as much repetitive motion of her arms. He noted her condition improved with treatment. (Ex. 14). In addition, he reiterated that he found no evidence of anxiety or depression. He added that he evaluated claimant for an autoimmune-type inflammatory condition but excluded that possibility because of a normal sedimentation rate and a negative rheumatoid factor and antinuclear bodies. (Ex. 15).

Finally, claimant was examined by Drs. Tsai and James at SAIF's request. At that time, claimant reported 85-90 percent improvement in her condition. The examination was unremarkable, with normal neurologic and orthopedic findings. As a result, the doctors were unable to render an opinion regarding causation. (Ex. 16).

The ALJ reviewed the medical record and found considerable uncertainty about the nature of claimant's condition, thus leaving him unpersuaded that work was the major cause of the condition. In our view, the medical record preponderates in favor of the claim. In particular, we rely on the reports of Dr. Dunn, who opined that repetitive arm activities at work were the major contributing cause of her arm conditions. He had an accurate history of claimant's activities and offered a reasoned explanation for his opinion. He explained that claimant engaged in no off-work activities which subjected her arms to the repetitive motions she experienced at work. He further explained that claimant's condition improved after she was released from work and, and it was responsive to treatment.

By contrast, the opinion of Dr. Dickerman is not as well reasoned. He diagnosed a chronic pain syndrome and conceded it could be related to overuse. He did not render a causation opinion because of his concern that the condition may be related to depression and/or a rheumatological condition. However, those possibilities were ruled out by Dr. Dunn, who found no evidence of anxiety, depression, or an autoimmune-type inflammatory condition. Accordingly, the only off-work causal factors suggested by Dr. Dickerman were excluded by Dr. Dunn, leaving work activities as the sole causal factor.

Although Drs. Gilsdorf and Sullivan concurred with Dr. Dickerman's opinion, their concurrences were conclusory and, therefore, unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Moreover, for the reasons discussed above, we conclude their opinions, like Dr. Dickerman's, were rebutted by Dr. Dunn.

Finally, we decline to give any weight to the report of Drs. Tsai and James. They first examined claimant several months after she began treating with Dr. Dunn. By the time of their examination, claimant reported 85-90 percent improvement in her condition. Given claimant's recovery, and the absence of examination findings, we conclude their opinion regarding the onset of claimant's condition several months earlier lacks probative value. We discount it accordingly.

For the aforementioned reasons, we conclude that Dr. Dunn's opinion is thorough and better-reasoned than the other opinions in the record. See Somers v. SAIF, 77 Or App 259, 263 (1986). Furthermore, as the treating physician, he had the opportunity to evaluate claimant's condition over time, whereas Drs. Dickerman, Tsai and James saw her only once. See Weiland v. SAIF, 64 Or App 810, 814 (1983). We reject SAIF's argument that Dr. Dunn's opinion relied solely on the exclusion of non-occupational causes for claimant's condition. See ORS 656.266. He explained that claimant's condition improved after she was released from work and that the condition responded to his treatment for overuse. That explanation exceeds what ORS 656.266 deems insufficient evidence. See Bronco Cleaners v. Velasquez, 141 Or App 295, 299 (1996). We conclude claimant has proven her claim by a preponderance of the evidence, and SAIF's denial shall be set aside.

Claimant's attorney is entitled to an assessed fee for prevailing against the denial. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney may go uncompensated.

ORDER

The ALJ's order dated April 25, 1996 is reversed. SAIF's January 9, 1996 denial is set aside, and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded an assessed fee of $4,000, payable by SAIF.

In the Matter of the Compensation of
GREG H. BOOTH, Claimant
WCB Case No. 95-04876
ORDER DENYING RECONSIDERATION
Karl Goodwin (Saif), Defense Attorney

On August 15, 1996, we issued a Third Order on Reconsideration that adhered to our decisions of May 23, 1996, June 24, 1996, and July 17, 1996, which found no compelling reason to remand for the taking of additional evidence and affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a sinus and upper respiratory condition. Claimant has submitted a letter to Board Chair Hall, along with a copy of his August 22, 1996 letter to the Board's Administrator.[1] Since these submissions raise several questions regarding our previous decisions, we treat claimant's letters as a motion for reconsideration of our August 15, 1996 order.

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[1] Inasmuch as it does not appear that SAIF has received copies of claimant's letters, copies of those letters have been included with SAIF's counsel's copy of this order.

After reviewing claimant's recent letters, we disagree with his assertions that we have previously neglected to address the questions he has raised.[2] Instead, we would characterize claimant's complaints as essentially representations of his displeasure with the manner in which we disposed of his particular contentions and requests, including our ultimate decision that his claim was not compensable. Since we have already considered and rejected the arguments raised in his recent letters, we decline to again consider such assertions.

Accordingly, claimant's motion for reconsideration is denied.[3] The parties' 30-day rights of appeal shall continue to run from the date of our August 15, 1996 order.

IT IS SO ORDERED.

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[2] Claimant raises four questions in his most recent submission. First, he asserts that we have failed to address the alleged lack of a medical record establishing that he had a history of "chronic sinusitis" prior to beginning his employment with SAIF's insured. To the contrary, in adopting the ALJ's order, we also found that Dr. Montanaro's opinion (which was based on the medical record and claimant's history) confirmed the existence of sinus problems which pre-dated his employment with SAIF's insured.

Second, claimant argues that we will not address our alleged erroneous identification of his 1979 nasal surgery as a "sinus procedure." We disagree. As noted in footnote 2 in our July 17, 1996 Second Order on Reconsideration, we referred to claimant's surgery as "nasal," not "sinus."

Third, claimant contends that we have neglected to consider a "post-hearing/post-surgery" report that attributes his disease to his work exposure (which we also allegedly deemed the report as "irrelevant"). Again, we must disagree. As explained in our June 24, 1996 Order on Reconsideration and our July 17, 1996 Second Order on Reconsideration, these "post-hearing" materials were considered for purposes of determining whether remand for further evidence taking was warranted. Because we concluded that this "post-hearing" evidence was unlikely to affect the outcome of the case (in light of the already existing medical record, as well as Dr. Lee's reference to work-related "symptoms," as opposed to a pathological worsening of the underlying condition), we held that remand was not justified.

Finally, claimant complains that we will not review several alleged deficiencies in Dr. Montanaro's opinion; i.e., the physician's reference to "cause unknown" when diagnosing claimant's condition, and the purported lack of a medical record to support his conclusion of a "chronic sinusitis" history. Since earlier in this footnote we have already responded to claimant's assertions regarding a lack of medical support for a "chronic sinusitis" history, he is referred to that section of this footnote. Concerning the "cause unknown" reference, we would merely note that the burden of establishing the compensability of a claim rests with the worker; it is not the responsibility of the carrier to disprove the claim. See ORS 656.266. In any event, as reasoned by the ALJ, and adopted by our prior decisions, Dr. Montanaro did not consider claimant's work to be a significant contributor to claimant's conditions. Likewise, as noted in our May 23, 1996 Order on Review adopting the ALJ's order, Dr. Montanaro's persuasive conclusions were concurred in by Dr. Cade, claimant's earlier attending physician.

[3] In reaching this conclusion, we acknowledge claimant's description of the physical, emotional, and financial burden caused by this claim. We further recognize his frustrations and displeasure with the processing of his claim, as well as with our decisions. Nonetheless, our review of a particular record and the issuance of our opinions can never be based on the potential ramifications (economic, social, and otherwise) to the parties. Rather, pursuant to our statutory authority, our responsibility is to apply the workers' compensation laws to the facts as presented.

In accordance with that authority, on four separate occasions, we have conducted our review and rendered our decisions finding that the preponderance of the medical and lay evidence was insufficient to establish that claimant's work exposure was the major contributing cause of his conditions or their worsening. Consistent with the statutory scheme, claimant's next available legal option is to seek judicial review of our decisions. Should he wish to do so, he is reminded that he must timely and properly comply with the instructions contained at the conclusion of our August 15, 1996 order.

In the Matter of the Compensation of
KEVIN J. ELLAM, Claimant
WCB Case Nos. 95-05847 & 95-05846
ORDER OF DISMISSAL
Alice M. Bartelt (Saif), Defense Attorney
Garrett, Hemann, et al, Defense Attorneys

Claimant, pro se, has requested review of Administrative Law Judge (ALJ) Johnstone's May 14, 1996 order. Contending that claimant's request for review was untimely filed, the SAIF Corporation has moved the Board for an order dismissing claimant's request for review. We have reviewed this request to determine if we have jurisdiction to consider this matter. Because the record does not establish that either the Board or the parties received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On May 14, 1996, ALJ Johnstone issued an Opinion and Order which upheld SAIF's denials of claimant's lumbar sprain condition. Parties to that order were claimant, claimant's attorney, the employers, SAIF and its attorneys. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

In a June 14, 1996 letter, claimant requested Board review of ALJ Johnstone's order. That letter was directed to SAIF rather than to the Board, and is date-stamped by SAIF as received on June 17, 1996. SAIF forwarded a copy of claimant's letter to the Board, which was received on June 21, 1996. Claimant's request did not indicate that copies had been provided to the other parties to the proceeding.

On June 24, 1996, the Board mailed its computer-generated letter to the parties acknowledging its June 21, 1996 receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. See ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b). If the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely. Id.

The failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or App 47, 51 (1985); Argonaut Insurance Co. v. King, supra. 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 May 14, 1996 order was June 13, 1996. Claimant's request for review was dated June 14, 1996, received by SAIF on June 17, 1996, and forwarded to the Board on June 21, 1996. Inasmuch as the request for review was not mailed by certified mail and was received by the Board on June 21, 1996, we conclude it was "filed" on that date. See OAR 438-005-0046(1)(b). Inasmuch as June 21, 1996 is more than 30 days after the ALJ's May 14, 1996 order, the request was untimely filed.

In addition, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, based on the date-stamped copy of claimant's letter, SAIF's first notice occurred when it received claimant's request on June 17, 1996. Since June 17, 1996 is more than 30 days after the ALJ's May 14, 1996 order, such notice is untimely.

Under such circumstances, we conclude that notice of claimant's request was neither filed with the Board nor provided to the other parties within 30 days after the ALJ's May 14, 1996 order.[1] Consequently, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has 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. Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] In the event that claimant can establish that he mailed a request for review to the Board and provided notice of his request for Board review to SAIF within 30 days of the ALJ's May 14, 1996 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 consider this order expires within 30 days after the date of this order, claimant must file his written submission as soon as possible.

In the Matter of the Compensation of
BETTY J. LANFEAR, Claimant
WCB Case No. 94-11138
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The insurer requests review, and claimant cross-requests review, of that portion of Administrative Law Judge (ALJ) Mongrain's order that found that the insurer's "denial" of claimant's vestibular condition was "void." The insurer also requests review of that portion of the ALJ's order that found that claimant's injury claim was prematurely closed. On review, the issues are the insurer's "denial," premature claim closure and, potentially, extent of unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except that we correct the reference to "labyrinthian concussion" on page 2 to "labyrinthine concussion."

CONCLUSIONS OF LAW AND OPINION

Insurer's "Denial"

We adopt and affirm that portion of the ALJ's order concerning this issue.

Premature Claim Closure

Claimant has an accepted claim for occipital scalp contusion, cervical strain, and labyrinthine concussion. Furthermore, we have agreed with the ALJ that, based on the language of the December 23, 1994 "denial" letter and the insurer's assertions and characterization of the letter, the accepted claim includes a vestibular condition.

A February 1994 Determination Order found claimant medically stationary on August 23, 1993 and awarded only temporary disability. In March 1994, claimant requested reconsideration, challenging only impairment findings and extent of unscheduled permanent disability. Claimant then underwent an examination by medical arbiter, Dr. Springate. The Order on Reconsideration awarded 11 percent unscheduled permanent disability.

Claimant then requested a hearing, asserting that her claim had been prematurely closed because she was not yet medically stationary. The ALJ agreed, finding that claimant's vestibular condition was not medically stationary at closure.

On December 13, 1993, Dr. Wayman, who has treated claimant since April 1992, indicated that claimant was medically stationary as of August 25, 1993. (Ex. 62). Dr. Wayman further indicated that he did not expect "any residual impairment from the original January, 1992 injury, but [claimant] will most likely continue to have occasional complaints of dizziness or ear pain." (Id.) Dr. Wayman subsequently reiterated that claimant's symptoms would wax and wane. (Ex. 65-1).

On August 4, 1994, medical arbiter Dr. Springate examined claimant. In his report, Dr. Springate noted claimant's episodes of dizziness, stating that he could not be "sure that the dizziness she's having is related to the inner ear although it's certainly a possibility." (Ex. 72-2). Dr. Springate further stated that claimant

> "has never had any significant evaluation of her vestibular system to see if, indeed, we can demonstrate any abnormality or demonstrate whether, indeed, her symptoms are related to the balance portion of her inner ear. I think it would be worthwhile for her to have either complete vestibular testing in the laboratories at the University or we could do an electronystagmographic examination here in my office[.]" (Id.)

Finally, Dr. Springate reported that "sometimes vestibular symptoms do not resolve quickly and it would not be unusual to take more than two years for her symptoms to improve." (Id. at 3).

In October 1994, claimant saw Dr. Steele concerning her dizziness and vertigo. (Ex. 74). On December 12, 1994, Dr. Wayman again indicated that claimant's "current complaints represent the anticipated waxing and waning of those same symptoms" of dizziness and positional vertigo she had been experiencing since the January 1992 injury. (Ex. 75). Dr. Steele concurred with Dr. Wayman. (Ex. 76).

In January 1995, Dr. Louie, neurosurgeon, saw claimant for dizziness and neck pain. He recommended no further diagnostic studies or surgical intervention. (Ex. 76B-4).

Finally, in January 1995, Dr. Steele reported that claimant again was experiencing a waxing and waning of her symptoms. (Ex. 77A-3). In February 1995, Dr. Steele reported that claimant was not receiving curative treatment, although she "suspected that [claimant] may very well improve with time and may improve with physical rehabilitation treatment." (Ex. 78). Dr. Steele was "unable to definitively say" whether claimant had any permanent disability as a result of her vestibular condition. (Ex. 79).

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to prove that she was not medically stationary on the date of closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). In determining whether claimant has carried this burden, we examine medical evidence at the time of closure, as well as evidence submitted after closure; medical

evidence, however, submitted after closure that pertains to changes in claimant's condition subsequent to closure is not properly considered. See Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). Furthermore, neither a recommendation for further diagnostic services nor continuing medical treatment for fluctuating symptoms necessarily prove that claimant is not medically stationary. E.g., Maarefi v. SAIF, 69 Or App 527, 531 (1984); Penny N. Kester, 45 Van Natta 1763 (1993).

Here, claimant's long-term treating physician, Dr. Wayman, declared claimant medically stationary as of August 25, 1993 and continued to indicate after that date that claimant's symptoms represented a waxing and waning. Dr. Steele, who subsequently treated claimant, agreed with Dr. Wayman that claimant was experiencing episodes of waxing and waning. She further stated that she had not rendered curative treatment. Although Dr. Steele also gave some indication that claimant could improve with time and physical rehabilitation, her statement was only in terms of possibility. We find such evidence to be persuasive proof that claimant was medically stationary in August 1993. Although claimant's symptoms fluctuated following closure, both Dr. Wayman and Dr. Steele considered claimant's condition as waxing and waning; neither physician expressed a reasonable expectation rising to the level of probability that her condition would materially improve.

Dr. Springate's report does not change this conclusion. We do not understand Dr. Springate's recommendation for further evaluation as an indication of a reasonable expectation of material improvement. Rather, his suggestion was provided in the context of exhausting all possible diagnostic procedures and, as such, was not necessarily offered with the expectation of improvement in claimant's condition. Thus, we conclude that Dr. Springate's report is insufficient evidence that claimant was not medically stationary.

Consequently, because claimant failed to prove that she was not medically stationary at the time of closure, we conclude that the claim was not prematurely closed.[1] We proceed to address the extent question.

Extent of Unscheduled Permanent Disability

At hearing, claimant asserted that she is entitled to a rating for impairment to the eighth cranial nerve. Under former OAR 436-35-390(7), a rating is given for permanent disturbances of the vestibular mechanism resulting in vestibular disequilibrium which limits activities. (WCD Admin. Order 6-1992). According to Dr. Springate's report, claimant is performing her regular job and is able to drive a motor vehicle. (Ex. 72-2). The report also states, however, that claimant is not performing at the same level of function as before her injury. Furthermore, Dr. Springate indicated that, although not significant, claimant had some permanent vestibular disequilibrium during those episodes when she experienced dizziness. (Id. at 3). Based on such evidence, we find that claimant proved the presence of signs of vestibular disequilibrium which limits activities and, thus, she is entitled to an additional 8 percent impairment. Former OAR 436-35-390(7)(a)(A).

Moreover, we note that the Order on Reconsideration, applying former OAR 436-35-280 and 436-35-310(2) (WCD Admin. Order 93-056), found a value of zero for age, education and adaptability. Subsequent to the Order on Reconsideration, the Court of Appeals determined that certain former standards giving a zero adaptability value were inconsistent with ORS 656.214(5) and 656.726(3)(f)(A). Carroll v. Boise Cascade Corp., 138 Or App 610 (1996). Applying the holding in Carroll to former OAR 436-35-280 and 436-35-310(2) in WCD Admin. Order 93-056, we have found such rules to be inconsistent with ORS 656.726(3)(f)(A). E.g., Joe R. Ray, 48 Van Natta 325 (1996). Instead, because age, education and skill factors must be considered under the standards, we assign claimant an adaptability factor of 1. Id.

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[1] The employer argues that, because claimant did not raise the issue of premature closure when requesting reconsideration of the Determination Order, she is prohibited by ORS 656.268(8) from challenging that issue at hearing and on review. ORS 656.268(8) provides: "No hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing." The ALJ found that the premature closure issue was raised by the Order on Reconsideration because the medical arbiter's report "raised the issue of whether the claimant was medically stationary." Because we conclude that, on the merits, the claim was not prematurely closed, we need not address this dispute.

We now calculate claimant's unscheduled permanent disability. Claimant's impairment value of 11 percent for limitation of cervical range of motion is combined with 8 percent for vestibular disequilibrium, which results in 15 percent. Claimant is over age 40, so she receives a value of 1 for age. Former OAR 436-35-290(1). The highest SVP of any job worked by claimant during the last five years is her job at injury, DOT 205.362-030, with an SVP of 4. Consequently, claimant's education value is 4. Former OAR 436-35-300(3)(b). Adding age and education together results in a value of 5. Former OAR 436-280(4).

As discussed above, claimant's adaptability value is 1. Multiplying that value with 5 results in 5. Former OAR 436-35-280(6). Adding that value with impairment of 15 percent totals to 20 percent unscheduled permanent disability. Former OAR 436-35-280(7). Therefore, claimant is awarded 20 percent unscheduled permanent disability for her compensable injury.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services on review concerning the insurer's "denial." ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning this issue is $500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Because our order also results in increased unscheduled permanent disability, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. ORS 656.386(2).

ORDER

The ALJ's order dated November 28, 1995, as reconsidered January 3, 1996, is affirmed in part and reversed in part. That portion of the order finding the claim prematurely closed is reversed. In addition to the Order on Reconsideration award of 11 percent (35.2 degrees) unscheduled permanent disability, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability, for a total award of 20 percent (64 degrees) unscheduled permanent disability. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation made payable by this order, not to exceed $3,800, payable by the insurer directly to claimant's attorney. For services on review concerning the insurer's "denial," claimant's attorney is awarded an assessed fee of $500, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
CHRISTI L. McCORKLE, Claimant
Own Motion No. 95-0353M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Pozzi, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The self-insured employer requests reconsideration of our July 3, 1996 Own Motion Order Reviewing Carrier Closure, which set aside the employer's April 3, 1996 Notice of Closure as premature. Contending that the Board erred in interpreting Dr. Carpenter's medical record after December 4, 1995 to establish that claimant was not medically stationary on April 3, 1996, the employer asks the Board to affirm its April 3, 1996 Notice of Closure. The employer further argues that the award of a penalty was not warranted, "where the claims administrator had a legitimate doubt as to its liability for time loss benefits after December 4, 1995, based upon Dr. Carpenter's declaration of medically stationary status on that date." On reconsideration, we adhere to the conclusion reached in our July 3, 1996 order. We base this conclusion on the following reasoning.

In our July 3, 1996 order, we concluded that, although Dr. Carpenter declared claimant medically stationary on December 4, 1995, the pivotal issue for our consideration was whether claimant was medically stationary on April 3, 1996, when the employer again closed the claim. We concluded, from the medical evidence in the record, that claimant established that she was not medically stationary on that date. We reasoned that on March 7, 1996, Dr. Carpenter recommended (as he had done on December 4, 1995 and February 13, 1996) that claimant be scheduled for a second opinion "before joint replacement is considered."[1] On April 8, 1996, Dr. Carpenter again noted that the employer had still not agreed to obtain a second opinion, "and this will be required before we consider further surgical intervention." Therefore, we concluded that Dr. Carpenter was considering surgery as appropriate because of the failure of conservative treatment, but he required a second opinion before he would confirm the appropriate "timing" of a total joint replacement. We were also persuaded by Dr. Carpenter's medical records, that the condition of claimant's knee (notwithstanding the surgery recommendation) was not medically stationary at closure pursuant to ORS 656.005(17). See Christi L. McCorkle, 48 Van Natta 1459 (1996). We assessed a penalty on back-due amounts of temporary disability compensation on the ground that the employer unreasonably closed the claim with a "proposed" Notice of Closure, ignoring the evidence available to it at the time of closure. See Christi McCorkle, 48 Van Natta 840 (1996). Finally, we allowed claimant's attomey an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded by our July 3, 1996 order.

The employer contends that claimant was medically stationary on April 3, 1996 because "nowhere in Dr. Carpenter's chart notes between December 4, [1995,] and April 3, [1996] does he state or infer that claimant's condition has worsened." The employer further argues that once claimant is readmitted for hospital care relative to a knee replacement surgery, "she will certainly have demonstrated a worsening of her condition to so trigger a re-opening of her claim." We disagree with the employer's reasoning that claimant's condition must "worsen" after she was declared medically stationary in order to be considered not medically stationary at claim closure. Because claimant's claim was in reopened status at that time, she was only required to provide evidence that her compensable knee condition was not medically stationary on April 3, 1996, when the employer "reclosed" her claim. ORS 656.005(17); Larry R. Comer, 47 Van Natta 1574 (1995). We based our conclusion that claimant was not medically stationary on the medical evidence in Dr. Carpenter's chart notes and medical records, and although Dr. Carpenter had not spoken the "magic words" or used statutory language that claimant was not medically stationary at claim closure, the record established that claimant's condition was not medically stationary pursuant to ORS 656.005(17). McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Therefore, claimant's condition did not remain medically stationary after December 4, 1995, and because

[1] In our March 14, 1996 Own Motion Order Reviewing Carrier Closure, we concluded that claimant's medically stationary status at the time of the November 28, 1995 Notice of Closure was not contingent upon claimant undergoing the proposed surgery. Citing Bill H. Davis, 47 Van Natta 219 (1995), we reasoned that, on November 28, 1995, no physician had recommended that claimant undergo surgery. However, by the time of the April 3, 1996 closure, the surgery recommendation was well documented in the record.

her claim was in reopened status, she was not required to again meet the requirements for "reopening" under ORS 656.278(1) (worsening of a compensable injury which requires inpatient hospitalization or outpatient surgery).

The employer further contends that claimant's ongoing symptoms and the provision of medical treatment after December 4, 1995, should not persuade the Board that claimant was not medically stationary at closure. Maarefi v. SAIF, 69 Or App 527, 531 (1984). The record establishes that claimant's treatments with Dr. Carpenter after December 4, 1995, constituted more than mere "ongoing care." The medical record establishes that conservative treatment to claimant's knee had failed at the time of closure (the injections to claimant's knee lasted barely longer than one week). Although Dr. Carpenter "resisted" replacement arthroplasty on December 4, 1995, he still recommended a second opinion be obtained. By April 8, 1996, Dr. Carpenter had recommended in four separate medical records/opinions that claimant be referred to an orthopedist for a second opinion. (See Dr. Carpenter's medical reports dated December 4, 1995, February 13, 1996, March 7, 1996 and April 8, 1996). Dr. Carpenter even suggested the names of physicians who could provide such an opinion on at least two separate occasions. Therefore, Dr. Carpenter's recommendation for surgery was still pending and awaiting the second opinion on April 3, 1996, when the employer closed the claim. We have concluded that Dr. Carpenter's April 8, 1996 post-closure recommendation to again seek a second opinion pertained to claimant's condition at claim-closure because he began recommending the referral in December 1995. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987). Because the status of claimant's surgery was pending at closure, we also consider the following evidence in support of claimant's contention that her condition at closure was not medically stationary.

In a June 4, 1996 chart note, Dr. Carpenter advised that claimant was finally scheduled to see Dr. Zirkle for a second opinion. Dr. Carpenter noted that she had continued effusion and discomfort over her right knee, and his "plan" on that date was to "[a]wait Dr. Zirkle's report as to his opinion regarding joint replacement." Two weeks later, claimant returned to Dr. Carpenter for another injection. Dr. Carpenter's assessment of her knee on that date was the same as it was on March 7, 1996: he noted effusion present, and degenerative changes, right knee, status-post right knee arthroscopy.

In a July 3, 1996 medical report, Dr. Zirkle opined that:

> "I agree with this [surgical intervention] because of pain being a major factor for a total knee. [Claimant] seems to be motivated to return to work and doesn't appear to be overstating her symptoms. I agree with [Dr. Carpenter's] decision to proceed ahead with a total knee."

In a July 10, 1996 chart note, Dr. Carpenter reported that:

> "[Claimant] is here to discuss the second opinion and the scheduling of a total knee arthroplasty.
>
> "The second opinion does agree with us that a total joint arthroplasty is most appropriate."

The employer has now authorized this surgery as appropriate, and it has been scheduled. Thus, claimant has established that her compensable condition at closure would be materially improved with the pending "medical treatment or the passage of time" (although she still need not establish a "worsening"). ORS 656.005(17).

Based on this medical evidence, which we conclude directly relates to the pending surgery and claimant's condition at claim closure, we continue to find that she has established that she was not medically stationary at closure. ORS 656.005(17); Scheuning v. J.R. Simplot & Co., supra.

We now turn to the penalty assessed in our prior order. The employer continues to contend that it did not unreasonably refuse payment of temporary disability compensation pursuant to our orders. Specifically, the employer contends that our assessment of a penalty in this case "ignores the complex procedural posture surrounding the Own Motion matter." We do not find evidence in the record to support the employer's argument.

In our prior order, we concluded that the employer ignored medical evidence in the record after the December 4, 1995 medically stationary date declared by Dr. Carpenter. We did not assess a penalty because the employer stopped the payment of TTD on December 4, 1995, nor did we order the employer to recommence the payment of temporary disability as of that date. Rather, we concluded that the employer unreasonably closed the claim by ignoring the medical evidence in the record on April 3, 1996, by issuing a "proposed" Notice of Closure (unreasonable claims processing), and by refusing the payment of temporary disability compensation then due claimant as awarded by our March 14, 1996 order.

In this regard, we continue to conclude that the employer disregarded its liability at the time of closure in light of the information available to it at that time. International Paper Co. v. Huntley, 106 Or App 107 (1991); Castle & Cook Inc. v. Porras, 103 Or App 65 (1990). Further, after we set aside its first closure of this claim, the employer issued a "proposed" Notice of Closure, which we continue to find transgresses claims processing procedures. It continued to ignore Dr. Carpenter's request for a second opinion prior to surgery, which is a reasonable request, given the complexity and drastic nature of the surgery and the age of the claimant. Finally, the employer continues to raise questions regarding Dr. Carpenter's medical records and opinions rendered prior to the first closure (on November 28, 1995), in an apparent attempt to require claimant to defend a closure status which we have previously and finally found to be premature.

We, therefore, continue to conclude that the record establishes that the employer unreasonably closed the claim on April 3, 1996, disregarding any doubt of its liability prior to that closure.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 3, 1996 order in its entirety. The penalty assessed in our prior order (25 percent of the amounts then due by virtue of our prior order and payable in equal shares to claimant and her attorney), shall be continued through the date of this order for amounts "then due." Claimant's attorney fee of 25 percent of the amount of increased disability compensation awarded under this order is approved.

IT IS SO ORDERED.

September 6, 1996 Cite as 48 Van Natta 1768 (1996)

In the Matter of the Compensation of
JACQUELYNE M. SCHULTE, Claimant
WCB Case No. 95-05380
ORDER OF ABATEMENT
W. Daniel Bates, Jr., Claimant Attorney
VavRosky, et al, Defense Attorneys

Claimant requests reconsideration of our August 8, 1996 Order on Review in which we set aside the employer's denial as a nullity because claimant had withdrawn her claim prior to its issuance. Seeking an attorney fee award under ORS 656.386(1), claimant requests that we reconsider our order which declined to award an attorney fee.

Both claimant and the employer have provided supplemental briefs addressing this issue. In order to consider this matter further, we hereby withdraw our August 8, 1996 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LEOTA J. DOOLITTLE, Claimant
WCB Case No. 94-03703
ORDER ON REMAND
John DeWenter, Claimant Attorney
Robert J. Jackson (Saif), Defense Attorney

This case is before the Board on remand from the Court of Appeals. SAIF v. Doolittle, 140 Or App 373 (1996). In our prior order, we modified the Administrative Law Judge's (ALJ's) order and increased claimant's unscheduled permanent disability award to 29 percent (92.8 degrees). Leota J. Doolittle, 47 Van Natta 813 (1995). We based the increased award on the finding that claimant's job-at-injury required "medium" strength.

The court reversed, reasoning that our prior order contained inconsistent factual findings regarding the physical demands of claimant's job-at-injury. The court has remanded for reconsideration of those findings. On reconsideration, and in lieu of our prior order, we issue this order.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the relevant facts. Claimant has an accepted claim for a cervical strain and left thoracocostal strain. The claim was closed by Notice of Closure in October 1993 with an award of 26 percent unscheduled permanent disability. By Order on Reconsideration dated March 17, 1994, the unscheduled permanent disability award was reduced to 17 percent. At hearing, the ALJ affirmed the Order on Reconsideration award of permanent disability.

On Board review, the only dispute concerned the rating of the adaptability factor.[1] In particular, the parties disputed the strength demand of claimant's job-at-injury. Claimant contended that his job-at-injury required the physical capacity to perform "medium" work, while the SAIF Corporation contended that it required the physical capacity to perform "light" work. We found that the Dictionary of Occupational Titles (DOT) code which most accurately described claimant's job-at-injury was Pet Shop Attendant (retail trade) (DOT 410.674-010), a medium strength job. Based on that finding, we concluded claimant's prior strength demand was medium. Inasmuch as the parties stipulated that claimant's residual functional capacity (RFC) was light, we concluded that claimant's adaptability value was 3 and, therefore, increased claimant's permanent disability award to 29 percent.

On judicial review, the court noted that we adopted the ALJ's factual findings regarding the specific duties of claimant's job-at-injury, including the finding that claimant lifted up to 50 pounds only on "an occasional basis." The court also noted that we made additional findings that "a significant portion" of claimant's job-at-injury involved heavy lifting and that heavy lifting was "more than an incidental part" of the job. Reasoning that those findings are inconsistent and were not resolved by our order, the court concluded that our order was not sufficiently explained for judicial review.

Turning to the merits, our task is to determine the appropriate DOT code which most accurately describes claimant's job-at-injury. See former OAR 436-35-270(3)(g)[2]; William L. Knox, 45 Van Natta 854 (1993). The strength demand of the appropriate DOT code will be claimant's prior strength demand.

Claimant's job-at-injury was working for a retail pet shop. The shop sold fish and birds and related accessories, as well as cat, dog and bird food, and dog kennels. Claimant's job duties varied but primarily involved sales to customers, shop cleaning, feeding and maintenance of pets, and stocking of merchandise. She waited on customers and rang up sales. She cleaned fish tanks and bird cages, and

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[1] At hearing, the parties stipulated to the values for the factors of age (1), education (5) and impairment (11).

[2] It is undisputed that the applicable standards for rating claimant's permanent disability are those set forth in WCD Admin. Order 6-1992, as amended by WCD Admin. Order 93-052.

vacuumed and dusted the store. Between customers, claimant restocked shelves and aisles with merchandise. She also lifted and carried fish tanks, dog kennels and pet food sacks. She carried 40 to 60-pound fish tanks on a monthly basis; lifted 15 to 40-pound bird cages on a daily to weekly basis; lifted 5 to 40-pound sacks of cat and dog food on a daily basis; lifted 35 to 40-pound dog kennels every few months; lifted 50 to 80-pound sacks of bird seed on a weekly or biweekly basis; and, with assistance, lifted fish tanks and stands weighing over 200 pounds on a very infrequent basis.[3]

SAIF argues that the appropriate DOT code is Salesperson, Pets and Pet Supplies (retail trade) (277.357-042), which sets forth the following duties:

> "Sells pets and pet accessories, equipment, food, remedies: Advises customer on care, training, feeding, living habits, and characteristics of pets, such as dogs, cats, birds, fish, and hamsters. Explains use of equipment, such as aquarium pumps and filters. Feeds and provides water for pets. Performs other duties as described under SALESPERSON (retail trade; wholesale tr.) Master Title. May clean cages and tanks...."

The Salesperson Master Title adds the following duty: "Places new merchandise on display." The Salesperson title has "light" physical demands, which involves "[l]ifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds." Former OAR 436-35-270(3)(g)(B) (Emphasis supplied.) "Frequent" means from 1/3 to 2/3 of the time, whereas "occasional" means up to 1/3 of the time. Former OAR 436-35-270(3)(g).

Claimant argues that the appropriate DOT code is Pet Shop Attendant (retail trade) (410.674-010), which sets forth the following duties:

> "Performs any combination of following duties to attend animals...on farms and in facilities, such as kennels, pounds, hospitals, and laboratories: Feeds and waters animals according to schedules. Cleans and disinfects cages, pens, and yards and sterilizes laboratory equipment and surgical instruments. Examines animals for signs of illness and treats them according to instructions. Transfers animals between quarters. Adjusts controls to regulate temperature and humidity of animals' quarters. Records information according to instructions, such as geneology, diet, weight, medications, food intake, and license number. Anesthetizes, inoculates, shaves, bathes, clips, and grooms animals. Repairs cages, pens, or fenced yards. May kill or skin animals, such as fox and rabbit, and packs pelts in crates."

The Pet Shop Attendant title has "medium" physical demands, which means "[l]ifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds." Former OAR 436-35-270(3)(g)(C).

After reviewing both DOT codes, we conclude that Salesperson, Pet and Pet Supplies (277.357-042) most accurately describes claimant's job-at-injury, based on the following reasoning. The Salesperson title involves primarily the sale of pets and related accessories, supplies and equipment, the maintenance of pets, and the stocking of merchandise. Those activities were the primary focus of claimant's job-at-injury. Although the Salesperson title does not include all of the lifting activities claimant performed, we are not persuaded that claimant's lifting activities were nearly as extensive as her sales, stocking and cleaning activities.

By contrast, the Pet Shop Attendant title involves primarily the intensive care and treatment of animals; it does not require customer sales or merchandise stocking. Claimant's job did not require intensive care of animals, only their maintenance. Moreover, the Pet Shop Attendant title requires "frequent" (i.e., from 1/3 to 2/3 of the time) lifting and/or carrying of up to 25 pounds. The evidence in this record does not persuade us that claimant lifted or carried up to 25 pounds for 1/3 of her work time. Hence, we do not find that claimant's job-at-injury required the "medium" strength demands of the Pet Shop Attendant title.

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[3] In making these findings, we have relied on claimant's testimony at hearing. We are mindful that, subsequent to issuance of the ALJ's and our orders in this case, the 1995 Legislature amended ORS 656.283(7) to bar admission of "post-reconsideration" evidence concerning issues arising from a notice of closure. Joe R. Ray, 48 Van Natta 325, recon 48 Van Natta 458 (1996). Amended ORS 656.283(7), which applies retroactively, went into effect on June 7, 1995. However, because the hearing record in this case was closed long before the effective date of the amended statute, the statutory exclusion of "post-reconsideration" evidence does not apply to this case. Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

Based on our conclusion that the Salesperson title most accurately describes claimant's job-at-injury, we find that claimant's prior strength demand was "light." See former OAR 436-35-270(3)(g). Accordingly, claimant's adaptability value is 1, and she is therefore entitled to an award of 17 percent unscheduled permanent disability, the same award made by the Order on Reconsideration and affirmed by the ALJ.

Accordingly, on reconsideration of our May 3, 1995 order, we affirm the ALJ's July 22, 1994 order.

IT IS SO ORDERED.

Board Chair Hall dissenting.

The court remanded this matter to us to resolve apparent inconsistencies in our findings of fact. Specifically, the court noted that, while we adopted the ALJ's finding that claimant lifted up to 50 pounds only on "an occasional basis," we also made additional (and apparently inconsistent) findings that a "significant" portion of claimant's work involved heavy lifting and that her work required more than light strength "on a relatively routine basis." Rather than resolve these apparent inconsistencies, however, the majority abandons our original decision that the DOT code for Pet Shop Attendant best describes claimant's job-at-injury. Because I continue to believe that our original decision is correct, and that the apparent inconsistencies identified by the court are readily reconcilable, I respectfully dissent.

The majority focuses on the frequency with which claimant lifted weights up to 25 pounds and, finding that the frequency was no more than "occasional," concludes that claimant's job-at-injury did not require "medium" strength. In my view, however, the frequency of claimant's lifting is not as significant a factor as the maximum weight she was required to lift in her job. Claimant testified that she sometimes (i.e., on a weekly to monthly basis) lifted 60 pound fish tanks and 80 pound sacks of bird seed. Those weights meet and exceed the maximum weight (50 pounds) for "medium" strength demands. In addition, claimant regularly lifted other items weighing up to 50 pounds.

These heavier lifting requirements were a "significant" portion of her duties and were performed on a "relatively routine basis," as we found in our original order, not because of the frequency with which she performed them (e.g., "occasional," "frequent," or "constant," as such terms are used in administrative rules) but "significant" because, regardless of the legally defined frequency or percentage, such duties were a critical, necessary requirement of the job she performed on a relatively routine basis. Thus, the apparent inconsistency in the findings of fact is reconciled in understanding the difference between the use of the legal term of "occasional" and the Board's use of the non-legal terminology of "significant" and "relatively routine basis."

Because claimant's job required her to lift items weighing significantly more than the maximum weight for "light" duty, i.e. 20 pounds, I would continue to find that the "light" DOT code of Pet Salesperson does not describe her job. Rather, the most accurate DOT code is the "medium" job of Pet Attendant. Although claimant did not perform all of the duties of a Pet Attendant, she was required to engage in the physical demands of that position. Based on the Pet Attendant code, I would raise claimant's adaptability value to 3 and increase her award to 29 percent unscheduled permanent disability.

September 11, 1996 Cite as 48 Van Natta 1771 (1996)

In the Matter of the Compensation of
PAUL E. HARGREAVES, Claimant
WCB Case No. 95-01401
ORDER OF ABATEMENT
Kirkpatrick & Zeitz, Claimant Attorneys
Roberts, et al, Defense Attorneys

The insurer requests abatement and reconsideration of our August 14, 1996 Order on Review in which we affirmed the ALJ's order which: (1) set aside its denial of claimant's lumbar disc conditions; and (2) awarded penalties for the insurer's allegedly unreasonable claim processing.

In order to consider this matter, we withdraw our August 14, 1996 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICK E. KELLY, Claimant
Own Motion No. 96-0308M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant, pro se, requests reconsideration of our August 8, 1996 Own Motion Order Reviewing Carrier Closure, which affirmed the SAIF Corporation's July 1, 1996 Notice of Closure in claimant's 1975 injury claim. Asserting that Dr. O'Meara's June 21, 1996 pre-closure chart note (which was not submitted to the Board previously) establishes that he was not medically stationary when SAIF closed his claim, claimant submits that chart note and asks that the Board consider Dr. O'Meara's opinion as such proof.

On August 20, 1996, we abated our August 8, 1996 order to allow SAIF the opportunity to respond to claimant's motion. SAIF contends that it based its closure of claimant's claim on Dr. Cronk's May 30, 1996 medical report, and it did so because Dr. Cronk is a member of the Managed Care Organization (MCO) and was claimant's treating physician at the time of surgery. SAIF did not submit a copy of Dr. O'Meara's chart note to the Board for consideration prior to the Board's review of claimant's July 1, 1996 Notice of Closure. On reconsideration, we issue the following order in place of our August 8, 1996 order.

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

SAIF contends that it based its decision to close claimant's claim on Dr. Cronk's May 30, 1996 medical report, in which he opined that claimant "has reached the point of maximum improvement and his condition is medically stationary."

Claimant contends that he requested that SAIF submit copies of Dr. O'Meara's June 5, 1996 and June 21, 1996 medical reports to the Board prior to our review of SAIF's closure in his claim. SAIF contends that because claimant's treating physician at the time of his last surgery was Dr. Cronk, and because Dr. O'Meara is not a member of SAIF's MCO, "[Dr. O'Meara] cannot be considered the treating physician." In an August 28, 1996 letter, SAIF further asserts that "[a]fter closure we agreed to let Dr. O'Meara treat [claimant] if he complied with the MCO contract." Apparently, Dr. O'Meara did not sign that contract. However, SAIF does not state why it did not send copies of Dr. O'Meara's pre-closure chart notes to the Board for consideration prior to our review of SAIF's closure.

Here, because we conclude that Dr. O'Meara was claimant's treating osteopath prior to and after surgery, his opinion is treated no less significantly because he was not a member of SAIF's MCO. Further, it is irrelevant for purposes of our review whether SAIF considered Dr. O'Meara as claimant's treating physician at the time of closure. When reviewing the record to determine whether a claim closure was premature, we consider all medical opinions which pertain to the claimant's condition at claim closure. We normally give greater weight to a treating physician's opinion; however, in some cases, the claimant may have a treating physician and a treating surgeon as well as other specialists, whose opinions may differ for various reasons. Weiland v. SAIF, supra; Somers v. SAIF, supra. Further, a medical opinion that is well-reasoned and based on complete information may be rendered by physicians other than the treating physician, or by physicians outside the insurers' MCO. See e.g., Marsha Brown, 47 Van Natta 1465 (1995).

In our prior order, we considered Dr. Roberts' July 12, 1996 medical report, in which he recommended that "[claimant's] care be transferred to Dr. Rod Beals at the University [Hospital] for consideration for left knee joint fusion." Dr. Roberts noted that he had never performed the left knee joint fusion procedure, and he preferred that Dr. Beals, who had much more experience with the procedure, make that determination. However, we were not persuaded by Dr. Roberts' opinion because: (1) although he had performed several surgeries on claimant's knee, Dr. Roberts did not examine claimant at claim closure and we had no evidence that he had examined claimant at any other time since 1991; (2) Dr. Roberts did not opine that claimant was not medically stationary at closure; and (3) Dr. Roberts recommended only that a surgery he had proposed in 1990 be "considered" for claimant, and referred claimant to Dr. Beals.

On August 13, 1996, claimant submitted two pre-closure chart notes from Dr. O'Meara. In his June 5, 1996 chart note, Dr. O'Meara noted that, on follow-up examination, claimant had no significant infusion on that date, but still had prominence at the medial aspect of the tibial plateau. Dr. O'Meara noted that he would contact claimant's "orthopedist," Dr. Cronk, for recommendations based on the arthroscopic findings of claimant's May 3, 1996 surgery. In his June 21, 1996 chart note, signed by Dr. O'Meara on June 24, 1996, the physician made the following observations:

> "[Claimant] is here for a follow-up. His knee is still swelling daily, mostly on the lateral aspect. [Claimant h]as catching and severe grinding sensation with associated pain with any significant weight bearing.
>
> "[A] letter from Dr. Cronk from June 12, 1996 was reviewed. His recommendation included only that a brace would probably not be helpful but he does not mention when or if partial or total knee replacement is indicated.
>
> "[Claimant's current condition is s]evere left knee sprain with arthritis, meniscus damage and recurrent effusion.
>
> "Records state that [claimant] should be considered medically stationary as of May of this year. I disagree with this and feel that [claimant's] problem has been progressive and will continue to progress and the workmen's claim should remain open until he has his final knee replacement. He will probably need 2 to 3 [more] of these over the next 30 to 40 years.
>
> "[Claimant] was told to contact Dr. Cronk, the orthopedic surgeon, to obtain more detailed information regarding surgical correction."

We are persuaded that, because Dr. O'Meara examined claimant on June 21, 1996, after Dr. Cronk's May 30, 1996 examination, his opinion is more contemporary than Dr. Cronk's, and is relevant to claimant's condition at claim closure. Dr. O'Meara was claimant's treating osteopath prior to his last surgery, and at that time, recommended that claimant be evaluated by Dr. Cronk for surgery. Dr. O'Meara continued to provide follow-up examinations after surgery, as demonstrated by his June 5, 1996 and June 21, 1996 chart notes. Here, on June 21, 1996, Dr. O'Meara again recommends that claimant contact Dr. Cronk for information regarding surgical correction. Therefore, we are persuaded by Dr. O'meara's opinion that claimant's compensable condition required surgery at claim closure. Marsha Brown, supra; Weiland v. SAIF, supra; Somers v. SAIF, supra.

According to an undated handwritten note from claimant received by the Board on August 13, 1996, claimant did not return to Dr. Cronk because Dr. Cronk did not return his telephone calls. Therefore, claimant contends that he was delayed for several weeks in being advised as to what Dr. Cronk discovered at surgery. Claimant advised SAIF that he wanted a "new" doctor, and requested that SAIF approve Dr. Roberts as his current physician. In a July 12, 1996 letter, SAIF notified claimant that it would approve Dr. Roberts as claimant's treating physician if Dr. Roberts agreed. Thus, instead of returning to Dr. Cronk, claimant returned to Dr. Roberts for examination. In light of Dr. O'Meara's opinion that claimant's knee condition is progressive and required "surgical correction," we find reason to review Dr. Roberts' July 12, 1996 post-closure recommendation that claimant be considered for additional surgery. Scheuning v. J.R. Simplot & Co., supra. Because Dr. Roberts' referral for surgical consideration supports Dr. O'Meara's opinion that claimant's knee condition required surgical intervention at closure, we conclude that his opinion addresses claimant's condition at closure. On this record, we are persuaded that claimant has established that his compensable injury was not medically stationary at claim closure.

Accordingly, we set aside SAIF's July 1, 1996 Notice of Closure as premature. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation
GASPAR LOPEZ, Claimant
WCB Case No. 95-13576
ORDER ON REVIEW (REMANDING
Bottini, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) admitted several documents which pertained to claimant's September 1990 low back injury; and (2) upheld the procedural validity of the insurer's denial of claimant's current right wrist condition. Noting that an Order on Reconsideration issued subsequent to the ALJ's order and found that claimant's previously accepted right wrist claim was properly classified as nondisabling, the insurer seeks remand for consideration of this evidence or, alternatively, requests that we take administrative notice of the reconsideration order. On review, the issues are evidence, administrative notice, remand, and the procedural validity of the insurer's denial. We vacate the ALJ's order and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In April 1995, the insurer accepted a right wrist strain resulting from claimant's employment as an assembler for a toy company. The insurer classified the claim as nondisabling. The insurer subsequently issued a denial of claimant's current condition on December 7, 1995. On March 1, 1996, a Determination Order changed the status of the claim to disabling. The insurer then requested reconsideration, which was pending at the time of the March 11, 1996 hearing concerning the insurer's denial.

Rejecting claimant's assertion that the insurer's denial was an invalid pre-closure partial denial, the ALJ upheld the insurer's denial on the merits. On review, claimant contends that the insurer's denial is an invalid pre-closure denial of a disabling claim because the March 1, 1996 Determination Order reclassified the claim to "disabling," and because the limited exception to the proscription against pre-closure denials in ORS 656.262(6)(c) and (7)(b) for "combined" and "consequential" conditions is inapplicable. The insurer responds by requesting that we remand for admission of an April 1996 Order on Reconsideration that rescinded the March 1, 1996 Determination Order and reclassified this claim to "nondisabling." Alternatively, the insurer requests that we take administrative notice of the April 1996 reconsideration order.[1]

Although we agree with the insurer that remand is appropriate, we do so not for the admission of additional evidence, but rather for consolidation with claimant's request for hearing regarding the April 1996 reconsideration order. We reach this conclusion for the following reasons.

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[1] The insurer designated its request for remand or administrative notice as a "cross-appeal." Claimant argues that we should not consider the insurer's request for lack of a formal cross-appeal of the ALJ's order. We disagree with claimant. A formal cross-request for review is not required as long as claimant's request for review is not withdrawn. See Catherine E. Wood, 47 Van Natta 2272, 2274 n. 1 (1995) (citing Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983)). Therefore, we consider the insurer's request for remand/administrative notice.

A "pre-closure" denial of a current condition is invalid when that condition is neither a "combined" nor a "consequential" condition. Elizabeth B. Berntsen, 48 Van Natta 1219 (1996) (rationale expressed in Roller v. Weyerhaeuser Co., 67 Or App 743, amplified 68 Or App 743, rev den 297 Or 601 (1984) remains viable despite enactment of amended ORS 656.262(6)(c) and (7)(b)). Here, the record does not establish that claimant's current condition is either a "combined" or a "consequential" condition. Therefore, the insurer's December 1995 denial of claimant's current condition may be invalid if it was issued prior to closure of a "disabling" claim.

When the insurer's denial was issued in December 1995, the claim was classified as "nondisabling." Inasmuch as there is no requirement that a "nondisabling" claim be closed, see ORS 656.268(2)(4); Robb L. Renne, 45 Van Natta 5 (1993), the December 1995 denial was not an improper pre-closure denial of a disabling condition when it issued. However, the March 1, 1996 Determination Order reclassified the claim to "disabling." Therefore, the insurer's denial would be an invalid pre-closure denial of claimant's current condition since the denial was issued prior to a valid claim closure. Elizabeth B. Berntsen, supra.

As previously noted, the insurer has requested that we remand for the admission of the April 1996 Order on Reconsideration that rescinded the March 1, 1996 Determination Order and reclassified the claim to "nondisabling" status. Alternatively, the insurer argues that we can take administrative notice of the reconsideration order. On the other hand, claimant notes that the reconsideration order is not final because he has requested a hearing challenging the order's classification of his claim. (WCB 96-04002). Claimant urges us to take administrative notice of the hearing request.

We may take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot readily be questioned." Rodney J. Thurman, 44 Van Natta 1572 (1992). The Department's April 4, 1996 Order on Reconsideration is an act of a state agency, which satisfies the aforementioned criteria. See Phyllis Swartling, 46 Van Natta 481 (1994). Similarly, the existence of a docketed appeal is a matter whose accuracy cannot reasonably be questioned . See Mark A. Crawford, 46 Van Natta 725, 727 (1994) (Although a Request for Hearing is not an agency order, it is a document which has procedural significance which enables an evaluation of the evidence); David Hill, 46 Van Natta 526 (1994). Accordingly, because the Order on Reconsideration and claimant's request for hearing regarding that order meet the aforementioned standard, we take administrative notice of them.

The procedural validity of the insurer's denial depends on the determination of whether claimant's claim is properly classified as nondisabling or disabling. We, accordingly, find that the issue in this case and the classification dispute in WCB 96-04002 are inextricably intertwined. For this reason, as well as to further administrative economy and to avoid the possibility of inconsistent results, we find a "compelling" reason to remand this case for consolidation with the proceedings in WCB 96-04002. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); cf. Greg V. Tomlinson, 47 Van Natta 1085 (1995); aff'd 139 Or App 512 (1996) (consolidated review appropriate where issues inextricably intertwined).

Accordingly, we vacate the ALJ's order and remand this case to ALJ Lipton, with instructions to reconsider this case in consolidation with the forthcoming hearing in WCB 96-04002.[2] Those proceedings may be conducted in any manner that ALJ Lipton determines will achieve substantial justice. Following a hearing and the closure of the record, the ALJ shall issue a final, appealable order addressing the issues raised in these consolidated cases.

IT IS SO ORDERED.

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[2] Given our disposition of this case, we need not address claimant's challenge to the ALJ's evidentiary ruling.

In the Matter of the Compensation of
STANLEY MEYERS, Claimant
WCB Case No. 90-09863
ORDER ON REMAND (REMANDING)
Doblie & Associates, Claimant Attorneys
Roberts, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corporation v. Meyers, 141 Or App 135 (1996). The court reversed our order, Stanley Meyers, 47 Van Natta 829 (1995), that: (1) set aside the insurer's partial denial of his medical services claim for chiropractic treatments provided in excess of the administrative guideline; and (2) set aside the insurer's denial of his aggravation claim for low back treatment. Citing Willhite v. Asplundh Tree Experts, 136 Or App 120 (1995), and Volk v. America West Airlines, 135 Or App 565 (1995), rev den 322 Or 645 (1996), the court reversed and remanded for reconsideration. In lieu of our prior orders, we issue the following order.

FINDINGS OF FACT

Claimant, a warehouseman, compensably injured his low back and left hip on September 17, 1986, when he was struck by a forklift being driven by a co-worker. The diagnosis was lumbar strain with myofascitis, and left hip strain. Claimant was released from work and treated conservatively. His claim was closed by Notice of Closure on December 15, 1986 with an award of temporary disability benefits only.

In January 1987, claimant sought treatment for left hip pain. He was diagnosed with a strain of the left sacroiliac joint and released from work. His claim was reopened and closed by Notice of Closure on June 1, 1987, with an award of additional temporary disability benefits only. The June 1987 closure notice was the claimant's last award of compensation.

Claimant continued working at his regular job and, in January 1989, he sought treatment with Dr. Ho for recurrent low back pain. Claimant did not follow up with treatment for his pain. In September 1989, claimant returned to Dr. Ho with recurrent low back pain. Dr. Ho treated with electrical stimulation, manipulation and trigger point injections. Claimant's condition improved, though he continued to have residual discomfort in his low back.

In February 1990, claimant began treating with Dr. Kennedy, a chiropractor, about once or twice per week. On April 24, 1990, the insurer partially denied claimant's chiropractic treatment in excess of the administrative guideline for such treatments, i.e., two visits per month.[1] On June 1, 1990, the insurer denied claimant's aggravation claim on the basis that there was no material worsening of his compensable back condition. Claimant requested a hearing on both denials and sought the assessment of penalties and attorney fees for the insurer's allegedly unreasonable denials.

PROCEDURAL HISTORY

The Administrative Law Judge (ALJ) (formerly called Referee) set aside both the medical services and aggravation denials, and assessed a penalty for unreasonable claim processing. On Board review, we vacated, for lack of jurisdiction, that portion of the ALJ's order that set aside the insurer's medical services denial. Stanley Meyers, 43 Van Natta 2643 (1991). We reasoned that the Director had exclusive jurisdiction over the issue of the reasonableness and necessity of medical treatment pursuant to ORS 656.327, and that the medical treatment dispute was not a matter concerning a claim over which the Hearings Division had jurisdiction. Id. In addition, we reversed the ALJ's assessment of a penalty and attorney fee, finding that the insurer's failure to seek Director review was not unreasonable. Id.

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[1] The administrative guideline in effect at the time of the disputed treatment, former OAR 436-10-040(2)(a), provided, in pertinent part:

> "Frequency and extent of treatment shall not be more than the nature of the injury or process of a recovery requires.... The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first 60 days from first date of treatment, and two visits a month thereafter." WCD Admin. Order 1-1990.

On the aggravation issue, we reversed the ALJ's order and reinstated and upheld the aggravation denial. Id. We reasoned that, although claimant experienced a symptomatic worsening of his compensable condition, he did not prove his earning capacity was diminished below what it was at the time his claim was last closed. Id.

The Court of Appeals reversed our order. On the medical services issue, the court determined that the Director acquires exclusive jurisdiction over a medical treatment dispute under ORS 656.327 only if a party or the Director "wishes" Director review and gives the appropriate notice. Meyers v. Darigold, Inc., 123 Or App 217, 221-22 (1993). Because no such "wish" was filed with the Director in this case, the court held that jurisdiction of this medical treatment dispute remained with the Board. Id.

On the aggravation issue, the court held that, inasmuch as claimant's aggravation claim was limited to medical services, he was not required to prove diminished earning capacity in order to establish his claim. Id. at 223. The court instructed us to determine, on remand, whether claimant's need for medical services was the result of the compensable injury. Id. at 224.

On remand, we set aside the medical services denial, finding that claimant's chiropractic treatments in excess of the administrative guideline were reasonable and necessary for the compensable injury. 47 Van Natta at 831. We also set aside the aggravation denial, finding that claimant suffered a symptomatic worsening of his compensable condition since the last award of compensation in June 1987. Id. at 832. However, we declined to assess penalties and related attorney fees against the insurer. Id. The insurer appealed our order to the court.

While this matter was pending before the court, the 1995 Legislature substantially amended the Workers' Compensation Law, effective June 7, 1995, and made the new law generally applicable to matters for which the time to appeal the Board's order had not expired or, if appealed, had not been finally resolved by the courts. See Volk v. America West Airlines, supra, 135 Or App at 572-73. In this case, because review of our order was sought, but was not finally resolved by the court at the time of the effective date of the new law, the new law is applicable. See id. Pursuant to the court's mandate, we now proceed to review this matter under the new law.

CONCLUSIONS OF LAW AND OPINION

Medical Treatment - Jurisdiction

The 1995 Legislature amended ORS 656.327(1) and added subsection (6) to ORS 656.245. Those provisions now invest the Director with exclusive jurisdiction over the review of medical treatment disputes, unless the claim for medical services is denied on the basis that the underlying claim is not compensable. Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413 (1995); Newell v. SAIF, 136 Or App 280 (1995); Sue A. Springer, 48 Van Natta 66 (1996); John L. Willhite, 47 Van Natta 2334 (1995); Walter L. Keeney, 47 Van Natta 1387, 1389 (1995).

Here, the dispute concerns the appropriateness of chiropractic treatments provided in excess of the administrative guideline. There is no dispute regarding the compensability of claimant's underlying current low back and left hip condition. See Arthur R. Morris, 48 Van Natta 349 (1996); Richard L. Wheeler, 47 Van Natta 2011 (1995). Because compensability is not at issue, we conclude that jurisdiction over the medical treatment dispute lies with the Director, not the Board. See amended ORS 656.245(6); Sue A. Springer, supra; John L. Willhite, supra. In addition, we lack jurisdiction over claimant's request for a penalty and related attorney fee concerning the reasonableness of the insurer's medical services denial. See amended ORS 656.385(5); Lynda J. Zeller, 47 Van Natta 1581, 1584, recon 47 Van Natta 2337 (1995).

Aggravation

As amended in 1995, ORS 656.273(1) now provides:

> "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 supplied.)

Unlike the former version, the current statute requires medical evidence of an "actual worsening" of the compensable condition. In Carmen C. Neill, 47 Van Natta 2371 (1995), we held that an "actual worsening" is established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the condition greater than that anticipated by the prior award of permanent disability. In addition, the statutory definition of "objective findings" has been amended as well. See amended ORS 656.005(19).

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, 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 review of a case is pending. See, e.g., Troy Shoopman, 46 Van Natta 21, 22 (1994) (case remanded to ALJ because record devoid of evidence regarding legal standard recently announced by Supreme Court); see also Betty S. Tee, 45 Van Natta 289 (1993) (Board remanded matter to ALJ in light of Supreme Court's intervening definition of relevant statutory term); cf. Rosalie S. Drews, 46 Van Natta 408, recon den 46 Van Natta 708 (1994) (Board declined to remand case to ALJ for additional evidence under Supreme Court's recent interpretation of statute, when record was sufficiently developed to analyze issue under that interpretation).

Here, while judicial review of this matter was pending, the "actual worsening" standard of amended ORS 656.273(1) went into effect. The record contains an opinion by Dr. Ho that claimant's condition in 1989 was "worse" and that he suffered a "recurrence of low back strain." (Ex. 15). In addition, Dr. Kennedy opined that claimant's condition was no longer medically stationary due to persistent back pain. (Ex. 27). Opposing opinions were offered by Drs. Kiest and Fechtel, who concluded that claimant's condition remained medically stationary since the 1987 claim closure, (Ex. 23), and by Dr. Ho who later concurred with the opinion of Drs. Kiest and Fechtel, (Ex. 26).

Notwithstanding the aforementioned evidence, we conclude the record is insufficiently developed to assist us in determining whether claimant sustained an "actual worsening" of his compensable condition (for which he has not previously received a permanent disability award). See Laura Maderos, 48 Van Natta 538, 541, recon 48 Van Natta 838 (1996); Carmen C. Neill, supra (remanding for submission of additional evidence regarding an "actual worsening" where the claimant had not received a prior award of permanent disability and where the parties lacked an opportunity to develop record regarding appropriate legal standard). Moreover, because amended ORS 656.273(1) went into effect after this record was developed and while review of this matter was pending, we find that there is a compelling reason to remand for the submission of additional evidence regarding whether claimant sustained an "actual worsening" with respect to his compensable condition. Finally, there is also compelling reason to remand for further evidence taking regarding the existence of any "objective findings" (as defined in amended ORS 656.005(19)) to prove a worsened condition.[2]

Accordingly, the ALJ's order dated August 3, 1990 is vacated. Claimant's request for hearing regarding the insurer's April 24, 1990 partial denial of chiropractic treatments is dismissed for lack of jurisdiction. The aggravation matter is remanded to the Presiding ALJ for assignment to another ALJ for further proceedings regarding the compensability of the aggravation claim and the propriety of assessing a penalty and related attorney fee based on the insurer's June 1, 1990 denial. 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 aggravation and accompanying penalty and attorney fee issues.

IT IS SO ORDERED.

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[2] On judicial review, the insurer appeared to suggest that the outcome of claimant's aggravation claim may depend on the resolution of the dispute regarding chiropractic treatments in excess of the guideline. If that was the case, we would have deferred this matter pending the outcome of the Director's medical review. E.g., Lisa L. Daulton, 48 Van Natta 273 (1996). In this case, based on the medical opinions, we do not find that the outcome of the aggravation issue depends on the propriety of the disputed chiropractic treatments. Therefore, we decline to defer the aggravation matter pending the Director's review of disputed treatment.

In the Matter of the Compensation of
ALAN T. SPAETH, Claimant
WCB Case Nos. 95-10954 & 95-08437
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Bogle & Gates, Attorneys
Roberts, et al, Defense Attorneys
Sather, Byerly, et al, Defense Attorneys

On August 23, 1996 , we abated our July 25, 1996 order that: (1) assessed an attorney fee against Cigna Insurance Company under ORS 656.382(2); and (2) affirmed the ALJ's award of an attorney fee against Geisy, Greer and Gunn (Geisy) pursuant to ORS 656.386(1). We took this action to consider Cigna's and Geisy's motions for reconsideration.

Cigna contends that Geisy should be responsible for any assessed fee under ORS 656.382(2) because Geisy's request for review put claimant's compensation at risk, even though Cigna was the only carrier to contest compensability on review. Geisy asserts that it is not responsible for an attorney fee under ORS 656.386(1) because it did not contest compensability at the hearing. Having fully considered the parties' arguments, we now proceed with our reconsideration.

We begin by briefly recounting the relevant facts. Cigna denied both compensability and responsibility. Geisy's denial was couched in terms of responsibility. The ALJ determined that Geisy was responsible for claimant's compensable condition and assessed an attorney fee under ORS 656.386(1) against Geisy because it took the position at hearing that claimant's condition was not compensable. Geisy requested review, contesting only responsibility. Cigna, however, continued to contest compensability on review, although it did not formally cross-request review.

On review, we affirmed the ALJ's determination that Geisy was responsible for claimant's condition. We also found that Geisy amended its denial at hearing to include a compensability defense. Thus, we affirmed the ALJ's assessment of an attorney fee pursuant to ORS 656.386(1) against Geisy. We also concluded that claimant's counsel was entitled to an assessed fee under ORS 656.382(2) for services on review regarding the compensability issue. We reasoned that, because claimant's compensation remained at risk due to Cigna's continued compensability defense, Cigna was responsible for the fee on review.

In SAIF v. Bates, 94 Or App 666 (1989), the court held that the carrier that initiated the request for Board review was responsible to claimant's attorney fee under ORS 656.382(2). The court reached this conclusion even though that carrier did not contest compensability at hearing or on review, and even though the other carrier argued at hearing and on review that claimant's claim was untimely. The court reasoned that, if the other carrier had prevailed on its timeliness defense and if that carrier was otherwise responsible for the claim, claimant may not have been entitled to compensation from either employer. Thus, the court concluded that the carrier requesting review was responsible for the attorney fee under ORS 656.382(2) because its request for review put compensability and responsibility at issue, thereby justifying claimant's active participation before the Board.

Bates is controlling here. Like the carrier that requested review in Bates, Geisy does not contest compensability on review. However, by reason of Cigna's continued compensability defense, Geisy's request for review has justified claimant's active participation before the Board. We acknowledge Geisy's argument that our decision to assess an attorney fee against Cigna is sound policy because it would discourage weak compensability arguments by carriers that do not formally request cross-review. However, we are constrained to follow the court's decision in Bates.

Accordingly, we conclude that our decision to assess a $1,000 attorney fee against Cigna under ORS 656.382(2) was in error. We instead assess the attorney fee against Geisy. Our order is modified in conformance with this decision.

Finally, Geisy requests that we reconsider our finding that it did not orally amend its denial at hearing to include a compensability defense. After further consideration of its issue, we continue to adhere to our reasoning on this issue. Geisy remains responsible for an attorney fee pursuant to ORS 656.386(1).

Accordingly, on reconsideration, as supplemented and modified herein, we republish our July 25, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

September 11, 1996 Cite as 48 Van Natta 1780 (1996)

In the Matter of the Compensation of
SHERI A. WHEELER, Claimant
WCB Case No. 95-13771
ORDER OF DISMISSAL
Coons, Cole, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

The insurer requested review of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its denial of claimant's neck, back, and right shoulder injury claim; and (2) assessed a penalty for allegedly unreasonable claim processing. In her respondent's brief, claimant moves for the assessment of a penalty under ORS 656.382(3) and sanctions under ORS 656.390 against the insurer's attorney for an allegedly frivolous appeal. In reply, in addition to seeking sanctions against claimant's counsel for an allegedly frivolous motion, the insurer withdraws its request for Board review.

We dismiss the insurer's request for review with the following supplementation regarding the motions for penalties and sanctions.

Claimant, a CNA, injured her back when she attempted to adjust a patient's position in bed. The insurer denied the claim contending that claimant had overstepped the boundaries of her work by attempting to move the patient by herself (which was allegedly contrary to her employer's instructions). Finding that claimant's activities were within her ultimate work (even assuming that she had violated her employer's instructions), the ALJ set aside the insurer's denial. The insurer requested Board review.

Claimant argues that the appeal became frivolous following the filing of the appeal, when the Supreme Court issued its decision in Andrews v. Tektronix, Inc., 323 Or 154 (1996) (employee's violation of an employment rule does not render his or her claim per se noncompensable). On this basis, claimant seeks sanctions against the insurer's attorney. In response, the insurer argues that ORS 656.390 contemplates the assessment of sanctions for frivolous appeals only if the appeal is "initiated" without reasonable prospects for success.

ORS 656.390(1) provides that if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the Board may impose an appropriate sanction upon the attorney who filed the request for review. "Frivolous" means that the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2); see also Winters v. Woodburn Carcraft Co., 142 Or App 182 (1996).

Here, the employer argued at hearing that claimant's injuries were not compensable because she violated the employer's directions by attempting to position a patient without help. Claimant argues that the Court's decision in Andrews v. Tektronix, Inc., supra, removed any reasonable prospect that the employer would prevail. However, the statute provides that the appeal must be initiated without reasonable prospect of prevailing. Because Andrews did not issue until after the appeal was initiated, we find that its issuance would have no effect on our determinations regarding whether the initiation of the appeal was frivolous. Moreover, the statute does not expressly provide for the imposition of sanctions where an already initiated appeal becomes frivolous after it is filed. In any case, even if an appeal can become frivolous for purposes of assessing sanctions, we cannot conclude that the insurer did not have at least a colorable argument that claimant was acting outside the course and scope of her employment by attempting to move the patient without assistance. See Gerald R. Schiller, 48 Van Natta 854 (1996). Under such circumstances, we are unable to find that the insurer's appeal was initiated without any reasonable prospect of prevailing.

Claimant seeks attorney fees under ORS 656.386(1) and a penalty under 656.382(3). Claimant is not entitled to a fee for services at the Board level under ORS 656.386(1). Claimant did not initiate the appeal of the ALJ's order. Moreover, she finally prevailed over the carrier's denial at the hearing level and has already been awarded an appropriate fee under ORS 656.386(1). We further note that, because the carrier's request for review has been dismissed, claimant is not entitled to a fee under ORS 656.382(2). See Terlouw v. Jesuit Seminary, 101 Or App 493 (1990). Finally, a penalty may not be awarded under ORS 656.382(3). ORS 656.382(3) allows an ALJ to assess a penalty if the carrier initiated a hearing for the purpose of delay or other vexatious reason without reasonable ground. The statute does not pertain to requests for Board review. Verl E. Smith, 43 Van Natta 1107, 1108 (1991); Donald G. Messer, 42 Van Natta 2085 (1990).

The insurer seeks the imposition of sanctions against claimant's attorney because of a frivolous motion for sanctions. As previously noted, with regard to Board review, ORS 656.390(1) expressly pertains to "appeals" that are frivolous or filed in bad faith. With the exception of motions for reconsideration of Court of Appeals or Supreme Court decisions, the statute does not expressly refer to frivolous motions. Consequently, it is questionable whether motions filed with the Board are encompassed within the terms "appeal" or "review" set forth in the statute. We need not resolve that question here, however, because we are persuaded that the claimant had at least a colorable argument that claimant's motion for sanctions based on the "post-initiation" Andrews holding was not frivolous. Therefore, even assuming ORS 656.390(1) is applicable to a motion for sanctions, we are likewise unable to say that the claimant's motion was initiated without any reasonable prospect of prevailing.

Accordingly, the insurer's request for review is dismissed. The motions for penalties and sanctions are denied.

IT IS SO ORDERED.

September 11, 1996 Cite as 48 Van Natta 1781 (1996)

In the Matter of the Compensation of
THOMAS M. SAVELICH, Claimant
WCB Case No. 95-09940
ORDER OF ABATEMENT
Malagon, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our August 14, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld the insurer's denials of claimant's occupational disease/aggravation claim for a low back condition; and (2) declined to reopen the record to admit a medical report. Claimant has also advised the Board that the parties are presently negotiating a comprehensive settlement of claimant's claim.

In order to further consider claimant's motion and in light of the settlement negotiations, we withdraw the Board's August 14, 1996 order. The insurer is granted an opportunity to respond to claimant's motion. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement. In the meantime, the parties are requested to keep us fully apprised of any further developments in this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
DARROLD D. WILLIS, Claimant
WCB Case No. 94-13468
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

On May 8, 1996, we abated our April 9, 1996 order that affirmed an Administrative Law Judge's (ALJ's) order which upheld the self-insured employer's partial denial of claimant's left knee condition. We took this action to consider claimant's motion for reconsideration. Having received the employer's response, we proceed with our reconsideration.

Claimant has an accepted claim for left knee strain. In March 1993, claimant underwent surgery for the left knee. An August 1993 Notice of Closure awarded 15 percent scheduled permanent disability for the left knee. The employer did not appeal the Notice of Closure. In October 1994, the employer partially denied claimant's current left knee condition.

The ALJ first found that claimant had a preexisting degenerative left knee condition and that such condition combined with the accepted injury. The ALJ further found that the preexisting condition was the major contributing cause of claimant's left knee condition and, thus, upheld the denial. On review, we adopted and affirmed the ALJ's order, and provided further reasoning for concluding that claimant failed to prove that his left knee condition was, in major part, caused by the compensable injury under ORS 656.005(7)(a)(B).

We abated our order to address claimant's argument that the employer is precluded from denying claimant's current condition because the Notice of Closure awarded disability, in part, based on impairment from the preexisting condition. Claimant relies on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (Messmer II).

In Messmer II, the court affirmed its earlier decision in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995) (Messmer I). In Messmer I, an employer failed to appeal a Determination Order which had awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease. The court held that claim preclusion barred the employer from denying the degenerative disease condition since it had failed to challenge the permanent disability award on the basis that it included an award for a noncompensable condition. 130 Or App at 258.

In Messmer II, the court considered the impact of the 1995 amendments to ORS 656.262(10)[1] on its decision in Messmer I. The Messmer II court found that, because the amended statute provides only that payment of permanent disability benefits does not preclude an employer from subsequently contesting compensability and says nothing about the preclusive consequences of an employer's failure to appeal a determination order, the new law did not affect the reasoning or holding of Messmer I. 140 Or App at 553-54. The court further explained that, even if the legislative history showed an intent to overrule Messmer I, the court could not rewrite the statute to give effect to what the legislature may have intended. Id. at 555.

Thus, pursuant to the holding in Messmer II, we consider whether the employer is precluded from denying the current condition because the award by the Notice of Closure was, in part, for the preexisting degenerative condition.[2]

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[1] In 1995, the legislature added the following sentence to ORS 656.262(10):

"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 amendment to ORS 656.262(10) retroactively applies. See Messmer II, supra, 140 Or App at 551, n 2.

[2] Because claimant's attorney at hearing explicitly stated that he was "raising an additional issue" based on Messmer II and the employer's attorney did not object, we reject the employer's contention on reconsideration that we should not address the Messmer issue because claimant failed to preserve the argument.

Following claimant's surgery, Dr. Vigeland, claimant's surgeon, noted "limited motion due to swelling." (Ex. 14). Dr. Vigeland suspected "this is from his degenerative disease." (Id.) Dr. Vigeland injected the knee, which "helped markedly." (Ex. 16). Dr. Vigeland found that "this confirms that he has an underlying synovitis secondary to a degenerative joint disease."

On July 26, 1993, Dr. Vigeland found claimant medically stationary. (Ex. 17). Dr. Vigeland found the presence of "mild effusion" and "some chronic, achy discomfort, due in all likelihood to his underlying osteoarthritis." (Id.) Dr. Vigeland also found that range of motion was 0 to 120 degrees and that "claim closure is appropriate with impairment related to 10% for his lateral meniscectomy." (Id.) Finally, Dr. Vigeland noted that claimant "undoubtedly will require some treatment in the future if his degenerative disease progresses." (Id.)

In the worksheet accompanying the Notice of Closure, the evaluator noted "11%" for "range of motion" and "5%" for "surgery." (Ex. 18). Claimant contends that the impairment for "range of motion" was due to the degenerative condition and, in this way, such condition was part of the permanent disability awarded by the Notice of Closure.

The resolution of this issue is close. Before declaring him medically stationary, Dr. Vigeland found limited motion due to swelling and attributed the condition to the degenerative disease. His closing examination, however, although noting "mild effusion," does not indicate that claimant's range of motion was affected by the swelling. Furthermore, Dr. Vigeland expressly stated that impairment was for the surgery. In discussing the degenerative disease, Dr. Vigeland notes only that claimant continues to have chronic discomfort and will require treatment for such condition in the future.

Based on Dr. Vigeland's express statement that impairment was for the surgery and the lack of any indication of a connection in the closing examination between the range of motion and the degenerative condition (including swelling, for which he previously found limited motion), we are not convinced that claimant's range of motion was affected by the degenerative disease. Consequently, we find that claimant failed to prove that the award in the Notice of Closure based on range of motion was for the degenerative condition. Thus, we conclude that the Notice of Closure does not preclude the employer from denying claimant's current left knee condition.

Finally, for the reasons stated in the Order on Review, we continue to conclude that claimant failed to prove the compensability of his current left knee condition.

On reconsideration, as supplemented herein, we adhere to and republish our April 9, 1996 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
RANDELL R. BROOD, Claimant
WCB Case No. 95-10587
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that directed the SAIF Corporation to recalculate the rate of temporary total disability (TTD) benefits based on hourly wages and incentive pay he received from August 1, 1994 until October 24, 1994, excluding a two-month "extended gap." On review, the issue is TTD rate. We modify.

FINDINGS OF FACT

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

In lieu of the finding that claimant received a 50 cent raise on or about August 1, 1994, we find that claimant received a 50 cent wage increase (from $6.50 to $7 per hour) sometime in August 1994.

In lieu of the finding that the employer informed employees of the plant shutdown two weeks after claimant's pay raise, we find that the employer informed employees of the shutdown on or about August 14, 1994.

In lieu of the finding that claimant injured his right wrist on October 24, 1994, we find that claimant injured his left wrist on that date and subsequently developed bilateral wrist tendinitis.

We do not adopt the finding that claimant returned to regular work.

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the relevant facts. Claimant, a mill worker, began working for the employer in May 1994 at an hourly wage of $6.50. Depending on his work crew's productivity, claimant also received incentive pay which varied from day to day. He worked four days per week, 10 hours per day. Sometime in August 1994, his hourly wage was increased to $7. On or about August 14, 1994, employees were notified that the plant would shut down for installation of new equipment, beginning August 28, 1994. Claimant was off work from August 28, 1995 until October 24, 1994. On October 24, 1994, claimant's first day back at work, he compensably injured his left wrist and later developed bilateral wrist tendinitis. He worked the next day but was subsequently released from work.

In determining the proper method of calculating claimant's TTD rate, the ALJ applied former OAR 436-60-025(5)(a) (DCBS Admin. Order 94-055), which provides:

> "For workers employed on call, paid hourly, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist and where there has been no change in the amount or method of the wage earning agreement, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. Where there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury. For workers employed less than four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker." (Emphasis supplied.)

The ALJ concluded that the emphasized portion of the rule applies to this case, because: (1) the two-week plant shutdown was an "extended gap" in claimant's employment; and (2) claimant's 50-cent pay raise in August 1994 was a change in the amount of the "wage earning agreement" which occurred during the 52-week period preceding the date of injury. On review, the parties do not contest those findings. Therefore, pursuant to the above-emphasized portion of the rule, SAIF was required to "use only the actual weeks under the 'wage earning agreement' at time of injury" in calculating claimant's average weekly earnings.

The parties do not dispute that under the "wage earning agreement" in effect at the time of the injury, claimant earned a base hourly wage of $7, plus any earned incentive pay. However, on review, claimant contends that the ALJ erroneously determined the "actual weeks" under the wage earning agreement at the time of injury.

The ALJ directed SAIF to calculate TTD based on hourly wages and incentive pay claimant earned from August 1 until October 24, 1994, excluding the two-month extended gap. The ALJ's determination of that time period was based on his finding that claimant received the 50-cent pay raise beginning on or about August 1, 1994. That finding is not supported by the record. At hearing, claimant testified that he could not recall the specific date in August 1994 when he began receiving the 50-cent pay raise. (Tr. 6-7). There was no other evidence in the record on that issue.

Because claimant has carried the burden of proving that he is entitled to calculation of his average weekly earnings in accordance with the aforementioned rule, it is SAIF's claim processing obligation to calculate claimant's average weekly earnings in accordance with the rule. See ORS 656.262(1). Therefore, to comply with the rule, SAIF shall be directed to recalculate claimant's average weekly wage based on weekly wages and incentive pay he earned during the weeks he was paid the hourly wage of $7, up to the date of injury (October 24, 1994) and excluding the two-month extended gap.

In reaching our conclusion, we reject claimant's argument that the averaging of actual weekly wages is inappropriate in this case. His argument is based on the last sentence of former OAR 436-60-025(5)(a): "For workers employed less then four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker." Under its plain meaning, however, that sentence has no application to this case because claimant was employed with the employer for more than four weeks.

Next, claimant contends that SAIF should also be required to determine his "average incentive pay" during the period from May 14, 1994 through October 24, 1994. He argues the average incentive pay should then be added to his hourly base wage to determine the average weekly wage. Claimant cites no rule or other authority for his "average incentive pay" approach. Moreover, his approach is contrary to the express requirement in former OAR 436-60-025(5)(a) that the carrier "use only the actual weeks under the wage earning agreement at time of injury." (Emphasis supplied.) Accordingly, we decline to adopt claimant's approach.

ORDER

The ALJ's order dated January 10, 1996, as reconsidered March 5, 1996, is modified in part and affirmed in part. The portion of the order directing SAIF to recalculate claimant's temporary disability is modified as follows: SAIF is directed to recalculate temporary disability based on weekly wages and incentive pay which claimant earned from the date he began receiving a base hourly wage of $7 up to the date of injury (October 24, 1994), excluding the two-month extended gap. Claimant's attorney is awarded an "out-of-compensation" attorney fee in the amount of 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, provided the total of fees approved by the ALJ and the Board does not exceed $3,800. The ALJ's order is otherwise affirmed.

September 12, 1996 Cite as 48 Van Natta 1785 (1996)

In the Matter of the Compensation of
WILLIAM J. DELOREY, Claimant
WCB Case No. 95-06144
ORDER OF ABATEMENT
Ernest M. Jenks, Claimant Attorney
G. Joseph Gorciak III, Defense Attorney

Claimant requests abatement and reconsideration of our August 14, 1996 Order on Review (Remanding), which remanded for the admission of additional evidence regarding claimant's treatment with Dr. O'Neill. Claimant requests bifurcation of the issues related to the date the insurer received knowledge of claimant's treatment by Dr. O'Neill. Specifically, claimant asserts that, before allowing the admission of additional evidence regarding Dr. O'Neill's treatment, a preliminary proceeding should be held to determine when Dr. O'Neill's records were provided to the insurer.

In order to further consider claimant's request, we withdraw our August 14, 1996 order. The insurer is granted an opportunity to respond to claimant's motion. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID G. HINES, Claimant
WCB Case No. 95-13876
ORDER ON REVIEW
Benjamin W. Ross, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Galton's order which increased claimant's award of scheduled permanent disability for loss of use or function of the left knee from 2 percent (3 degrees), as granted by a Notice of Closure (and affirmed by an Order on Reconsideration), to 7 percent (10.50 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his left knee on December 9, 1994. SAIF accepted the claim for a fractured left patella. Claimant's attending physician, Dr. Coletti, declared claimant medically stationary on March 21, 1995 with a mild degree of residual chondromalacia of the left patella. Dr. Colletti stated that there was no leg length discrepancy. (Ex. 18).

SAIF closed the claim by Notice of Closure issued on April 7, 1995, with an award of 2 percent scheduled permanent disability based on loss of range of motion. Claimant requested reconsideration and appointment of a medical arbiter.

A medical arbiter's examination was scheduled, but claimant failed to appear for the appointment. A December 21, 1995 Order on Reconsideration then issued which affirmed the Notice of Closure's award of permanent disability. Claimant requested a hearing contesting the reconsideration order.

The medical arbiter's examination occurred on December 28, 1995. The medical arbiter, Dr. Rand, stated that there was no measurable leg length discrepancy. (Ex. 26-4). However, Dr. Rand's examination findings listed a one-eighth inch length discrepancy of the left leg. (Ex. 26-3).

CONCLUSIONS OF LAW AND OPINION

The ALJ granted claimant an increased award of 5 percent scheduled permanent disability, finding that the medical arbiter's report established that claimant had a one-eighth inch leg length discrepancy due to the compensable injury. The ALJ reasoned that, since Dr. Rand was instructed to report permanent impairment resulting from the accepted condition, claimant's left leg length discrepancy listed in Dr. Rand's examination findings was a result of the compensable injury.

On review, SAIF contends that the ALJ improperly granted claimant an increase in scheduled permanent disability because claimant failed to prove he has a leg length discrepancy due to the compensable left knee injury. We agree.

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. Coletti, claimant's attending physician. Dr. Coletti has been claimant's attending physician throughout the course of this claim. Dr. Coletti concluded in his closing examination that claimant has no leg length discrepancy. (Ex. 18). Given his familiarity with claimant's medical condition, we find his assessment of claimant's permanent impairment to be persuasive.

Although Dr. Rand, the medical arbiter, listed a one-eighth inch leg length discrepancy in his report of examination findings, he specifically stated in the discussion portion of his report that claimant had no measurable leg length discrepancy. (Ex. 26-4). As previously noted, we rely on the most well-

reasoned evaluation of claimant's permanent impairment. Given the ambiguity in Dr.Rand'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 do not consider Dr. Rand's one-time evaluation to be more persuasive than Dr. Colletti's opinion based on his observation of claimant's left leg condition.

Accordingly, we reinstate the award of 2 percent scheduled permanent disability in the Notice of Closure as affirmed by the reconsideration order. Inasmuch as we have reduced claimant's permanent disability as a result of SAIF's request for review, claimant's counsel is not entitled to an attorney fee under ORS 656.382(2) for services rendered on review.

ORDER

The ALJ's order dated March 28, 1996 is reversed. The Order on Reconsideration award of 2 percent (3 degrees) scheduled permanent disability is reinstated and affirmed. The ALJ's out-of-compensation attorney fee award is also reversed.

In the Matter of the Compensation of
JOHN H. JOHNSON, Claimant
WCB Case No. 95-11378
ORDER ON REVIEW
Carney, 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) Hoguet's order that: (1) denied the insurer's motion for a continuance to obtain an additional medical report; and (2) set aside its partial denial of claimant's bilateral osteoarthritis condition. On review, the issues are evidence and compensability.

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

The insurer contends that the ALJ erred in denying its motion for a continuance to obtain an additional medical examination. We disagree.

ALJ's are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. They may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the ALJ's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

Claimant filed his request for hearing on October 13, 1995. The hearing was held on January 12, 1996. There is no evidence that, during the three months between claimant's request for hearing and the hearing, the insurer made any attempt to request authorization for an additional medical examination,[1] nor did it attempt to obtain a medical records review. We do not consider it an abuse of discretion for the ALJ to have denied the insurer's request due to a lack of due diligence in preparing the case for hearing. See OAR 438-006-081(4); 438-06-091(4); James D. Brusseau II, supra.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 12, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by the insurer.

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[1] Claimant had three examinations at the insurer's request prior to claim closure; therefore, the insurer must receive authorization by the Director for an additional examination. See ORS 656.325(1)(a); OAR 436-10-100.

In the Matter of the Compensation of
WILLIAM T. MASTERS, Claimant
WCB Case No. 95-08380
ORDER ON REVIEW
Benjamin W. Ross, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) declined to consider claimant's contention that his temporary disability rate had been incorrectly calculated, because he had not raised the issue during the reconsideration proceeding; and (2) authorized the SAIF Corporation to offset overpaid temporary disability benefits. On review, the issues are rate of temporary disability and offset.

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

At hearing, claimant argued that SAIF had improperly calculated the rate of his temporary disability benefits. The ALJ concluded that, pursuant to ORS 656.283(7), claimant was precluded from raising the issue for the first time at hearing, because the issue was not raised at the time of reconsideration. We agree.

On review, claimant contends that he did raise the issue of temporary disability benefits on reconsideration. Claimant argues that, on the request for reconsideration form, he checked "yes" next to the box identifying temporary disability benefits as an issue.

Notwithstanding claimant's argument, we conclude that the record does not support the contention that the rate of temporary disability benefits issue was raised at the time of reconsideration. The request for reconsideration form box checked by claimant identified the issue as "temporary total disability (TTD) or temporary partial disability (TPD) dates." (Emphasis added). (Ex. 24-3). More importantly, in the cover letter accompanying the request for reconsideration form, claimant's counsel expressly listed the medically stationary date as issue "number 1." In identifying the issue of temporary disability benefits, claimant's letter provided only, "See number 1." (Ex. 24-1).

Under the circumstances, we find that claimant raised the issue of temporary disability benefits only in conjunction with the issue of the medically stationary date. There is no indication that claimant raised the issue of rate of temporary disability benefits at the time of the reconsideration proceeding. Consequently, we agree with the ALJ that, pursuant to ORS 656.283(7), the issue could not be raised for the first time at hearing.[1]

Finally, although we find that claimant is precluded from raising the issue of rate of temporary disability benefits with respect to this particular closure, we note that our decision does not foreclose claimant from contesting the rate of temporary disability benefits arising from any future closures of his claim. See, e.g., Hammon Stage Line v. Stinson, 123 Or App 418 (1993).

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[1] We disagree with the dissent's conclusion that claimant was not required to request reconsideration on the rate issue. First, we note that, on review, claimant does not assert such a position. Rather, claimant contends that he did raise the issue at the time of reconsideration. Claimant's Appellant's Brief, pg. 3. Furthermore, even if claimant did take such a position, we disagree with the dissent's contention that the issue in this case did not arise out of the closure of the claim. Claimant's claim was closed by a Notice of Closure which awarded temporary disability benefits for the period of "7-26-94 through 10-14-94," and approved an offset against any overpaid benefits. (Ex. 17). Subsequently, SAIF notified claimant that, for the period "July 26, 1994 through July 31, 1994," the time-loss rate had been based on incorrect wage information. (Ex. 19). SAIF further informed claimant of the total overpayment amount which would be deducted from future benefits. (Ex. 19). Accordingly, in this case, the rate issue clearly arose from the closure.

The dissent also argues that the Department and Board forms support a conclusion that the rate issue is not a proper issue for reconsideration. However, the statute, rather than the forms, have compelled our decision in this case. Finally, the case cited by the dissent did not involve a closure or amended ORS 656.283 and, therefore, is not applicable in this case. In other words, the holding of our decision is limited to temporary disability rate closure issues which arise out of the closure of a claim. The facts set forth in Baker (i.e., where there was no claim closure or reconsideration request, and the rate issue was challenged at the time the carrier began to pay temporary disability benefits) do not appear before us in the present case.

ORDER

The ALJ's order dated January 22, 1996 is affirmed.

Board Chair Hall dissenting.

I disagree with the majority's conclusion that claimant was required to first request reconsideration on the issue of rate of temporary disability, prior to raising the issue at hearing.[1] The majority relies on amended ORS 656.283(7) which provides that issues not raised at reconsideration may not be raised for the first time at hearing. However, that statute applies to issues regarding claim closure. Here, the issue of rate of temporary disability benefits is one that may arise at any time, and is not an issue which arises out of claim closure. Consequently, ORS 656.283(7) does not apply, and the majority has incorrectly held that the issue cannot be brought directly to hearing.

The forms in this record also support a conclusion contrary to the majority's decision. The Department of Consumer and Business Services' form provides an opportunity for the parties to check a box only if they wish reconsideration of "Temporary total disability (TTD) or temporary partial disability (TPD) dates." (Emphasis supplied) (Ex. 24-3). The Board's own hearing request form provides that parties may only request a hearing on "extent of temporary disability," if they have an evaluation reconsideration date. However, parties can request a hearing on "temporary disability rate," regardless of whether they have proceeded through reconsideration. (See e.g. Request for Hearing form/Pleadings file).[2]

Finally, the majority's holding in this case is not consistent with our prior case law on the issue. See e.g. Nathaniel P. Baker, 46 Van Natta 233 (1994) (Board has jurisdiction over issue of rate of temporary disability benefits, notwithstanding the fact that neither party first sought a determination by Compliance. Dispute over the rate of temporary disability benefits is a "matter concerning a claim," over which the Board and the Hearings Division have jurisdiction).[3]

Accordingly, for the aforementioned reasons, I would find that claimant may raise the issue of rate of temporary disability benefits for the first time at hearing. Therefore, I respectfully dissent.

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[1] Although the majority argues that claimant is not asserting this position, the Board is required to apply the correct law on review. See Daniel S. Field, 47 Van Natta 1457 (1995).

[2] The dissent acknowledges that the statute, not agency forms, controls. The dissent does not suggest otherwise. Nevertheless, the forms "support" the dissent's analysis.

[3] The majority contends that Baker is not applicable. However, Baker is still good law as there is nothing in the statute or the legislative history to indicate that the rate of temporary disability was intended to be subject to the reconsideration procedure. Furthermore, the majority attempts to distinguish Baker from the instant case by suggesting that the rate of temporary disability is handled differently depending on when the issue is raised or challenged. The majority has provided no authority for creating such a distinction. Does the majority suggest that, at the time of closure, the attending physician, the medical arbiter, or the Department's evaluator consider the issue of rate of temporary disability, such that it would properly be an issue on reconsideration?

In the Matter of the Compensation of
ANDREW D. KIRKPATRICK, Claimant
WCB Case No. 95-00554
ORDER DENYING RECONSIDERATION
Coons, Cole, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our August 28, 1996 Order on Reconsideration. Specifically, claimant seeks en banc review and objects to our conclusion that he did not establish an "actual worsening" under ORS 656.273(1).

After reviewing claimant's motion and the insurer's response, we have nothing further to add to our prior order.[1] Consequently, the request for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our August 28, 1996 order.

IT IS SO ORDERED.

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[1] Claimant reiterates his request for en banc review, arguing that this case presents significant issues which warrant such review. In the exercise of our de novo review, we select for en banc review those cases which raise issues of first impression that would have a widespread impact on the workers' compensation system or cases requiring disavowal of prior Board case law: This "significant case" review standard is applied to all cases before the Board. Here, in light of our holding in Carmen C. Neill, 47 Van Natta 2371 (1995), which set forth the requirements for establishing an "actual worsening" under ORS 656.273(1) and is therefore controlling in this case, we do not find that this case presents issues of sufficient novelty or legal significance to warrant en banc review. Accordingly, we decline to reconsider our decision to deny claimant's request for en banc review.

Chair Hall dissenting.

I believe that claimant has raised legally significant arguments regarding application of the "actual worsening" standard set forth in ORS 656.273(1). Based on those arguments, I would conclude that the requirements for en banc review by the Board have been met in this case. I therefore dissent from the majority's denial of reconsideration.

In the Matter of the Compensation of
MARGUERITE R. MURDOCH, Claimant
WCB Case Nos. 95-10545 & 95-05310
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) set aside the self-insured employer's partial denial of her psychological condition; and (2) affirmed the Order on Reconsideration finding that her claim was not prematurely closed. In the event that the employer's partial denial is set aside, claimant requests that her claim be remanded to the Department of Consumer and Business Services for a determination of whether her psychological condition is medically stationary. On review, the issues are res judicata, compensability, premature closure and remand.

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

On review, claimant argues that the employer is precluded from denying the compensability of her psychological condition because it failed to appeal an earlier Order on Reconsideration that set aside the claim closure as premature based on the finding that the psychological condition was not medically stationary. Claimant asserted the same argument at hearing, relying on the Court of Appeals' decision in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) (hereinafter called "Messmer I"), which held that an employer's failure to appeal a determination order award of permanent disability benefits for a noncompensable condition precluded the employer from later denying the condition.

The ALJ concluded that the Messmer I holding was overruled by the 1995 amendments to ORS 656.262(10), which took effect June 7, 1995. As amended, ORS 656.262(10) provides, in pertinent part:

> "Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted."

Interpreting amended ORS 656.262(10) to mean that the rating of a condition in a closure order does not make an unaccepted condition compensable even if the employer fails to appeal the closure order, the ALJ concluded that the present employer's failure to appeal the earlier Order on Reconsideration did not preclude it from denying claimant's psychological condition. Although we agree with the ALJ's ultimate conclusion that claim preclusion does not apply, we do so based on the following reasoning.

Subsequent to the ALJ's order, the Court of Appeals revisited the Messmer case in the light of amended ORS 656.262(10). Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (hereinafter called "Messmer II"). The court in Messmer II reviewed the text and legislative history of amended ORS 656.262(10) and concluded that the amended statute did not overrule its decision in Messmer I. The court reasoned that, whereas its Messmer I decision applied claim preclusion based on the employer's failure to challenge a determination order award of permanent disability benefits, the statute addresses only the employer's payment of such benefits. Id. at 554.

Thus, the Messmer rule is unaffected by amended ORS 656.262(10). Nevertheless, we conclude that the Messmer rule does not apply in this case to preclude the employer from denying claimant's psychological condition. Our conclusion in this regard is based on the factual distinctions between the Messmer case and this case.

In Messmer, the claimant had an accepted claim for a neck and back strain. He was subsequently diagnosed with degenerative disc disease in the neck. The employer neither accepted nor denied compensability of the disease, but the employer authorized surgery for it. Later, the claim was closed by a determination order which awarded the claimant permanent disability benefits based in part on the effects of the surgery for the disease. The employer did not appeal the determination order. Two years later, the claimant's pain worsened and his physician requested authorization for treatment of degenerative changes in the neck. The employer denied compensability of the degenerative condition. However, the court held that, because the employer failed to appeal the determination order award of permanent disability benefits for the noncompensable, degenerative condition, the employer was barred by claim preclusion from later arguing that the condition for which the award was made is not part of the accepted claim.

In this case, by contrast, no permanent disability benefits have been finally awarded for claimant's psychological condition. Indeed, there has been no final award of compensation for that condition. Claimant argues that claim preclusion applies because the employer did not appeal an Order on Reconsideration which set aside a claim closure as premature. The claim closure was found premature by the Department based on the finding that claimant's psychological condition, which has not been accepted, was not medically stationary at the time of claim closure.

Notwithstanding the finding made by the Department in setting aside the claim closure as premature, in the absence of a final award of compensation for claimant's psychological condition, we do not find there was any final determination that the psychological condition was compensable. For this reason, we conclude that Messmer II is distinguishable and not controlling authority in this case.

Because we agree with and adopt the ALJ's conclusion that claimant's psychological condition is not compensable on the merits, we do not need to address claimant's remand request.

ORDER

The ALJ's order dated February 21, 1996, as amended February 29, 1996, is affirmed.

In the Matter of the Compensation of
FLORENCE G. SELVIDGE, Claimant
WCB Case No. 95-13524
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Claimant requests reconsideration of our August 22, 1996 Order on Review in which we reversed the ALJ's order and reinstated the award of 23 percent unscheduled permanent disability in an Order on Reconsideration. Specifically, claimant asserts that she is entitled to an assessed attorney fee under ORS 656.382(2) for services at hearing because SAIF was ultimately not successful in reducing her award of permanent disability. SAIF does not object to claimant's request.

We agree that claimant is entitled to an assessed fee pursuant to ORS 656.382(2). See Patricia L. McVay, 48 Van Natta 317 (1996). Therefore, we grant claimant's motion.

After consideration of the factors in OAR 438-015-0010(4), we find that a reasonable attorney fee award for claimant's counsel's services at the hearings level in defense of the Order on Reconsideration's permanent disability award is $1,000, to be paid by SAIF. 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, the nature of the proceedings, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented herein, we republish our August 22, 1996 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
COLLEEN M. BLANCHARD, Claimant
WCB Case No. 95-09678
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a right shoulder/upper back condition. On review, the sole issue is compensability.

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

On page one of his order, the ALJ found that claimant received chiropractic treatment for right shoulder symptoms fifteen times between December 20, 1991 and October 28, 1994. We instead find that only nine of these treatments were directed to the right shoulder/upper back area. (Ex. E-A).

On pages one and four of his order, the ALJ found that claimant's right shoulder/upper back symptoms began to increase after his last chiropractic treatment on October 28, 1994. We instead find that claimant began to experience increased symptoms at least three weeks prior to the October 28, 1994 treatment. (Ex. 1; Tr. 38).

On page four of his order, the ALJ stated that "[i]t is not known if Dr. Erickson was aware that claimant's pain would increase in the evening after work, rather than at work, and sometimes would be severe without apparent reason." We instead find that Dr. Erickson was aware of this symptomatic history, as claimant's physical therapist included this information in a progress report sent to Dr. Erickson in May 1995. (Ex. 1-C).

In addition to these corrected findings, we also find that claimant has experienced intermittent flare-ups of right shoulder/upper back pain with muscle spasm since the October 1991 motor vehicle accident.

We adopt the ALJ's conclusions of law and reasoning and offer the following comment regarding claimant's argument on review.

Claimant relies on the opinion of Dr. Erickson that work activity with the employer was the major contributing cause of a pathological worsening of claimant's preexisting right shoulder/upper back condition. Dr. Erickson had previously opined that there was no objective medical evidence that the work activity with the employer had pathologically worsened claimant's condition. The ALJ concluded that Dr. Erickson's revised opinion was not persuasive because it represented a conclusory, unexplained change in his earlier opinion, and because Dr. Erickson did not have an accurate understanding of claimant's work activity with the employer.

Claimant argues on review that the ALJ erred in concluding that claimant cannot rely on a "baseline change" in symptoms to establish a pathological worsening. Claimant also contends that Dr. Erickson's change in opinion is explained by the fact that his prior opinion was based on an incorrect understanding of the applicable law and claimant's symptoms and treatment following his October 1991 off-work automobile accident. In particular, claimant argues that Dr. Erickson wrongly assumed that a pathological worsening of a preexisting condition must be established by medical evidence supported by objective findings.

The objective findings required to establish a pathological worsening under ORS 656.802(2)(b) are the same objective findings required to establish the existence of an occupational disease or worsening of a preexisting disease under ORS 656.802(2)(d). Thus, a claimant can establish a pathological worsening with medical evidence supported by reproducible, measurable and observable physical findings or subjective responses, including palpable muscle spasm and reduced range of motion. ORS 656.005(19).

Here, claimant has not presented persuasive medical evidence that her muscle spasms, reduced range of motion and other symptomatic changes are indicative of a pathological change in her condition. Like the ALJ, we discount Dr. Erickson's opinion because he did not explain why he revised his earlier opinion that claimant's work activity had not resulted in a pathological worsening. Without such an explanation, we are unwilling to impute a reasonable basis for the revised opinion from the doctor's interim review of medical records and applicable law.[1]

ORDER

The ALJ's order dated February 27, 1996 is affirmed.

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[1] Claimant also argues that Dr. Erickson's opinion establishes a pathological worsening under the court's decision in Sullivan v. Sears Roebuck and Co., 136 Or App 302 (1995). The Sullivan case involved an aggravation claim under amended ORS 656.273, which requires proof of an "actual worsening" to establish a compensable aggravation claim. Claimant argues that, under the Sullivan decision, her change in baseline symptoms is sufficient to establish a "pathological worsening" under ORS 656.802(2)(b) as well as an "actual worsening" under ORS 656.273. We need not address this argument given our conclusion that Dr. Erickson's opinion is not persuasive for reasons independent of his reliance on claimant's change in baseline symptoms. If we were to address claimant's argument, we would conclude that the Sullivan case is not applicable to this occupational disease claim. The Sullivan court did not address whether that claimant's baseline symptoms established an "actual worsening." Rather, the court summarily remanded that matter back to the Board to reconsider the claimant's aggravation claim under amended ORS 656.273. Moreover, we are not persuaded by claimant's argument that the legal standards of "actual worsening" and "pathological worsening" are interchangeable. See Carmen C. Neill, 47 Van Natta 2371 (1995) ("actual worsening" required under amended ORS 656.273 is not limited to pathological worsening and includes symptomatic worsening not anticipated by a prior permanent disability award.)

In the Matter of the Compensation of
SYLVIA EBERLEI, Claimant
WCB Case No. 94-04135
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Scott Terrall & Culberson, Defense Attorneys

Reviewed by Board Members Hall, Christian and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denial of claimant's claim for a neck and back injury; and (2) awarded a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review 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 March 10, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

Board Member Moller dissenting.

The majority upholds the compensability of claimant's injury claim and the imposition of a penalty for the employer's allegedly unreasonable denial of that injury. Because I find claimant's testimony concerning the alleged work incident to be unreliable and, therefore, the medical opinions that depend on claimant's reported history to be unpersuasive, I would find that claimant has failed to

sustain her burden of proof. Further, regardless of compensability of the claim, the employer possessed a legitimate doubt as to its liability for the claim so that its denial was reasonable. For these reasons, I respectfully dissent.

The outcome of this case turns on claimant's credibility. The majority adopts the opinion of the ALJ which concludes that, at least with regard to the circumstances of her injury, claimant's credibility remains intact. I cannot agree. Although I do agree with the ALJ that, in some situations, inconsistencies and misstatements may be probative of an issue that is not in dispute while, at the same time, not germane to the contested issue, I do not believe that this is such a case. The questions raised by the record in this case render it impossible for me to find that claimant has experienced an accidental injury at her employment that is a material contributing cause of a need for medical treatment or disability.

The reasons for my inability to accept claimant as a credible witness on her own behalf are myriad. Claimant and her son both worked for the employer. Less than three weeks after commencing work with the employer, claimant reported "extreme fatigue" and obtained a medical statement from a family friend recommending a change in her work shifts. Also during the first month of their employment, claimant's son had become involved in a work place dispute. As a result, claimant and her son were transferred from a Hillsboro job site to downtown Portland. Claimant was angry about the relocation. Her unwitnessed injury occurred one month after commencing her employment and on the first night at the new location.

The paramedics who arrived on the scene of claimant's alleged injury found claimant "shouting loudly and at times thrashing." She exhibited "histrionic" behavior and a lack of cooperation. Because of claimant's inconsistent responses to palpation, one paramedic distracted claimant while another paramedic "applied painful stimulus to areas that the patient had previously indicated were extremely painful (tender) by screaming and thrashing. When [claimant] was distracted, these same areas elicited no response when even more pressure was applied * * *." Based on these inconsistencies, the paramedics concluded that claimant was not being truthful and alerted the emergency room physician that claimant might be exhibiting drug seeking behavior. When claimant arrived home from the hospital, she wrote a three and a half page narrative regarding her injury.

In a chart note three days after the alleged injury, Dr. Thomas McWeeney reported that claimant "was concerned about being forced to go back to work and apparently talked to her sister's lawyer who recommended that she seek a 2nd opinion." At hearing, however, claimant testified that she did not have a sister and did not talk to a lawyer.

A physical therapist assistant who worked with claimant on several occasions testified that, after the alleged incident, she observed claimant in a restaurant and, whereas claimant was "very guarded, was unable to move, turn her head or bend like flex her back, move very much at all" during physical therapy, in the restaurant claimant appeared to be much improved. (Tr. 93-94). The witness further testified that she was certain the individual she observed from a distance of about 15 feet was claimant. (Tr. 96). Claimant testified that she had never been in the restaurant and did not even know where the restaurant was located. (Tr. 110).

At hearing, claimant testified that she had never had any prior workers' compensation claims. In fact, claimant had made at least four prior claims, one of which was accepted and time loss benefits provided. Claimant was asked if she had previously experienced neck or back pain or numbness in her arms or legs. She responded that she had never experienced such symptoms. In fact, one of claimant's prior workers' compensation claims involved pain in her back and numbness in her arm and all of the fingers on her left hand.

Claimant also relies on the testimony of her son to support her claim. However, the testimony of claimant's son is equally unreliable. Claimant's son stated that he and his mother had lived together ever since her accident but he did not know whether she had gone back to work after the accident. (Tr. 10). In fact, claimant and her son moved to Tennessee for a period of time prior to hearing. Whereas claimant informed IME physicians that she had worked for ten months as a housekeeper in Tennessee, claimant's son testified that she did not work while they were in Tennessee.

Although no single factor disproves claimant's claim, considered together, these factors cast considerable doubt on her report of the incident. In light of the above evidence, I would find that claimant has not established by a preponderance of the evidence that she sustained a neck and back injury arising out of and in the course of her employment. Contrary to the majority, I would reinstate the employer's denial and reverse the penalty award.

In the Matter of the Compensation of
THEODORE C. FICKER, Claimant
WCB Case Nos. 94-04634 & 94-00678
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Lundeen, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation (Liberty) requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's injury claim for a 1992 low back strain; (2) set aside its denial of claimant's current low back condition; and (3) upheld the SAIF Corporation's denial of claimant's current low back condition. On review, the issues are compensability and responsibility.

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

First, we agree with the ALJ that claimant had sustained compensable low back strains in 1989 (while employed by SAIF's insured) and in 1992 (while employed by Liberty's insured).[1] We also agree with the ALJ's conclusion that claimant's current low back condition is compensable as a new occupational disease.

With regard to responsibility for claimant's current low back condition, we first address whether ORS 656.308(1) applies. We conclude that it does not.

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).

Here, claimant's prior accepted low back claims both involved low back strain injuries. Claimant's current compensable low back condition is diagnosed as chronic low back strain with mild degenerative changes. For the reasons expressed in the ALJ's order, we rely on the persuasive opinion of Dr. Atcherman. Dr. Atcherman differentiates between claimant's prior acute strain injuries and his current chronic low back condition. (Ex. 137, pages 8-10). Atcherman opines that the current chronic low back condition first became manifest after claimant's 1992 injury. (Ex. 137, pages 21-22). Based on Dr. Atcherman's persuasive opinion, we conclude that claimant's current low back condition is different from his prior accepted conditions. Accordingly, ORS 656.308(1) does not apply. SAIF v. Yokum, supra. Under such circumstances, unless actual causation is established against a specific employer, we turn to judicially created rules regarding assignment of responsibility in successive employments. See Eva R. Billings, 45 Van Natta 2142, 2143 (1993).

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[1] With regard to the 1992 low back strain claim, Liberty contends that the ALJ should have applied the major contributing cause test to determine whether claimant sustained a new compensable injury in September 1992 while employed by Liberty's insured. Because the persuasive medical evidence establishes that the major contributing cause of claimant's September 1992 low back strain was the injury at Liberty's insured, it is unnecessary for us to resolve whether the material or major contributing cause standard is applicable. (Ex. 137-7, 8).

Liberty argues that the preponderance of the evidence establishes that claimant's work at SAIF's insured is the actual cause of claimant's current low back condition. We disagree with Liberty's reading of the medical evidence. The persuasive medical evidence implicates claimant's lifetime of work activities, including those at Liberty's insured, as the major contributing cause of his current low back condition. (Ex. 137, pages 10-11). Under such circumstances, we agree with the ALJ that, under the last injury rule, Liberty has not rebutted the presumption under Industrial Indemnity v. Kearns, 70 Or App 583 (1984), that the September 1992 injury independently contributed to claimant's current condition. See Raymond H. Timmel, 47 Van Natta 31 (1995).

Alternatively, assuming that this case should be analyzed under the last injurious exposure rule, we would still conclude that Liberty is responsible for claimant's current low back condition.

Under the last injurious exposure rule, where a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to cause or worsen the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, claimant first became disabled and sought treatment for his current low back condition (chronic strain with mild degenerative disc disease) in October of 1992, while Liberty was on the risk. (Ex. 137, pages 21 to 22). Accordingly, Liberty is presumptively responsible for claimant's current low back condition. Liberty can shift responsibility to SAIF, the prior carrier, by showing that claimant's work at SAIF's insured was the sole cause of claimant's current low back condition, or that it was impossible for conditions while Liberty was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985).

The persuasive medical evidence from Dr. Achterman is that claimant's lifetime of work (including his 1983 injury), is the major contributing cause of his current low back condition. (Ex. 137, pages 11-14 and 24-25). Based on Dr. Achterman's opinion, we find that claimant's lifetime of work, including his work for Liberty's insured, caused his current low back condition. Thus, we are not persuaded that claimant's work activities with SAIF was the sole cause of claimant's low back condition or that it was impossible for claimant's work activities at Liberty's insured to have caused his low back condition. Accordingly, even if the last injurious exposure rule applied to this case, we would still find that Liberty was responsible.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated February 23, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by Liberty.

In the Matter of the Compensation of
SHARON L. HAND, Claimant
WCB Case No. 95-12761
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board en banc.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Otto's order which held that claimant's "post-June 7, 1995" scheduled permanent disability award was properly paid by the self-insured employer in accordance with Section 18(1) of Senate Bill 369. In its respondent's brief, the employer contests that portion of the ALJ's order that declined to assess sanctions under ORS 656.390 against claimant for an allegedly frivolous request for hearing. The employer also seeks sanctions for claimant's allegedly frivolous request for Board review. On review, the issues are claim processing and sanctions. We deny the sanction request and affirm.

FINDINGS OF FACT

The parties stipulated to the following facts:

Claimant compensably fractured her right hand on February 2, 1993. The claim (including a consequential carpal tunnel condition) was closed by Notice of Closure on December 21, 1993, which awarded her 4 percent (6 degrees) scheduled permanent disability for her right wrist. The insurer paid the award at $315.63 per degree ($1893.78 total).

Claimant requested reconsideration of the permanent partial disability (PPD) award. An Order on Reconsideration dated September 12, 1994 increased the award to a total of 34 percent (51 degrees) scheduled PPD. The employer requested a hearing and did not pay the increase pending the appeal.

Following a hearing, ALJ Poland issued an Opinion and Order dated August 4, 1995, reducing the total PPD award to 30 percent (45 degrees) scheduled PPD. The employer had already paid 6 degrees of the award at the time of the Notice of Closure, leaving 24 degrees to be paid. Computing those degrees at $315.63 each, the employer paid the remaining $12,309.57 in PPD to claimant and her counsel ($11,078.62 and $1,230.95 respectively).

We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Permanent Disability Rate

The ALJ concluded that, because claimant's injury occurred between January 1, 1992 and December 31, 1995, the rate at which claimant's permanent disability benefits are paid was governed by Section 18(1) of Senate Bill 369, which amended Section 2, chapter 745, Oregon Laws 1991.

Claimant argues that her disability rate should have been determined by amended ORS 656.214 (Or Laws 1995, ch 332, § 17). Claimant argues that amended ORS 656.214 applies to all claims or causes of action existing or arising on or after June 7, 1995, and, therefore, necessarily applies to her claim.

In construing a statute, our task is to discern the intent of the legislature. The first level of analysis is to examine both the text and the context of the statute, including other provisions of the same statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). If the legislature's intent is clear, no further inquiry is necessary. If the intent of the legislature is not clear from the text and the context of the statute, we then consider the legislative history of the statute. Id. at 611-12.

Before the effective date of Senate Bill 369, former ORS 656.214(2) provided that injured workers

received $305 per degree for scheduled injuries.[1] ORS 656.214(2) was amended in 1995 and now 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. The worker shall receive [$305] **$347.51** for each degree stated against such disability in subsections (2) to (4) of this section as follows * * *." (Added words are in bold face type; deleted words are in brackets).

At hearing, the employer conceded that none of the exceptions to retroactivity in Senate Bill 369 apply to exempt this case from application of the new law. However, the employer argued that Section 18 retained the PPD rates that always applied to claims between 1992 and 1995. According to the employer, the rate applicable to 1993 claims under the old law and the new law is the same, so "retroactively" applying the new law accomplishes no change in the result.

Section 18 of Senate Bill 369 amended Section 2, chapter 745, Oregon Laws 1991 to provide, in part:

> "Sec. 2. (1) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (2), for injuries occurring during the period beginning January 1, 1992, and ending December 31, 1995, the worker shall receive an amount equal to 71 percent of the average weekly wage times the number of degrees stated against the disability as provided in ORS 656.214 (2) to (4). However, as annual changes in the average weekly wage occur, the amount of the average weekly wage used in calculation of the benefit amount pursuant to this subsection shall not be more than five percent larger than the amount used in the previous year.
>
> "(2)(a) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (5), for injuries occurring during the period beginning January 1, 1992, and ending [January 1, 1996] **December 31, 1995**, the worker shall receive an amount equal to [different percentages of the average weekly wage depending upon the number of degrees awarded]." (Added words are in bold face type; deleted words are in brackets).

Except as otherwise provided, Senate Bill 369 applies to matters for which the time to appeal the ALJ's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 115 Or App 565, 572-73 (1995). There are no express exceptions applicable to the amendment of ORS 656.214 or Section 18. Section 66(1) (Or Laws 1995, ch 332, § 66(1)) 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."

We interpret "this Act" in section 66(1) to refer to all sections of Senate Bill 369, including the 1995 amendments to ORS 656.214(2) (Section 17) and Section 18, which amended Section 2, chapter 745, Oregon Laws 1991. Thus, amended ORS 656.214(2) and Section 18 apply to "all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented[.]" Since amended ORS 656.214(2) applies "regardless of the date of injury," and since claimant's request for an increase in the rate of permanent partial disability benefits arose after June 7, 1995, amended ORS 656.214(2) would arguably apply to this case. However, for the following reasons, we conclude that Section 18(1) controls this case.

---

[1] The parties stipulated that the employer paid claimant's award at $315.63 per degree. In the employer's hearing memorandum, it explained the payment rate:

> "Each year, the Department revises Bulletin No. 111, advising insurers of the 'annual changes' in the state's official 'average weekly wage' and the resultant PPD rates derived from it for dates of injury covered by the Bulletin. At the time of this worker's February 2, 1993 injury, the May 26, 1992 revision of Bulletin No. 111 was in effect. * * * That Bulletin indicates (at page 3), that for injuries after July 1, 1992, the scheduled PPD rate was $315.63 per degree. That is the rate at which the insurer paid this award." (Employer's Hearing Memorandum and Motion for Sanctions at 2).

Section 18(1) provides, in part:

> "Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (2), for injuries occurring during the period beginning January 1, 1992, and ending December 31, 1995, the worker shall receive an amount equal to 71 percent of the average weekly wage times the number of degrees stated against the disability as provided in ORS 656.214 (2) to (4)." (Emphasis added).

The function of a "notwithstanding" clause in a statute is to except the remainder of the sentence containing the clause from other provisions of a law referenced in that particular notwithstanding clause. See O'Mara v. Douglas County, 318 Or 72, 76 (1993) ("notwithstanding" clause in first sentence of ORS 215.301 functioned to except remainder of sentence from other provisions of law referenced in clause).

Here, the "notwithstanding" clause at the beginning of subsection (1) of Section 18 excepts the remainder of the sentence, which pertains to injuries between January 1, 1992 and December 31, 1995, from the provisions of ORS 656.214(2). Thus, since subsection (1) of Section 18 specifically states that it applies to injuries between January 1, 1992 and December 31, 1995, "[n]otwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214(2)," the legislature clearly indicated that Section 18 applies instead of ORS 656.214(2) to injuries between January 1, 1992 and December 31, 1995. Thus, section 18 and amended ORS 656.214(2) are reconcilable based on the text of the statute.

Alternatively, even if we assume that there is a conflict between amended ORS 656.214(2) and Section 18 of Senate Bill 369 (amending Section 2, chapter 745, Oregon Laws 1991), we would reach the same result. Our analysis of the text and context of the statute includes consideration of rules of construction that "bear directly on the interpretation of the statutory provision in context." PGE v. Bureau of Labor and Industries, supra, 317 Or at 611. One such rule is expressed in ORS 174.020, which provides:

> "In the construction of a statute the intention of the legislature is to be pursued if possible; and when a general and particular provision are inconsistent, the latter is paramount to the former. So a particular intent shall control a general one that is inconsistent with it." (Emphasis supplied.)

The Supreme Court has restated that rule as follows:

> "[W]here there is a conflict between two statutes, both of which would otherwise have equal force and effect, and the provisions of one are particular, special and specific in their directions, and those of the other are general in their terms, the special provisions must prevail over the general provisions[.]" Smith v. Multnomah County Board of Commissioners, 318 Or 302, 309 (1994) (quoting State v. Preston, 103 Or 631, 637 (1922)).

In such a case, the specific statute is considered an exception to the general statute. Id.

Section 18(1) of Senate Bill 369 (amending Section 2, chapter 745, Oregon Laws 1991), is the more specific statute. Section 18(1) applies specifically to the method of calculating permanent partial disability benefits for "injuries occurring during the period beginning January 1, 1992, and ending December 31, 1995." On the other hand, amended ORS 656.214(2) is general and applies "[w]hen permanent partial disability results from an injury." Application of each provision would lead to a different result. The inconsistency between the general statute, amended ORS 656.214(2), and the specific statute, Section 18(1), leads us to conclude that the specific provision should control. See ORS 174.020; Smith v. Multnomah County Board of Commissioners, supra.

The legislative history of Senate Bill 369 supports our conclusion that Section 18(1) should apply to this case. On May 26, 1995, Jerry Keene, a workers' compensation insurance defense attorney and drafter of some of Senate Bill 369's text, engaged in the following colloquy with Chair Derfler during a Joint Conference Committee meeting:

> [JERRY KEENE:] "Section 17 addresses permanent partial disability benefits and their values. Originally Senate Bill 360 -- excuse me, let me take you back a bit. The 1990 changes to the case law increased permanent partial disability to injured workers and made those changes temporary -- sunsetted them -- until June of this year. This change

takes the current benefits level that those changes had resulted in for 1995, and writes them into the basic law. It becomes the new floor. A default law. The default values for permanent partial disability for workers unscheduled and scheduled has been reinstated into Section 656.214 --

CHAIR DERFLER: So that when this sunsetted it goes back to the '95 level --

JERRY KEENE: Exactly.

CHAIR DERFLER: -- instead of the '90 level.

JERRY KEENE: And instead -- and -- and where those -- that before was reflected by a formula, now it's just reflected by the dollar figure that those benefits are currently at, as of this date. You'll see -- you'll see that the numbers substituted -- 305 has become 347.51 on line 4, and it continues through. Section 18 corrects a mistake actually in the 1991 sunset clause that has been in the act since then. It takes care of the gap in benefits, it -- it specifies that the -- the current law will continue with regard to values of PPD between June, which was the original sunset, and December of this year. As a result of the negotiations of the Governor's office, it was agreed that current values would extend to the end of this year, and then the increased values that are mandated by Senate Bill 369 will kick in as of January 1 of next year. Page 39, section 20, contains the increases that Senate Bill 369 actually --

CHAIR DERFLER: Just a minute. You left -- left me. What page are you on?

JERRY KEENE: I'm sorry. Page 39, section 20. This section creates the new additional values that were arrived at. In fact they are greater than were originally there in Senate Bill 369. These reflect increases that were negotiated with the Governor's group." Tape Recording, Joint Conference Committee, May 26, 1995, Tape 2A (emphasis added).

Mr. Keene's testimony indicates that, based on negotiations of the Governor's office, Section 18 was intended to remain effective for injuries occurring from January 1, 1992 through December 31, 1995. Thus, Mr. Keene's testimony supports our conclusion that the specific provision of Section 18(1) should apply to this case. See ORS 174.020; Smith v. Multnomah County Board of Commissioners, supra. We conclude that the employer properly paid claimant's permanent disability benefits.

Sanctions

In its respondent's brief, the employer contests that portion of the ALJ's order that declined to assess sanctions under ORS 656.390 against claimant's attorney for an allegedly frivolous request for hearing. The employer also seeks sanctions for claimant's attorney's allegedly frivolous request for Board review.

ORS 656.390(1) allows an ALJ or the Board to impose an appropriate sanction against an attorney who files a frivolous request for hearing or review. "'[F]rivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2); see Westfall v. Rust International, 314 Or 553, 559 (1992) (defining "frivolous" under former ORS 656.390).

Here, claimant's request for hearing and request for review are not frivolous. As we have discussed, the statutory language is not entirely clear in this case. We find that claimant's request for hearing raised arguments that were sufficiently developed so as to create a reasonable prospect of prevailing. See Winters v. Woodburn Carcraft Co., 142 Or App 182 (July 10, 1996); Gerard R. Schiller, 48 Van Natta 854 (1996). We agree with the ALJ, albeit for different reasons, that the employer's request for sanctions at hearing should be denied. Furthermore, we deny the employer's request for sanctions on review.

ORDER

The ALJ's order dated March 4, 1996 is affirmed.

In the Matter of the Compensation of
GARY L. MARTIN, Claimant
Own Motion No. 96-0366M
OWN MOTION ORDER ON RECONSIDERATION (POSTPONING)
David C. Force, Claimant Attorney
Bailey & Associates, Defense Attorneys

On August 27, 1996, the Board postponed action on claimant's request for own motion relief in his 1984 injury claim pending outcome of litigation at the Hearings Division. Contending that "the Board, in its Own Motion capacity must exercise jurisdiction pursuant to ORS 656.278 and OAR 438-12-030 prior to the Hearings Division having jurisdiction to hear or decide issues with respect to claims in Own Motion status," the insurer requests that the Board reconsider its August 27, 1996 order postponing action in this claim. The insurer further requests that the Board determine the own motion matter without additional evidence and without referral to the Hearings Division. Because we do not have jurisdiction to consider the matter at this time, the motion is denied.

FINDINGS OF FACT

Claimant sustained a compensable left knee meniscal injury on July 20, 1984. Claimant's claim was first closed on January 31, 1985. Claimant's aggravation rights expired on January 31, 1990.

On July 12, 1995, the Board issued an Own Motion Order reopening claimant's claim for the payment of temporary disability compensation. On October 11, 1995, the insurer closed claimant's claim. Claimant did not appeal that closure.

The insurer received claimant's new request for reopening of his claim on July 10, 1996. Contending that claimant had sustained a "new and distinct injury on or about 7/8/96," the insurer issued a denial of responsibility for claimant's current "left knee problems." The denial advised claimant that:

> **"IF YOU THINK THIS DENIAL IS NOT RIGHT WITHIN 60 DAYS AFTER YOU ARE NOTIFIED OF THIS DENIAL YOU MUST FILE A LETTER WITH THE WORKERS' COMPENSATION BOARD, SPINNAKER POINTE, 2250 MCGILCHRIST SE, SALEM OREGON 97310. YOUR LETTER MUST STATE THAT YOU WANT A HEARING, YOUR ADDRESS AND THE DATE OF YOUR ACCIDENT IF YOU KNOW THE DATE. IF YOUR CLAIM QUALIFIES, YOU MAY RECEIVE AN EXPEDITED HEARING WITHIN 30 DAYS. YOUR REQUEST CANNOT, BY LAW, AFFECT YOUR EMPLOYMENT. IF YOU DO NOT FILE A REQUEST WITHIN 60 DAYS, YOU WILL LOSE ANY RIGHT YOU MAY HAVE TO COMPENSATION UNLESS YOU CAN SHOW GOOD CAUSE FOR DELAY BEYOND 60 DAYS. AFTER 180 DAYS ALL YOUR RIGHTS WILL BE LOST. YOU MAY BE REPRESENTED BY AN ATTORNEY OF YOUR CHOICE AT NO COST TO YOU FOR ATTORNEY FEES."**

In addition to denying responsibility for claimant's current condition, the insurer opposes the reopening of the claim on the ground that claimant's current condition is not causally related to the compensable injury.

In an August 22, 1996 letter, the insurer asserted that, pursuant to OAR 438-012-0040, "this matter can be appropriately determined without additional evidence and without referral to the Hearings Division." Claimant requested a hearing with the Hearings Division, appealing the insurer's July 26, 1996 denial. (WCB Case No. 96-07106). On August 27, 1996, we postponed action on the own motion matter pending outcome of litigation at the Hearings Division.

On August 22, 1996, the insurer submitted its Motion to Dismiss to the Hearings Division. Contending that this claim "is not appropriately before the hearings division," the insurer moved the Administrative Law Judge (ALJ) to dismiss claimant's hearing request. The insurer further requests that the Board reconsider its August 27, 1996 Order Postponing Action on Own Motion Request.

CONCLUSIONS OF LAW AND OPINION

The Board's Own Motion authority is provided under ORS 656.278. Except for claims for injuries which occurred prior to January 1, 1966, ORS 656.278(1) limits the Board's authority to those

cases where 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. Under the law, the Board, in its own motion authority, has sole jurisdiction to authorize only the payment of temporary disability compensation, unless the claimant was injured prior to January 1, 1966.

The insurer cites OAR 438-012-0040 in its argument that this claim is not appropriately before the Hearings Division. However, that provision applies only to those cases in which the sole issue is whether or not a claimant is entitled to temporary disability pursuant to ORS 656.278. Here, the applicable rule is OAR 438-012-0050, which provides that the Board will act promptly upon a request for relief under the provisions of ORS 656.278 and our rules unless: (1) the claimant has available administrative remedies under the provisions of ORS 656.273; (2) the claimant's condition is the subject of a contested case under ORS 656.283 to 656.295, ORS 656.307 or ORS 656.308, or an arbitration or mediation proceeding under ORS 307; or (3) the claimant's request for temporary disability compensation is based on surgery or hospitalization that is the subject of a Director's medical review under ORS 656.245, 656.260 or 656.327.

Claimant has requested a hearing (as he was directed to do by the insurer's July 26, 1996 denial) to appeal the insurer's denial of responsibility for claimant's current condition. The insurer contends that the Board, in its own motion authority, has sole jurisdiction to decide this dispute.[1] Our jurisdiction extends only to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. The Board, in its Own Motion authority, does not have jurisdiction to decide matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization (pre-1966 injuries excepted). Rather, jurisdiction over these disputes rests either with the Hearings Division pursuant to ORS 656.283 to 656.295 or with the Director under ORS 656.245, 656.260 or 656.327. We have appropriately postponed action on the own motion matter pending resolution of that litigation.

When the issue of responsibility is finally decided, as requested in our August 27, 1996 order postponing action, the ALJ will forward a copy of the hearing order or settlement document to the Board. If that order is not appealed, we would issue our order based, in part, on the ALJ's decision. If the order is appealed to the Board, we would continue to postpone action pending issuance of a Board order. At that time, we would issue our order based, in part, on the Board order. Therefore, we disagree with the insurer's contention that "[a]ny hearing conducted, and any order [issued by the ALJ)] would necessarily be "null and void" under the current status of this case." Quite the contrary, any final, appealable order issued by the Board in its own motion authority at this juncture would be "null and void" until the responsibility decision becomes final.

Finally, a hearing requested by an insurer or claimant can only be dismissed by the ALJ. See OAR Chapter 438, Division 006. We do not have the own motion authority to intervene in action being taken at the Hearings Division. In that respect, we restrict our decision in this order to our authority to act without completion of the appeal process in this claim. Because the insurer issued a "denial of all medical and disability benefits related to the intervening injury of 7/8/96," claimant's claim was properly appealed to the Hearings Division.

The insurer's request for reconsideration of our August 27, 1996 order postponing is denied. Furthermore, we are unable to grant the insurer's to determine the own motion matter "without additional evidence and without referral to the Hearings Division." Pursuant to our August 27, 1996 order and the order issued this date, we continue to postpone action on the own motion matter pending resolution of the issues at the Hearings Division.

IT IS SO ORDERED.

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[1] In its motion, the insurer cites Carl C. Clayton, 47 Van Natta 1069 (1995), in which the Board ordered that a claim reopened under the Board's Own Motion authority, must be closed under ORS 656.278. The insurer further cites Wendy Youravish, 47 Van Natta 2297 (1995) in its argument that claims reopened under own motion must be closed under own motion. These cases do not address our authority to consider appeals of compensability, responsibility or reasonableness and necessity, nor are they relevant to our consideration here.

In the Matter of the Compensation of
TREVER McFADDEN, Claimant
WCB Case Nos. 95-05032, 95-05031 & 95-01571
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
SAFECO Legal, Defense Attorney
David O. Horne, Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Poland's order which: (1) upheld Safeco's compensability and responsibility denial of a low back condition; (2) upheld Wausau's compensability and responsibility denial of the same condition; and (3) upheld Farmers' responsibility denial of the same condition. On review, the issues are compensability and, potentially, responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable lumbar strain on January 20, 1992, for which Safeco is responsible. (Ex. 2A). On July 22, 1992, claimant injured his mid-back, a claim that Wausau accepted as a thoracic strain. (Ex. 7A).

Safeco issued a Notice of Closure on April 12, 1993, which did not award permanent disability. (Ex. 8). On April 28, 1995, the Board set aside the closure as premature. Trever McFadden, 47 Van Natta 790 (1995). The Wausau claim remained open until it was closed by an October 6, 1995 Notice of Closure, which awarded no temporary or permanent disability. (Ex. 27).

In the meantime, claimant experienced a flare-up of low back pain on November 30, 1994, while working for Farmers' insured as a gas attendant. (Ex. 13). Dr. Passman, claimant's attending physician, diagnosed a lumbar strain on December 1, 1994 and reported reduced range of motion, L5 tenderness, tense muscles and a positive straight leg raise. (Ex. 15). Dr. Thrall provided follow-up care in December 1994 and in January 1995. Dr. Thrall diagnosed a lumbar strain and reported limited lumbar range of motion. (Ex. 15D). Drs. Utterback and Gambee later examined claimant and reported inconsistencies in examination, functional overlay and a lack of objective findings. (Exs. 21, 25, 26).

Claimant filed claims for his current low back condition with Safeco, Farmers and Wausau. Safeco and Wausau denied both compensabilty and responsibility on March 20, 1995 and January 17, 1995 respectively, while Farmers denied only responsibility on May 25, 1995.

Relying on the medical reports of Drs. Passman and Thrall, the ALJ determined that claimant had sustained a lumbar strain when he sought treatment on December 1, 1994. However, the ALJ upheld all the denials issued in the claim, reasoning that the medical evidence did not establish a causal relationship to claimant's accepted injuries in 1992 or to the alleged incident on November 30, 1994.

On review, claimant first contends that the compensability denials of Safeco and Wausau were procedurally improper because they were issued while those claims were still in open status. See Roller v. Weyerhaeuser Co., 67 Or App 583, mod 68 Or App 743, rev den 297 Or 124 (1984); Elizabeth B. Berntsen, 47 Van Natta 1219 (1996) (Roller still applies to cases not involving "combined" or "consequential" conditions). However, we agree with Safeco and Wausau that claimant never raised the issue of invalid preclosure partial denials at the hearing. (Tr. 3). Therefore, we do not consider that issue on review. See Patricia L. Serpa, 47 Van Natta 747, 748 (1995) (where claimant could have raised "pre-closure" partial denial issue at hearing, ALJ should not have addressed the issue on his own initiative).

Claimant next contends that the ALJ mixed the compensability and responsibility issues. Claimant asserts that he need not establish which employer caused his condition, only that his low back condition was caused by either a discrete new employment exposure or was an aggravation of a prior

accepted injury. Claimant argues that compensability was established in general and that responsibility should be determined in accordance with ORS 656.308(1). We disagree with claimant's conclusion that compensability was established, although our reasoning differs somewhat from that of the ALJ.

In Smurfit Newsprint v. DeRosset, 118 Or App 368, 371-72 (1993), the court stated:

> "ORS 656.308(1) is presumably intended to simplify the processing of claims involving multiple employers or insurers and successive compensable injuries involving the same condition or body part. We conclude that, when benefits are sought for "further compensable medical services and disability subsequent to a new injury," ORS 656.308 is applicable if it is determined that the "further" disability or treatment for which benefits are sought is compensable, i.e., that it is materially related to a compensable injury, and that it involves a condition that has previously been processed as a part of a compensable claim. Responsibility is then assigned to the employer or insurer with the most recent accepted claim for that condition." (Emphasis added).

Therefore, in order to establish a compensable claim in a case of successive injuries, claimant must establish that his need for treatment is materially related to a compensable injury. The only physician to relate claimant's current low back condition to a compensable injury is Dr. Thrall. Dr. Thrall signed a concurrence letter on February 7, 1995, in which he agreed that the incident on November 30, 1994 was not a new injury, but was an "aggravation" of his "preexisting condition" and that the major contributing cause of claimant's need for treatment was the January 30, 1992 injury "or" the July 22, 1992 injury. (Ex. 22).

We agree with the ALJ that Dr. Thrall's opinion is not persuasive because it is equivocal and conclusory. Somers v. SAIF, 77 Or App 259 (1986) (greatest weight given to well-reasoned medical reports); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical opinion). Dr. Thrall provides no explanation of his opinion, which is contradicted by the evidence the ALJ cited which indicates that claimant's January 1992 Safeco injury had resolved. Moreover, we agree with the ALJ's reasoning that Wausau's July 1992 injury affected claimant's thoracic spine, whereas claimant's current condition involves the lumbar spine. Thus, Dr. Thrall's opinion that claimant's current condition may be related to the July 1992 Wausau claim is unpersuasive as well.

We recognize that claimant demonstrated objective evidence of a low back strain the day after the alleged November 30, 1994 incident, including reduced range of motion and spasm. See ORS 656.005(19). However, in the absence of a persuasive medical opinion establishing a material causal nexus between claimant's current low back condition and a compensable injury, we agree with the ALJ that this claim is not compensable.[1]

ORDER

The ALJ's order dated January 31, 1996 is affirmed.

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[1] The relevant factors for determining whether expert testimony of causation is required are: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly consults with a physician; (4) whether the worker promptly reports the occurrence to a superior; (5) whether the worker previously was free from disability of the kind involved; and (6) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. Uris v. Compensation Department, 247 Or 420, 426 (1967); Barnett v. SAIF Corp., 122 Or App 279, 283 (1993), on remand Betty Barnett, 46 Van Natta 9 (1994). This claim appears to satisfy some of the criteria that would excuse the necessity of providing expert medical evidence regarding causation. It is unrebutted that claimant's symptoms appeared immediately after the November 30, 1994 incident (Tr. 12) and that claimant sought treatment the next day. (Ex. 14). Moreover, the injury was apparently promptly reported on the day it occurred because the form 801 contains a date of employer knowledge of November 30, 1994. (Ex. 13). Although claimant had prior back symptoms, they were the result of prior accepted injuries. However, both Dr. Utterback and Dr. Gambee provided medical evidence which questioned the validity of claimant's symptoms and attributed claimant's condition to malingering or hysteria. (Exs. 25, 26-6, 29-17). Because there was expert evidence and testimony that the alleged precipitating event could not have been the cause of claimant's alleged injury, we conclude that this was not a simple case. Barnett v. SAIF Corp., supra. Thus, the ALJ properly required expert medical evidence establishing causation. Because Dr. Thrall's opinion on causation is not persuasive, this claim fails for lack of medical causation.

Board Chair Hall dissenting.

The majority construes the medical evidence from Drs. Gambee and Utterback as expert testimony that the November 30, 1994 incident could not have been the cause of claimant's injury. From that construction of the evidence, the majority then concludes that one of the factors in Barnett v. SAIF Corp., 122 Or App 279 (1993) has not been satisfied. Thus, the majority reasons that this case presents a complex medical question requiring expert medical evidence. Because the majority's analysis is based on a factual error, I must respectfully dissent.

Drs. Utterback and Gambee do not state that the November 1994 incident could not have been the cause of claimant's diagnosed low back strain. To the contrary, Dr. Gambee testified that claimant could have been injured and recovered prior to his examination on August 8, 1995. (Ex. 28-11). Dr. Utterback testified that he could not address the presence of objective findings on December 1, 1994 because he did not examine claimant on that date. (Ex. 29-19). Indeed, Dr. Utterback acknowledged that claimant may experience back pain with activities of daily living, such as bending down as he did at work on November 30, 1994. (Ex. 29-11). Therefore, the medical evidence from Drs. Utterback and Gambee satisfies (or does not defeat) the last requirement of Barnett, i.e., the absence of medical evidence that the alleged precipitating event could not have been the cause of the injury.

Furthermore, the medical evidence from Drs. Gambee and Utterback on which the majority relies was based on examinations performed months after claimant's November 30, 1994 injury. (Exs. 21, 26). As Dr. Gambee stated, claimant could have been injured and recovered before his examination of claimant. Therefore, that medical evidence does not counter the original objective findings of a low back strain, including reduced range of motion and spasm. (Exs. 14, 15D).

Accordingly, unlike the majority, I would conclude that the medical evidence from Drs. Utterback and Gambee does not rule out the November 30, 1994 incident as the cause of claimant's lumbar strain, a diagnosis that even the majority concedes was supported by objective findings contemporaneous with the date of injury. Because the majority's Barnett analysis is flawed, due to a factual error, I must respectfully dissent .

In the Matter of the Compensation of
ROSS E. MEYERS, Claimant
WCB Case No. 95-10030
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Christian, Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Daughtry's order that set aside its denial of claimant's injury claim for a syncopal episode (fainting spell). On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a volunteer firefighter, was relaxing at home on Sunday, April 2, 1995, when he was "paged" to the fire station. Claimant drove to the fire station, parked his car, grabbed a 35 pound bag which contained his firefighting gear, and quickly jogged 100 feet to the fire truck. Claimant had just begun putting on his fire fighting clothes, and the truck had just begun leaving the station, when the occupants were notified the truck was not needed. After the truck backed into the station, claimant exited and began walking towards a bench. Claimant passed out and collapsed to the floor, whereupon he was transported to the hospital and treated. Syncopal episode, resolved, and preexisting aortic stenosis were diagnosed.

Finding no persuasive medical evidence that claimant's injury "combined with" his preexisting aortic stenosis condition, the ALJ analyzed this injury claim under ORS 656.005(7)(a). Finding further that claimant's work activities and exertions were a material contributing cause of the syncopal episode, the ALJ concluded that the claim was compensable and, thus, set aside SAIF's denial.

On review, SAIF argues that the ALJ erred in not applying the major contributing cause standard of ORS 656.005(7)(a)(B). Specifically, SAIF contends that the opinion of Dr. Nelson, claimant's treating family physician, establishes that claimant's preexisting condition "combined with" work conditions to cause his syncopal episode. We agree.

It is claimant's burden to prove the compensability of his claim by a preponderance of the evidence. ORS 656.266. When a preexisting disease or condition combines with a compensable injury to cause or prolong disability or the need for treatment, the combined condition is compensable only if the compensable injury is the major contributing cause of the combined 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).

Here, there is no dispute that claimant has a preexisting aortic stenosis condition. Moreover, Dr. Nelson has opined that claimant's preexisting aortic stenosis contributed to the syncopal episode. We interpret Dr. Nelson as indicating that the syncopal episode constitutes a "combined condition" which resulted from the combination of claimant's April 1995 work injury (exertion) with his preexisting aortic stenosis condition.[1] Under such circumstances, we agree with SAIF that this case is governed by ORS 656.005(7)(a)(B).

We distinguish this case from Leon M. Haley, 47 Van Natta 2056, on recon 47 Van Natta 2206 (1995). In Haley, the claimant sustained a compensable neck and shoulder injury in September 1993. The physician who treated the claimant for his earlier injury explained that at the time of his December 1993 neck and back injury, the claimant was still under active treatment for his shoulder condition. Nonetheless, the medical record was silent on the question of whether the claimant's December 1993 work injury combined with his preexisting shoulder and neck condition. Absent such evidence, we found that the claimant needed only to establish that his work injury was a material contributing cause of his disability and need for treatment. See ORS 656.005(7)(a).

Unlike Haley, based on the opinion of claimant's physician, the medical record in the present case supports the conclusion that claimant's preexisting aortic stenosis condition combined with his April 1995 work injury (exertion). Thus, compensability is properly analyzed under ORS 656.005(7)(a)(B).

The remaining issue is whether claimant has established that his work injury (exertion) 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. We conclude that claimant has failed to meet his burden of proof.

Two physicians relate the syncopal episode to claimant's work. Dr. Nelson indicated that claimant's "blackout is legitimately work related." However, he did not state that the work activities were the major contributing cause, nor did he compare the contribution of work activities to the contribution from the preexisting aortic stenosis condition. See Dietz v. Ramuda, supra. Dr. Nelson then referred claimant to Dr. Gory, cardiologist.

Dr. Gory opined that on-the-job excitement and exertion were a "material but not major" contributing cause of claimant's need for medical treatment. Thus, no physician opined that claimant's work conditions were the major contributing cause of his syncopal episode and need for medical treatment. Accordingly, we conclude that claimant has failed to prove the compensability of his injury

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[1] Alternatively, Dr. Nelson's opinion could be read to mean that claimant's preexisting aortic stenosis, to some degree, directly caused the syncopal episode. Because Dr. Nelson did not apportion the causes of the syncopal episode, see Dietz v. Ramuda, 130 Or App 397, 401 (1994) (determining the "major contributing cause" of an injury or disease involves evaluating the relative contribution of different causes and deciding which is the primary cause), his opinion would not be sufficient to support compensability.

claim under ORS 656.005(7)(a)(B). Consequently, we reverse that portion of the ALJ's order that found claimant's syncopal episode condition to be compensable.[2]

ORDER

The ALJ's order dated February 14, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the SAIF Corporation's denial of claimant's injury claim for a syncopal episode is reversed. SAIF's denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

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[2] Because we have reversed the ALJ's order setting aside SAIF's denial under ORS 656.005(7)(a)(B), we need not address SAIF's alternative argument that if claimant's syncopal episode was caused by mental stress rather than physical stress, his injury claim should be analyzed as a mental disorder under ORS 656.802(3). See Karen Hudson, 48 Van Natta 113, recon den 48 Van Natta 287, recon den 48 Van Natta 453 (1996) ("physical conditions that are caused or worsened by mental stress are considered 'mental disorders' and are therefore subject to the requirements set out in amended ORS 656.802(3) for establishing compensable mental disorders"). But see, Marvin L. Miller, 48 Van Natta 495 (1996) (where fatigue from physical exertion and lack of sleep, rather than from "mental stress," was implicated in causing the claimant's chest pain, Board declined to analyze the claim as a mental disorder under ORS 656.802(3)).

Moreover, because we have not decided this case under ORS 656.802(3), we need not address claimant's request that the case be held in abeyance pending final disposition of the Hudson case. But see, e.g., Weston C. Foucher, 47 Van Natta 1518 (1995); Preston E. Jones, 46 Van Natta 2137 (1994); John B. Gordon, 44 Van Natta 1601 (1992); Alfonso S. Alvarado, 43 Van Natta 1303 (1991) (Board declined to hold review in abeyance pending Supreme Court decision because to do so would be inconsistent with its role as a decision maker or in furthering the dispute resolution process).

Chair Hall dissenting.

For the following reasons, this case does not involve a "combined condition" and, thus, ORS 656.005(7)(a)(B) is not implicated. Therefore, I respectfully dissent from the majority opinion.

In analyzing this claim, the majority relies on the opinion of Dr. Nelson, claimant's treating physician, to find that claimant's preexisting aortic stenosis condition "combined with" the April 1995 work injury, such that ORS 656.005(7)(a)(B) applies. I do not find his opinion to be persuasive evidence of a "combined" condition. See Leon M. Haley, 47 Van Natta 2056, on recon 47 Van Natta 2206 (1995); Charles E. Crawford, 45 Van Natta 1007 (1993); Gary Stevens, 44 Van Natta 1179 (1992).

ORS 656.005(7)(a)(B) provides:

> "If an otherwise compensable injury combines . . . with a preexisting condition to cause or prolong disability or the need for treatment, the combined condition is compensable only if . . . the otherwise compensable injury is the major contributing cause of . . . the combined condition." (Emphasis added).

Thus, the statute contemplates a "combined" condition as a precedent to applying the major "contributing" cause standard.

Dr. Nelson has identified claimant's conditions as: "1. Syncopal episode, resolved. 2. Aortic stenosis, contributing to #1." Contrary to the majority, I find that Dr. Nelson's opinion establishes only that claimant's preexisting aortic stenosis "contributed" to the compensable work injury. Accordingly, in the absence of persuasive medical evidence that claimant's work injury "combined with" his preexisting aortic stenosis condition, I find no basis to distinguish this case from Leon M. Haley, supra.

Furthermore, ORS 656.005(7)(a)(B) governs compensability of a "combined condition," not of a "resultant condition." See former ORS 656.005(7)(a)(B); James Martin, 47 Van Natta 2369 (1995) (Board Chair Hall specially concurring). Here, claimant is making a claim for the syncopal episode, not the aortic stenosis or a combination of the two. Even if the aortic stenosis did contribute to cause the syncopal episode, and even if the syncopal episode is the result of said contribution, no claim is being made for a combined condition and, thus, amended ORS 656.005(7)(a)(B) does not apply.

On this record, compensability is properly analyzed under the material contributing cause standard of ORS 656.005(7)(a). Consequently, I would affirm the ALJ's finding that claimant has met his burden of proving the compensability of his syncopal episode injury claim. The majority concludes otherwise and, therefore, I dissent.

In the Matter of the Compensation of
WILLIAM V. TURNER, Claimant
WCB Case No. 95-13433
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Christian, Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Odell's order that set aside its denial of claimant's claim for a low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, 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 May 3, 1996 is affirmed. For services on review, claimant's attorney is awarded $800, payable by SAIF.

Board Member Haynes dissenting.

The record establishes that claimant is not a credible witness and that he has failed to establish that his injury occurred at work.

In this regard, claimant told a co-worker that he hurt his back while working on his truck at home on the weekend. (Tr. 33). Furthermore, the co-worker, who worked closely with claimant, observed that claimant was acting normal on the day of the alleged injury and did not appear to be having problems. (Tr. 32). In addition, the only medical evidence supporting the compensability of claimant's claim comes from his chiropractor, Dr. Powell, who was unaware that claimant worked on his truck the weekend prior to seeking treatment. Thus, Dr. Powell's opinion is unpersuasive since he has an incorrect history. (Exs. 4; 5).

Finally, when questioned by the claims examiner, claimant initially denied working on his truck the weekend before he sought treatment. When confronted with information from the employer that he had worked on his truck, claimant recanted and admitted working on the truck. (Tr. 55-57).

This record establishes that claimant is not a straightforward and credible witness. Claimant's admission to his co-worker and his evasiveness when questioned about working on his truck cast significant doubt on the legitimacy of this claim. Under the circumstances, I would find that claimant has failed in his burden of proof. For these reasons, I dissent from the majority's decision.

In the Matter of the Compensation of
KEVIN L. MURPHY, Claimant
WCB Case No. 95-07885
ORDER ON REVIEW
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Johnstone's order that: (1) upheld the self-insured employer's partial denial of claimant's injury claim for left hand, left leg/foot, low back, left shoulder/trapezius, jaw, and C5-6 disc bulge complaints; (2) upheld the employer's partial denial of claimant's current neck condition; and (3) declined to assess penalties or attorney fees for allegedly unreasonable denials. Claimant has submitted copies of additional documents that were not offered into the record at hearing. Since our review is confined to the record developed before the ALJ, we treat claimant's submission as a motion to remand for the taking of additional evidence. See ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand, compensability, penalties and attorney fees.

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

Remand

On review, claimant has submitted a Civil Rights Determination from the Bureau of Labor and Industries, dated May 8, 1996, which found substantial evidence to support claimant's allegations of retaliation by the employer for his use of the Workers' Compensation system. Claimant has also submitted a Final Order Concerning a Medical Fee Dispute from the Workers' Compensation Division, dated August 8, 1995, which orders the employer to pay for claimant's two emergency room visits in May 1995.

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).

Here, we are not persuaded the additional documents submitted by claimant are likely to affect the outcome of this case. The ALJ concluded that claimant had not carried his burden of proving compensability of his current conditions because he is not credible and his history of the mechanism of the injury is not reliable. The ALJ's credibility and reliability determinations were based on the inconsistent histories (regarding the mechanism of his injury) that claimant provided to doctors and at hearing and the contradiction in his testimony regarding the extent of his disability and need for a cane in early 1995.

Claimant does not explain why the evidence of retaliatory conduct by the employer and the employer's liability for emergency room treatments are relevant to the ultimately dispositive issue of claimant's credibility and reliability. Furthermore, the proffered documents are not inconsistent with the ALJ's decision in this case. That is, the occurrence of retaliatory conduct by the employer does not tend to prove that claimant's complaints are, in fact, compensably related to the accepted injury. Moreover, the employer's liability for emergency room treatments in May 1995 does not prove the compensability of his multiple, current complaints. Because we do not find that the additional documents submitted by claimant would affect the outcome of this case, we find no compelling basis to remand and, therefore, deny the motion.

Compensability

On review, claimant asserts the ALJ made a number of "extremely unreliable and misleading" statements in his order. However, based on our review of the record, we agree with and adopt the

ALJ's findings, opinion and conclusions. Of particular note is that claimant makes no attempt on review to reconcile either: (1) the clearly inconsistent histories he provided to doctors and at hearing regarding the mechanism of the injury; or (2) his directly contradictory testimony regarding the extent of his alleged disability and need for a cane in early 1995. Those inconsistencies and contradiction were critical to the ALJ's credibility and reliability determinations.

Because we agree with the ALJ's credibility and reliability determinations, we find no persuasive and reliable evidence to prove that claimant's current complaints/conditions are related, in either material or major part, to the industrial injury. Accordingly, the employer's denials are upheld.

ORDER

The ALJ's order dated April 22, 1996 is affirmed.

September 16, 1996 Cite as 48 Van Natta 1811 (1996)

In the Matter of the Compensation of
RICHARDDEAN H. BELOG, Claimant
WCB Case No. 94-12672
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order which: (1) upheld the insurer's "de facto" denial of claimant's injury claim for cervical disc bulges and a cervical disc herniation; and (2) declined to award penalties or attorney fees for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability, penalties and attorney fees.

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

Claimant was compensably injured in an explosion on May 13, 1994. The insurer accepted the claim for right trapezius strain and cervical strain, but claimant later requested a hearing alleging that the insurer "de facto" denied cervical disc bulges at C4/5 and C5/6 and a disc herniation at C6/7.

The ALJ upheld the insurer's "de facto" denial of claimant's cervical condition on the ground that a preponderance of the medical evidence established that claimant did not have any cervical disc bulges or disc herniations resulting from his compensable May 1994 injury. In reaching this conclusion, the ALJ noted that claimant's current attending physician, Dr. Thomas, had received an erroneous history that claimant had been "thrown down" as a result of the explosion on May 13, 1994. (Ex. 17-1). Concluding that this history was inaccurate and that it was a potentially significant factual error, the ALJ found that Dr. Thomas' opinion that claimant's cervical condition was compensable was undermined to "some degree."

Claimant contends that this was an improper basis on which to discount Dr. Thomas' opinion because there is no indication that he relied on this history as the mechanism of injury. We agree with claimant that the defect in Dr. Thomas' history is not significant since the record does not establish that it played a role in his medical opinion. (Exs. 17A, 25). Nevertheless, we agree for the other reasons cited by the ALJ that claimant failed to sustain his burden of proving that he has any cervical disc bulges or herniations resulting from the May 1994 explosion. Therefore, we affirm the ALJ's decision upholding the insurer's "de facto" denial.

ORDER

The ALJ's order dated April 25, 1996 is affirmed.

In the Matter of the Compensation of
NATALIE M. ZAMBRANO, Claimant
WCB Case No. 95-10599
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Schultz's order that: (1) "reinstated" claimant's scheduled permanent disability award of 7 percent (10.5 degrees) for loss of use or function of her right leg; (2) increased claimant's unscheduled permanent disability award for a low back condition from 32 percent (102.40 degrees), as awarded by a Determination Order, to 41 percent (131.20 degrees); and (3) assessed a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are extent of scheduled and unscheduled permanent disability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes and supplementation. We change the ALJ's order to reflect that Exhibits 207 through 211 were admitted, rather than Exhibits 207 through 221.

After the third paragraph of the findings of fact, we insert the following:

> Claimant requested reconsideration of the June 14, 1995 Determination Order. On September 14, 1995, the Department issued an Order Denying Request for Reconsideration, finding that, pursuant to Weyerhaeuser Co. v. Purdy, 130 Or App 322 (1994), a reconsideration review was not a prerequisite for a claimant to request a hearing regarding a claim closure or determination order affecting an accepted authorized training program opening. (Ex. 203). On September 19, 1995, claimant requested a hearing regarding, inter alia, scheduled and unscheduled permanent disability.

We do not adopt the last paragraph of the findings of fact or the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

An October 5, 1993 Notice of Closure awarded claimant 43 percent unscheduled permanent disability for her low back and 7 percent scheduled permanent disability for loss of use or function of her right leg. (Ex. 115). Claimant was later involved in an authorized training program. When the training ended, claimant's claim was submitted to the Department for redetermination. A Determination Order issued on June 14, 1995, reducing claimant's total unscheduled award from 43 percent to 32 percent. (Ex. 192). The June 14, 1995 Determination Order did not refer to claimant's scheduled permanent disability award. Claimant requested a hearing.

The ALJ "reinstated" claimant's scheduled permanent disability award. The ALJ reasoned that, pursuant to amended ORS 656.268(9), claimant's award of scheduled permanent disability was not subject, as a matter of law, to redetermination. The ALJ also found that the October 5, 1993 Notice of Closure (which had awarded the 7 percent scheduled permanent disability award) was never appealed.

The insurer argues that the June 14, 1995 Determination Order reduced claimant's entire award of permanent disability, not just the unscheduled portion of the award. On the other hand, claimant contends that closure following completion of an authorized training program does not allow redetermination of a scheduled permanent disability award.

The 1995 legislature amended ORS 656.268. The amendments, in part: (1) created a new ORS 656.268(8); (2) renumbered former ORS 656.268(8) as amended ORS 656.268(9), both deleting and adding provisions to that renumbered subsection; and (3) deleted former ORS 656.268(9).

Our first task is to determine if the amendments apply to the present case. Except as otherwise provided, Senate Bill 369 applies to matters for which the time to appeal the ALJ's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 115 Or App 565, 572-73 (1995). Here, Section 66(4) provides, in part, that the amendments to ORS 656.268(9)

by section 30 of the Act "shall apply only to claims that become medically stationary on or after the effective date of this Act." Or Laws 1995, ch 332, § 66(4). Because Senate Bill 369 contains an emergency clause, its effective date is June 7, 1995, the date the Governor signed the bill into law. See Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). Claimant was found to be medically stationary on July 25, 1993, non-stationary on September 2, 1994 and was again found to be medically stationary on May 9, 1995. (Ex. 192). Since claimant was found to be medically stationary before June 7, 1995, the amendments to ORS 656.268(9) do not apply retroactively to claimant's claim. See Richard La France, 48 Van Natta 427 (1996).

In construing a statute, our task is to discern the intent of the legislature. The first level of analysis is to examine both the text and the context of the statute, including other provisions of the same statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). If the legislature's intent is clear, no further inquiry is necessary. If the intent of the legislature is not clear from the text and the context of the statute, we then consider the legislative history of the statute. Id. at 611-12.

Former ORS 656.268(8) provided:

> "If, after the determination made or notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the determination or closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the Department of Consumer and Business Services shall reconsider the claim pursuant to this section unless the worker's condition is not medically stationary. If the worker has returned to work, the insurer or self-insured employer may reevaluate and close the claim without the issuance of a determination order by the Department of Consumer and Business Services."

Amended ORS 656.268(9) provides that "[p]ermanent disability compensation shall be redetermined for unscheduled disability only." However, former ORS 656.268(8) contained no such limitation. Moreover, the previous administrative rules did not limit the redetermination to unscheduled disability. Former OAR 436-35-007(6)[1] (WCD Admin. Order 6-1992) provided:

> "Any time a worker ceases to be enrolled and actively engaged in training pursuant to ORS 656.268(8), the worker is entitled to have the amount of permanent disability for an accepted condition reevaluated under these rules. The reevaluation may increase, decrease or affirm the worker's permanent disability award."

Former OAR 436-30-030(15)[2] (WCD Admin. Order 94-059) provided, in part:

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[1] OAR 436-035-0007(9) (WCD Admin. Order No. 96-051) now provides:

"When a worker ceases to be enrolled and actively engaged in training pursuant to ORS 656.268(9) and there is no accepted aggravation in the current open period, the worker is entitled to have the amount of unscheduled permanent disability for a compensable condition reevaluated under these rules. The reevaluation may increase, decrease or affirm the worker's unscheduled permanent disability award." (Emphasis added).

[2] OAR 436-030-0030(15) (WCD Admin. Order 96-052) now provides, in part:

"If, after claim closure, when a worker is medically stationary prior to June 7, 1995, and the worker becomes enrolled and actively engaged in a department approved training program pursuant to OAR 436-0120:

"(a) Permanent disability shall be redetermined pursuant to ORS 656.268 when the worker has ended training and the worker's accepted compensable condition is medically stationary. * * *"

OAR 436-030-0030(16) (WCD Admin. Order 96-052) now provides, in part:

"If, after claim closure, when a worker is medically stationary on or after June 7, 1995, and the worker becomes enrolled and actively engaged in a department approved training program pursuant to OAR 436-0120:

"(a) Unscheduled permanent disability shall be redetermined pursuant to ORS 656.268 when the worker has ended training and the worker's accepted compensable condition is medically stationary or the claim otherwise qualifies for closure in accordance with these rules. * * *

"(b) No redetermination of permanent disability shall be made for scheduled claims or portions of claims. The scheduled permanent disability shall remain unchanged from the last award of compensation in that claim." (Emphasis added).

> "If, after claim closure, a worker becomes enrolled and actively engaged in a Department approved training program pursuant to OAR 436-120, permanent disability shall be redetermined pursuant to ORS 656.268 when the worker has ended training and the worker's accepted compensable condition is medically stationary."

In interpreting a statute, we are "not to insert what has been omitted, or to omit what has been inserted." ORS 174.010. Former ORS 656.268(8) provided that, when claimant was enrolled in the authorized training program, "any permanent disability payments due" were suspended. (Emphasis added). The suspension of permanent disability payments was not limited to unscheduled permanent disability payments. After claimant's training ended and she was medically stationary as of May 9, 1995, former ORS 656.268(8) provided that the Department was to "reconsider" the claim. Reconsideration of the "claim" was not limited to unscheduled permanent disability.

Thus, the language of the statute indicates that claimant's entire award of permanent disability was subject to reconsideration, not just the unscheduled portion of the award. That interpretation is consistent with former OAR 436-35-007(6) and former OAR 436-30-030(15), which required a reevaluation and redetermination of claimant's "permanent disability" award for an accepted condition. Therefore, we agree with the insurer that the June 14, 1995 Determination Order reduced claimant's entire award of permanent disability, not just the unscheduled portion of the award.[3]

On the merits of the scheduled award, the insurer contends that claimant was not entitled to any scheduled permanent disability. Claimant argues that the insurer cannot now argue about the merits of the scheduled permanent disability award because that award has become final as a matter of law. Citing former ORS 656.268(4)(b), claimant asserts that, since the October 5, 1993 Notice of Closure was not appealed, that order became final as a matter of law 180 days after the Notice of Closure was issued.

The initial Notice of Closure was issued on October 5, 1993. (Ex. 115). Claimant was awarded 43 percent (137.6 degrees) unscheduled permanent disability for her low back ($13,760) and 7 percent (10.5 degrees) scheduled permanent disability for loss of use or function of her right leg ($3,202.50). On October 18, 1993, the insurer informed claimant that it was deducting an overpayment of $2,366.08 from the amount due, leaving a balance of $14,596.42, which would be paid at a monthly rate of $1,070.06 for 13 months, with a final payment of $685.64. (Ex. 118). The ALJ found that a total of $10,732.03 had been paid claimant on the award granted by the October 5, 1993 Notice of Closure.

The payment of claimant's permanent disability award was interrupted while she was engaged in an authorized training program. Pursuant to former ORS 656.268(8), payments on a permanent disability award are suspended while the worker is involved in training. Former ORS 656.268(8) provided, in part:

> "If, after the determination made or notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the determination or closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training." (Emphasis added).

However, former ORS 656.268(8) does not provide that a Determination Order or Notice of Closure is itself affected when the worker enters a training program. See SAIF v. Sweeney, 115 Or App 506, 509 (1992), mod 121 Or App 142 (1993) (interpreting former ORS 656.268(5), later renumbered to ORS 656.268(8)).

Similarly, the administrative rules provide only for the suspension of permanent disability payments while the worker is involved in a training program. Former OAR 436-60-040 (WCD Admin. Order No. 94-055), provided, in part:

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[3] Since the intent of the legislature is clear from the text and context of the statute, further inquiry is unnecessary. PGE v. Bureau of Labor and Industries, supra, 317 Or at 611.

> "(2) When training commences in accordance with OAR 436-120 after the issuance of a determination order, notice of closure, Opinion and Order of a Referee, Order on Review, or Mandate of the Court of Appeals, the insurer shall suspend any award payments due under the order or mandate and pay temporary disability benefits.
>
> "(3) The insurer shall stop temporary disability compensation payments and resume any suspended award payments upon the worker's completion or ending of the training, unless the worker is not then medically stationary. If no award payment remains due, temporary disability compensation payments shall continue pending a subsequent determination order by the Division. However, if the worker has returned to work, the insurer may reevaluate and close the claim without the issuance of a determination order by the Division." (Emphasis added).

In SAIF v. Sweeney, supra, the initial determination order was issued on July 28, 1989. The court found that, under former OAR 436-60-150(5),[4] the employer had 30 days to begin paying the claimant's permanent partial disability award. SAIF v. Sweeney, supra, 121 Or App at 145. On July 31, 1989, the claimant entered a vocational training program and the employer's duty to pay the permanent partial disability award was suspended. The claimant completed the training program on April 13, 1990. The court held that the employer's obligation to pay the permanent partial disability award resumed. Id. However, the employer still had 27 days to begin paying, or until May 10, 1990. On April 30, 1990, the employer issued its notice of closure that reduced the permanent partial disability award to 17 percent. The court held:

> "We conclude that, because the notice of closure was issued before employer was obligated to begin payment under the original determination order, employer's issuance of its notice of closure effectively reduced the award and excused employer from payment under the original award. Had payment under the original determination order come due, employer would have been obligated to make the lump sum payment required by that award." Id.

The present case differs from SAIF v. Sweeney, supra, in that claimant was receiving monthly payments of her permanent partial disability award. See 656.216(1).[5] Nevertheless, the court's analysis remains applicable.

Pursuant to former OAR 436-60-150(6)(a),[6] the insurer's obligation to begin paying permanent disability benefits began no later than the 30th day after the "pre-authorized training program" Notice of Closure. In accordance with ORS 656.216(1), the insurer chose to pay the permanent disability award in monthly installments. The insurer's last monthly payment prior to the reinstated November 28, 1994 authorized training program was made on November 23, 1994. (Ex. 121A). When claimant's program ended on May 27, 1995, the insurer became obligated to resume the suspended permanent disability payments. See former OAR 436-60-040(3). Since those payments were being made on a monthly basis and because the last "pre-authorized training program" payment had been made 5 days before the reinstated program, the first "post-authorized training program" payment was due June 21, 1995 (25 days after the ending of the program). See ORS 656.216(1); former OAR 436-60-150(6)(a); SAIF v. Sweeney, supra.

The "post-authorized training program" Determination Order issued on June 14, 1995. Because the Determination Order issued before the insurer was obligated to continue the monthly payments of permanent partial disability, and the Determination Order reduced the award, the insurer was effectively excused from the remaining payments of the original permanent partial disability award. See SAIF v. Sweeney, supra, 121 Or App at 145; Richard LaFrance, supra, 48 Van Natta at 431 (the

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[4] Although the court cited former OAR 436-60-150(5), which deals with the payment of temporary disability, the correct rule appears to be former OAR 436-60-150(6), which deals with payment of permanent disability benefits.

[5] ORS 656.216(1) provides: "Compensation for permanent partial disability may be paid monthly at 4.35 times the rate per week as provided for compensation for temporary total disability at the time the determination is made. In no case shall such payments be less than $108.75 per month."

[6] Former OAR 436-60-150(6)(a) provides that permanent disability benefits shall be paid no later than the 30th day after "[t]he date of a notice of claim closure issued by the insurer[.]"

claimant's "post-authorized training program" Determination Order remained the final determination of the claimant's disability to date). In other words, the insurer was no longer obligated to make the remaining payments due under the October 5, 1993 Notice of Closure.

Our conclusion is further supported by ORS 656.268(13), which provides:

> "Any determination or notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid."

In other words, issuance of the "post-authorized training program" Determination Order represents an adjustment of permanent disability that was made pursuant to the "pre-authorized training program" Notice of Closure.

On the merits, we agree with the insurer that claimant is no longer entitled to an award of scheduled permanent disability. On September 2, 1994, Dr. Stowell performed a neurologic exam and reported that claimant's reflexes were "2+ and symmetric at the knee and ankle. No focal or sensory deficits identified." (Ex. 156). On November 16, 1994, Dr. Weiss reported that claimant had "[c]hronic back and right leg pain with non-significant right leg decreased measurement and nonphysiological sensory loss." (Ex. 168-3). On November 17, 1994, an occupational therapist from the Idaho Elks Rehabilitation Hospital reported that claimant's primary physical complaints included lower back pain, but did not refer to any right leg pain. (Ex. 171). Based on these reports, we conclude that claimant is not entitled to an award of scheduled permanent disability for loss of use or function of her right leg.

Extent of Unscheduled Permanent Disability

The sole issue at hearing was adaptability, in particular claimant's residual functional capacity. The ALJ found that claimant was capable of performing only sedentary work with restrictions, and, therefore, the adaptability factor should be 6 rather than 3. The ALJ increased claimant's unscheduled permanent disability award for a low back condition from 32 percent (102.40 degrees), as awarded by the June 14, 1995 Determination Order, to 41 percent (131.20 degrees).

The claim was originally closed with an October 5, 1993 Notice of Closure. After claimant's training ended, her claim was resubmitted for redetermination and a Determination Order issued on June 14, 1995. (Ex. 192). Because the claim closed with a June 14, 1995 Determination Order, the applicable standards for determining claimant's entitlement to unscheduled permanent disability are contained in WCD Admin. Order No. 93-056.

Adaptability is measured by comparing base functional capacity (BFC) to the worker's residual functional capacity (RFC) at the time of becoming medically stationary. Former 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." Former OAR 436-35-310(3)(b).

The ALJ relied on Dr. Stowell's work restrictions in determining that claimant's RFC was sedentary with restrictions. The ALJ rejected evidence from an Idaho occupational therapist because there was no indication that the Oregon definitions of medium, light or sedentary work were being used.

The insurer argues that claimant is capable of performing light duty work. The insurer relies on the November 17, 1994 report from an occupational therapist at the Idaho Elks Rehabilitation Hospital which indicated that claimant could return to work at the "light-work level." (Ex. 171). On May 9, 1995, Dr. Smith concurred with the restrictions given by the Idaho Elks Rehabilitation Hospital. (Ex. 182).

Claimant's RFC is the greatest capacity evidenced by the attending physician's release or a preponderance of the medical opinion. Former OAR 436-35-310(5). Claimant relies on the work restrictions from her attending physician, Dr. Stowell.[7]

Dr. Stowell performed claimant's impairment evaluation on August 10, 1993. (Ex. 112). Dr. Smith concurred with Dr. Stowell's findings. (Ex. 114).

In November 1993, Dr. Stowell released claimant to perform the work of a sorter and a processor with modifications. (Exs. 128, 130, 131, 132). Claimant began an authorized training program on January 3, 1994. (Ex. 127, 164). Claimant's training was terminated on July 28, 1994 and claimant returned to work as a sorter. (Ex. 164).

On September 2, 1994, Dr. Stowell reported that claimant had been working as a potato sorter and was experiencing worsening low back discomfort. (Ex. 156). Dr. Stowell opined that claimant's current job would lead to recurrent symptoms and pain behavior over time and he recommended "sedentary duty work such as a desk job, allowing sitting with the back supported and intermittent standing on an hourly basis, no lifting beyond 10 pounds." (Id.; Ex. 157). On September 17, 1994, Dr. Smith reported that, "considering [Dr. Stowell's] training in rehabilitation, I have no reason to differ with his recommendations regarding the limitation of [claimant] to sedentary work." (Ex. 160). Dr. Stowell reiterated the same work restrictions on September 20, 1994. (Ex. 162).

On October 21, 1994, the Director concluded that claimant was eligible for additional training and the insurer was ordered to reinstate claimant's training plan. (Ex. 164). On October 25, 1994, Dr. Stowell did not recommend any changes in claimant's current work restrictions, which were "essentially sedentary duty." (Ex. 165). Dr. Stowell continued to recommend vocational retraining for office work.

A November 17, 1994 report from an occupational therapist at the Idaho Elks Rehabilitation Hospital indicated that claimant could return to work at the "light-work level." (Ex. 171). On May 9, 1995, Dr. Smith commented that he had not seen claimant since summer 1994 and based on his records, he concurred with the restrictions given by the Idaho Elks Rehabilitation Hospital. (Ex. 182). Dr. Stowell reported on May 15, 1995 that he had not seen claimant since October 1994 and she had been medically stationary at that time. (Ex. 183).

Claimant's RFC is the greatest capacity evidenced by the attending physician's release or a preponderance of the medical opinion. Former OAR 436-35-310(5). Dr. Stowell, claimant's attending physician, had released claimant to sedentary work with restrictions. (Exs.156, 157, 162, 165). We agree with the ALJ that this is the most persuasive medical evidence regarding claimant's RFC at the time of determination. Accordingly, claimant's adaptability is rated as 6. See OAR 436-35-310(6). We agree with the ALJ that claimant's unscheduled permanent disability award should be increased to 41 percent.

Penalties

The ALJ concluded that, in view of the clear directive in amended ORS 656.268(9) that allowed redetermination of only unscheduled permanent disability, it was unreasonable for the insurer not to pay the amount owed to claimant on her scheduled disability award from the original October 5, 1993 Notice of Closure.

In light of our decision that amended ORS 656.268(9) does not apply to this case and our conclusion that claimant is not entitled to an award of scheduled permanent disability, no penalties for the insurer's alleged unreasonable claim processing are warranted.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services on review concerning the unscheduled permanent disability award. ORS 656.382(2). After considering the factors set forth in

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[7] Although Dr. Smith, neurosurgeon, performed claimant's back surgeries on June 6, 1991 and November 5, 1992, (Exs. 26, 68), Dr. Stowell, a specialist in physical medicine and rehabilitation, provided most of claimant's treatment for her rehabiliation.

OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the unscheduled permanent disability award is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 15, 1996 is affirmed in part and reversed in part. The portions of the ALJ's order "reinstating" claimant's scheduled permanent partial disability award of 7 percent (10.5 degrees) for loss of use or function of her right leg and awarding penalties and "out-of-compensation" attorney fees based on this "reinstated" award are reversed. The ALJ's "out-of-compensation" attorney fee award is adjusted accordingly. For services on review concerning the unscheduled permanent disability award, claimant is awarded $1,000, payable by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
ELDON R. YARBROUGH, Claimant
WCB Case No. 95-05252
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Yeager's order that: (1) concluded that claimant's claim for neck and left shoulder conditions was barred by a prior stipulation; and (2) upheld the SAIF Corporation's partial denial of those conditions. On review, the issue is the preclusive effect of a prior stipulation.

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

ORDER

The ALJ's order dated March 11, 1996 is affirmed.

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[1] We recently considered the preclusive effect of a settlement stipulation whereby the parties agreed to settle "all issues raised or raisable at this time." Theodore J. McVay, 48 Van Natta 1518, 1520 (1996). There, we interpreted the phrase "at this time" to mean the date of the parties' execution of the agreement. Reasoning that the doctor's report which related the disputed condition to work activities was not received by the claimant's attorney until after the date of the last signature of the parties, we concluded that the claimant was not precluded by the stipulation from litigating the compensability of the condition. Id.

Like the stipulation in McVay, the stipulation in this case also settled all issues raised or raisable "at this time." However, this case is distinguishable from McVay for the following reason. The parties' signatures are undated in this case. In addition, Dr. Knower's report which notified claimant's attorney of a potential claim for injuries to the neck and left shoulder, (Ex. 9), was received by claimant's attorney on February 4, 1993, one month before the stipulation was approved by an ALJ on March 5, 1993. (Ex. 17). Given these facts, we conclude our holding in McVay is not applicable here.

In the Matter of the Compensation of
ARNOLD E. PONCE, Claimant
WCB Case No. 95-10880
ORDER ON REVIEW
James L. Francesconi, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

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

FINDINGS OF FACT

Claimant, age 48 at the time of hearing, works for the employer as a warehouse clerk. Since young adulthood, claimant has worn tinted glasses to overcome photophobia, a condition which makes his eyes unusually sensitive to light. He has worked for the employer since 1969.

The employer transferred claimant from California to Portland in April 1993. From April to August 1993, claimant worked driving power equipment in the employer's warehouse. In August 1993, the employer asked claimant to remove his tinted glasses when operating the mobile equipment. Claimant refused, and he was taken off mobile equipment duties and moved to another, lower-paid position (a picker/packer) in the employer's warehouse.

In January 1994, the employer's medical director, Dr. Elnick, recommended that the employer not allow its warehouse workers to wear tinted glasses that filter out more than 20 percent of transmitted light. Claimant's tinted glasses (No. 3 and No. 4 rose-tint) filter out more than the 20 percent maximum.

In February 1994, claimant filed an employment discrimination complaint with the Equal Opportunity Employment Commission and the Oregon Bureau of Labor and Industries, contending that he was improperly removed from his mobile equipment operator job because of his disability and need for tinted glasses. The complaint was denied in May 1994.

In August 1994, the employer was advised by OR-OSHA that allowing employees to wear tinted glasses indoors in an active warehouse environment was an unsafe and unacceptable practice as well as a violation of the Oregon Safe Employment Act.

In April 1995, the employer published a policy prohibiting the wearing of sunglasses by employees working indoors, unless the tinted lenses were a No. 2 rose tint or less, and were prescribed by a doctor to correct an eye condition.

On August 9, 1995, the employer advised claimant that he could no longer wear his tinted glasses in the warehouse. Claimant began working without his glasses. Shortly thereafter, claimant sought treatment for headaches, resulting from his exposure to untinted light at work, then filed an occupational disease claim.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's headaches were a symptom of his photophobia, and that claimant failed to establish that his employment conditions (exposure to untinted light) was the major contributing cause of his condition. On review, claimant argues that his exposure to light at work was the sole cause of his need for treatment, and therefore his headaches are compensable under ORS 656.802. We disagree.

ORS 656.802(2)(a) requires that claimant prove that his employment conditions were the major contributing cause of his disease. ORS 656.802(2)(e) requires that preexisting conditions "be deemed causes in determining major contributing cause."

In this case, claimant does not seek compensation for his photophobia but rather for his headaches, a condition which the medical experts agree is "secondary to" the photophobia. (See Exs. 8, 10A, 12-2). Because claimant's preexisting, noncompensable photophobia contributed to his headache condition, it must be considered a cause in determining the major contributing cause under the occupational disease statute. ORS 656.802(2)(e).

"Major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. See Dietz v. Ramuda, 130 Or App 387 (1994), McGarrah v. SAIF, 296 Or 145, 166 (1983). After considering the entire record in this case, we are not persuaded that the lighting in the employer's warehouse contributed more to the cause of claimant's headaches, than his preexisting photophobia. Therefore, we conclude that claimant has failed to prove the compensability of his claim under ORS 656.802 and 656.266.

ORDER

The ALJ's order dated January 11, 1996, as reconsidered and amended March 5, 1996, is affirmed.

September 17, 1996 Cite as 48 Van Natta 1820 (1996)

In the Matter of the Compensation of
JEFFREY T. KNUDSON, Claimant
Own Motion No. 94-0439M
OWN MOTION ORDER OF ABATEMENT
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our August 23, 1996 Own Motion Order, in which we directed SAIF to process claimant's claim to closure pursuant to OAR 438-012-0055 and our March 8, 1996 Own Motion Order. Our August 23, 1996 order further ordered SAIF to recommence temporary disability compensation beginning February 2, 1995, until it is authorized to terminate that compensation, assigned a penalty based on the unpaid temporary disability compensation between March 28, 1996 and the date of our order, and approved an out-of compensation attorney fee based on the increased compensation awarded by our order (not to exceed $1,050), from February 2, 1995 through August 23, 1996. SAIF contends that "all TTD was paid timely and therefore SAIF Corporation does not owe a penalty." SAIF further asserts that "TTD was paid from April 9, 1996 ongoing with the exception of the March 15, 1995 to January 31, 1996 period for which we were awaiting Dr. Salib's authorization."

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. Claimant is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS M. INGLETT, Claimant
WCB Case No. 95-12696
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its alleged "de facto" denial of claimant's right shoulder internal derangement condition; (2) found that claimant's right shoulder condition claim was prematurely closed; and (3) awarded claimant an attorney fee pursuant to ORS 656.386(1) for prevailing over the alleged "de facto" denial. On review, the issues are "de facto" denial, premature claim closure, and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Facts," except for the last two paragraphs, with the following supplementation and summary of the relevant facts.

After an October 1994 injury to claimant's right shoulder (then variously diagnosed as rotator cuff tendinitis, minor rotator cuff tear, supraspinatus tendinitis and shoulder strain), SAIF initially accepted a disabling "right rotator cuff tendinitis." Claimant filed a request for hearing on January 20, 1995, alleging, inter alia, "de facto" denial.

On March 3, 1995, Dr. Woods, treating neurologist, examined claimant and noted 5/5 strength in the upper extremities, full range of motion of the right shoulder, and intact and normal upper extremity reflexes. Dr. Woods released claimant to return to regular work. Dr. Platt, treating chiropractic physician, concurred.

On April 13, 1995, Drs. Gardner and Vessely examined claimant at SAIF's request. Other than mild loss of motion in the right shoulder due to pain inhibition, Drs. Gardner and Vessely reported normal findings. The physicians opined that claimant was medically stationary, and agreed with Dr. Woods that claimant could return to his regular work as of March 3, 1995.

On April 24, 1995, the parties signed a Stipulation and Order. SAIF agreed to modify its acceptance to read "Right Shoulder Strain with Rotator Cuff Tendonitis" (to more closely reflect the diagnosis of an examining physician) and to pay a sum for alleged nonpayment of temporary total disability benefits due for the period from February 21, 1995 through March 3, 1995 (the date claimant was declared to be medically stationary); claimant agreed to withdraw his Request for Hearing. Finally, the parties agreed that the stipulation settled "all issues raised or raisable" between them.

On May 5, 1995, a Determination Order issued finding claimant medically stationary on March 3, 1995. The Determination Order awarded no permanent disability. Claimant requested reconsideration and the appointment of an arbiter.

Medical arbiter, Dr. Gritzka, examined claimant in October 1995. He noted full range of motion of the right shoulder, 5/5 strength in the shoulder girdle, and no findings of impairment attributable to the compensable injury. Dr. Gritzka diagnosed "[c]hronic right supraspinatus tendinitis; probable minor internal derangement of the right shoulder," opined that claimant had not reached maximum medical improvement, and suggested that claimant might benefit from a short (four to six week) course of physical therapy.

An Order on Reconsideration issued on November 15, 1995, affirming the Determination Order in its entirety. Based on Dr. Woods' opinion, as concurred in by Dr. Platt, D.C., the reconsideration order affirmed the March 3, 1995 medically stationary date and found that claim closure was not premature.

Thereafter, by letter to the Board dated November 17, 1995, copied to SAIF, claimant requested a hearing from the Order on Reconsideration and from SAIF's alleged "de facto" denial of the conditions listed by the arbiter. SAIF contacted Dr. Gritzka and inquired whether chronic right supraspinatus tendinitis and internal derangement of the right shoulder are similar to or the same as the right shoulder conditions it had previously accepted. Dr. Gritzka responded that right supraspinatus tendinitis and

right shoulder rotator cuff tendinitis are "the same thing." He further stated that "internal derangement" of the right shoulder is "not a specific diagnosis." Rather, Dr. Gritzka explained, "internal derangement" is a descriptive term for various pathological changes in the shoulder joint and bicipital tendon manifested as tendinitis.

On December 15, 1995, SAIF issued a partial denial, stating, in relevant part:

> "Right shoulder rotator cuff tendonitis has been accepted and associated benefits provided. The chronic right supraspinatus tendonitis and internal derangement of the right shoulder are similar to or the same as the accepted condition."

On December 20, 1995, claimant filed another request for hearing. The parties proceeded to hearing on February 13, 1996.

CONCLUSIONS OF LAW AND OPINION

"De Facto" Denial

Citing ORS 656.262(7)(a),[1] the ALJ noted that a carrier is not required to accept each and every diagnosis or medical condition with particularity, so long as its acceptance reasonably apprises the claimant of the nature of the compensable condition. Relying on Dr. Gritzka's explanation, the ALJ found that SAIF's stipulated acceptance of a strain with rotator cuff tendonitis encompassed the condition that now has been identified as "internal derangement." The ALJ concluded, therefore, that claimant's internal derangement condition "is 'part and parcel' of the condition which the carrier has already accepted." [Emphasis supplied]. Nonetheless, reciting that SAIF "failed to clarify its denial to indicate that the 'condition' at issue was part of the accepted claim, [the ALJ] deem[ed] the 'condition' to have been, de facto, denied."[2]

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[1] Amended ORS 656.262(7)(a) provides:

> "After claim acceptance, written notice of acceptance or denial of claims for aggravations or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions. Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."

[2] The ALJ also noted that neither party mentioned nor discussed the claim notification requirements of ORS 656.262(7)(a), nor raised compliance with or application of the statute as an issue. The ALJ however "infer[red] that the insurer had notice of the claim, perhaps by claimant's November 17, 1995 letter to the Board, copied to the insurer." See Guillermo Rivera, 47 Van Natta 1723 (1995) (finding that the claimant's request for hearing alleging a "de facto" denial constituted a "communication in writing" to the employer of the claimant's objections to the notice of acceptance, thus satisfying amended ORS 656.262(6)(d)).

Subsequent to the ALJ's order, in Shannon E. Jenkins, 48 Van Natta 1482 (1996), we disavowed Rivera. The claimant in Jenkins filed a request for hearing alleging a "de facto" denial. We considered the legislative history supporting ORS 656.262(6)(d), and concluded that it reveals the legislature's intent that the worker's "communication in writing" under ORS 656.262(6)(d) must precede the worker's request for hearing. The "communication in writing" requirement was intended to inform the carrier of claimant's objections to the notice of acceptance and allow the carrier to respond before there is any litigation. Finding no evidence that the claimant first communicated in writing her objections to the notice of acceptance before filing a request for hearing, we concluded that the claimant had not satisfied amended ORS 656.262(6)(d) and, thus, was precluded from alleging at hearing that the employer had "de facto" denied a claimed condition.

Here too, claimant only filed a request for hearing alleging a "de facto" denial. There is no evidence that claimant first requested in writing that SAIF accept the "internal derangement" condition before filing a request for hearing. However, inasmuch as SAIF has not questioned the validity of claimant's request for hearing, and in light of our conclusion that SAIF did not "de facto" deny claimant's internal derangement condition, we do not address this issue.

SAIF cites Debra S. Harrison, 48 Van Natta 420 (1996), in support of its argument that its acceptances include claimant's right shoulder internal derangement condition. Based on the following reasoning, we find there was no "de facto" denial.

First, we agree with and adopt the ALJ's reasoning and conclusions that SAIF's stipulated acceptance encompasses the condition that now has been identified as "internal derangement." We further agree with and adopt the ALJ's reasoning and conclusions that claimant's right shoulder internal derangement condition is part of the condition which SAIF "has already accepted."

In addition, we find that, here, claimant has been given different diagnoses for his right shoulder condition. However, as is clear from the opinion of arbiter Gritzka (upon whom claimant relies in making his claim), claimant has not received treatment for a condition different from those accepted by SAIF. Although Dr. Gritzka refers to "chronic right supraspinatus tendinitis; probable minor internal derangement of the right shoulder," Dr. Gritzka notes that "internal derangement" is not a specific diagnosis. Rather, Dr. Gritzka explains, "internal derangement" is a descriptive term for the pathological changes in the shoulder joint and bicipital tendon which manifest as the condition denominated "tendinitis."

Thus, there is no evidence that claimant has a condition in his right shoulder different and separate from that accepted by SAIF. Therefore, we find that claimant's right shoulder condition is the same condition that it has been since the original injury, even though different diagnoses/medical terminology has been employed. Consequently, we conclude that SAIF did not "de facto" deny claimant's "probable internal derangement" condition, as it is, and has been, a part of the accepted claim. See Debra S. Harrison, supra (where different diagnoses/medical terminology employed, but the claimant's current condition was the same condition that it had been since the original injury, no "de facto" denial found); Karen S. Boling, 46 Van Natta 1522 (1994) (same); Leslie C. Muto, 46 Van Natta 1685 (1994) (same); Warren R. Friend, 46 Van Natta 1520 (1994) (where diagnoses were used interchangeably, but the medical evidence established that the claimant had but one condition, no "de facto" denial found).[3]

Premature Closure

First, SAIF argues that, because claimant chose to raise the medically stationary date in the April 1995 stipulation by asserting that he was entitled to temporary total disability payments up to his medically stationary date of March 3, 1995, claimant is now precluded from asserting that the medically stationary date is incorrect. See Good Samaritan Hospital v. Stoddard, 126 Or App 69, 73, rev den 319 Or 572 (1994) (when the agreement purports to resolve all issues which were raised or could been have raised, the settlement bars a subsequent claim for a condition that could have been negotiated at the time of the settlement); Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993) (a party may not relitigate any issue resolved by a stipulation, since a party is bound to the terms of the agreement).

Even if we assume, without deciding, that claimant is not barred[4] by the Stipulation and Order from asserting that his condition was not medically stationary on March 3, 1995, the next inquiry would be whether, on the merits, claimant has proved that he was not medically stationary on the date of closure. For the following reasons, we conclude that claimant has not sustained his burden of proof.

The ALJ found that claimant's claim was prematurely closed. In so doing, the ALJ found persuasive arbiter Gritzka's opinion that claimant's condition might improve with a short course of physical therapy. On review, SAIF contends the opinions of attending physicians, Drs. Woods and Platt, who opined that claimant was medically stationary as of March 3, 1995, as supported by examining physicians, Drs. Gardner and Vessely, should instead be found persuasive. We agree with SAIF.

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[3] Neither do we find, as claimant contends, that SAIF's December 1995 denial constitutes a "de facto" "back-up" denial of the strain. To the contrary, SAIF's December 1995 denial was a partial denial only. We do not see where SAIF partially or fully denied the strain, which it specifically accepted by stipulation and which remains a part of the claim.

[4] Claimant responds that the Board should not reach SAIF's preclusion argument because it was not raised at hearing.

It is claimant's burden to prove that his 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 May 5, 1995 Determination Order. 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). Finally, the Board generally gives greater weight to the conclusions of a treating physician absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, we find no persuasive reason not to defer to the medical opinions of Drs. Woods and Platt. First, these physicians have treated claimant over the course of his injury. Dr. Platt began treating claimant within a few days of the October 19, 1994 injury; Dr. Woods began treating claimant within a month of the injury. Second, we find that Dr. Woods' opinion was based on complete information and is well-reasoned. Specifically, on March 3, 1995, Dr. Woods reexamined claimant. He reported 5/5 strength in the upper extremities and full range of motion of the right shoulder. In view of those findings, Dr. Woods released claimant to return to regular work. Dr. Platt concurred with Dr. Woods' closing report. In addition, Drs. Gardner and Vessely also concluded that claimant was medically stationary on March 3, 1995.

Dr. Gritzka performed an arbiter examination in October 1995. He too found full range of right shoulder motion and 5/5 muscle strength. Based on the same objective findings present when Dr. Woods declared claimant medically stationary seven months earlier, however, Dr. Gritzka opined that claimant was not medically stationary and might benefit from a short course of physical therapy.

Dr. Gritzka's one-time examination does not overcome the weight accorded to Drs. Woods and Platt. As treating physicians, they were in a better position to evaluate claimant's condition. As such, we conclude, based on Drs. Woods and Platt's opinions (as supported by Drs. Gardner and Vessely), that claimant has not carried his burden of establishing that his claim was prematurely closed.

Attorney Fee for "De Facto" Denial

The ALJ awarded claimant an attorney fee pursuant to ORS 656.386(1) for prevailing over SAIF's "de facto" denial. On review, SAIF contends that there was no "de facto" denial and, because SAIF did not refuse to pay compensation on the express grounds that claimant's "internal derangement" condition is not compensable, no "denied claim" within the meaning of ORS 656.386(1). Even had we found there was a "de facto" denial, as explained below, we agree with SAIF that there is no "denied claim" within the meaning of ORS 656.386(1).

ORS 656.386(1) is the statutory provision for attorney fees in cases involving "denied claims." For purposes of that statutory section, a "denied claim" is one which the 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." In deciding whether there is a "denied claim," our orders focus on whether there is evidence that the carrier has refused to pay compensation because it questioned causation. E.g., Michael J. Galbraith, 48 Van Natta 351 (1996).

Here, when claimant's attorney requested that SAIF amend its acceptance, SAIF indicated that the internal derangement condition was similar to or the same as the accepted right shoulder condition, for which all benefits had been paid. The response, therefore, did not expressly deny compensability of the newly claimed condition. There is no contention that any benefits for the internal derangement condition have been unpaid. In addition, the record does not establish that SAIF refused to pay compensation on the express ground that the additional condition was not compensable or did not give rise to an entitlement to compensation. Under such circumstances, we conclude that a "denied claim" has not been established and, consequently, no attorney fee may be awarded under ORS 656.386(1). See Michael Galbraith, supra.

ORDER

The ALJ's order dated March 13, 1996 is reversed. The ALJ's finding that the SAIF Corporation "de facto" denied claimant's right shoulder internal derangement condition is reversed. The May 5, 1995 Determination Order and November 15, 1995 Order on Reconsideration are reinstated and affirmed in their entireties. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
THERESA G. PETERSON, Claimant
WCB Case No. 95-13095
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) found that claimant's claim had not been prematurely closed; and (2) set aside an Order on Reconsideration. If we conclude that the claim has been prematurely closed, claimant requests an "out-of-compensation" attorney fee beyond the 10 percent (not to exceed $1,050) awarded by the Department's Order on Reconsideration. The employer moves to strike claimant's reply brief as untimely. On review, the issues are motion to strike, premature closure and attorney fees. We deny the motion, and reverse.

FINDINGS OF FACT

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

On March 3, 1994, claimant returned to Dr. Baldwin, her treating knee specialist, with complaints of knee pain. Dr. Baldwin concluded that claimant was in need of a repeat arthroscopy and a proximal tibial osteotomy to relieve her pain and improve her function. Dr. Baldwin requested permission to proceed with the surgery. The employer denied Dr. Baldwin's surgery request on the basis that claimant had become subject to an MCO and that the surgery must be precertified through the MCO. On May 21, 1994, Dr. Brenneke examined claimant. On June 1, 1994, Dr. Quarum, who reviewed claimant's medical record for the employer, concurred that claimant needed additional medical treatment. (Ex. 119-3).

A prior ALJ concluded that the employer could require claimant to change physicians and treat with an MCO physician. (Ex. 119-4). Claimant began treating with Dr. Brenneke.

On November 29, 1994, Dr. Brenneke performed an arthroscopy for claimant's internal knee derangement. In addition to the arthroscopy, Dr. Brenneke was to assess claimant's intro-articular status to make sure that she had satisfactory findings and no contraindications to proceed with a proximal tibial osteotomy. (Ex. 123).

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The employer moved to strike claimant's reply brief, which was due on or before July 11, 1996, on the ground that the brief was untimely filed. The employer relies on the fact that the post office cancellation on the envelope containing the brief is dated July 15, 1996.

Under OAR 438-005-0046(1)(c), briefs are timely filed if mailed by "first class mail, postage prepaid. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date." In this case, the certificate of service attached to the brief indicates that it was deposited in the mail on July 11, 1996. Thus, under the applicable administrative rule, the employer's respondent's brief was timely filed. See Elva M. McBride, 46 Van Natta 2206 (1994); Lucy E. Buckallew, 46 Van Natta 115 (1994); Duane R. Paxton, 44 Van Natta 375, 376 (1992). Consequently, the motion to strike is denied.

Premature Claim Closure

Relying on Dr. Brenneke's April 7, 1995, report, the ALJ concluded that claimant was medically stationary as of that date and set aside the November 30, 1995 Order on Reconsideration that set aside the Notice of Closure as premature. On review, claimant contends that she was not medically stationary on April 7, 1995. We agree.

Claims shall not be closed until the worker's condition has become medically stationary. ORS 656.268(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).

In determining whether a claim was prematurely closed, we determine whether the worker's condition was medically stationary on the date of closure, without considering subsequent changes in the worker's condition. Where evidence indicates that claimant's condition did not change after closure, post-closure medical evidence addressing the issue of whether or not claimant was medically stationary on the date of closure may be considered.[1] Scheuning v. J.R. Simplot & Company, 84 Or App 622 (1987).

Here, Dr. Baldwin concluded in March 1994 that claimant was in need of a repeat arthroscopy and a proximal tibial osteotomy to relieve her pain and improve her knee function. Dr. Baldwin requested permission from the employer to proceed with the surgery. The employer denied the surgery on the basis that claimant was required to change her physician to an MCO physician. Claimant began treatment with Dr. Brenneke, who performed an arthroscopy on November 29, 1994. Dr. Brenneke noted that claimant had evidence of degeneration and a varus knee and had been recommended for a proximal tibial osteotomy. As part of the arthroscopic procedure, Dr. Brenneke was to assess claimant's intra-articular status to make sure that she had satisfactory findings and no contraindications for performance of the osteotomy. When Dr. Brenneke declared claimant medically stationary on April 7, 1995, he failed to assess claimant's knee in regard to the recommended osteotomy surgery, although he noted that claimant continued to have significant limitations in the use of her knee. (Ex. 138).

Subsequently, when claimant returned for follow-up, Dr. Brenneke recommended a total knee implant rather than the tibial osteotomy as originally requested by Dr. Baldwin. (Ex. 145). Because Dr. Brenneke did not perform total knee implants, he referred claimant to Dr. Mandiberg. (Ex. 146). In his letter to Dr. Mandiberg, Dr. Brenneke recommended a total joint implant rather than the proximal tibial osteotomy, noting that claimant's arthroscopy and partial medial meniscectomy surgery had not been successful and that claimant had degeneration in the medial compartment, and a varus knee (the same condition he had diagnosed prior to his November 1994 surgery). Dr. Brenneke provided a copy of his and Dr. Baldwin's records, as well as photographs of the November 1994 surgery, to Dr. Mandiberg. He deferred the decision regarding the choice and timing of the appropriate surgical procedure to Dr. Mandiberg.

In outlining claimant's history to Dr. Mandiberg, Dr. Brenneke did not indicate that claimant's condition had changed. Rather, he indicated that claimant had had a course of medical treatment (arthroscopic surgery) that did not produce the results he had anticipated in regard to correcting claimant's degeneration in the medial compartment and for which Dr. Baldwin had requested the osteotomy in March 1994. Dr. Brenneke's referral of claimant to Dr. Mandiberg indicates that Dr. Brenneke believed that claimant would benefit from a total knee replacement. Because the medical evidence indicates that claimant's condition did not change after closure, we consider Dr. Brenneke's post-closure report and letter to Dr. Mandiberg. Scheuning v. J.R. Simplot & Company, supra.

Accordingly, based on the complete medical record, we conclude that at the time of claim closure, material improvement was reasonably expected from further medical treatment. Therefore, claimant was not medically stationary on April 7, 1995. We accordingly reverse the ALJ's opinion and reinstate the Order on Reconsideration.

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[1] We note that Exhibits 145 and 146, post-closure medical reports by Dr. Brenneke, were submitted at the reconsideration proceeding and are, therefore, admissible under ORS 656.283(7).

Attorney Fees

The Order on Reconsideration found that claimant's claim was prematurely closed because claimant's knee condition was not medically stationary at the time of claim closure. Therefore, the Order on Reconsideration set aside the Notice of Closure as premature and ordered the insurer to pay claimant's attorney 10 percent of any additional compensation awarded, but not more than the maximum attorney fee allowed in OAR 438-15-040(1), (2), and 438-15-045 ($1,050).[2] Citing Timothy W. Krushwitz, 47 Van Natta 2207 (1995), claimant argues that the Order on Reconsideration's limit on attorney fees is inappropriate. We agree.

In Krushwitz, supra, we concluded that former ORS 656.268(6)(a) (now renumbered ORS 656.268(6)(c)) provides that the Department, in any reconsideration proceeding, shall order the insurer or self-insured employer to pay the attorney 10 percent of any additional compensation awarded to the worker, but imposes no maximum award. We further concluded that, because there is no authority that requires the Director to adopt the Board's rules concerning attorney fees, which do impose maximum awards, we reversed the reconsideration order's imposition of a maximum attorney fee award. Instead, in accordance with former ORS 656.268(6)(a), we held that the claimant's attorney was entitled to an "out-of-compensation" fee equal to 10 percent of the temporary disability resulting from the Order on Reconsideration.

Here, accordingly, claimant's attorney is entitled to an "out-of-compensation" attorney fee equal to 10 percent of the temporary disability resulting from the Order on Reconsideration, without a maximum limitation. In the event that this increased temporary disability award has already been paid to claimant pursuant to the November 30, 1995 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).

ORDER

The ALJ's order dated March 26, 1996 is reversed. The November 30, 1995 Order on Reconsideration is reinstated in part and reversed in part. That portion of the Order on Reconsideration that found that claimant's claim was prematurely closed and set aside the Notice of Closure is reinstated. 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.

[2] Effective January 1, 1996, these Board rules were renumbered as OAR 438-015-0040 and 438-015-0045; aside from changing "referee" to "Administrative Law Judge," no change was made in their text.

September 18, 1996 Cite as 48 Van Natta 1827 (1996)

In the Matter of the Compensation of
JASON R. WILLIAMS, Claimant
WCB Case No. 95-11299
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) declined to admit medical reports which were not part of the Director's reconsideration record; (2) excluded claimant's testimony; and (3) affirmed an Order on Reconsideration that awarded no permanent disability for a low back injury. On review, the issues are evidence and extent of unscheduled permanent disability.

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

On review, claimant argues that the record contains sufficient evidence to establish his entitlement to permanent disability benefits and, alternatively, that the ALJ's exclusion of evidence which was not a part of the reconsideration record violated his constitutional right to due process. We address the latter argument first.

Exclusion of Evidence

Amended ORS 656.283(7) provides, in part, that "[e]vidence on an issue regarding a notice of closure or determination that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing[.]" That statute went into effect on June 7, 1995, prior to claimant's June 20, 1995 request for reconsideration of the Determination Order. The statute applies here. See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

In Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996) (Members Hall and Gunn dissenting), we held that, under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process, and not made a part of the reconsideration record, is inadmissible at a subsequent hearing regarding the extent of an injured worker's permanent partial disability. Our holding in Ray has been overruled by the court's decision in Plummer to the extent that evidence concerning the extent of an injured worker's permanent partial disability that was properly admitted at hearing, can be considered on review. However, where the hearing concerning the extent of permanent partial disability was held after June 7, 1995, the exclusion of evidence set forth in amended ORS 656.283(7) is applicable. Thus, we continue to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995. Dean J. Evans, 48 Van Natta 1092, recon 48 Van Natta 1196 (1996).

Here, because the hearing was convened after June 7, 1995, evidence that was not submitted during the reconsideration process, and not made a part of the reconsideration record, is not admissible and the ALJ properly declined to consider it. See id.; Joe R. Ray, supra. Furthermore, for the reasons set forth in Ray, we reject claimant's argument that application of amended ORS 656.283(7) to this case violates her procedural due process rights under the Fourteenth Amendment to the U.S. Constitution. 48 Van Natta at 329-33.

Extent of Disability

Alternatively, even if we were to consider the evidence excluded under amended ORS 656.283(7), we would still conclude that claimant has not carried his burden of proving he suffered permanent impairment due to the compensable injury. Findings of permanent impairment may be made by: (1) the attending physician; (2) other physicians, if the attending physician concurs with the findings; and (3) if reconsideration is requested, the medical arbiter. See former OAR 436-35-007(8), (9).[1]

Claimant has an accepted claim for a lumbar strain. His condition became medically stationary on March 20, 1995.[2] Subsequent to that date, claimant saw his attending physician, Dr. Peter, on April 24, 1995. (Ex. 23B). On that date, Dr. Peter made no specific impairment ratings which he related to the compensable injury. (Id.) There is no indication claimant returned to Dr. Peter, nor did Dr. Peter concur with any other impairment findings.

Thus, claimant's entitlement to permanent disability rests entirely on the opinion of the medical arbiter, Dr. Dinneen. The doctor found evidence of reduced ranges of lumbar motion and decreased ability to repetitively use the lumbar spine. He added, however, that "[i]t cannot be attributed in a medically probable fashion to the reported incident of August 1, 1994. I do not know the cause." (Ex. 28-3). While Dr. Dinneen's last comment was apparently directed to claimant's decreased ability to

[1] The applicable standards for rating claimant's permanent disability are set forth in WCD Admin. Order 6-1992, as amended by WCD Admin. Orders 93-056 and 96-068.

[2] The medically stationary date was administratively determined based on claimant's failure to seek treatment. Claimant does not contest that determination.

repetitively use his lumbar spine, we conclude it also casts doubt on the causal relationship between the reduced ranges of motion and the compensable injury. For this reason, we do not find that claimant has carried his burden of proving he sustained permanent impairment due to the compensable injury.

Claimant argues that, because the medical arbiter did not relate the impairment findings to other causative factors, they should be deemed to be related to the compensable injury. He relies on Kim E. Danboise, 47 Van Natta 2163 (1995). However, the medical arbiter in Danboise did not question the causal relationship between the impairment findings (in the cervical spine) and the compensable injury, and did not relate the findings to causes other than the compensable injury. Under those circumstances, and because the impairment findings were consistent with the compensable injury, we concluded the findings were due to the compensable injury. Id. at 2164. In contrast to Danboise, the medical arbiter in this case expressly opined that the impairment findings could not be attributed to the compensable injury. Therefore, Danboise is distinguishable on its facts and not applicable to this case.

ORDER

The ALJ's order dated March 26, 1996 is affirmed.

In the Matter of the Compensation of
DAN BELLON, Claimant
WCB Case No. 95-13453
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall, Christian and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that: (1) found that the insurer improperly terminated claimant's temporary disability benefits; and (2) assessed a penalty for the insurer's allegedly unreasonable termination of temporary disability benefits. On review, the issues are temporary disability benefits and penalties.

We adopt and affirm the ALJ's order. See Marie E. Kendall, 46 Van Natta 2520 (1994), on recon 47 Van Natta 335 (1995) (holding that, in order for a modified job offer to comply with former OAR 436-60-030(5)(c), notification must provide the duration of the job or, if duration is not known, information of that fact).

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

ORDER

The ALJ's order dated April 1, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the insurer.

Board Member Moller dissenting.

The issue in this case involves the insurer's termination of temporary disability benefits due to claimant's failure to accept an offer of modified employment. Relying on our prior decision in Marie E. Kendall, 46 Van Natta 2520 (1994), on recon 47 Van Natta 335 (1995), the majority concludes that the insurer's termination of benefits was improper because the employer's modified job offer was inadequate. I believe that our decision in Kendall was based on an erroneous application of the court cases cited therein. Because I conclude that our decision in Kendall was legally incorrect, I respectfully dissent.

In Kendall, as here, the dispositive question was whether the employer's modified job offer complied with the requirements of former OAR 436-60-030(12)(c). As relevant, former OAR 436-60-030(12) provides:

> "An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation * * * when an injured worker fails to begin wage earning employment * * * , under the following conditions:
>
> "(a) the attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;
>
> "(b) the attending physician agrees the employment appears to be within the worker's capabilities; and
>
> "(c) the employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities." (Emphasis supplied).

An employer seeking to rely on that rule to justify a termination of TTD benefits must fully comply with its procedural requirements. Eastman v. Georgia Pacific Corp., 79 Or App 610, 613 (1986). We concluded in Kendall that the employer failed to comply with the rule because its offer of modified employment "neither specified the duration of the job nor whether the employer knew the duration of the job." 47 Van Natta at 335. In light of the "clear and specific" language of the rule, I am unable to agree that an offer of modified employment must expressly state "whether the employer knew of the duration of the job." The rule unambiguously requires that the employer "state * * * the duration of the job, if known." By its express terms, it does not require the employer to state that the duration is unknown, if that is the case.

In arriving at our decision in Kendall, I believe that we have extended the court's holding in Eastman far beyond its intended scope. In Eastman, the "offer" of modified employment stated in its entirety:

> "We do have light duty work available and since your physician has released you to light duty work, compensation benefits will cease as of April 4, 1983."

The court found that the requirements of the rule were not met because the "offer" did not describe the jobs available and did not inform the claimant of the beginning time or date or the duration of the job. The court rejected the employer's argument that it had substantially complied with the rule. The court reasoned that the requirements of the rule were "clear, unambiguous and specific in what is required[.]" Id. at 613.

There is simply no comparison between the purported "offer" in Eastman and the employer's notice to claimant in this case. The "offer" in Eastman was woefully deficient in light of the requirements of the rule. Here, by contrast, the offer was detailed and complete. Even if the employer was required to state that the duration of the modified job was unknown, that is precisely what the employer did when it stated that "[t]he continued availability of this position will be re-evaluated periodically." The only reasonable interpretation of this statement is that the duration was unknown. In either event, the employer's offer here fully complied with the rule.

Subsequent court decisions applying Eastman lead to the same conclusion. In Safeway Stores, Inc. v. Little, 107 Or App 316 (1991), the "offer" of employment on which the employer initially relied to terminate benefits was a letter to claimant from a physician -- whom the Board found to be a nonattending physician -- that stated:

> "I have been contacted by the Central Office at Safeway Stores, Inc. They have informed me that they are willing to offer you any sort of limited duty employment that you can tolerate. Thusly, I am approving you for limited duty to return to work."

As in Eastman, the court concluded that this "offer" was inadequate to meet the rule. Again, in light of the glaring deficiencies in the employer's offer in Safeway Stores, Inc., the court's decision is hardly support for the proposition that the employer's offer in this case is inadequate.

The final court decision on which we relied in Kendall was Fairlawn Care Center v. Douglas, 108 Or App 698 (1991). In Fairlawn Care Center, the "offer" made no reference to the starting date for the job. Instead, the employer's letter directed the claimant to telephone the employer if she wanted to accept the job. The Board found the employer's letter to be insufficient because it failed to state the starting date and the duration of the job. Notably, on judicial review, the court relied solely on the absence of a specification of a starting date. The court did not indicate agreement with the Board's conclusion that the "offer" failed to state the duration of the job.

An additional reason for concluding that the offer of employment need not expressly state that the duration of the job is unknown arises from the history of the rule itself. The version of the rule that was applied by the court in Eastman did not contain a qualification that the duration of the modified work was to be provided "if known." Instead, the rule simply mandated that the offer include "the duration of the job." Former OAR 436-54-222(6). The current version of the rule, as well as the version applied in Fairlawn Care Center, now contains the "if known" qualifying language. If, when the rule was revised, the intent had been to require an affirmative statement of either the duration of the job or a statement that the duration was unknown, that could easily have been drafted into the rule (*e.g.* the rule could have provided that the offer must state "the duration of the job, or that the duration is unknown." Instead, the rule was drafted to provide that the offer state "the duration of the job, if known."

In sum, I cannot agree with the majority that the requirement that the offer of employment state "the duration of the job, if know" clearly, unambiguously and specifically requires an employer to expressly state that the duration is unknown, if that is the case. Rather, I find the rule to provide clearly and unambiguously that the duration needs to be stated only if known. To the extent that the rule may be unclear or ambiguous, the employer's statement that "[t]he continued availability of this position will be re-evaluated periodically" is susceptible of only one interpretation, *i.e.*, that the duration of the job was undetermined. The employer fully complied with the rule and its termination of benefits was proper.

Therefore, I respectfully dissent.

September 19, 1996 Cite as 48 Van Natta 1831 (1996)

In the Matter of the Compensation of
DEBORA L. DOPPELMAYR, Claimant
WCB Case No. 95-10108
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order which assessed a 25 percent penalty for its allegedly unreasonable denial. On review, the issue is penalties.

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

Claimant filed a mental stress claim based on alleged sexual conduct and comments by the employer and alleged retaliatory measures taken by the employer after claimant filed a sexual harassment complaint with the Bureau of Labor and Industries (BOLI). SAIF denied the claim on the ground that claimant's psychological condition was not compensably related to her employment. Claimant requested a hearing contesting the denial and requesting penalties and attorney fees for unreasonable denial.

At hearing, claimant's and the employer's version of events leading to the filing of claimant's mental disorder claim differed considerably. The employer denied claimant's allegations, including the contention of retaliation after the BOLI complaint was filed. The ALJ set aside SAIF's denial, concluding that claimant had established all the elements of ORS 656.802(3). The ALJ also determined that SAIF's denial was unreasonable, relying on Anfilofieff v. SAIF, 52 Or App 127 (1981) (Where the employer's misconduct and misinformation contributed to the carrier's denial, the claimant was entitled to penalties for unreasonable denial of injury claim).

Specifically, the ALJ reasoned that SAIF's denial was unreasonable because the employer was not credible and had given false information to SAIF which led to issuance of its denial. In addition, the ALJ observed that SAIF had no medical information at the time of the denial that contradicted claimant's physician's report that the employer's actions had caused claimant's mental disorder.

On review, SAIF does not contest the merits of the ALJ's decision regarding the compensability of claimant's mental disorder. As a result, it does not dispute the ALJ's credibility findings, including the determination that the employer's version of events was not credible and that the employer provided false information to SAIF that led to its denial.

Instead, SAIF contends that its denial was not unreasonable because the requirements of proving a mental disorder claim are more rigorous than those for proving a compensable injury. Moreover, SAIF argues that, since a mental stress claim invariably involves a complex mixture of factual, legal and medical issues that can only be resolved through a hearing, it had a legitimate basis for denying claimant's mental disorder claim. We disagree.

A penalty may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." 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)). Thus, if the carrier had a legitimate doubt about its liability, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

SAIF is correct that the standards for establishing a compensable mental disorder claim are more stringent than those pertaining to an injury claim. To establish the compensability of a stress-related mental condition, claimant must prove that employment conditions were the major contributing cause of her disease. ORS 656.802(2)(a). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment, or employment decisions attendant upon ordinary business or financial cycles. Furthermore, there must be a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the medical disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

However, it is undisputed that the employer's version of events leading to the filing of claimant's claim was false. SAIF does not dispute the ALJ's finding that SAIF's denial was based on this misinformation. A carrier may not reasonably deny a claim based on an employer's misinformation or misconduct. Anfilofieff, supra. Although SAIF argues that Anfilofieff is distinguishable because it concerned an injury, not a mental disorder claim, we agree with the ALJ that this case is sufficiently similar to Anfilofieff. Where, as here, an employer provides false information to a carrier which leads to a denial, the issuance of such a denial is unreasonable and the claimant is entitled to a penalty under ORS 656.262(11). We reach this conclusion regardless of whether the claim is for an injury or for a stress-related mental disorder.

Finally, we note that claimant is not entitled to an attorney fee for services rendered on review concerning the penalty issue. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The ALJ's order dated April 3, 1996, as reconsidered on April 29, 1996, is affirmed.

In the Matter of the Compensation of
PATRICIA L. HODGES, Claimant
WCB Case No. 95-12789
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of our August 23, 1996 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order declining to award an attorney fee for the SAIF Corporation's rescission of its denial of claimant's low back injury claim. Specifically, we concluded that there was no "denied claim" to award an attorney fee under ORS 656.386(1) because SAIF accepted the claim before claimant's attorney filed a request for hearing.

In requesting reconsideration, claimant's attorney first asks that we take administrative notice of a Form 1502, which he indicates was "forwarded" to the Department. We are not inclined to do so. Rodney J. Thurman, 44 Van Natta 1572, 1573-74 (1992). In any event, even if we considered the form, it would not alter our ultimate conclusion that claimant is not entitled to a carrier-paid attorney fee award under ORS 656.386(1). We base such a conclusion on the following reasoning.

SAIF first denied the July 9, 1995 low back injury on August 30, 1995. On November 1, 1995, SAIF and claimant entered into a stipulation whereby SAIF agreed to accept the injury claim. On November 7, 1995, SAIF issued another denial of the low back injury claim. On November 8, 1995, SAIF issued a notice of acceptance for the July 9, 1995 low back injury claim. That same day, SAIF also forwarded a Form 1502 to the Department, documenting its acceptance of the claim pursuant to the November 1, 1995 stipulation. On November 22, 1995, claimant's attorney filed a request for hearing from the November 7 denial. On December 5, 1995, SAIF informed claimant's attorney that the November 7 document had issued in error and that, pursuant to the November 8 Notice of Acceptance, the claim remained accepted.

Since the November 8 Notice of Acceptance issued after the November 7 denial and because the date of injury for the accepted claim carried the same date of injury as the claim denied on November 7, we conclude that such an unqualified acceptance effectively constituted the rescission of the November 7 denial. Such a conclusion is further confirmed by SAIF's "post-hearing request" letter stating that the claim remained accepted.

In reaching this conclusion, we do not share claimant's counsel's apparent confusion on what action should have been taken in response to SAIF's November 7 denial. Since the 60-day period to seek a hearing had just begun, claimant could merely have contacted SAIF to confirm that the July 1995 low back injury claim remained in accepted status, notwithstanding the November 7 denial. If such confirmation was received, no further action from claimant or her counsel would be necessary.

On the other hand, if SAIF either declined to respond to claimant's request for clarification or stood by its November 7 denial, claimant could then request a hearing still well within the 60-day "appeal period." Thereafter, if SAIF subsequently rescinded its denial, claimant's counsel would likely have satisfied the statutory prerequisite for receiving an attorney fee award under ORS 656.386(1).

In conclusion, under the facts of this case, we continue to conclude that, because SAIF issued its November 8, 1995 unqualified acceptance of the July 1995 low back injury claim before claimant filed the request for hearing, claimant's attorney was not instrumental in obtaining a rescission of the November 7, 1995 denial of the July 1995 low back injury claim. Thus, as supplemented herein, we adhere to the reasoning and conclusion contained in our August 23, 1996 order.

Accordingly, we withdraw our August 23, 1996 order for reconsideration. On reconsideration, as supplemented herein, we republish our August 23, 1996 order. The parties' 30-day rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES J. LUNSKI, Claimant
WCB Case No. 95-12221
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall, Christian and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Michael V. Johnson's order that increased claimant's unscheduled permanent disability award for a low back condition from zero, as awarded by an Order on Reconsideration, to 26 percent (83.2 degrees). On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following change and supplementation. After the first sentence of the first paragraph of page 3, we change "Ex. 8-1" to "Ex. 8A."

The insurer argues that Dr. Edwardson, claimant's attending physician, did not specifically agree with the PCE range of motion findings. The insurer contends that, without the express concurrence from Dr. Edwardson, the PCE findings cannot be used to rate impairment.

On February 7, 1995, Dr. Edwardson reported that he had reviewed the findings of Dr. Donovan and the work capacity evaluation. (Ex. 8A). Dr. Edwardson commented on some of the details of the report and stated: "[A]fter review of these things and discussing it with [claimant], I concur with this and do recommend claim closure, that [claimant] is medically stationary as of this date 2/7/95." (Id.) Although Dr. Edwardson did not specifically agree to the range of motion findings, he stated that he had reviewed the PCE and indicated his concurrence. Under these circumstances, we are satisfied that Dr. Edwardson concurred with the PCE range of motion findings.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by 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 16, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by insurer.

Board Member Haynes dissenting.

Although I agree with the majority that Dr. Edwardson concurred with the physical capacities evaluation (PCE), I disagree with the majority's conclusion that claimant is entitled to an award of unscheduled permanent disability.

Former OAR 436-35-007(9) provides that, on reconsideration, impairment is determined by the medical arbiter, "except where a preponderance of medical opinion establishes a different level of impairment." Here, the preponderance of medical opinion does not establish a different level of impairment. The opinion of the medical arbiter, Dr. Rand, is more persuasive. Dr. Rand reported:

> "In my opinion, none of the findings on this examination appeared to be valid due to the significant pain behavior exhibited during the examination and functional overlay at attempts to measure ranges of motion in the cervical, thoracic and lumbar spine." (Ex. 13).

Dr. Rand also concluded that claimant did not have a loss of his ability to repetitively use the spine. Because the arbiter's report is a thorough and well-reasoned evaluation of claimant's injury-related impairment, I would rely on the arbiter's findings.

Claimant relies on the range of motion findings in the January 23, 1995 PCE. The PCE reviewer found that claimant's true lumbar flexion range of motion was invalid. (Ex. 6). Although claimant was cooperative and appeared to put forth consistent effort, the PCE reviewer commented:

"However, [claimant] also reported and exhibited a moderate to intense amount of pain

behavior while performing functional activities such as lifting, walking, and stair and ladder climbing during the evaluation." (Id.)

Dr. Edwardson reviewed the work capacity evaluation findings and concurred with the report on February 7, 1995. (Ex. 8A). However, Dr. Edwardson commented that claimant was not a good candidate for the industrial medicine program primarily for psychological reasons. (Id.)

Dr. Edwardson's later reports indicated that he was concerned about the effect of claimant's psychological problems. On August 4, 1995, Dr. Edwardson reported that, since February 24, 1995, claimant had experienced an exacerbation of pain. (Ex. 9C). Dr. Edwardson commented that it was "difficult now to say whether he remains totally disabled from that position as there are many psychodynamic factors which enter into his disability that are beyond my scope of practice and are mentioned in his evaluation by the Salem Rehab and Dr. Donovan as well as Dr. Olson." (Id.)

Contrary to the majority's conclusion, the preponderance of medical opinion does not establish a different level of impairment from that of the medical arbiter. The PCE reviewer commented that claimant exhibited a "moderate to intense amount of pain behavior" and found claimant's true lumbar flexion range of motion was invalid. Furthermore, Dr. Edwardson acknowledged later that many "psychodynamic factors" entered into claimant's disability. Under these circumstances, the majority errs by awarding claimant an award of unscheduled permanent disability.

In the Matter of the Compensation of
BETTY J. LANFEAR, Claimant
WCB Case No. 94-11138
ORDER ON RECONSIDERATION
Strooband & Ousey, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

On September 4, 1996, we issued an Order on Review that, in part, found that claimant's injury claim was not prematurely closed and awarded 20 percent unscheduled permanent disability. Following the issuance of the order, we found that claimant's unscheduled permanent disability award was incorrectly calculated. Thus, we replace that portion of the Order on Review with the following.

Claimant's impairment value of 11 percent for limitation of cervical range of motion is combined with 8 percent for vestibular disequilibrium, which results in 18 percent. Claimant is over age 40, so she receives a value of 1 for age. Former OAR 436-35-290(1). The highest SVP of any job worked by claimant during the last five years is her job at injury, DOT 205.362-030, with an SVP of 4. Consequently, claimant's education value is 4. Former OAR 436-35-300(3)(b). Adding age and education together results in a value of 5. Former OAR 436-35-280(4).

Claimant adaptability value is 1. Multiplying that value with 5 results in 5. Former OAR 436-35-280(6). Adding that value with impairment of 18 percent totals to 23 percent unscheduled permanent disability. Former OAR 436-35-280(7). Therefore, claimant is awarded 23 percent unscheduled permanent disability for her compensable injury.

Finally, we note that, in discussing the premature closure issue, our order refers to evidence that was not admitted on reconsideration, which could be construed to be contrary to ORS 656.283(7), providing that 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.

First, as discussed in the Order on Review, because neither party raised the issue of premature closure during the reconsideration proceeding, the self-insured employer argued that claimant was prohibited by ORS 656.268(8) from challenging the issue at hearing or on review. Given this context of the case, there is some question of the applicability of ORS 656.283(7) and, specifically, whether the premature closure matter is an "issue regarding a notice of closure or determination order that was submitted at the reconsideration[.]" In any case, like the dispute concerning ORS 656.268(8), we need not resolve the ORS 656.283(7) evidentiary issue since we would reach the same conclusion that the claim was not prematurely closed even if our review was limited only to evidence that was submitted on reconsideration.

Accordingly, we withdraw our September 4, 1996 order. On reconsideration, as corrected and supplemented herein, we adhere to and republish our September 4, 1996 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
TERRY L. MALTBIA, Claimant
WCB Case No. 96-00005
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Otto's order that awarded 13 percent (41.6 degrees) unscheduled permanent disability for claimant's low back condition, whereas an Order on Reconsideration had not awarded permanent disability. In his brief, claimant contends that the ALJ erred in: (1) declining to admit Exhibit 33, a supplemental medical arbiter report; and (2) reducing an Amended Order on Reconsideration's award of scheduled permanent disability for a right ankle (foot) condition from 2 percent (2.7 degrees) to zero. On review, the issues are evidence and extent of unscheduled and scheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

We begin by recapping the relevant facts. Claimant, who compensably injured his low back and right ankle, requested reconsideration of an April 10, 1995 Notice of Closure that awarded no permanent disability, raising the issues of scheduled and unscheduled permanent disability. (Ex. 27). The Department appointed a medical arbiter, Dr. Amundson, who examined claimant's low back on December 7, 1995. (Exs. 30, 31). On December 21, 1995, the medical arbiter reexamined claimant's right ankle for the Department. (Ex. 33).

On December 29, 1995, the Department issued an Order on Reconsideration that affirmed the Notice of Closure. (Ex. 34). Claimant requested a hearing on the same date. On January 2, 1996, the Department received the December 21, 1995 medical arbiter's supplemental report. (Ex. 33). On January 12, 1996, the Department issued an Amended Order on Reconsideration, awarding claimant 2 percent scheduled permanent disability for loss of use or function of his right ankle. (Ex. 35).

At hearing, the employer objected to Exhibit 33, the medical arbiter's supplemental report, contending that, because claimant's December 29, 1995 request for hearing divested the Department of jurisdiction over the reconsideration process, Exhibit 33 was inadmissible pursuant to amended ORS 656.283(7).[1] (Tr. 1, 2). Even though the parties stipulated that Exhibit 33 was part of the

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[1] Amended ORS 656.283(7) provides in relevant part:

"Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing * * * . However, nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of that evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268."

The statue applies to those cases in which the hearing convened after the date SB 369 took effect. Dean J. Evans, 48 Van Natta 1092, on recon 48 Van Natta 1196 (1996).

reconsideration record (Tr. 7), the ALJ declined to admit Exhibit 33. The ALJ concluded that claimant's December 29, 1995 request for hearing divested the Department of jurisdiction over the reconsideration process as of that date. Then, citing Joe R. Ray, 48 Van Natta 325 (1996), the ALJ reasoned that, even though Exhibit 33 was submitted at hearing as part of the Department's reconsideration record, it was not submitted "at the reconsideration process," as required by ORS 656.283(7). On review, claimant contends that the admission of Exhibit 33 is governed by ORS 656.268(6)(e) (formerly numbered ORS 656.268(6)(a)).[2] We agree.

Former ORS 656.268(6)(a) allows for the admission of a medical arbiter's report as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding. See Joyce A. Crump, 47 Van Natta 1516 (1995). In Crump, the Department scheduled the claimant for a medical arbiter examination which she did not attend. An Order on Reconsideration issued and the claimant requested a hearing in response to the reconsideration order. Subsequent to the claimant's request for hearing, the Department rescheduled the claimant's medical arbiter examination. The claimant was then examined by the medical arbiter.

We found that the claimant was referred by the Director for the medical arbiter's examination prior to the Order on Reconsideration and the claimant's request for hearing. Thus, at the time of the referral, the Director properly had jurisdiction over the claim. We accordingly concluded that, regardless of the fact that the examination was neither rescheduled nor performed until after the hearing request, the Department continued to have jurisdiction to refer the claimant for the arbiter's examination. We then applied former ORS 656.268(6)(a), noting that the statute contemplates that an arbiter's report may not be prepared in time for the reconsideration proceeding, though it may be considered at hearing. We held, therefore, that the medical arbiter's report was admissible evidence at hearing.

Here, the Department scheduled claimant for a medical arbiter examination prior to December 7, 1995. At the time of the referral, the Department properly had jurisdiction over the claim. Because the ankle portion of the evaluation was inadequate, the arbiter reexamined claimant's right ankle on December 21, 1995. Both of the arbiter's examinations took place prior to claimant's request for hearing, even though the Department did not receive the arbiter's report until after the request for hearing. Any medical arbiter report may be received as evidence at hearing even if the report is not prepared in time for use in the reconsideration proceeding. Former ORS 656.268(6)(a). We consequently conclude that Exhibit 33, the December 21, 1995 medical arbiter's report, is admissible at hearing. Joyce A. Crump, supra.

Moreover, the Department submitted Exhibit 33 as part of the reconsideration record. Accordingly, we further conclude that amended ORS 656.283(7) does not operate to exclude Exhibit 33. We reason as follows.

The reconsideration process vests in the Director the discretion to abate, withdraw and/or amend the Order on Reconsideration within the time limit permitted to appeal the Notice of Closure until a hearing is requested. OAR 436-30-008(1)(b); see OAR 436-30-115(3) (Director has discretion to abate, withdraw and/or amend Order on Reconsideration). See Duane B. Onstott, 48 Van Natta 753 (1996); Joe R. Ray, 48 Van Natta 325 (1996). Although by the terms of its own rules, the Department lost its discretion to amend the Order on Reconsideration when claimant requested a hearing on December 29, 1995, there is nothing in the rules to indicate that claimant's filing of a hearing request divested the Director of its jurisdiction over the original referral for an arbiter's examination. Moreover, the parties stipulated pursuant to OAR 438-007-0018(5) that Exhibit 33 was part of the reconsideration record, even though it was not considered at the time of the December 19, 1995 Order on Reconsideration. Thus, Exhibit 33 was part of the reconsideration record and is therefore admissible. Roberto Garcia, 48 Van Natta 879 (1996) (Documents in the reconsideration record are admissible at hearing under ORS 656.283(7)). Because we find Exhibit 33 to be admissible, we consider this exhibit on review.

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[2] The amendments to the Workers' Compensation Law by Senate Bill 369 renumbered ORS 656.268(6)(a) as ORS 656.268(6)(e) without making any substantive change to the provision itself. Or Laws 1995, ch 332 § 30. However, according to § 66(4), the amendments to ORS 656.268(6) only apply to claims that become medically stationary on or after the effective date of the act. Inasmuch as claimant became medically stationary on March 16, 1995, prior to the June 7, 1995 effective date of the Act, we apply former ORS 656.268(6)(a) in this case.

Extent of Scheduled Permanent Disability

Dr. Amundsen, the medical arbiter, found the following ranges of motion in the right and left ankles:

Dorsiflexion, right - 12 degrees; left -14 degrees;
Plantar flexion, right - 44 degrees; left - 56 degrees;
Eversion, right - 9 degrees; left - 10 degrees;
Inversion, right - 20 degrees; left - 17 degrees. (Ex. 33).

Applying OAR 436-35-190 according to the method set out in OAR 436-35-007(16) results in the following: Dorsiflexion - 1.2 %; Plantar Flexion - 0 %; Eversion - .4 %; Inversion - 0 %. The total range of motion is 1.6 percent, which is rounded to 2 percent. OAR 436-35-190(10) and OAR 436-35-007(10). We thus conclude that claimant's scheduled permanent impairment for the loss of use and function of his right ankle is 2 percent.

Extent of Unscheduled Permanent Disability

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

Attorney Fees

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

Claimant's attorney requested a $1,000 assessed fee under ORS 656.382(2) for services at hearing if we reinstate the Amended Order on Reconsideration's award of scheduled permanent partial disability. As noted above, the ALJ concluded, and we agree, that the Director no longer had jurisdiction to issue an amended Order on Reconsideration subsequent to December 29, 1995, the date claimant requested a hearing. The ALJ accordingly properly set aside the null and void January 12, 1996 Amended Order on Reconsideration for lack of jurisdiction. Because claimant received no award of scheduled permanent disability on the original Order on Reconsideration, there was no award to reinstate and no basis for a carrier-paid attorney fee award for services at hearing.

However, because we have increased claimant's scheduled permanent disability award from zero to 2 percent, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation created by this order (the 2 percent increase between the zero Order on Reconsideration award and our scheduled permanent disability award), not to exceed $3,800. See ORS 656.386(2); OAR 438-015-0055(1). In the event that this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), aff'd Volk v. America West Airlines, 135 Or App 565 (1995).

ORDER

The ALJ's order dated April 11, 1996 is modified in part and affirmed in part. In lieu of the Order on Reconsideration, which awarded no scheduled permanent disability, claimant is awarded 2 percent (2.7 degrees) scheduled permanent disability. Claimant is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order (2 percent), not to exceed $3,800. In the event that this "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. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,000, to be paid by the employer.

In the Matter of the Compensation of
SHANNON L. MATHEWS, Claimant
WCB Case No. 96-00328
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denial of her occupational disease claim for a bilateral carpal tunnel condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin by recapping the relevant facts. Claimant worked for the employer as a Certified Nurse's Assistant (CNA) from 1976 to 1989, when she began secretarial work for a floor manager. About one-eighth of claimant's time was spent in staffing, scheduling, stocking, filing and typing. Writing occupied about 25 percent of her time. In 1990, claimant had a right mastectomy, which caused some right arm swelling. From August 1991 until April 1992, claimant worked as a full-time staffing secretary, which involved about 80 percent of her time on computers and writing. Claimant's Carpal Tunnel Syndrome (CTS) symptoms began during this period. In April 1992, claimant became a Modular Care Technician, which included both CNA and secretarial duties; she spent about 25 percent of her time on the computer. In September 1993, she became a half-time unit secretary. Her secretarial duties included computer keyboarding for about 40 percent of her time, handwriting another 40 percent, telephone use about 10 percent and 10 percent other general secretarial tasks. (Tr. 4-6; 47, 48).

In June 1995, claimant was diagnosed with moderately severe bilateral CTS, right greater than left. (Exs. 1, 9-2). Dr. Gilbertson referred claimant to Dr. Young for evaluation and treatment of her CTS condition.

Claimant is five feet six inches tall and currently weighs about 325 pounds. Claimant's weight has fluctuated from a high of 375 pounds in 1989 to a low of 220 pounds in August 1990. Claimant's hobbies were painting and crocheting.

Relying on the opinion of Dr. Appleby, the ALJ concluded that claimant failed to carry her burden to prove that her work activities were the major contributing cause of her CTS. See ORS 656.802. Claimant argues on review that Dr. Young's opinion is more persuasive than that of Dr. Appleby. We agree.

Claimant must prove that her employment conditions were the major contributing cause of her CTS condition. ORS 656.802(2)(d); 656.005(7). Considering the passage of time and claimant's employment exposures, the determination of the major cause of claimant's condition is complex and requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993). In this case, we do not give special deference to the evidence from the treating physician, because resolution involves expert analysis rather than expert external observation. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini, 43 Or App 299 (1979).

Opinions regarding causation were provided by Dr. Appleby, orthopedic surgeon, and Dr. Young, hand specialist. After evaluating the relative contributions of claimant's recreational activities, which he considered to be minimal (Ex. 9); her weight; and her mastectomy,[1] Dr. Young opined that

[1] Dr. Young reported the date of the mastectomy as 1995. Claimant's surgery actually took place in 1990. (Tr. 13). Dr. Young correctly noted that claimant first noticed CTS symptoms after her mastectomy-related right arm symptoms had subsided. Claimant noticed hand numbness in about 1991. We accordingly conclude that the 1995 date in Dr. Young's report is a typographical error.

the major contributing cause of claimant's CTS condition was claimant's work. Dr. Young found that claimant's post-mastectory pain in her right arm with radiation into her hand had improved with exercise and that tests indicated that claimant had no evidence of CTS at that time. Dr. Young also found that the development of claimant's CTS was in inverse relation to the improvement of her post-mastectomy right arm symptoms. (Ex. 8-2, 9-2). Dr.Young also found that claimant's fluctuating weight had no correlation with her CTS symptoms, thus indicating that her weight was of lesser causal importance.[2] (Ex. 9-2). Finally, after evaluating the relative contributions of the non-work factors to claimant's condition, Dr. Young then reviewed claimant's work history and her symptoms, noting the correlation between improvement in symptoms when claimant was off work and an increase in symptoms with her work activities. (Exs. 8-1, 9-1, 9-2). Based on the positive correlation of claimant's CTS symptoms with work, the lack of any correlation of her symptoms with her fluctuating obesity, and the inverse correlation with her post-mastectomy right arm complaints, Dr. Young concluded that work was the major contributing cause of claimant's CTS condition.

Dr. Appleby, who also addressed the factors of obesity, mastectomy, work activities and recreational activities, concluded that claimant's obesity was the overwhelming factor for the development of her condition. Dr. Appleby opined that both claimant's obesity and her mastectomy were predisposing factors to her CTS, although he did not find any symptoms related to the mastectomy during his examination. Dr. Appleby based his opinion that claimant's obesity was the major cause of her CTS on patients he had seen clinically and reports about the correlation of obesity with CTS, stating that a massively obese individual is particularly prone to fatty accumulation in the median nerve area and, therefore, the space occupying effect of that greatly compromises the patient's tolerance for any swelling in the arm. (Ex. 6). Dr. Appleby did not explain how this accumulation of fat affected claimant's CTS condition, nor did he explain his statement that fatty accumulation "generally compromises the tolerance for any swelling in the arm", particularly since he found no evidence of swelling in claimant's arm. We do not find Dr. Appleby's opinion persuasive, as he is applying generalities, rather than establishing that a relationship between claimant's obesity and the development of her bilateral CTS, greater on the right, applies in this case. Somers v. SAIF, 77 Or App 259 (1986); see also Lucke v. Compensation Dept., 254 Or 439 (1969) (Statistical evidence that a causal connection is rare does not defeat a claim if an expert establishes the relationship in a particular case).

We are more persuaded by Dr. Young's well-reasoned opinion that is based on complete information and that weighs the relative contribution of each potentially causative factor. Somers v. SAIF, supra; Hammons v. Perini Corp., 43 Or App 299, 302 (1979); see also Dietz v. Ramuda, 130 Or App 397 (1994) (Determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause).

We accordingly find that claimant has established the compensability of her CTS condition. Consequently, we set aside the employer's denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 30, 1996 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the self-insured employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,500, to be paid by the employer.

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[2] The ALJ concluded that Dr. Young's discounting of claimant's obesity as a cause of her condition, based on the fact that claimant had no symptoms when her obesity was greater, was a temporal analysis argument forbidden by ORS 656.266. Subsequent to the ALJ's opinion, the court held in Bronco Cleaners v. Velazquez, 141 Or App 295 (1996), that the statute addresses the sufficiency of a record in which other explanations for a condition are excluded as the sole predicate for the conclusion that the condition is work related. The court held that, where observation is made of temporal relationships over a period of time in order to demonstrate a correlation with exposure to workplace conditions, such proof is appropriate, even where the physician applies the methodology of exclusionary analysis, as Dr. Young did here.

In the Matter of the Compensation of
JAMES R. MONTOYA, Claimant
WCB Case No. 95-13199
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Christian, Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that upheld the SAIF Corporation's denial of his left foot injury claim. On review, the issue is compensability.

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

The ALJ upheld the denial on the ground that claimant has established legal causation but not medical causation. In regards to legal causation, the ALJ found that claimant's injury arose out of and in the course of employment. Because we conclude that claimant has not established his injury arose out of employment, we agree claimant has not proven his claim, but we modify the ALJ's conclusions and opinion.

We begin with a brief summary of the facts. Claimant felt the acute onset of sharp burning pain in the back of his left heel while walking up a flight of stairs at work. He sought immediate treatment and was diagnosed with ligament strain and arthritis. Treatment was conservative initially. A month later, after an episode of increased pain and swelling at home, claimant was diagnosed with a fracture of the left calcaneus and underwent surgical repair. The post-operative diagnosis was complete avulsion of the Tendino-Achilles, or Achilles tendon rupture.

To be entitled to compensation, an injured worker must prove that the injury arose "out of and in the course of employment." ORS 656.005(7)(a). There are two elements of the compensability inquiry. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). One element, the requirement that the injury occur "in the course of employment," concerns the time, place, and circumstances of the injury. Id. The other element, the requirement that the injury "arise out of" the worker's employment, examines the causal relationship between the injury and the employment. Id. To satisfy the "arising out of employment" element, it is not enough to show that the injury occurred on work premises during work hours; rather, the worker must show a causal link between the occurrence of the injury and a risk connected with employment. Id. at 368-69; Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983).

In James D. Johnson, 48 Van Natta 303 (1996) (Board Chair Hall dissenting), we concluded that the claimant had not established the requisite causal connection between his injury and a risk associated with his employment. There, the claimant's knee buckled, resulting in a medial meniscus tear, when he took a step at work on the level floor of the plant. There was no evidence that the claimant slipped, twisted or tripped over anything on the floor. The claimant's doctors related the knee injury to work but gave no explanation of how the work environment or activities contributed to the injury. The medical evidence established no causal connection between the injury and employment other than the fact that the injury occurred at work during working hours. We concluded the evidence was insufficient to carry the claimant's burden of proving his injury arose out of employment.

Here, the parties agree that claimant's injury occurred in the course of his employment. Their dispute is over whether the injury arose out of his employment. We conclude, as we did in Johnson, that the record does not sufficiently prove a causal connection between claimant's injury and a risk associated with his employment. Dr. Zirschky, treating orthopedic surgeon, stated that the calcaneal fracture was "sustained at work," (Ex. 10-2), and has described the injury as "work related," (Ex. 16). Dr. Zirschky further opined:

> "It was quite clear that intra-operatively [claimant] had had an acute rupture related to some kind of stress. It may have been that at work he caused a stress fracture and then it went on to displace later on but it is clear that what we are treating him for is not an old injury and it is not pre-existing. While it is true he may have had osteopenia and diabetes prior to his work injury, it is also as clear that he sustained this problem due to his work exposure. There is no doubt in my mind that within a reasonable medical probability, his treatment, thus far, has been due to the episode of climbing stairs..." (Ex. 16, emphasis added).

In a subsequent report, Dr. Zirschky related the injury to the "accident at work" and "work exposure." (Ex. 17).

Dr. Fuller, examining orthopedic surgeon, opined that claimant's injury could be idiopathic. Noting nothing unusual about claimant's activity of walking up the stairs at the time of the injury, Dr. Fuller stated: "It would appear that the rupture at work occurred purely on the basis of coincidence and was not intrinsically caused by his work activity per se." (Ex. 16A-5).

Based on our review of medical record, we are not persuaded that claimant has carried her burden of proving a causal relationship between his injury and any risk connected to his employment. There was nothing unusual or abnormal about claimant's activity of ascending the stairs. He did not slip, twist or trip over anything. Like the injury in Johnson, supra, it appears the only connection that existed between the injury and employment was the fact that the injury occurred on work premises during working hours. That is not sufficient to prove compensability. See Norpac Foods, Inc. v. Gilmore, supra; Phil A. Livesley v. Russ, supra; James D. Johnson, supra.

ORDER

The ALJ's order dated March 27, 1996 is affirmed.

Board Chair Hall dissenting.

I disagree with the majority's conclusion that claimant has not proven his foot injury arose out of employment.[1] It is undisputed that he suffered the foot injury while engaged in a work activity, i.e., climbing stairs. Like the ALJ, I find the risk of injury from that activity was a risk associated with his employment. While there is no evidence that claimant slipped, twisted or tripped over anything, such evidence is not required. All that is required is proof of a causal connection between the injury and a risk connected with employment.

Dr. Zirschky, the treating orthopedic surgeon, expressly related the foot injury to the activity of climbing stairs. His opinion is more persuasive than that of Dr. Fuller because it is supported by the undisputed fact that the onset of sharp foot pain coincided with the stair climbing activity. Claimant has established, therefore, that his injury is connected to a specific work activity. Because the risk of engaging in that activity was one associated with his employment, I would conclude his injury arose from employment. I would further conclude that Dr. Zirschky's opinion, which relates the injury to the stair climbing activity, is sufficient to establish the injury claim is compensable.

[1] I also respectfully disagree with the majority's summary of the medical record in James D. Johnson, 48 Van Natta 303 (1996) to the extent that the majority states the doctors gave no explanation for (or that the medical evidence failed to establish) a causal connection between the injury and employment.

In the Matter of the Compensation of
JAY G. POTTER, Deceased, Claimant
WCB Case No. 95-12214
ORDER ON REVIEW (REMANDING)
Michael M. Bruce, Claimant Attorney
Gleaves, et al, Defense Attorneys

Reviewed by Board Members Christian and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) denied the employer's motion for a continuance or reopening of the record; (2) directed the employer to pay a remarriage benefit to claimant (the deceased worker's surviving spouse); and (3) assessed penalties against the employer for allegedly unreasonable claim processing. We remand.

FINDINGS OF FACT

A hearing in this matter was scheduled for February 21, 1996 at 9:00 a.m. in Klamath Falls. According to the sworn statement of Rod Johnson, Vice President of the employer, he and Michael

Christian, another representative of the employer, intended to attend the hearing on behalf of the employer. Johnson's affidavit indicates that he attempted to telephone claimant's attorney the morning of the hearing, but was unable to reach him. Johnson also checked the State Police road report and received information that road conditions to Klamath Falls were hazardous. Johnson advised Christian that the roads to Klamath Falls were extremely hazardous and that they should not risk driving to the hearing. Johnson instructed Christian to notify the ALJ of their predicament. According to Christian's statement, he was only able to reach the court reporter to whom he explained the situation and attempted to relay a request for a postponement of the hearing. Christian indicated that, but for the snow storm and hazardous driving conditions, he intended to attend the February 21, 1996 hearing to represent the employer's interests.

Johnson is not an active member of the state bar and Christian is not an attorney. There is no indication in the record that the employer received notice prior to the hearing that it must be represented by an attorney to proceed at the hearing.

The hearing was convened on February 21, 1996 with claimant and her attorney present. No representative for the employer was present. The issues before the ALJ were entitlement to a remarriage benefit, penalties and attorney fees for alleged nonpayment of the remarriage benefit, and penalties and attorney fees for allegedly late payment of benefits to the deceased worker's son.

After the hearing, but before the ALJ issued his order, the employer obtained legal counsel and filed a "motion to continue hearing or in the alternative reopen the record." Claimant responded to the motion. The record contains affidavits from claimant's attorney, Michael Christian and Rod Johnson regarding the events on the morning of the scheduled hearing.

In his order, the ALJ denied the employer's motion for continuance/ reopening of the record. The ALJ noted that the employer was a corporation and must be represented by an attorney at any proceeding. Reasoning that neither of the corporate representatives who intended to attend the hearing were active members of the bar, the ALJ found that the reasons for Johnson and Christian's failure to attend the hearing were irrelevant. Addressing the issues raised by claimant's hearing request, the ALJ found that claimant was entitled to the remarriage benefit and assessed penalties and attorney fees for failure to pay the benefits and late payment of benefits.

CONCLUSIONS OF LAW AND OPINION

The ALJ denied the employer's motion for a continuance or reopening of the record. In addition, the ALJ found that claimant was entitled to a $5,000 remarriage benefit and assessed penalties and attorney fees for failure to pay the remarriage benefit and assessed a separate penalty for late payment of benefits to the deceased worker's son.

The employer, which is now represented by legal counsel, has requested review of the ALJ's order. Specifically, the employer challenges the ALJ's denial of its motion for a continuance.

To begin, although the employer would not have been represented by an attorney at the scheduled hearing had Johnson and Christian made it to the hearing, the record does not establish that the employer had notice prior to the date of hearing that it must be represented by an attorney. Under similar circumstances, we have previously found that a continuance should be granted. See Donald L. Grant, 47 Van Natta 816 (1995) (where an unrepresented corporate employer attended the hearing, but lacked notice prior to the scheduled hearing that it must be represented by an attorney, an ALJ's failure to grant a continuance was an abuse of discretion). In other words, although a corporation may not proceed with a hearing without representation by an attorney, a corporation may appear at a hearing without an attorney for the purpose of arguing that a continuance should be granted under OAR 438-006-0091 to allow it to obtain legal counsel. Id. Thus, the pivotal question becomes whether the employer's representatives' failure to attend the hearing constitutes "extraordinary circumstances."

Pursuant to OAR 438-006-0091(4), a continuance may be granted for any reason that would justify postponement of a scheduled hearing under OAR 438-006-0081. According to OAR 438-006-0081, a scheduled hearing shall not be postponed except upon a finding by the ALJ of "extraordinary circumstances" beyond the control of the party or parties requesting the postponement. Our review of an ALJ's continuance ruling is for an abuse of discretion. See Georgia-Pacific v. Kight, 126 Or App 244, 246 (1994).

The employer's representatives could arguably have been more diligent in attempting to contact the ALJ and claimant's attorney to explain the reason for their failure to attend the hearing. Nevertheless, based on the affidavits of Johnson and Christian, the record establishes that the road conditions on the morning of the scheduled hearing were hazardous because of the snowstorm. In addition, based on their sworn statements, Johnson and Christian did make some efforts, albeit unsuccessful, to contact claimant's attorney and the ALJ. Johnson also checked the State Police road report and discovered that road conditions to Klamath Falls were hazardous. In the absence of contrary evidence, the record supports a conclusion that extraordinary circumstances beyond the control of the employer representatives prevented them from attending the hearing. Thus, we conclude that it was an abuse of discretion for the ALJ to have denied the employer's motion for a continuance of the hearing.

Accordingly, the ALJ's order dated April 17, 1996 is vacated. Because we find extraordinary circumstances justifying a continuance, we remand this matter to ALJ Brown for further proceedings consistent with this order. At the continued hearing, the ALJ may proceed in any manner that achieves substantial justice. ORS 656.283(7). Thereafter, the ALJ shall issue a final appealable order reconsidering those issues raised at hearing.[1]

ORDER

The ALJ's order dated April 17, 1996 is vacated. This matter is remanded to ALJ Brown for further proceedings consistent with this order.

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[1] Claimant asserts that the employer is not appealing the ALJ's award of a penalty for late payments of benefits and requests that the employer be ordered to pay the penalty. However, in its appeal, the employer has effectively done so through its objection to the ALJ's denial of a continuance of the hearing. Because a continuance of the hearing has been granted, all issues raised at the original hearing remain potentially at issue at the continued hearing.

September 19, 1996 Cite as 48 Van Natta 1844 (1996)

In the Matter of the Compensation of
SONYA G. RICHARDSON, Claimant
WCB Case No. 95-12880
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order which upheld the SAIF Corporation's denial of her right shoulder condition. In its brief, SAIF contends that the ALJ incorrectly increased claimant's award of unscheduled permanent disability from 7 percent (22.4 degrees), as granted by an Order on Reconsideration, to 14 percent (44.8 degrees). On review, the issues are the scope of SAIF's denial, compensability and extent of unscheduled permanent disability. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's finding of fact.

CONCLUSIONS OF LAW AND OPINION

Scope of Denial

On April 12, 1993, claimant filed a claim for an injury to her hips and shoulders that SAIF accepted as a "dorsal and lumbosacral strain." On May 5, 1994, a prior ALJ approved a Stipulation and Order between the parties, whereby they agreed to settle "all issue(s) raised or raisable" by SAIF amending its acceptance to include bilateral ankle and wrist strain/contusions, as well as left hip and cervical strains.

Claimant sought treatment in July 1994 from Dr. Morrison for right shoulder symptoms after she had lifted her shoulder and felt a "popping" sensation. Claimant had been receiving physical therapy at the time for her compensable injury. SAIF eventually denied claimant's right shoulder condition, diagnosed as rotator cuff tendonitis, on December 29, 1995, on the sole ground that claimant was precluded from making a claim for her right shoulder condition by the May 1994 stipulation, which had resolved all issues raised or raisable.

The ALJ concluded that claimant's right shoulder claim was not barred by the May 1994 Stipulation and Order, reasoning that claimant's current right shoulder condition did not arise until after the parties had executed the stipulation. See Safeway Stores, Inc. v. Seney, 124 Or App 450, 454 (1993); Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994). Nevertheless, the ALJ determined that claimant's right shoulder condition was not compensable, finding that there was no persuasive medical evidence to support claimant's contention that her condition was a compensable consequence of physical therapy prescribed for the effects of her compensable April 1993 injury. See ORS 656.005(7)(a)(A); Barrett Business Services v. Hames, 130 Or App 190 (1994).

Claimant requested reconsideration, arguing that, since the sole basis for SAIF's denial was that her right shoulder claim was barred by issue/claim preclusion, the ALJ erred in finding the right shoulder claim not compensable on another basis, i.e., lack of medical causation. See Tattoo v. Barrett Business Services, 118 Or App 348 (1993) (carriers bound by language of their denials). While agreeing with claimant that the language of SAIF's denial was limited to only one basis for the denial (that the claim was barred by claim or issue preclusion), the ALJ likened the circumstances of this claim to those in Judith M. Morley, 46 Van Natta 882, 883, on recon 46 Van Natta 983 (1994), and found that the parties had implicitly agreed to try both the claim preclusion and underlying compensability issues. Therefore, the ALJ continued to find claimant's right shoulder condition not compensable for lack of proof of medical causation.

On review, claimant contends that the parties did not implicitly agree to try a medical causation issue and that SAIF's denial should be set aside. We agree.

An insurer is bound by the express language of its denial. Tattoo v. Barrett Business Services, supra, 118 Or App at 351-52. In this case, the basis for the insurer's denial was limited to an allegation that claimant's right shoulder claim was barred by the prior stipulation. No causation issue is expressly raised by the insurer's denial.

Parties to a workers' compensation proceeding may, however, by express or implicit 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, supra. We disagree, however, with the ALJ's conclusion that the parties implicitly agreed to do so in this case.

There is no evidence in this record that the parties agreed to litigate an issue outside the scope of the express language of SAIF's denial. To the contrary, the hearing transcript indicates that the parties agreed only to litigate extent of disability and SAIF's denial, which did not expressly raise a causation issue (Tr. 5). Although SAIF solicited medical reports that addressed causation (Exs. 27, 30, 31), and claimant did not object to their admission into evidence, we are unwilling to find that claimant's failure to object to admission of those medical reports constituted an implied agreement to litigate a causation issue, given the parties' express agreement at hearing regarding the scope of the issues.

SAIF contends that, in asserting that her shoulder condition arose after the stipulation and was related to physical therapy, claimant raised a medical causation issue. We reject that contention. Claimant never contended that she injured her shoulder during physical therapy. (Tr. 5).

Based on our review of the record, we find that the parties sufficiently identified the issues to be litigated at the commencement of the hearing. There is no evidence in the record that the parties expressly or implicitly agreed to expand those issues beyond the defense raised by the express language of SAIF's denial. Under these circumstances, we conclude that a medical causation issue was not raised

at hearing.[1] Inasmuch as SAIF does not contest the ALJ's finding that the prior stipulation does not bar the current right shoulder claim, we further conclude that SAIF's denial should be set aside.

Inasmuch as claimant has finally prevailed against SAIF's denial, claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the denial issue is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Permanent Disability

An Order on Reconsideration awarded claimant 7 percent unscheduled permanent disability based on reduced range of cervical, thoracic and left hip motion. The ALJ determined that claimant was entitled to an additional 7 percent unscheduled permanent disability, in part based on his finding that claimant was entitled to 5 percent impairment for a "chronic condition" limiting repetitive use of claimant's left hip. In awarding "chronic condition" impairment, the ALJ relied on the findings of the medical arbiter, Dr. Scheinberg. Dr. Scheinberg commented as follows regarding the presence of a chronic left hip condition:

> "There did appear to be some limitation of abduction in the left hip relative to the right, which, perhaps, could cause this worker to have a limited or partial ability to repetitively use the left hip due to a diagnosed chronic and permanent medical condition arising out of the accepted condition of left hip contusion." (Ex. 37-9) (Emphasis supplied).

In order to receive an unscheduled chronic condition impairment award, a preponderance of medical opinion must establish that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. OAR 436-35-320(5). This rule requires medical evidence of, at least, a partial loss of ability to repetitively use the body part. See Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995); Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

SAIF argues that Dr. Scheinberg's report is insufficient to establish a chronic condition award. We agree. Because Dr. Scheinberg used words such as "perhaps" and "could" to describe whether claimant has a "chronic condition," we conclude that his report does not establish to a degree of medical probability that claimant has such a condition. See Deborah L. Vilanj, 45 Van Natta 260 (1993) (chronic condition must be established to a degree of medical probability)

Therefore, we reduce claimant's award of unscheduled permanent disability by 5 percent. Consequently, claimant is entitled to an award of 9 percent unscheduled permanent disability and the ALJ's permanent disability award is modified accordingly.

ORDER

The ALJ's order dated March 1, 1996, as reconsidered on April 22, 1996, is reversed in part and modified in part. That portion of the ALJ's order that upheld SAIF's denial is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an attorney fee of $3,500, payable by SAIF. That portion of the ALJ's order which awarded claimant an additional 7 percent (22.4 degrees) unscheduled permanent disability (for a total of 14 percent (44.8 degrees)) is modified. In lieu of the ALJ's award, claimant is awarded an additional 2 percent (6.4 degrees) unscheduled permanent disability, for a total award of 9 percent (28.8 degrees). Claimant's "out-of-compensation" attorney fee award shall be modified accordingly.

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[1] The ALJ noted that claimant contended in closing argument that the claim should be considered one for a consequential condition under ORS 656.005(7)(a)(A). However, closing argument is not the proper time to raise a new issue. See Robert D. Lawrence, 47 Van Natta 1619 (1995) (Board will not consider issue first raised in closing argument).

In the Matter of the Compensation of
KEVIN R. RITCHEY, Claimant
WCB Case No. 95-13252
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Ronald K. Pomeroy, Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's trapezius muscle strain 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

Citing Barnett v. SAIF, 122 Or App 279 (1993), the ALJ found that this was not a complicated case requiring medical evidence of causation. Therefore, relying on claimant's testimony, the fact that claimant reported the work incident to his supervisor within an hour of its occurrence, sought treatment within 24 hours, and the doctor made findings not inconsistent with claimant's reported work activity, the ALJ found that claimant had established a compensable claim. We disagree.

There is no evidence that claimant had any preexisting shoulder or neck condition; consequently, ORS 656.005(7)(a)(B) is not applicable. Therefore, in order to establish a compensable injury, claimant must show an accidental injury arising out of and in the course of employment. ORS 656.005(7)(a). The injury must be established by medical evidence, supported by objective findings. Id. Claimant's disability or need for treatment is compensable if the industrial injury is a material contributing factor. Mark Weidle, 43 Van Natta 855 (1991). Claimant has the burden of proving a compensable injury. ORS 656.266.

In Barnett v. SAIF, supra, the court applied the factors enumerated in Uris v. Compensation Department, 247 Or 420 (1967), for determining whether medical evidence of causation is required. These factors are: (1) an uncomplicated situation; (2) the immediate appearance of symptoms; (3) the prompt reporting of the occurrence to a superior; (4) the worker was previously free from disability of the kind involved; and (5) there was no expert testimony that the alleged precipitating event could not have been the cause of the injury. 122 Or App at 283. For the following reasons, we do not find this case presents an uncomplicated situation that does not require medical evidence of causation.

Claimant works as a cook and testified that he had no prior shoulder or neck problems. He testified that, on August 1, 1995, his left shoulder became painful while making egg salad sandwiches, which involved holding a two gallon stainless steel bowl filled with about a gallon of egg salad with his left hand/arm while spreading the egg salad with his right hand. (Tr. 7-9). This pain worked up into claimant's shoulder and neck and became "excruciatingly painful." (Tr. 9). Claimant continued to work about an hour or two, then he called his supervisor, told her what happened, and asked to have someone relieve him. (Tr. 11-13). After the relief cook arrived, claimant went home and attempted to self-treat the pain. (Tr. 13).

The next day, claimant saw Dr. Miller, M.D., who later wrote a narrative opinion regarding claimant's examination. (Ex. 4). Dr. Miller noted that claimant had no history of trauma. Id. She also noted that the "physical exam revealed spasm of the trapezius on the left" and her "impression at the time was muscle strain." Id. She treated claimant with pain medication. She stated that, at the time she examined claimant, "the only reproducible findings were the cervical spasm." Id. She was not sure that claimant claimed this was a work injury at the time she saw him. Id. Finally, Dr. Miller stated that she did "not know if this could be due to work related activity. It is very unclear." Id.

On August 5, 1995, claimant saw Dr. Dunn, M.D., who works in the same clinic as Dr. Miller. (Exs. 2, 4). Dr. Dunn noted findings of "Tenderness L[eft] rhomboid & trapezius. . . " and diagnosed "L[eft] shoulder pain, ? gleno-humeral." (Ex. 2). He also filled out an 827 form for Dr. Miller, listing a diagnosis of "joint pain [with] muscle strain of trapezius" and listing the nature of the injury/exposure as "lifting @ work = > sh [sic] pain." (Exs. 1, 4). Dr. Dunn treated claimant with different medications. (Exs. 2, 4). Claimant's shoulder/neck pain resolved and he has not sought further treatment. (Tr. 16).

On this record, we do not find that this is an uncomplicated situation that does not require medical evidence regarding causation. In this regard, Dr. Miller specifically stated that the situation was "very unclear." (Ex. 4). Where a treating physician finds the situation "very unclear," we are without the expertise to supplant her medical judgment and declare the situation uncomplicated. Accordingly, based on Dr. Miller's opinion, we find the situation complex and, therefore, in need of medical evidence to establish causation. Uris v. Compensation Department, supra; Barnett v. SAIF Corporation, supra.

Regarding causation, Dr. Miller stated that she did "not know if this could be due to work related activity." (Ex. 4). Although the 827 form, ostensibly signed by Dr. Miller, lists the nature of the injury/exposure as "lifting @ work = > sh [sic] pain," Dr. Miller explained that the 827 form was filled out for her by Dr. Dunn. (Exs. 1, 4). Given Dr. Miller's clarification, we find that her opinion is that she does not know whether claimant's strain was due to his work activity. Moreover, without further explanation, we do not consider the statement "lifting @ work = > sh [sic] pain" as persuasive evidence of causation. In this regard, it is unclear whether Dr. Dunn is giving his own opinion or his interpretation of Dr. Miller's opinion, given the fact that he filled out the 827 form for Dr. Miller. (Exs. 1, 4). In any event, this statement is conclusory. Somers v. SAIF, 77 Or App 259 (1986).

On this record, we conclude that claimant has failed to meet his burden of proving a compensable injury. Accordingly, we reverse the ALJ's order that set aside SAIF's denial and awarded claimant's attorney a $3,500 fee for prevailing over that denial.

ORDER

The ALJ's order dated March 7, 1996 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

Board Chair Hall dissenting.

While I agree with the majority's recitation of the facts and their statement of the law, I disagree with their application of that law to the facts. Therefore, I must respectfully dissent.

Contrary to the majority's conclusion, this is not a complicated situation requiring medical evidence of causation. Here, claimant had an immediate appearance of symptoms while performing specific work duties. In this regard, claimant testified that, while making egg salad sandwiches at work, he had an onset of left shoulder pain that worked up into his shoulder and neck and became "excruciatingly painful really fast." (Tr. 9). Claimant reported this occurrence to his supervisor promptly, within one or two hours. (Tr. 11-13). He sought medical treatment the next day. Furthermore, claimant was previously free from any disability in his neck or shoulder, the kind of disability involved in the work incident. Finally, there is no expert testimony that the work activity could not have been the cause of the injury. In total, this case presents a straight-forward "uncomplicated situation". The only thing that arguably complicates the case is Dr. Miller's unexplained statement that she did "not know if this could be due to work related activity. It is very unclear." (Ex. 4). Dr. Miller's unexplained statements, by themselves, do not turn this into a complicated situation.

Within the guidelines of Barnett v. SAIF, 122 Or App 279 (1993), the record establishes that this is an uncomplicated situation. However, the majority has taken an uncomplicated situation and, based on nothing more than a single unexplained sentence, turned it into a "complicated situation." In effect, the majority takes the Barnett elements and blurs the line.

On this record, I agree with the ALJ that this case does not require medical evidence of causation. Furthermore, I agree with the ALJ that claimant has established a compensable trapezius muscle strain injury claim. Therefore, I would affirm the ALJ.

In the Matter of the Compensation of
BRADLEY B. ROGERS, Claimant
WCB Case No. 95-11898
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that set aside its partial denial of claimant's cervical spine condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his low back at work on November 14, 1993 while pulling on a pipe wrench. A November 29, 1993 MRI revealed a right disk herniation at L5-S1. The insurer accepted a disabling low back strain on December 14, 1993.

On December 29, 1993, Dr. Macha performed a laminotomy and discectomy on claimant at L5-S1, right side. On January 19, 1994, Dr. Macha recommended claimant begin a post-laminectomy flexibility and strengthening program, and sent him to a physical therapist for instruction. Dr. Macha released claimant for light duty work, and directed him to change positions frequently and not engage in vigorous activity for three months, until he was completely reconditioned. Claimant met with the physical therapist on January 24, 1994, who instructed him regarding flexibility and strengthening exercises.

Claimant fell at work on February 23, 1994 and exacerbated his low back symptoms. His symptoms were improved by March 9, 1994, and Dr. Macha released claimant to increase his work activities and continue his exercise program on his own.

On April 8, 1994, Dr. Macha reported that claimant was medically stationary. Dr. Macha found decreased range of motion and decreased sensation in the S1 distribution, and prescribed a back support to enable claimant to continue his work activities without limitation. Dr. Macha also recommended that claimant continue his conditioning exercises to avoid recurrent back pain.

Claimant's claim was closed by Determination Order issued May 2, 1994, finding claimant medically stationary on April 8, 1994, and awarding temporary disability and 17 percent (54.4 degrees) unscheduled permanent disability.

In March 1995, claimant developed worsened low back pain after twisting and lifting 50 pound bags of concrete at work. Dr. Macha authorized time loss, prescribed medication and four to six sessions of physical therapy. The objectives of the physical therapy were to normalize joint mechanics, soft tissue mobility and range of motion. On March 14 and 17, 1995, the physical therapist instructed claimant regarding exercises for his low back condition, and advised claimant that he could do his exercises while at work. By March 30, 1995, claimant's symptoms resolved and he returned to his pre-exacerbation status. Dr. Macha advised claimant that it was important that he continue with his home exercise program.

Claimant continued with his exercises, and routinely did them at work before his shift started and during his scheduled breaks. On August 17, 1995, claimant sought treatment for pain and stiffness in his cervical spine and numbness and tingling into the hand. He reported to Dr. Macha that he hyperextended his neck doing sit-ups as part of his back exercise program.

Dr. Macha diagnosed neck pain and a possible herniated disc. A cervical MRI scan showed minor cervical spondylosis at C6-7 with possible disc bulging, but no significant disc herniation.

On October 19, 1995, the insurer issued a partial denial of claimant's cervical spine condition. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the injurious activity, sit ups or "abdominal crunch" exercises, were reasonable and necessary treatment for claimant's compensable low back condition and, therefore, claimant's cervical condition was compensable as a consequential condition under ORS 656.005(7)(a)(A).

On review, the insurer argues that claimant's compensable injury is not the major contributing cause of his cervical condition because it did not arise directly out of "medical treatment" for his compensable injury. We agree.

In Barrett Business Services v. Hames, 130 Or App 190, 193 (1994), the court held that when a worker sustains a new injury "as a 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)." There, the claimant sustained an injury to his right ulnar nerve during physical therapy designed to treat his compensable shoulder dislocation injury, and the court found that the ulnar nerve injury was a direct consequence of appropriate treatment for the shoulder injury.

Hames is distinguishable from Hicks v. Spectra Physics, 117 Or App 293 (1992), where the later injury was not a "direct consequence" of medical treatment for the compensable injury. In Hicks, the claimant was injured in an auto accident while returning from treatment for a compensable injury. Although the two injuries were related, the court held that a "but for" analysis of causation was insufficient to establish compensability under the major contributing cause standard of ORS 656.005(7)(a)(A). See also Kephart v. Green River Lumber, 118 Or App 76, rev den, 317 Or 272 (1993) (upholding the denial of compensation for a shoulder injury the claimant suffered when he fell from a truck in the course of vocational rehabilitation for a compensable hand injury because the fall from the truck was the major contributing cause of shoulder injury).

We applied the Hames rule in Martin J. Fowler, 47 Van Natta 614 (1995), where the claimant injured his neck during the course of a weightlifting activity prescribed to treat his compensable right hip injury. Based primarily on the treating doctor's characterization of the weightlifting activity as an "integral part" of the claimant's "recovery" from the original hip injury, we found persuasive evidence that the weightlifting was reasonable and necessary treatment. We therefore concluded that the claimant had established the compensability of his cervical condition under ORS 656.005(7)(a)(A). We further noted that "[t]he weightlifting activity was directed and overseen by the physical therapist rather than performed on claimant's own initiative." Martin J. Fowler, supra.

As the insurer notes, this case is similar to, but distinguishable from, Fowler. Unlike Fowler, claimant's exercise program was not being directed and overseen by a medical provider when he injured his neck. Although Dr. Macha prescribed the exercises as a way to maintain claimant's low back flexibility and avoid recurrent pain, and the physical therapist instructed claimant on how to perform the exercises, claimant did them on his own at work without any medical supervision. In addition, contrary to Fowler, claimant's exercises were not prescribed as a curative treatment to aid claimant's "recovery," but as a preventative measure, to maintain flexibility and avoid recurrent pain after he became medically stationary.[1]

Unlike the ALJ, we find these distinctions significant. Based on our review of the analyses in Hames, Fowler, Hicks and Kephart, we find the causal relationship in this case between claimant's compensable low back injury and his cervical injury to be too tenuous and indirect to render the latter a compensable consequence of the former under ORS 656.005(7)(a)(A). Since claimant was doing his "abdominal crunch" exercises on his own as a preventative measure, several months after claim closure and without any direct medical supervision, we conclude that claimant's home exercise program does not constitute "medical treatment" for his compensable low back injury for purposes of the Hames analysis.

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[1] In both Hames and Fowler, the claimants were injured in the course of a prescribed physical therapy program during their recovery from their respective compensable injuries.

Consequently, on this record, we find that claimant has not established that his cervical condition arose as a "direct result of reasonable and necessary medical treatment for a compensable injury."[2] We therefore reinstate the insurer's denial.

ORDER

The ALJ's order dated March 1, 1996 is reversed. The ALJ's attorney fee award is also reversed. The insurer's October 19, 1995 denial of claimant's cervical condition is reinstated and upheld.

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[2] Contrary to the analogy cited by the dissent, we see a distinction between claimant's unsupervised home exercise program and prescribed medication. Although a patient may take the pills pursuant to his or her physician's instructions and without direct supervision, it is still "medication" prescribed to cure or medically treat the patient's condition. As explained in the order, under the specific circumstances of this case, we do not consider claimant's home exercise program, which he was advised to continue on a permanent basis to maintain low back flexibility and strength, to be "medical treatment" for purposes of the Hames analysis.

Board Chair Hall dissenting.

The majority has found the causal relationship between claimant's compensable low back injury and his subsequent cervical injury to be "too tenuous and indirect," and therefore holds that claimant's cervical injury is not compensable as a consequential condition under ORS 656.005(7)(a)(A). I dissent, because I believe that this case fits squarely within the criteria established by Barrett Business Services v. Hames, 130 Or App 190 (1994), and that claimant injured his neck as a "direct result of reasonable and necessary treatment of a compensable injury."

Claimant was instructed on how to perform flexibility and strengthening exercises while recovering from the surgery necessitated by his compensable low back injury. Dr. Macha specifically advised claimant that it was important that he continue this exercise program on his own, to maintain flexibility and avoid recurrent pain.

Unlike the majority, I do not find this case distinguishable from Hames or Martin J. Fowler, 47 Van Natta 614 (1995). In fact, I believe the majority is creating a distinction that need not be made. It is immaterial, for purposes of the Hames analysis, that claimant was performing these exercises on his own without "direct supervision" by Dr. Macha or the physical therapist.

Indeed, I see claimant's consequential cervical injury in this case as analogous to the situation where a patient suffers an unexpected side effect from medication prescribed for a compensable condition. As a general rule, a physician will issue a prescription and instruct the patient on how and when to take the medication. Once prescribed, the physician does not hand out each pill. Instead, the patient is responsible for taking the medication on his own, pursuant to the physician's instructions. If that medication causes, for example, an ulcer, that ulcer would certainly be compensable as a consequence of the original condition, even though the patient had taken the medication without "direct supervision."

Here, the treating physician essentially issued a prescription for exercise and claimant was given specific instructions on performing the exercises by the physical therapist. After he became medically stationary, claimant was advised to continue with this exercise program permanently. As the ALJ found, the record establishes that this exercise activity was reasonable and necessary treatment for maintaining claimant's medically stationary status. Since it is undisputed that claimant injured his neck during the course of this exercise activity, I would find that claimant's new injury is compensable under ORS 656.005(7)(a)(A) and Hames, supra.

I am also concerned that the message sent by the majority's decision, i.e., that home exercise programs prescribed for compensable injuries do not constitute "medical treatment," will encourage physicians to prescribe, and claimants to go through, additional out-patient treatment or physical therapy programs rather than home treatment plans, which will result in increased costs for claimants, employers and insurers alike.

In the Matter of the Compensation of
PATRICIA A. TURNER, Claimant
WCB Case No. 95-00056
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Christian, Hall and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Johnstone's order that set aside its denial of claimant's bilateral knee condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,700, payable by employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 27, 1996 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,700, to be paid by the self-insured employer.

Board Member Moller dissenting.

Claimant has an accepted claim for left wrist and bilateral knee contusions as a result of an August 1994 slip-and-fall. Those conditions are not in dispute in this proceeding. Instead, claimant seeks to establish entitlement to benefits for the combined effect of her compensable slip-and-fall and her preexisting bilateral knee osteoarthritis. By adopting and affirming the ALJ, the majority agrees that the opinion of Dr. Miller is sufficient to carry claimant's burden of proof under the "combined condition" provisions of ORS 656.005(7)(a)(B). Because I believe that Dr. Miller's opinion both fails to address the relevant legal issue and is based on an inaccurate history, I dissent.

Dr. Miller, osteopath, is the only physician whose opinion supports claimant's claim. Noting that claimant previously had "missed minimal time" from work, Dr. Miller first reported that the work fall had caused a "significant aggravation to the underlying inflammatory process." (Ex. 28-2). In October 1995, Dr. Miller was deposed and further explained his opinion. (Ex. 31). Dr. Miller denied that claimant's left knee had been "giving her trouble for about 30 years." Rather, he relied on a history that "the knee had had surgery 30 years previously and had not been a problem of significance to her; although there was some instability from the previous surgery." (Ex. 31-8 through 9). Dr. Miller concluded that "the worsening [of claimant's preexisting osteoarthritic condition] was the sole result [sic] of her accident." (Id. at 23).

I find Dr. Miller's opinion unpersuasive for several reasons. Because Dr. Miller believes that the preexisting condition was worsened by the August 1994 incident, the pre-fall status of claimant's arthritic condition is crucial to the medical and legal issues in this case. Dr. Miller's understanding of that pre-injury status, as set forth above, is contrary to the more reliable medical evidence. In this regard, Dr. Sedgewick, claimant's initial treating physician, reviewed x-rays of claimant's knees and indicated that the major contributing cause of claimant's need for treatment was the preexisting condition and that such condition had not been pathologically worsened by the industrial accident. (Ex. 30). Dr. Miller, who opined that claimant's preexisting condition was pathologically worsened by her slip-and-fall, did not review the x-rays (although Dr. Miller acknowledged that her x-rays had been interpreted to disclose "advanced degenerative joint changes of the left knee"). (Ex. 24-1). Without having personally reviewed claimant's x-rays, Dr. Miller's opinion concerning worsening of the preexisting condition is less persuasive than the opinion of Dr. Sedgewick.

Moreover, Dr. Miller understood that claimant's pre-injury knee "trouble" was confined to left knee instability. (Ex. 31-9, 22). However, claimant reported to Dr. Sedgwick that she experienced bilateral crepitus prior to the incident. (Ex. 8-1). Dr. Miller identifies crepitus as the "real giveaway" of an arthritic condition. (Ex. 31-17). In addition, claimant experienced symptoms of aching in her knees before the slip-and-fall. (Ex. 9-2). In fact, one of the stated goals of physical therapy was to reduce

claimant's left knee pain "to pre-fall level." (Ex. 3-2). Inasmuch as Dr. Miller's "worsening" theory rests on an inaccurate history of the pre-fall status of claimant's arthritic condition, the persuasiveness of his opinion is further reduced.

Similarly, Dr. Miller's understanding of the slip-and-fall incident itself is critically flawed. Dr. Miller's opinion - as stated in his deposition more than one year after the incident - was premised on his understanding that claimant's left wrist and left knee "sustained the major load" resulting from the fall. (Ex. 31-7). However, on referral to physical therapy less than two weeks after the incident, claimant reported the "she hurt the [right] knee more than the [left], but the [left] one has given her trouble for about 30 years (when she first had cartilage removed)." (Ex. 3-2).

Finally, and most importantly, Dr. Miller's opinion does not support the theory of compensability asserted by claimant throughout the proceeding. That is, Dr. Miller does not indicate 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." See ORS 656.005(7)(a)(B). Rather, his ultimate conclusion is that the "worsening of her preexisting condition" was solely the result of her accident. (Ex. 31-23). Thus, Dr. Miller focuses on the cause of any incremental worsening of claimant's preexisting "advanced degenerative joint changes." Even if Dr. Miller's opinion was persuasive on the issue of "worsening" of the preexisting condition, that is not the correct legal inquiry under ORS 656.005(7)(a)(B).

The correct legal inquiry focuses on the causes of the need for treatment or disability of the combined condition rather than the cause of incremental changes in the preexisting condition. For this reason, Dr. Miller's opinion is inadequate to prove compensability under ORS 656.005(7)(a)(B). Furthermore, to the extent Dr. Miller does address the relevant inquiry, *i.e.*, the relative contributions to claimant's disability and need for treatment, he states in his closing examination of claimant that claimant's knees are "very slow in healing secondary to underlying arthritic condition" and that "the underlying condition may prevent this woman from returning to her previous levels of activity." (Ex. 24-3). Therefore, Dr. Miller's truly relevant opinion is that claimant's need for treatment and disability are due to her preexisting arthritic condition rather than the compensable injury.

In conclusion, because this case lacks persuasive medical evidence establishing compensability under the applicable legal standard set forth in ORS 656.005(7)(a)(B), I dissent.

In the Matter of the Compensation of
ANDREW D. KIRKPATRICK, Claimant
WCB Case No. 95-00554
SECOND ORDER DENYING RECONSIDERATION
Coons, Cole, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant again requests reconsideration of our August 28, 1996 Order on Reconsideration which republished our July 3, 1996 Order on Review that upheld the insurer's aggravation denial. Noting that our September 12, 1996 Order Denying Reconsideration was signed by only three of the five Board members, claimant seeks further consideration of his request for en banc review.

As explained in our September 12, 1996 order, each case which is subject to the Board's review undergoes an appraisal regarding whether the dispute presents a potentially significant issue. This case was no exception. Because the issue in this case was considered to be subject to the rationale expressed in a previous "en banc" decision, the case was determined by the reviewing members of the panel not to satisfy the criteria for potential significance. Since the Board's decision on the merits has issued, claimant's subsequent requests for en banc review does not automatically require the participation of the entire Board membership. To the contrary, a decision of a panel shall be by a majority of the panel. ORS 656.718(3). In this particular case, that majority has rejected, and continues to reject, claimant's request for en banc review for the reasons previously expressed.

Accordingly, claimant's request for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our August 28, 1996 order.

IT IS SO ORDERED.

Board Chair Hall dissenting.

I continue to adhere to the reasoning articulated in my dissenting opinion to the Board's September 12, 1996 Order Denying Reconsideration.

In the Matter of the Compensation of
ROBERTA S. HAMRICK, Claimant
WCB Case No. 95-03166
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller and Christian.

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

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

Claimant argues that the employer's failure to call as witnesses members of claimant's work crew shows that those co-workers would not have supported the employer's case. We disagree. Claimant has the burden of proof. ORS 656.266. Since claimant identified a member of her work crew[1] as a witness in her favor, but did not produce that member or explain why she was not called at hearing, we construe the failure to call members of claimant's work crew against claimant. See, e.g., John Mahon, 27 Van Natta 1647 (1995); Gloria A. Vaneekhoven, 47 Van Natta 670 (1995); Kirk Meyers, 42 Van Natta 2757 (1990) (where the claimant did not produce a witness at hearing who could allegedly verify that he was injured at this job, he failed to sustain his burden of proving that his injury occurred in the course and scope of employment).

ORDER

The ALJ's order dated March 12, 1996 is affirmed.

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[1] Claimant testified that she could not remember this work crew member's name; however, there is no evidence that claimant made any attempt to discover this co-worker's name or to produce her as a witness. (Tr. 11).

In the Matter of the Compensation of
JACK L. BARBEE, Claimant
WCB Case Nos. 94-04153 & 94-04152
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney
SAFECO Legal, Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) found that claimant had established "good cause" for failing to timely file his request for hearing from SAIF's denial of his "new occupational disease" claim for a right knee condition; (2) set aside SAIF's denial; and (3) upheld SAFECO Insurance Company's denials of claimant's current condition and aggravation claims for the same condition. In his brief, claimant requests review of that portion of the ALJ's order that declined to assess penalties and attorney fees for SAIF's allegedly unreasonable failure to process his September 1994 occupational disease claim for the same right knee condition. On review, the issues are timeliness, responsibility, penalties and attorney fees. We vacate in part, reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the third paragraph in the ALJ's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Timeliness / Hearing Request from SAIF's January 26, 1994 Denial

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 SAIF's denial earlier because he did not understand that there was a difference between SAIF and SAFECO. The ALJ concluded that claimant's reason for not appealing SAIF's denial until April 1994 constituted mistake and excusable neglect. In addition, the ALJ held that claimant's current right knee condition is compensable as to SAIF. We disagree.

Under ORS 656.319(1)(b), claimant has the burden of proving "good cause" for the late filing of his request for hearing. See Cogswell v. SAIF, 74 Or App 234 (1985). In this context, good cause means "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1). Hempel v. SAIF, 100 Or App 68, 70 (1990). Lack of diligence does not constitute good cause. Cogswell, supra. Moreover, confusion regarding the contents of a denial does not, without reasonable diligence, constitute good cause. See, e.g., Bertha Vega, 45 Van Natta 378 (1993) (claimant's inability to understand English did not establish good cause, nor did claimant's daughter's mistaken translation of denial letter); Tuan A. Ho, 45 Van Natta 2413 (1993).

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

The evidence shows that claimant received SAIF's responsibility disclaimer and claim denial (identifying SAFECO as the potentially responsible insurer) on January 27, 1994. The letter informed claimant that if he did not file a request for hearing on SAIF's denial within 60 days, he would lose any right to compensation unless he could show good cause for delay beyond 60 days. Claimant testified that he read that portion of the letter when he received it. Claimant testified that he did not request a hearing at that time, because "I figured that SAFECO was taking care of it and that I didn't need to go any further than that." (Tr. 44).

Claimant also testified that he received SAFECO's February 24, 1994 Notice of Intent to Disclaim Responsibility (identifying SAIF as the potentially responsible carrier) in late February. Claimant then discussed the denials with Ms. Stogsdill, the employer's office manager in charge of workers' compensation matters. Ms. Stogsdill testified that she advised claimant to "[deal] directly with the insurance [carriers] because there's nothing really I can do." (Tr. 28). Claimant testified that he then called SAIF once and SAFECO four or five times. Each time claimant called SAFECO, "they said they were still reviewing my claim." (Tr. 43). Claimant does not contend that either carrier or the employer indicated that one of the carriers would accept the claim.

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, on recon 47 Van Natta 789 (1995), aff'd Gillander v. SAIF, 140 Or App 210 (1996) (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); 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).

On these facts, we conclude that claimant has not established good cause for his failure to timely request a hearing on SAIF's denial. ORS 656.319(1)(b).

Alternatively, claimant contends that, inasmuch as his April 1994 request for hearing raised issues alleging incorrect processing of his claim, his request for hearing was timely under amended ORS 656.319(6). That statute provides that hearings for improper claim processing shall not be granted unless the hearing request is filed within two years of the alleged action or inaction. SAIF responds that amended ORS 656.319(6) does not apply retroactively, that claimant's request for hearing did not allege incorrect claim processing, and that the Court of Appeals has recently rejected the same argument. We agree that the new statute does not apply. We base our conclusion on the following reasoning.

In Gillander v. SAIF, supra, the claimant asserted that the Board should have considered in the first instance whether her hearing request was timely under amended ORS 656.319(6). The court declined to decide whether the amendments to ORS 656.319 were retroactively applicable. Reasoning that ORS 656.319(6) was intended to apply to challenges of a carrier's claim processing, the court concluded that the statute did not apply to a dispute which concerned a substantive denial of the claim. Id.

Here, we conclude that the dispute over the compensability of claimant's occupational disease claim likewise involves the denial of the claim, rather than the processing of the claim. Consequently, for the reasons expressed by the court in Gillander, we conclude that the statute does not apply. Therefore, we likewise reject claimant's contention that his request for hearing from SAIF's January 1994 denial of his "new occupational disease" claim was timely filed under amended ORS 656.319(6).

Responsibility

Claimant has worked for the employer since 1987. In December 1989, while SAFECO was on the risk, claimant compensably injured his right knee. SAFECO accepted a claim for right knee strain. Dr. Jones, claimant's treating orthopedic surgeon, performed a partial medial meniscectomy in February 1990. Claimant returned to his at-injury job in April 1990; the claim was closed in July 1990.

SAIF came on the risk April 1, 1990.

On January 17, 1994, claimant presented to Dr. Jacobsen with right knee pain and swelling. Dr. Jacobsen referred claimant to Dr. Jones. Dr. Jones obtained x-rays which revealed mild degenerative changes and recommended further surgery. SAFECO denied responsibility for claimant's current right knee condition and aggravation claim under its accepted 1989 injury claim. SAIF denied the compensability of and responsibility for a new occupational disease.

Applying ORS 656.005(7)(a)(B) in the context of amended ORS 656.802(2)(b), the ALJ concluded that, because claimant's employment conditions while SAIF was on the risk were the major contributing cause of a pathological worsening of his right knee condition, claimant suffered a "new occupational disease." Thus, the ALJ held that SAFECO had successfully shifted responsibility for claimant's current right knee condition to SAIF under ORS 656.308.

On review, relying on Dan D. Cone, 47 Van Natta 2220 (1995), SAIF argues that the ALJ applied the wrong standard of proof. SAIF contends that it is not sufficient to show that post-1989 injury work conditions were the major contributing cause of only a worsening of the preexisting disease, but, rather, SAFECO must prove that claimant's work conditions after claim closure were the major contributing cause of the combined condition and the major contributing cause of the pathological worsening of the disease. SAFECO concedes that is the standard, but contends that it has sustained its burden of proof. After conducting our review, we conclude that SAFECO has failed to meet its burden of proving that a new compensable right knee occupational disease arose after its 1989 claim was closed.

Because this occupational disease claim is based on a worsening of claimant's preexisting right knee condition, in order to establish a new occupational disease, SAFECO must prove that claimant's employment conditions subsequent to the 1990 closure of his accepted claim were the major contributing cause of the combined condition and pathological worsening of his right knee condition. ORS 656.802(2)(b); Tivis E. Hay, 48 Van Natta 558 (1996) (citing Dan D. Cone, supra at 2221). The parties do not dispute that the 1989 injury with SAFECO constitutes a "preexisting disease" within the meaning of ORS 656.005(24) or that claimant's current degenerative right knee condition constitutes a "combined" condition which resulted from the combination of the 1989 injury and the repetitive trauma of claimant's work conditions since SAIF came on the risk. Thus, the remaining question is whether work activities after April 1990 were the major contributing cause of the combined condition and the major contributing cause of the pathological worsening of the disease.

None of the medical experts opined that claimant's work activities after April 1990 were the major contributing cause of claimant's "combined condition" itself. In his post-hearing deposition, Dr. Jones testified that claimant's work activities since 1990 were the major cause of the change/progression/acceleration in the underlying pathology in claimant's right knee. When asked to compare claimant's pre-1990 knee condition to his post-1990 "combined" condition, Dr. Jones was unable to answer, except to state that claimant's knee symptomatology and pathology were accelerated by the post-1990 work activities.

Under such circumstances, we are unable to find that claimant's "post-1990" employment exposure was the major contributing cause of the combined condition and pathological worsening of the disease. Thus, SAFECO has failed to establish that claimant suffered a new occupational disease involving his right knee condition following closure of its 1989 injury. Accordingly, SAFECO, under its 1989 claim, remains responsible for claimant's current right knee condition. See ORS 656.308(1); ORS 656.802(2)(b); Tivis E. Hay, supra; Dan D. Cone, supra. Consequently, we reverse that portion of the ALJ's decision that placed responsibility for claimant's right knee condition on SAIF.

Penalty and Attorney Fee / SAIF

On January 17, 1994, claimant completed an 801 Form which the employer submitted to SAIF. SAIF denied compensability and responsibility of claimant's "alleged injury and/or occupational disease" claim on January 26, 1994. Claimant filed a request for hearing from that denial on April 1, 1994. In September 1994, claimant filed a right knee occupational disease claim against SAIF for the same condition. Noting that claimant had filed a claim for the same right knee condition in January 1994, SAIF declined to process "another" claim for the same condition. Instead, SAIF advised claimant that the compensability of his right knee occupational disease claim could be litigated under the existing right knee occupational disease claim which was then pending hearing.

Because he concluded that claimant's January 1994 "new occupational disease" claim against SAIF was compensable, the ALJ found claimant's September 1994 occupational disease claim for the same right knee condition moot. As we have herein determined that claimant's "new occupational disease" claim against SAIF is not compensable, we address his contention that penalties and attorney fees should be assessed against SAIF for refusing to process the September 1994 claim.

In light of our previous conclusion that claimant has failed to establish the compensability of a new occupational disease involving his right knee condition while SAIF was on the risk, there has been no unreasonable resistance to the payment of compensation. Furthermore, there are no amounts due upon which to base a penalty. Consequently, there is no basis for assessing penalties against SAIF for allegedly unreasonable claim processing. Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).[1]

In sum, we reverse those portions of the ALJ's decision that set aside SAIF's disclaimer of responsibility for claimant's right knee condition and upheld SAFECO's disclaimers of responsibility and denials of claimant's current condition and aggravation claims. Moreover, given this conclusion, we also reverse the ALJ's assessment of a $1,000 attorney fee for prevailing over SAIF's responsibility denial.

However, by virtue of this order, SAFECO's responsibility denial has been overturned. Inasmuch as claimant has finally prevailed against SAFECO's responsibility denial, claimant's counsel is entitled to an attorney fee pursuant to ORS 656.308(2)(d). See Paul R. Huddleston, 48 Van Natta 4 (1996); Julie M. Baldie, 47 Van Natta 2249 (1995). 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. There is no allegation of "extraordinary circumstances" presented by claimant's counsel. We conclude, therefore, that claimant is entitled to a $1,000 attorney fee for services at hearing and on review, payable by SAFECO. See Tammy Locke, 48 Van Natta 250 (1996) ($1,000 attorney fee limitation under ORS 656.308(2)(d) is cumulative for all levels of litigation).

Finally, although not argued on Board review, the ALJ's order also addressed the compensability of claimant's condition. Under such circumstances, claimant's attorney is also entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the compensability issue which was potentially at risk by virtue of our de novo review of the ALJ's order. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 252-53 (1992), mod 119 Or App 447 (1993); Paul R. Huddleston, supra. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by 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. We note that claimant is not entitled to an attorney fee for services on review concerning his unsuccessful request regarding the penalty and attorney fee issue.

ORDER

The ALJ's order dated February 9, 1996, as amended February 14, 1996, is vacated in part, reversed in part, modified in part, and affirmed in part. Claimant's hearing request against the SAIF Corporation is dismissed as untimely. SAFECO's disclaimers of responsibility and denials of claimant's current condition and aggravation claims under its 1989 claim are set aside, and the claim is remanded to SAFECO for further processing in accordance with law. In lieu of the ALJ's $1,000 attorney fee award against SAIF, claimant's attorney is awarded $1,000, to be paid by SAFECO, for services at hearing and on review in finally prevailing over its responsibility denial. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $750, payable by SAIF.

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[1] Moreover, inasmuch as there is no evidence that claimant's condition worsened or that his diagnosis changed since SAIF's January 26, 1994 denial, under the res judicata doctrine of claim preclusion, we find that claimant's September 1994 occupational disease claim is barred by his failure to timely request a hearing from the January 1994 denial of the same claim for the same period of occupational exposure. See 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).

Chair Hall dissenting in part and concurring in part.

I join the majority in finding that SAFECO has failed to establish that claimant suffered a new occupational disease involving his right knee condition while SAIF was on the risk, such that SAFECO, under its 1989 claim, remains responsible for claimant's current right knee condition. I write separately, however, to register my continuing concern with the Board's overly narrow interpretation of the phrase "good cause" in ORS 656.319(1)(b).

As set forth in my dissenting opinions in Randall Davis, 48 Van Natta 369 (1996) (Board Chair Hall, dissenting), Juli E. Allgire, 48 Van Natta 205 (1996) (Board Chair Hall, dissenting), Joan C. Gillander, supra (Board Member Hall, dissenting), and Debra A. Gould, 47 Van Natta 1072 (1995) (Board Member Hall, dissenting), I believe that "good cause" can be established by showing actual and reasonable confusion regarding particular claims processing activities. This interpretation of "good cause" comports with appellate case law construing the terms "mistake, inadvertence, surprise or excusable neglect" and the long standing policy favoring resolution of matters on the merits. See, e.g., Wagar v. Prudential Ins. Co., 276 Or 827, 832 (1976) (statute allowing for setting aside of default judgments is to be liberally construed); King v. Mitchell, 188 Or 434 (1950) (same).

Under the circumstances in this case, I would find that claimant has established reasonable confusion about the claim processing activities of SAIF and SAFECO to sustain a finding of "good cause" for failing to timely file a hearing request on SAIF's January 26, 1994 denial. Consequently, I would affirm the ALJ's finding that claimant's request for hearing from SAIF's denial is not barred.

September 24, 1996 Cite as 48 Van Natta 1859 (1996)

In the Matter of the Compensation of
MARLENE J. ANDRE, Claimant
Own Motion No. 95-0458M
OWN MOTION ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
Larry Schucht (Saif), Defense Attorney

Claimant requests reconsideration of our February 21, 1996 Own Motion Order in which we declined to reopen her 1987 industrial injury claim for the payment of temporary disability compensation because she failed to establish that she was willing to work when her compensable condition worsened requiring surgery.

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

SAIF contends that claimant has not demonstrated that she was willing or motivated to work at the time of her current disability. Claimant has the burden of proof on this issue and, pursuant to the Dawkins criteria above, must provide persuasive evidence that she was willing to work or to seek work at the time of disability.

We noted in our prior order that exhibits which were supposed to be attached to claimant's October 4, 1995 response to SAIF's recommendation, were not received by the Board. With her request for reconsideration, claimant submitted those documents, but the aforementioned exhibits were "supplemented by additional documents and a videotape statement of Dr. Manley." SAIF responded to the admission of supplemental evidence, requesting that the Board either disallow the new evidence because it was available at the time of our prior order, or, in the alternative, allow SAIF additional 30 days for it to provide rebuttal evidence. In an April 15, 1996 Interim Own Motion Order, we allowed claimant's new evidence, and granted SAIF's request for an extension of time within which to respond to claimant's new evidence and argument. After reviewing the new evidence and supporting argument,

we continue to find that the record supports a conclusion that claimant was unwilling to work at the time of disability.[1]

Claimant underwent knee surgery on August 30, 1995. The videotape submitted by claimant was recorded on January 5, 1996. In that tape, Dr. Manley opined that it would have been futile for claimant to seek work because of her knee condition prior to surgery. As mentioned in our prior order, claimant has not worked since 1987. We were persuaded by the evidence in the record that claimant was unwilling to work at the time of disability. In reaching that conclusion, we considered the October 12, 1995 Vocational Summary of Ms. d'Autremont, the vocational counselor who had provided claimant's contemporary return-to-work job analyses, vocational services/programs and barriers to employment. Ms. d'Autremont reported that claimant refused a position because she felt it did not pay enough, refused to attend interviews, appeared unwilling to prospective employers, and presented herself as unable to perform certain jobs, even though her physicians had approved those duties. In a May 1, 1996 supplemental report, issued after reviewing Dr. Manley's January 5, 1996 tape, Ms. d'Autremont confirmed her previous summary of claimant's work history and return-to-work progress, noting that claimant's physical capacities still supported her qualification for several job analyses through June 1995.

In an April 25, 1996 transcribed interview, Dr. North opined that, when he treated claimant in May and June 1994, he "did not see any reason why [claimant] could not perform sedentary type work." Dr. Manley had treated claimant previously (beginning in January 1995), and had released claimant to return to work in May 1995. Claimant did not return to work, although Dr. Manley agreed that she qualified for several positions at that time. Thus, although Dr. Manley opined that it was futile for claimant to seek work "during the relevant time period," we are not persuaded that claimant was willing to work or to seek work at that time.[2] We have reviewed the entire record, and we are unable to conclude that claimant has carried her burden of proving that she was willing to work at the time of disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 21, 1996 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] In our prior order, we noted that we had no evidence that claimant's back, breast or psychiatric conditions were compensable. Claimant asserts that her back condition is a compensable condition. Because we have no evidence that claimant's back is not compensable, we acknowledge that claimant's compensable conditions include her back, hands and right knee. However, this conclusion does not alter our finding that claimant was unwilling to work at the time of Dr. Manley's July 1995 request for knee surgery.

[2] In our prior order, we concluded that claimant had not established that she was willing to work at the time of disability, and, therefore, it was unnecessary to determine whether it was futile for claimant to seek work at that time. Dawkins v. Pacific Motor Trucking, supra; Arthur R. Morris, 42 Van Natta 2820 (1990); Donald J. Fendrich, 44 Van Natta 773 (1992); Stephen v. Oregon Shipyards, 115 Or App 521 (1992); Katherine L. Hunt, 45 Van Natta 1166 (1993); Martin L. Moynahan, 48 Van Natta 103 (1996). Here, the "new" evidence proffered by claimant, e.g., Dr. Manley's taped interview, is unconvincing insofar as it relates to claimant's willingness to work at the time of disability. On May 23, 1995, Dr. Manley had approved claimant's physical capacities and training status, effective June 13, 1995. Three weeks later, on July 7, 1995, Dr. Manley advised that a total knee arthroplasty was scheduled for August 30, 1995. In his January 1996 statement, Dr. Manley opined that it was futile for claimant to seek work at the time of disability. In light of these conflicting opinions, we are not persuaded by Dr. Manley's opinion that claimant was willing to work during the relevant time.

In the Matter of the Compensation of
DONALD J. BOIES, Claimant
WCB Case Nos. 95-07781 & 95-04236
ORDER ON RECONSIDERATION
Emmons, Kropp, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

On July 18, 1996, we abated our June 21, 1996 order that: (1) set aside the SAIF Corporation's responsibility denial of claimant's occupational disease claim for bilateral hearing loss; and (2) upheld the self-insured employer's (Boise Cascade's) denial of an occupational disease claim for the same condition. We took this action to consider SAIF's motion for reconsideration. Having received Boise Cascade's and claimant's responses, we now proceed with our reconsideration.

In our order, we determined that, although the medical evidence established that claimant's employment at SAIF's insured (OREMET) did not cause or contribute to his hearing loss, no physician opined that claimant's Boise Cascade work was the major contributing cause of his hearing loss. Accordingly, we concluded that actual causation was not established with respect to Boise Cascade.

Citing Winfred L. Swonger, 48 Van Natta 280 (1996), SAIF first contends that it has established that claimant's employment with Boise Cascade actually caused claimant's hearing loss. SAIF asserts that, under Swonger, it is not required to produce an express opinion that claimant's Boise Cascade employment was the major contributing cause of his hearing loss, in order to prove actual causation. We disagree.

Although SAIF argues that Swonger does not require an express "major contributing cause" opinion, we found in Swonger that actual causation was proven based on a medical opinion that an employment was the "full cause" of the claimant's hearing loss. 48 Van Natta at 283. Inasmuch as our finding in Swonger of actual causation was based on a medical opinion attributing the claimant's hearing loss to a specific employment, and because a similar opinion is lacking in this case, we once again conclude that there is insufficient evidence that claimant's Boise Cascade employment actually caused his hearing loss.

SAIF next contends that, even assuming that the last injurious exposure rule (LIER) applies, we incorrectly found that claimant first sought medical treatment while it was on the risk. SAIF argues that claimant first sought treatment while employed by Boise Cascade when he underwent audiometric tests and purchased a hearing aid. We disagree.

Citing Norman L. Selthon, 45 Van Natta 2358 (1993), we found that claimant's hearing loss tests during his Boise Cascade employment did not constitute medical treatment sufficient to establish the onset of disability. We further concluded that, while the medical records indicated that claimant purchased a hearing aid while employed by Boise Cascade, there was no evidence that claimant sought medical treatment during that time.

Although SAIF attempts to distinguish Selthon by asserting that claimant's hearing loss here is much more severe than the claimant's in that case, we are nevertheless still persuaded that Selthon is controlling. Thus, we once more conclude that claimant's hearing loss tests while employed by Boise Cascade did not constitute the first medical treatment for the purposes of LIER. Moreover, while claimant may have purchased a hearing aid while working at Boise Cascade, there is no evidence in this record that claimant sought medical treatment in connection with that purchase.

Finally, SAIF argues that Dr. Ediger's March 13, 1995 examination to evaluate claimant's hearing loss (while it was on the risk) cannot constitute the first medical treatment under LIER. We disagree. See Gregory A. Wilson, 45 Van Natta 235 (1993) (date of first medical evaluation was the triggering date where the claimant missed no work and otherwise sought no medical treatment for his hearing loss).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 21, 1996 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
VOLLINA DRAPER, Claimant
WCB Case No. 94-14143
ORDER ON RECONSIDERATION (REMANDING TO THE DIRECTOR)
Willner & Associates, Claimant Attorneys
David G. Low, Attorney

The Director has requested reconsideration of our July 10, 1996 Order of Dismissal remanding this matter to Administrative Law Judge (ALJ) Otto. On August 7, 1996 we abated our order and permitted claimant and the employer an opportunity to respond to the Director's reconsideration request. Having received no response from either party within the allotted time, we proceed with our reconsideration.

In our July 10, 1996 order, we dismissed claimant's request for Board review of ALJ Otto's order affirming the Director's determination that claimant was not a subject worker of the employer at the time of her alleged injury. In taking this action, we relied on the court's recent decision in Lankford v. Copeland, 141 Or App 138 (1996). In Lankford, the court determined that review of an ALJ order affirming the Director's determination that the claimant was not a subject worker was not a matter concerning a claim within the meaning of ORS 656.704(3). Thus, the court concluded that review of the ALJ's order rested directly with the court under ORS 183.482. Reasoning that the ALJ's inclusion of an incorrect notice of appeal rights to the Board affected a substantial right of claimant, the court remanded the case to the Board for it to dismiss the request for review and remand to the Director for the issuance of a corrected order with the proper notice of appeal rights.

Here, as in Lankford, claimant requested review of an ALJ order which affirms the Director's nonsubjectivity ruling and includes an incorrect notice of appeal rights to the Board. Consistent with Lankford, our July 10, 1996 order dismissed claimant's hearing request and remanded the case to the ALJ to issue a corrected order (on behalf of the Director) with the proper notice of appeal rights to the court.

In his request for reconsideration of that ruling, the Director notes our lack of appellate authority in this matter and asserts that we are likewise without authority "to review this matter or remand (on behalf of the Director) to the Administrative Law Judge." We disagree. While the Lankford court held that we do not have jurisdiction over the merits of the Director's nonsubjectivity ruling, that decision did not divest us of the authority to direct this matter back to the proper reviewing body. To the contrary, the Lankford court recognized our authority to do so when it remanded that case through the Board with express instructions to remand the case to the director for the issuance of a corrected order. Furthermore, we acted properly in remanding this matter to the ALJ as the Director's last designee of record. See Cindy Lankford, 48 Van Natta 1870 (1996). We did so because we considered that to be the most efficient and expedient way to issue the corrected order required under the court's decision in Lankford.

Nevertheless, in light of the Director's exclusive jurisdiction over this matter, he has a legitimate interest in determining the appropriate official to issue the corrected order. For this reason, we choose to defer to the Director's apparent wish to act directly in this matter rather than through the previously designated ALJ. See Jarrett v. U.S. National Bank, 95 Or App 334 (1989) (even when a trial court, on remand, has no discretion and must do a specific act, it has the discretion to determine how to do that act within the limitations that the appellate court sets).

Accordingly, claimant's request for Board review is dismissed, and this matter is remanded to the Director for issuance of a corrected order with the proper notice of appeal rights in accordance with ORS 183.482 and Lankford. As modified herein, our July 10, 1996 order is republished in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES A. GODDEN, Claimant
WCB Case No. 95-13791
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that increased claimant's award of unscheduled permanent disability from zero, as determined by an Order on Reconsideration, to 16 percent (51.2 degrees). On review, the issue is extent of unscheduled permanent disability.

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

The ALJ found that claimant was entitled to 5 percent impairment due to a fractured pelvis that healed with displacement. See OAR 436-35-370(2). In reaching this conclusion, the ALJ relied on the finding of the attending physician, Dr. Welch, who was asked if claimant's fractures were "Displaced" or "Non-displaced." (Ex. 48). Dr. Welch wrote "Impacted" next to the word "Displaced." Although SAIF contends that Dr. Welch's response does not establish that claimant's fractures were "displaced," we conclude that Dr. Welch's report does satisfy claimant's burden of proving entitlement to an award of permanent impairment due to a fractured pelvis. Moreover, we reject SAIF's contention that, based on an interpretation of x-rays by a consulting physician, Dr. Steele, claimant's fracture healed without displacement or deformity. (Ex. 63-2).[1]

With the exception of the medical arbiter, only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). However, impairment findings from a physician other than the attending physician may be used if those findings are ratified by the attending physician. See OAR 436-35-007(8); Roseburg Forest Products v. Owen, 127 Or App 442 (1994). Inasmuch as Dr. Welch did not ratify Dr. Steele's finding, we do not consider Dr. Steele's interpretation of claimant's x-rays in rating claimant's permanent impairment.

The ALJ also awarded permanent impairment for reduced range of motion in the lumbar spine based on the findings of the medical arbiter, Dr. Martens. (Ex. 62-3). SAIF contends that the ALJ's reliance on those range of motion findings was in error because the arbiter did not state that his findings were due to the compensable injury. SAIF also notes that Dr. Welch stated that claimant had no reduced range of motion. (Ex. 46-1). Thus, SAIF contends that a preponderance of the medical evidence establishes that claimant has no ratable impairment from loss of range of motion.

To be entitled to permanent disability compensation for his lumbar 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 construe the findings as showing that the impairment is due to the compensable injury. See Kim E. Danboise, 47 Van Natta 2163, 2164 (1995). However, where the medical arbiter related the claimant's impairment to causes other than the compensable injury, the medical arbiter's opinion is not considered persuasive evidence of injury-related impairment. Julie A. Widby, 46 Van Natta 1065 (1994); see Christine M. Hasvold, 47 Van Natta 979, 980 (1995).

Here, the medical arbiter was specifically instructed to rate permanent impairment due to the accepted condition. (Ex. 60-2). Moreover, the arbiter did not attribute claimant's reduced range of motion to causes other than the compensable injury. We thus construe the findings as due to the compensable injury. Kim E. Danboise, supra.

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[1] Dr. Steele reported that x-rays showed "solid healing" of the pubic fracture. (Ex. 63-2).

Because the arbiter's examination was conducted closer in time to the reconsideration order and because his report is a thorough and well-reasoned evaluation of claimant's injury-related impairment, the ALJ properly relied on the arbiter's range of motion findings over those of Dr. Welch. See Carlos S. Cobian, 45 Van Natta 1582 (1993) (Board will rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

SAIF requested review and we have found that claimant's compensation should not be reduced. Therefore, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $510, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by 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 17, 1995 is affirmed. For services on review, claimant's attorney is awarded $510, payable by SAIF.

In the Matter of the Compensation of
FROILAN R. GONZALEZ, Claimant
WCB Case No. 96-01159
ORDER ON REVIEW (REMANDING)
Shelley K. Edling, Claimant Attorney
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the self-insured employer's denial of his injury/occupational disease claim for a left shoulder condition. Claimant has submitted supplemental "post-hearing" medical evidence and requests that we consider the additional evidence on review or remand to the ALJ for further proceedings. On review, the issues are remand and compensability. We remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the employer's denial of claimant's claim for left shoulder tendonitis. On review, claimant has submitted for our consideration "post-hearing" chart notes and a medical report from Dr. Buuck, claimant's attending physician. Claimant contends this evidence was not obtainable with due diligence at the time of the hearing and establishes that his left shoulder condition is work-related.

The employer responds that the documents submitted pertain to a condition (suprascapular nerve) other than the rotator cuff tendonitis which was denied and litigated. Thus, the employer contends that the new medical evidence claimant presents is not compelling evidence in support of a remand because it is not likely to change the outcome of the hearing pertaining to the denied tendonitis condition. The employer asserts that claimant must file a "new medical condition" claim pursuant to ORS 656.262(7)(a) for which it has 90 days to investigate and to accept or deny the suprascapular condition. We disagree with the employer's contentions and find that remand is appropriate.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. Bailey v. SAIF, 296 Or 41, 45 n 3

(1985). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Although the employer contends that claimant must file a new medical condition claim for the suprascapular condition, ORS 656.262(7)(a) applies to accepted claims only.[1] Inasmuch as there is no accepted claim in this case, ORS 656.262(7)(a) is not applicable. We now proceed with our determination of whether remand is appropriate.

As a result of "post-hearing" medical treatment, new findings have been discovered in claimant's left shoulder which indicate that claimant sustained a suprascapular nerve injury as a result of the alleged July 1995 injury. Since these findings were the result of medical treatment provided after the April 18, 1996 hearing, this medical evidence was not available at the time of the hearing. Moreover, we are persuaded that the substantive information contained in the reports was not obtainable with the exercise of due diligence prior to the hearing. In addition, Dr. Buuck, who has authored previous reports/chart notes supporting the compensability of claimant's left shoulder condition, has opined that these new findings constitute persuasive evidence that a traction injury probably occurred in July 1995 as a result of claimant's work activities. Thus, we find that these additional records are reasonably likely to affect the outcome in this case. Accordingly, we find a "compelling" reason to remand to the ALJ for further proceedings. Compton v. Weyerhaeuser Co., supra.

The employer argues that, if we allow remand, it should be allowed an opportunity to cross-examine Dr. Buuck or obtain rebuttal evidence. In response, we note that, upon remand, the ALJ may proceed in any manner that will achieve substantial justice. Therefore, we leave it to the ALJ to rule on those matters raised by the employer.

Accordingly, the ALJ's order dated May 15, 1996 is vacated. This matter is remanded to ALJ Mills for further proceedings consistent with this order. Following these proceedings, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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

"After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions. Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time." (Emphasis added).

In the Matter of the Compensation of
JEFF HARDEN, Claimant
WCB Case No. 95-13172
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order which upheld the insurer's denial of his claim for a low back injury on October 3, 1995. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the ALJ's finding that claimant did not mention his October 3, 1995 injury to Dr. Barron. Instead, we find that Dr. Barron's October 5, 1995 chart note does not contain a history of the alleged October 3, 1995 injury. (Ex. 1). However, a form 827, signed both by claimant and Dr. Barron on October 5, 1995 contains a history of an October 1995 injury, but the date of injury is listed as October 1, 1995. (Ex. 2).

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial of an October 3, 1995 low back injury claim, reasoning that claimant's account of how and when he was injured was contrary to most of the lay and medical evidence in the record. Acknowledging that claimant's testimony that he injured his low back lifting a pipe on October 3, 1995 was corroborated to some degree by a co-worker (Massey)[1], the ALJ noted that the remaining witnesses testified that claimant did not mention back pain to them between October 3, 1995 and October 5, 1995, when claimant left the job site in anger when told he would have to perform a different job. The ALJ also observed that claimant was motivated to leave work for reasons unrelated to work. Finally, the ALJ was most influenced by the absence of a reference to the alleged October 3, 1995 injury in an October 5, 1995 chart note written by Dr. Barron, from whom claimant first sought treatment. (Ex. 1).

On review, claimant contends that the ALJ overlooked the form 827, signed by both claimant and Dr. Barron on October 5, 1995, that briefly refers to an alleged October 1995 injury. (Ex. 2). Moreover, claimant asserts that the ALJ ignored the testimony of Massey that he overheard claimant tell his supervisor (Stewart) on October 5, 1995 that his back was painful. (Trs. 55, 56). Therefore, claimant argues that the ALJ misread the record in concluding (1) that the contemporary medical records did not support claimant's assertion that he was injured on October 3, 1995 and (2) that there was no evidence that claimant mentioned back pain to workers other than Massey.

Based on our de novo review of the record, we find that claimant sustained his burden of proving that he sustained a compensable injury in October 1995. We reach this conclusion for the following reasons.

First, the October 5, 1995 form 827 contains a history of a specific incident of injury in October 1995. Although it contains a date of injury (October 1, 1995) different from the date that claimant contends that he was injured, the form 827 supports an inference that Dr. Barron was aware of the October 1995 incident, but neglected to mention the specific injury in her chart note recounting details of claimant's office visit. For this reason, we agree with claimant that the contemporary medical records do not contradict claimant's contention that he was injured at work on October 3, 1995.

Second, Massey credibly testified that claimant mentioned hurting his back on October 3, 1995. Moreover, Massey also credibly testified that claimant told his supervisor on October 5, 1995 that his back was painful. Stewart also testified that he may not have paid attention to claimant when he mentioned back pain to him. (Trs. 94, 95). Thus, there is credible evidence that claimant did mention low back pain to another witness. Moreover, we find that claimant has consistently described the mechanism of injury in the medical reports. (Exs. 2, 3, 7, 8).

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[1] Massey testified that claimant mentioned an injury while they were driving home after work. (Tr. 55).

Accordingly, based on our de novo review, we conclude that claimant has established legal causation, i.e., that a lifting incident occurred on October 3, 1995.[2] Carter v. Crown Zellerbach Corp., 52 Or App 215 (1981). The insurer contends, however, that claimant did not establish medical causation. We disagree with the insurer's contention.

At the outset, we find that this claim presents a complex question of medical causation as claimant previously injured his low back in March 1995 and testified that he had continuous symptoms since that injury.[3] (Tr. 11). Therefore, claimant was required to present expert medical evidence to establish medical causation. See Barnett v. SAIF, 122 Or App 279 (1993).

Claimant submitted two supporting medical reports addressing causation from Dr. Barron and Dr. Powell, a chiropractor from whom claimant sought treatment beginning on October 15, 1995. (Exs. 13, 14). Both physicians concluded that the alleged October 3, 1995 pipe-lifting incident was the major contributing cause of claimant's low back condition.[4] The insurer contends that their opinions should be discounted because they are conclusory. We disagree.

Although expressed in the form of "check-the-box" concurrence letters, both opinions were based on a review of medical records, claimant's history, their treatment, and a description of the October 3, 1995 lifting incident. (Exs. 13, 14). Under these circumstances, we find that these reports are persuasive medical evidence. See Marta I. Gomez, 46 Van Natta 1654 (1994) (persuasiveness of expert's opinion depends on the persuasiveness of the foundation on which the opinion is based). Thus, we conclude that claimant has established medical causation. Carter v. Crown Zellerbach Corp., supra.

Accordingly, we conclude that claimant has proven that he sustained a compensable low back injury on October 3, 1995. Therefore, we reverse the ALJ's decision upholding the insurer's denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 15, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order which upheld the insurer's denial of the October 3, 1995 injury claim is reversed. The insurer's December 1, 1995 denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $3,500, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

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[2] The insurer notes that claimant had no objective findings on examination on October 5, 1995 and October 19, 1995, but that claimant reported substantial pain on October 25, 1995 when visiting a chiropractor. Citing Kathryn P. English, 47 Van Natta 1963, on recon 47 Van Natta 2189 (1995), the insurer contends that claimant's inconsistent symptomatology casts doubt on his credibility. We find English distinguishable. Unlike English, where the claimant's physicians expressed doubts concerning the reliability of the claimant's symptoms and could not affirmatively relate the claimant's condition to a work incident, here, in contrast, claimant's physicians have not questioned the reliability of claimant's complaints, and, moreover, they have related claimant's condition to a specific work incident.

[3] Claimant filed a claim in May 1995 for the March 1995 injury, but did not appeal the insurer's June 8, 1995 denial until February 20, 1996, more than 180 days after issuance of the denial. The ALJ dismissed claimant's request for hearing as untimely, a ruling that claimant does not contest on review.

[4] The insurer contends that the major contributing cause standard of ORS 656.005(7)(a)(B) applies, arguing that claimant's back complaints related to the March 1995 injury constitute a "preexisting condition." However, even assuming that the insurer is correct that claimant's pre-October 1995 back complaints represent a preexisting condition, there is no evidence of a "combined condition" for the purposes of ORS 656.005(7)(a)(B). However, we need not resolve this issue, for even if the major contributing cause standard of that statute applies, we find that the medical evidence satisfies that legal standard.

In the Matter of the Compensation of
JOHN H. HAWKS, Claimant
WCB Case Nos. 96-00871 & 95-13922
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that set aside its denial of claimant's psychological claim. SAIF asserts only that, because the ALJ found that claimant's psychological condition is a compensable consequential condition of his accepted shoulder injury claim, SAIF's denial of an occupational disease claim for a psychological condition should be upheld and the psychological condition remanded to SAIF for processing under the claim number for the accepted injury. On review, the issue is claim processing.

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

On January 18, 1996, SAIF issued the following denial:

"You filed a claim for an alleged occupational disease to your nervous system which you believe occurred on or about May 1, 1994, while you were employed at [the employer].

"Information received indicates your psychological condition is not compensably related to your employment pursuant to ORS 656.802.

"Therefore, we must deny your claim." (Ex. 41).

The ALJ set aside the denial after concluding that claimant proved that his accepted injury was the major contributing cause of his psychological condition and, thus, proved compensability under ORS 656.005(7)(a)(A). SAIF asserts that the denial was for an occupational disease and, thus, the denial should be upheld. SAIF does not challenge the ALJ's decision that claimant proved compensability of his psychological condition as a compensable consequence of his accepted shoulder injury claim.

We agree with SAIF that, because the denial is directed towards a psychological claim under ORS 656.802, it can be interpreted to deny a new occupational disease. Because the denial also refers to the compensable injury date, it can also be characterized as denying a consequential condition. This characterization is also consistent with statements at hearing. (Tr. 1).

Inasmuch as the ALJ found compensability was proven under ORS 656.005(7)(a)(A), we agree with SAIF that, for processing the psychological claim, the denial should be upheld to the extent that it encompassed a new occupational disease and we modify the ALJ's order accordingly. Furthermore, the psychological claim is remanded to SAIF for processing as part of the accepted shoulder injury claim (claim number 7801075D). To the extent, however, that the denial encompassed a consequential condition, we affirm the ALJ's order setting aside the denial.

ORDER

The ALJ's order dated April 15, 1996 is modified in part and affirmed in part. That portion of the ALJ's order setting aside SAIF's January 18, 1996 denial to the extent that it encompassed claimant's occupational disease claim for a psychological condition is modified. The psychological claim is remanded for processing under claimant's accepted shoulder injury claim (number 7801075D). The remainder of the order is affirmed.

In the Matter of the Compensation of
DIETRICH G. ILLMANN, Claimant
WCB Case No. 95-09926
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall, Christian and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that set aside its denial of claimant's occupational disease claim for a herniated disc at L4-5. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, 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, 1996 is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the insurer.

Board Member Moller dissenting.

In adopting and affirming the ALJ's order, the majority holds that claimant has established the compensability of his herniated disc as an occupational disease. That determination is based on claimant's assertion that he changed the manner in which he performed his work duties in response to a prior compensable neck and shoulder injury, as well as claimant's statements concerning the onset of his low back symptoms. Unlike the majority, I find that numerous inconsistencies in the record on review render claimant's reported history and testimony unreliable; therefore, the medical opinions based on claimant's statements are insufficient to sustain his burden of proof. Accordingly, I respectfully dissent.

Claimant relies on the opinion of Dr. Nagel to establish compensability of his low back condition. Claimant asserts that the onset of his symptoms occurred sometime in early to mid June 1995 while performing his work duties. However, Dr. Nagel did not first examine claimant until August 10, 1995. At that time, claimant informed Dr. Nagel that he had experienced the onset of low back pain "two months previously during an ocean fishing trip sponsored by the company on June 10, 1995." It was not until more than four months following the onset of claimant's symptoms, and after MRI confirmation of a herniated disc, that claimant advised Dr. Nagel of the altered manner by which he asserts he was performing his work activities. Consequently, the persuasiveness of Dr. Nagel's opinion is largely dependent on the accuracy of claimant's reported history.

The majority adopts the ALJ's conclusion that inconsistencies in the record concerning the appearance of claimant's low back symptoms are likely attributable to the gradual onset of his symptoms and/or his doctors' misinterpretation of his remarks.[1] However, claimant has not indicated a gradual onset of symptoms. Rather, claimant variously reported that his symptoms appeared during the June 10, 1995 fishing trip or, on his claim form, that the symptoms appeared July 12, 1995, while he was operating a metal lathe at work. With regard to the inconsistency between the June date and the July date, claimant explained that he has a bad memory for dates. The correct date, he testified, was June 12 rather than July 12. However, on the same claim form, claimant entered "8/15/95" as the date of

[1] The ALJ reasoned that, rather than claimant intentionally providing false histories, it was more plausible that claimant has "probably not always been clear" and that those who have recorded his prior statements "have probably sometimes misinterpreted his remarks."

diagnosis and he dated his signature as "8/16/95." If claimant's explanation is accepted, then he could not remember in mid-August that he had first experienced low back difficulties in mid-June rather than mid-July. This explanation lacks plausibility.

Further, the recorded histories of claimant's low back complaints have been detailed and precise rather than vague and speculative. For example, a physical therapist's August 15, 1995 chart note refers to the onset of symptoms during a Saturday, June 10th fishing trip. That history is consistent with Dr. Nagel's memory of the history given by claimant. It is also consistent with the history set forth in a letter sent to Dr. Nagel by claimant's counsel. That letter advised the doctor that "claimant recalls the time frame [for the onset of his symptoms] because he recalls being uncomfortable during a company fishing trip." In his deposition, Dr. Nagel testified that, on his initial examination of claimant, claimant reported experiencing burning pain in his right hip and back during a fishing trip, which was several hours long and on rough ocean.

The history of a June 10, 1995 "fishing trip" onset is in direct conflict with claimant's statement on his claim form that his symptoms began at work on July 12, 1995 while operating a metal lathe. At hearing, claimant provided yet another version of events. Claimant denied experiencing any symptoms during the company fishing trip on June 10, 1995. He testified that he was merely using the trip as a "reference date" because his low back pain began at work in the week following the trip. Considering claimant's prior statement that he became uncomfortable during the company fishing trip and the other evidence pointing to the fishing trip as the event which precipitated claimant's low back symptoms, I cannot accept claimant's testimony that he was asymptomatic during that trip and that his symptoms began at work the week of June 12, 1995.

In sum, I find this to be the type of complex medical case in which material inconsistencies in the record raise such doubt concerning claimant's reliability that I cannot find claimant's medical evidence to be persuasive. Accordingly, unlike the majority, I would reinstate the insurer's denial.

September 24, 1996 Cite as 48 Van Natta 1870 (1996)

In the Matter of the Compensation of
CINDY LANKFORD, Claimant
WCB Case No. 92-06391
ORDER ON REMAND (REMANDING TO DIRECTOR)
David R. Nepom, Claimant Attorney
Allen, Stortz, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Lankford v. Copeland, 141 Or App 138 (1996). The court has reversed our prior order, Cindy Lankford, 46 Van Natta 149 (1994), that had affirmed an Administrative Law Judge's (ALJ's) order which had affirmed a Director's determination finding that claimant was not a subject worker. Concluding that we lacked jurisdiction to review the ALJ's decision, the court has held that review of the ALJ's order is pursuant to ORS 183.482. Furthermore, because the ALJ's order incorrectly advised the parties that any request for review should be filed with the Board, the court has remanded the case to us with instructions to dismiss claimant's request for review and to remand to the Director for the issuance of a corrected order.

In accordance with the court's instructions, claimant's request for Board review is dismissed. In addition, this matter is remanded to the Director for issuance of a corrected order consistent with the court's decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN A. LAWHORN, Claimant
WCB Case No. 96-00771
ORDER OF DISMISSAL
McGill & Kapranos, Claimant Attorneys
Robert J. Yanity (Saif), Defense Attorney

Claimant has requested review of Administrative Law Judge (ALJ) Galton's April 19, 1996 order. We have reviewed this request on our own motion to determine if we have jurisdiction to consider this matter. Because the record does not establish that all parties received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On April 19, 1996, ALJ Galton issued an Opinion and Order which upheld the SAIF Corporation's denial of claimant's right neck and shoulder conditions. The order indicated that copies of the order had been mailed to all of the parties at their addresses, as well as to their attorneys. The order also contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On September 3, 1996, the Board received claimant's attorney's request for review. The letter, which was mailed by certified mail on August 30, 1996, stated that claimant's attorney's copy of ALJ Galton's April 19, 1996 order was mailed to him on August 5, 1996, as indicated by an envelope which contained the ALJ's order.

On September 9, 1996, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. See ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

The failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992). "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(21). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986).

Here, the 30th day after the ALJ's April 19, 1996 order was May 19, 1996, a Sunday. Therefore, the last day on which to perfect a timely appeal of the ALJ's order was Monday, May 20, 1996. Anita L. Clifton, 43 Van Natta 1921 (1991). Inasmuch as claimant's request for review was mailed by certified mail on August 30, 1996, it was "filed" on that date. Because August 30, 1996 is more than 30 days after April 19, 1996, we conclude the request was untimely filed.

Further, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, based on claimant's attorney's certified request, which was mailed to all parties on August 30, 1996, such notice is untimely.

Claimant's counsel recognizes that the request has been filed more than 30 days after the ALJ's April 19, 1996 order. However, asserting that he did not receive a copy of the ALJ's order until August 5, 1996, claimant's attorney contends that the appeal is timely. Based on the following reasoning, we disagree.

In support of his contention that the ALJ's order was not mailed to him until August 5, 1996, claimant's counsel submits a copy of the envelope in which the ALJ's order was mailed to claimant's attorney. Yet, attorneys are not "parties" to the proceeding. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266 n. 1 (1988); Frank F. Pucher, Jr., 41 Van Natta 794, 795 (1989). Moreover, a party's failure to receive a copy of the ALJ's order is not determinative. Rather, the pivotal issue is whether the ALJ's order was mailed timely to the parties to the proceeding. ORS 656.289(3); Michael D. Hogan, Jr., 47 Van Natta 1519 (1995).

Therefore, in order to avoid the dismissal of his appeal as untimely, claimant must establish that the ALJ's order was not mailed to him. See Lee R. Jones, 48 Van Natta 1287 (1996). The record does not support such a conclusion.

The ALJ's order represents that a copy of the order was mailed to claimant on April 19, 1996 at his listed address. Furthermore, no copy of the order was returned to the Board as undeliverable. Under such circumstances, the record preponderates that copies of the ALJ's order were mailed to claimant and the other parties (as well as their respective legal representatives) on April 19, 1996. Therefore, since claimant's request for Board review of the ALJ's April 19, 1996 order was not filed with the Board within 30 days of the order and notice of the appeal was not provided to the other parties within 30 days of the order, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Michael D. Hogan, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROCKY MALONE, Claimant
WCB Case No. 95-07799
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McKean's order that found that claimant was not a subject worker. On review, the issue is subjectivity and, potentially, compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not a subject worker when he was injured while performing concrete finishing work on a construction project. Claimant challenges this conclusion, arguing that he qualified as a subject worker under the "right to control" test.

The ALJ appropriately addressed the threshold issue of subjectivity. We conclude, however, that regardless of whether or not claimant is a subject worker, his claim fails because he did not prove a compensable injury. First, although claimant worked for the employer on November 11, 1993, he did not seek any treatment until August 1994 and he did not file a claim until April 3, 1995. Under such circumstances, we consider the claim to be medically complex and, therefore, must be supported by expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993).

The sole medical opinion concerning causation is a "check-the-box" report addressed to Dr. Brown indicating agreement that "the event of November, 1993 * * * was a 'injury' to [claimant], and was the major contributing cause of [claimant's] subsequent need for treatment." (Ex. 10). A handwritten notation provides:

> "I took over for Dr. Brown & have seen [claimant] on two occasions for his back. My diagnosis is chronic lumbar strain which most certainly could have been a result of the above stated injury. I was not his Dr. at time of injury. Dr. Brown has retired." (Id.)

As noted by the ALJ, the signature on the report is not decipherable.

A medical opinion that establishes only a possible causal relationship is not sufficient to carry claimant's burden of proof. Miller v. SAIF, 60 Or App 557, 561-62 (1982). Here, because Dr. Brown reports that the November 1993 event "could have" caused claimant's low back condition, we find that it does not prove compensability to the degree of reasonable medical probability. See Lenox v. SAIF, 54 Or App 551, 554 (1981). Inasmuch as we uphold the insurer's denial on this basis, we need not decide the issue of subjectivity.

ORDER

The ALJ's order dated April 3, 1996 is affirmed.

September 24, 1996 Cite as 48 Van Natta 1873 (1996)

In the Matter of the Compensation of
JACQUELYNE M. SCHULTE, Claimant
WCB Case No. 95-05380
ORDER ON RECONSIDERATION
W. Daniel Bates, Jr., Claimant Attorney
VavRosky, et al, Defense Attorneys

Claimant requests reconsideration of our August 8, 1996 Order on Review in which we set aside the employer's denial as a nullity because claimant had withdrawn her claim prior to its issuance. Seeking an attorney fee award under ORS 656.386(1), claimant requests that we reconsider our order which declined to address the issue of claimant's entitlement to an attorney fee. On September 6, 1996, we abated and withdrew our order to further review this matter. Having completed our review, we conclude as follows.

As we noted in our order, claimant did not request a penalty or attorney fee, only that we set aside the employer's denial as premature. Thus, we are not inclined to address claimant's request for an attorney fee. Moreover, even if we were to address the issue, we would deny claimant's request. See William C. Becker, 47 Van Natta 1993, 1934 (1995) (Member Hall dissenting).

In Becker, we held that a claimant must "prevail" under ORS 656.386(1) in order to be entitled to an attorney fee. Because the claimant in Becker had withdrawn his claim, we reasoned that he would receive no benefits as a result of our decision that the carrier's denial of a "withdrawn" claim was a nullity. We, therefore, held that the claimant had not "prevailed" and was not entitled to an attorney fee under ORS 656.386(1).

In this case, we have also determined that claimant withdrew her claim prior to the employer's denial. Thus, like the claimant in Becker, claimant here will also receive no benefits as a result of our determination that the employer's denial is a nullity. Thus, we conclude that claimant has not "prevailed" over a denied claim and is, therefore, not entitled to an attorney fee under ORS 656.386(1). William C. Becker, supra.[1]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 8, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant urges us to disavow Becker, as well as the case we cited therein, Patricia E. McGrath, 45 Van Natta 1256 (1993). Claimant argues that she need only succeed in setting aside and invalidating a denial in order to "prevail" under ORS 656.386(1). Upon further consideration of claimant's contentions, we continue to adhere to our reasoning in Becker and McGrath.

In the Matter of the Compensation of
KENNETH D. CHALK, Claimant
WCB Case No. C602350
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Hollander, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

On August 22, 1996, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On September 3, 1996, we wrote to the parties regarding a provision in the CDA which indicated that all calculations in the CDA were based on the "assumption and agreement" that claimant is permanently totally disabled. The CDA also stated that claimant had requested a hearing on an Order on Reconsideration which did not award him permanent total disability. The hearing had been postponed and had not been re-set. Noting that it appeared the parties might be using the CDA to dispose of a dispute over claimant's entitlement to permanent and total disability, we requested that the parties submit an addendum.

Notwithstanding our previous request for clarification of the parties' intentions, after considering this matter further, we conclude that an addendum to the CDA is unnecessary. Rather than resolving a dispute over claimant's entitlement to permanent total disability benefits, we find that the language in the CDA pertaining to permanent total disability was merely an explanation of how the parties calculated the amount of consideration to be paid to claimant under the CDA.[1] Under such circumstances, the language regarding permanent total disability requires no further clarification.

Therefore, we conclude that the parties' agreement is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1)(a); OAR 438-009-0020(1). Accordingly, the parties' claim disposition agreement is approved.

IT IS SO ORDERED.

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[1] Had the CDA been interpreted as granting permanent total disability, we would have declined to approve the disposition. It is well settled that CDAs are not designed for purposes of claim processing. See Kenneth R. Free, 47 Van Natta 1537 (1995). Under such circumstances, we would have recommended that the parties submit a stipulation to the Hearings Division awarding claimant permanent total disability benefits. Thereafter, they could submit a CDA releasing claimant's future rights to benefits, including permanent total disability benefits.

In the Matter of the Compensation of
ROBERT S. RICHEY, Claimant
Own Motion No. 96-0369M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Gatti, et al, Claimant Attorneys
Sally Anne Curey, Defense Attorney

The insurer requests reconsideration of our September 17, 1996 Own Motion Order on Reconsideration, which authorized an approved fee for claimant's attorney's services culminating in our August 28, 1996 Own Motion Order reopening his claim. The insurer contends that, because claimant's attorney received an assessed fee as a result of a February 28, 1996 Stipulated Settlement in this claim, "any fee at [the Own Motion] level would be unreasonable because [claimant's attorney] has already received a fee for services rendered on this issue."

The insurer initially submitted claimant's request for temporary disability compensation for his right knee injury. Claimant's aggravation rights on that claim expired on May 3, 1993. The insurer recommended that the Board authorize the reopening of claimant's 1988 injury claim for the payment of temporary disability compensation. On February 28, 1996, Administrative Law Judge (ALJ) Michael Johnson approved the parties' "Stipulated Settlement," which was designed to resolve "all issues raised or raisable" at the time the stipulation was approved. Pursuant to that settlement, the insurer agreed "to accept responsibility for claimant's current re-tear of the right medial meniscus and will reopen and process [the claim] according to law." In an August 28, 1996 Own Motion Order, the Board authorized the reopening of claimant's 1988 claim for the payment of temporary disability compensation, beginning the date claimant underwent surgery. On September 11, 1996, claimant submitted a signed retainer agreement, and requested reconsideration of our order "so that it may be modified to include an award of attorney fees." On September 17, 1996, we issued our order approving an attorney fee in the "amount of 25 percent of the increased temporary compensation," not to exceed $1,050, awarded by our prior order.

Here, claimant's attorney was awarded an assessed fee, payable by the insurer, for his services during litigation under ORS 656.308(2)(d), which resulted in the stipulated settlement. That fee was awarded to claimant's attorney, in addition to any other compensation awarded to claimant, for his attorney's efforts in obtaining medical services in a denied (responsibility) claim. Therefore, claimant's attorney's insurer-paid fee was awarded for claimant's rights to services rendered in prevailing over the insurer's responsibility denial and for securing medical services.

On the other hand, our September 17, 1996 order authorized an out-of-compensation fee for claimant's attorney's services in securing temporary disability compensation for claimant under ORS 656.278. Claimant's attorney's 25 percent out-of-compensation fee is payable from claimant's temporary disability award, rather than in addition to the award, and is not to exceed $1,050. OAR 438-015-0010(4); 438-015-0080.

The issues in this case were resolved in different forums and under different statutory and administrative authority. Although similar, the issues resolved pursuant to the stipulation were issues over which the Board, in its own motion authority, has no jurisdiction. Furthermore, the Hearings Division does not have authority to award temporary disability compensation in an own motion claim. ORS 656.278.

Therefore, the insurer's argument that "[c]laimant is not entitled to two fees for the same service," is incorrect. The insurer apparently contends that, because claimant's claim was in own motion status at the time of the February 28, 1996 stipulated settlement, that the agreement pertained to claimant's entitlement to medical services and temporary disability compensation relative to reopening this claim. However, as discussed above, such is not the case, nor would it have been within the authority of the ALJ to approve such an agreement.

In conclusion, although not subject to our review pursuant to ORS 656.278, the parties' stipulation properly awarded claimant's attorney an assessed fee under ORS 656.308(2)(d). Likewise, regardless of whether claimant's claim was in own motion status at the time of the settlement agreement, we continue to hold that claimant's counsel was entitled to an approved or out-of-compensation fee under ORS 656.278 for services rendered in securing the reopening of his claim for the payment of temporary disability compensation.

On reconsideration, we adhere to and republish our September 17, 1996 order in its entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KIM S. ANDERSON, Claimant
WCB Case No. 96-01034
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that awarded claimant 5 percent (9.6 degrees) scheduled permanent disability for a left arm condition, whereas an Order on Reconsideration awarded no scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, although claimant's accepted condition was a left shoulder condition, which had resulted in an award of 24 percent unscheduled permanent disability, claimant was nevertheless entitled to an additional scheduled permanent disability award for a chronic condition limiting the repetitive use of her left arm. In reaching his conclusion, the ALJ relied on our decision in Alvena M. Peterson, 47 Van Natta 1331 (1995). For the following reasons, we find that Peterson is distinguishable.

In Peterson, we found that the claimant was entitled to a scheduled chronic condition award for her arm, in addition to an unscheduled award for a shoulder condition. Relying on Foster v. SAIF, 259 Or 86 (1971), we found that, if an injury to an unscheduled portion of the body results in disability to both unscheduled and scheduled portions, a claimant is entitled to separate disability awards. Accordingly, in Peterson, we found that, because the medical arbiter had found a chronic condition ("limitations related to chronic and repetitive use of [the] right arm"), the claimant was entitled to a separate scheduled permanent disability award for her chronic arm condition.

Here, however, although claimant specifically requested that an arbiter exam was being sought in order to determine whether claimant had a "right arm chronic use award," (Ex. 90-2), the arbiter did not find that claimant had such a condition. Rather, the arbiter found that claimant had a "limited or partial loss of ability to repetitively use the shoulder * * *." (Ex. 92-4).

The determination of a chronic condition requires a medical opinion of the medical arbiter or claimant's attending physician, from which it can be found that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition. ORS 656.245(2)(b)(B); 656.268(7); Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995). There must be medical evidence of at least a partial loss of ability to repetitively use the body part. See Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993). Claimant has the burden of proving a chronic condition impairment. ORS 656.266.

Although the ALJ concluded that limited use of claimant's arm would necessarily flow from limitations in the use of her shoulder (and, thus, claimant was entitled to an award for a chronic arm condition), we are unable to construe the arbiter's report in that manner. Here, the arbiter's opinion

specified only that claimant was unable to repetitively use her shoulder.[1] Because the statute and the rules require a medical opinion which establishes evidence regarding the body part, we are unable to substitute our own judgment or opinion to find that the chronic condition in this case is actually for claimant's arm, when the arbiter specified that the chronic condition impairment was found in the shoulder.

Accordingly, we reverse the ALJ's chronic condition award for the left arm.

ORDER

The ALJ's order dated May 28, 1996 is reversed. The Order on Reconsideration dated December 26, 1995 is affirmed. The ALJ's approved attorney fee award is also reversed.

[1] Because claimant had already established a total unscheduled impairment award in the shoulder in excess of 5 percent, no chronic condition award was made for the shoulder at the time of reconsideration. See OAR 436-35-320(5); Gregory D. Schultz, 47 Van Natta 2265, corrected 47 Van Natta 2297 (1995).

September 26, 1996 Cite as 48 Van Natta 1877 (1996)

In the Matter of the Compensation of
ORBEN BALDWIN, Claimant
Own Motion No. 95-0220M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Stebbins & Coffey, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's July 16, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from February 9, 1995 through June 10, 1996. SAIF declared claimant medically stationary as of June 10, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

FINDINGS OF FACT

Claimant sustained a compensable left foot injury on June 5, 1984. Claimant's aggravation rights in this claim expired on April 24, 1990.

On April 22, 1994, Dr. Gurney, claimant's family physician, referred claimant to Dr. Maurer for his foot condition, and to Dr. Louie for his hips and back, also compensable injuries. In September 1994, SAIF notified claimant that Dr. Maurer was not a member of the managed care organization (MCO), and could no longer be approved as his treating physician. Thereafter, Dr. Gurney referred claimant to Dr. Kendall for his foot treatment. Dr. Kendall referred claimant to Dr. Sampson, who eventually performed claimant's foot surgery on February 9, 1995.

On April 26, 1995, SAIF submitted to the Board claimant's request to reopen his claim. On August 23, 1995, the Board authorized the reopening of claimant's claim for the payment of temporary disability compensation, beginning the date he was hospitalized for that surgery.

Claimant began treating with Dr. Kitchel for lower back problems sometime in 1996. Claimant began treating with Dr. Wuest in April 1996. Dr. Wuest proposed foot surgery to relieve claimant's pain. SAIF approved the surgery, but subsequently referred claimant for an independent medical examination performed by Dr. Holmes. Dr. Holmes referred claimant to Progressive Rehabilitation Associates (PRA) for pain counseling. Claimant entered the pain program on May 20, 1996.

In a June 10, 1996 "Pain Center Discharge Summary and Physical Capacities Evaluation," Ms. Dodge, occupational therapist for PRA, reported that claimant was released to full time, light work as of that date. Dr. Jensen, the on-staff physician at PRA, reported that claimant "refused to complete the [pain] program." Both Dr. Jensen and Dr. Smith, clinical psychologist, recommended that "based on these behaviors, inconsistencies and psychological assessment, [claimant] is not expected to have a positive outcome from elective surgery."

PRA forwarded its evaluation to three of the physicians who had previously treated claimant, asking whether they concurred with the closing examination report. On June 21, 1996, Dr. Maurer reported that he had no comment because he had not seen claimant in two years. Also on June 21, 1996, Dr. Kitchel, claimant's low back specialist, opined that he agreed with the closing examination report, but he noted that claimant was to follow up with Dr. Maurer for his foot. On June 21, 1996, Dr. Gurney opined that he agreed with the report. In a June 21, 1996 chart note, Dr. Wuest, claimant's then-treating physician, opined that he "would essentially concur with the report of PRA," but that claimant "may benefit from decompression of the peroneal tendons, possible calcaneal osteotomy versus a talonavicular and/or calcaneal cuboid arthrodesis." However, Dr. Wuest noted that he would "defer any surgical treatment to Dr. Maurer."

On July 16, 1996, SAIF closed the claim, declaring claimant medically stationary on June 10, 1996.

CONCLUSIONS OF LAW AND OPINION

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 16, 1996 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980). We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987)

On July 3, 1996, Dr. Maurer examined claimant's left ankle. Dr. Maurer reported that:

> "Since [claimant] was here last, he had surgery by Dr. Sampson which involved a debridement of the lateral aspect of the left foot. There were problems with wound healing which took three months to correct. [Claimant] has been under the care of Dr. Wuest in Eugene who had elected to proceed with a calcaneal osteotomy along with a calcaneal cuboid arthrodesis and probable fibular peroneal decompression. That was approved by SAIF Corporation only to have SAIF send [claimant] to Dr. Holmes for an independent medical examination. Dr. Holmes suggested that [claimant] seek counseling through a pain clinic. Interestingly, Dr. Holmes has some interest in that pain clinic. By virtue of [claimant's] less than cooperative behavior at the pain clinic, it was felt that he would be an unsuitable candidate for any further surgery. Dr. Wuest then withdrew his offer and [claimant] is here seeking additional help."

Dr. Maurer placed claimant in a short leg walking cast, and documented that he wished to confer with Dr. Wuest, and perhaps Dr. Sampson, for an update on claimant's foot and ankle problems. There are no reports in the record from Dr. Sampson subsequent to claimant's February 1995 surgery, nor did PRA request Dr. Sampson's opinion regarding its closing report.

In a July 30, 1996 chart note, Dr. Maurer opined that, because claimant experienced relief after wearing the short leg cast, "it is apparent that at least a good portion of [claimant's] foot and ankle pain is coming indeed from his ankle joint." Dr. Maurer noted that SAIF had "disallowed any further changes in attending physician," but that "[t]his will obviously have to be appealed as I was [claimant's] initial treating physician." Dr. Maurer further reported that he had contacted Dr. Wuest, and that Dr. Wuest "clearly admits that he had recommended a decompression of the talofibular joint along with a calcaneal cuboid fusion, but has now thought better of that in light of the report from Progressive Rehab

Pain Center which raises questions about [claimant's] ability to cooperate with a postop rehabilitation program and/or [claimant's] likelihood of success from any surgical procedure." Dr. Maurer opined that claimant had a complex chronic pain problem, but that claimant "is reasonable and cooperative in his approach to pain." Because the July 30, 1996 examination was a follow-up to Dr. Maurer's July 3, 1996 examination, we conclude that Dr. Maurer was addressing claimant's condition at the time of claim closure. Scheuning v. J.R. Simplot & Co., supra.

In a September 5, 1996 letter, Dr. Maurer opined that claimant was not medically stationary. Dr. Maurer further opined that, based on physical findings and response to treatment demonstrated to him by claimant during the summer, "I feel there are still potential therapies that would improve his condition." Because Dr. Maurer examined claimant two weeks prior to claim closure, we are persuaded that Dr. Maurer's opinion relates directly to claimant's condition at the time of closure. Scheuning v. J.R. Simplot & Co., supra.

We rely on the opinion of Dr. Maurer in this case because his treatment of claimant resumed prior to claim closure. Further, Dr. Wuest, who had become claimant's attending physician in April 1996, had recommended further treatment for claimant's foot and ankle condition, but withdrew that recommendation based on the opinions of the physical therapist, psychologist and physician at PRA who only had contact with claimant during his time at the clinic. Finally, of the numerous physicians who have treated claimant, Dr. Maurer is most familiar with the etiology of claimant's compensable conditions. Claimant was precluded from returning to Dr. Maurer's care by the managed care organization. We have previously relied on the opinions of non-MCO physicians when the record indicates that the physicians' opinions are well-reasoned and based on medical evidence. See e.g., Marsha Brown, 47 Van Natta 1465 (1995) (non-MCO treating physician's opinion persuasive and supported by medical evidence); Richard Uhing, 48 Van Natta 465 (1996) (non-MCO physician's opinion based on complete information while MCO physician's opinion lacked reasoning and supporting medical evidence). In our review of the record, we considered all opinions rendered by all physicians. Here, because other MCO physicians have deferred treatment of claimant's foot to Dr. Maurer, we find that we have no reason not to rely on his opinion. Weiland v. SAIF, supra; Somers v. SAIF; supra; Marsha Brown, supra; Richard Uhing, supra.

The record also indicates that, although Dr. Kitchel indicated that he agreed with PRA's closing examination report in a "check-the-box" inquiry, Dr. Kitchel was treating claimant's back condition, and noted that claimant was to follow up with Dr. Maurer. There is nothing in the record to suggest that Dr. Gurney examined claimant after his referral to Dr. Wuest. Examining claimant on June 21, 1996, Dr. Wuest opined that claimant may benefit from further treatment, but deferred any opinion regarding surgical treatment of claimant's foot to Dr. Maurer. Dr. Maurer noted that Dr. Wuest had clearly recommended surgery, but "withdrew his offer" when he received PRA's report of claimant's non-cooperation. Therefore, Dr. Wuest's recommendation, even though withdrawn for other reasons, supports Dr. Maurer's opinion that claimant's foot and ankle require further treatment.

Here, the record persuades us that claimant's left foot condition required further treatment when SAIF closed the claim. Contrary to PRA's opinions regarding claimant's cooperative efforts, claimant's non-MCO treating physician opined otherwise. Finally, the treatments recommended by Dr. Wuest and Dr. Maurer are similar, and both physicians opine that claimant's compensable condition would improve with further treatment.

Accordingly, we set aside SAIF's July 16, 1996 Notice of Closure as premature and order the reinstatement of claimant's temporary disability effective the date SAIF previously terminated the payment of such benefits. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANETTE D. BATEY, Claimant
WCB Case No. 95-12921
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Christian and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that declined to award an assessed attorney fee. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In May 1995, SAIF first accepted a nondisabling claim for right wrist overuse syndrome. In August 1995, claimant informed SAIF that the claim was disabling, then filed an aggravation claim. In November 1995, SAIF denied the aggravation claim. In February 1996, SAIF advised claimant that, in response to the August 1995 request to reclassify the claim, it should have reclassified the claim or referred the matter to the Director. SAIF then indicated it would "remedy the problem" by reclassifying the claim to disabling and "withdraw" its November 1995 denial as a "procedural nullity."

The ALJ found that claimant was entitled to a penalty under ORS 656.262(11)(a) for SAIF's termination of authorized temporary disability benefits. The ALJ declined to award a penalty, however, for SAIF's failure to timely process the August 1995 reclassification request, finding that "no amounts" were due to claimant upon which to base a penalty. On review, claimant first asserts that she also is entitled to an attorney fee under ORS 656.382(1) for SAIF's untimely claim reclassification.

Misconduct that is subject to a penalty under ORS 656.262(11)(a)[1] cannot also be the basis for an attorney fee under ORS 656.382(1).[2] Oliver v. Norstar, Inc., 116 Or App 333, 336 (1992). An attorney fee, however, may be awarded when the employer's conduct would not subject it to a penalty but is appropriate for the assessment of an attorney fee award. Id.

Here, the ALJ imposed a penalty because SAIF, after receiving the attending physician's authorization of time loss for a period through December 4, 1995, terminated temporary disability as of November 22, 1995, when it issued its aggravation denial. SAIF asserts that its failure to timely reclassify the claim is encompassed by the misconduct for which the ALJ imposed a penalty because "it was SAIF's failure to process the reclassification request properly that resulted in the nonpayment of time loss after November 22, 1995." Thus, according to SAIF, it committed only one processing violation (failure to correctly process the request for reclassification) and, because claimant received a penalty from the ALJ for "the unpaid compensation that resulted from that failure," she cannot also be awarded an assessed attorney fee under ORS 656.382(1).

As noted above, SAIF concedes that it engaged in misconduct by failing to correctly process the reclassification request. On review, SAIF has not objected to the ALJ's imposition of a penalty for its termination of temporary disability notwithstanding the authorization of such benefits. The first misconduct violates ORS 656.277 while the second violates ORS 656.262. Thus, because the two activities violate separate processing requirements, we conclude that claimant is entitled to an assessed attorney fee under ORS 656.382(1) for SAIF's failure to properly process the reclassification request.

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[1] ORS 656.262(11)(a) provides, in relevant part: "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of amounts then due."

[2] ORS 656.382(1) provides, in relevant part: "If an insurer or self-insured employer * * * unreasonably resists the payment of compensation, * * * the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee[.]"

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for SAIF's failure to properly process the reclassification request is $1,000, payable by SAIF. 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.

Claimant next contends that she should be awarded an attorney fee under ORS 656.386(1) for SAIF's rescission of the aggravation denial. SAIF concedes that, under Vickie M. Emerson, 48 Van Natta 821 (1996), claimant is entitled to such a fee but argues that we should reconsider and overrule Emerson.

The relevant portion of ORS 656.386(1) provides:

> "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."

In Emerson, the carrier accepted a disabling claim, then denied a reopening of the claim on the basis that claimant's condition had not worsened. After the claimant requested a hearing from the denial and also requested that the carrier reclassify the claim to disabling, the carrier withdrew its aggravation denial as "null and void." We found that the claimant was entitled to an attorney fee under ORS 656.386(1) because she had obtained a rescission of the aggravation denial. In particular, we reasoned that there was a "denied claim" under the statute because the carrier expressly denied that the claimant was entitled to any compensation. 48 Van Natta at 822. Furthermore, we found that the claimant, through the hearing request, had obtained a "rescission" of the denial prior the hearing. Id.

We continue to adhere to the reasoning and conclusion in Emerson and we decline SAIF's request to now overturn its holding. Thus, pursuant to Emerson, we conclude that there was a "denied claim" when SAIF issued its aggravation denial and that SAIF rescinded the denial before hearing when SAIF "withdrew" the denial. Consequently, claimant is entitled to an assessed attorney fee under ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at the hearing level in obtaining a rescission of the aggravation denial is $1,000, payable by SAIF. 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 nature of the processing, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated February 26, 1996 is reversed in part and affirmed in part. Those portions of the order that declined to award assessed attorney fees under ORS 656.382(1) and 656.386(1) are reversed. Claimant is awarded a reasonable attorney fee of $1,000 for SAIF's failure to properly process the reclassification request and $1,000 for obtaining a rescission of the aggravation denial, both fees payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
ALLEN COMAN, Claimant
WCB Case No. 95-12947
ORDER ON REVIEW
Richard M. Walsh, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian, and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) ruled not to compel discovery of certain medical records; and (2) upheld the SAIF Corporation's denial of claimant's tuberculosis claim. On review, the issues are evidence and compensability.

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

Claimant is a correctional officer at Oregon State Correctional Institute (OSCI). In September 1995, claimant tested positive for tuberculosis (TB). TB is contagious only when the disease is "active."

At hearing, claimant's attorney stated that he had asked the employer to provide information concerning any active TB cases at the prison and that the employer responded that there were no active cases. (Tr. 33). Claimant's attorney moved to compel discovery of medical records for those inmates who had tested positive for TB in order to allow claimant to investigate whether the employer was correct in stating that it had no inmates with active TB. The ALJ refused the motion, citing to the confidentiality of such documents. The ALJ also indicated, however, that she would reconsider her ruling if claimant could show that the prison had active cases of TB, thus establishing that such documents were relevant to claimant's case.

We review the ALJ's evidentiary ruling for abuse of discretion. James D. Brusseau II, 43 Van Natta 541 (1991). At hearing, there was testimony from Jerry Smith, the health service manager at OSCI and a registered nurse. Mr. Smith stated that one inmate had been transferred from the prison because that person was suspected of having active TB. (Tr. 43). Mr. Smith further testified, however, that no active cases of TB had been identified at OSCI between September 1994 and September 1995. (Id. at 55). Mr. Smith later testified that the transferred inmate returned to OSCI within 5 days, indicating that he did not have an active case since inmates having active TB were not kept at OSCI. (Id. 109).

Georgia Timm, who worked as a nurse at OSCI, also testified that the inmate who had been transferred had tested positive with TB, but had not been diagnosed with an active case. (Id. at 73, 81-82).

Both Mr. Smith and Ms. Timm had access to the inmates' medical records and had medical training as registered nurses. Because both testified that no active TB case had been confirmed at OSCI, we find the ALJ justified in not granting claimant's motion to compel evidence. In other words, because the testimony shows that the medical records would not prove that claimant was exposed to a prisoner with active TB and in view of the confidentiality of such records,[1] we find no abuse of discretion by the ALJ in not granting claimant's motion to compel discovery of the documents.[2]

ORDER

The ALJ's order dated March 5, 1996 is affirmed.

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[1] ORS 192.525 provides for the state's policy of confidentiality for medical records.

[2] In reaching this conclusion, we are not saying that it would have been improper for the ALJ to have examined the inmates' medical records by means of an in camera proceeding as the dissent asserts should have been done. Rather, we are merely holding that, under these particular circumstances, it was not an abuse of discretion for the ALJ to deny claimant's discovery motion.

Board Chair Hall dissenting.

I disagree with the majority that the ALJ did not abuse her discretion in failing to compel discovery of the medical records. I also disagree with the majority that claimant did not prove compensability. Consequently, I dissent.

First, in deciding that the ALJ did not abuse her discretion in refusing to compel the employer to provide discovery of the medical records of those inmates who tested positive for TB, the majority ignores claimant's argument that discovery would not necessarily destroy confidentiality. For instance, the ALJ could have first viewed the records in camera and/or inmate names could have been omitted from the documents. In other words, the ALJ could have worked with prison officials to fashion a means of obtaining the vital information without violating inmate confidentiality.

Furthermore, the records were relevant and important to claimant's case. Claimant had no other available evidence to prove that there was an active case of TB at the prison. The ALJ is to conduct the hearing in a manner that will achieve substantial justice. ORS 656.283(7). In view of the available methods to protect confidentiality and the relevance of the medical records, I believe that substantial justice required the discovery of the medical evidence.

I would also find that claimant carried his burden of proving compensability. The ALJ concluded that, because claimant provided no evidence that he was exposed to an "active" case of TB, he failed to prove that work conditions caused his condition. Claimant's treating physician, Dr. Bloespflug, provided an opinion that claimant contracted his infection from "job exposure." (Ex. 4-2). Dr. Bloespflug explained that his opinion was supported by the increased prevalence of TB in the prison system in comparison to the population as a whole. (Id.) Furthermore, Dr. Bloespflug found it "highly likely" that there was at least one active TB carrier at the prison since at least two persons within the year had tested positive to TB. (Id.)

I find that the physician's opinion provides persuasive reasoning supporting his conclusion that claimant was infected by an active TB carrier at the prison. Dr. Bloespflug does not merely state that work conditions provided the highest risk for contracting the infection. Rather, based on an accurate understanding of test results at the prison and reasonable medical certainty, Dr. Bloespflug explains why he determined that there was an active TB carrier who infected claimant at his work.

For these reasons, I would reverse the ALJ's order and find the claim compensable.

September 24, 1996 Cite as 48 Van Natta 1883 (1996)

In the Matter of the Compensation of
TREVOR E. SHAW, Claimant
WCB Case No. 95-01654
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Claimant has requested reconsideration of that portion of our July 30, 1996 order, as reconsidered on August 27, 1996, in which we held that the insurer was not obligated to pay additional temporary disability compensation pursuant to a final Board order.

In order to allow sufficient time to consider the motion, we withdraw our prior orders. The insurer is granted an opportunity to respond. To be considered, the insurer's response should be submitted within 14 days of the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
TOMMY J. LIVELY, Claimant
WCB Case Nos. 95-06564 & 95-06563
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Bottini, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Galton's order that: (1) upheld Alexis Risk Management's denial of his aggravation claim for a cervical disc condition; (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition; and (3) declined to award interim compensation. On review, the issues are compensability, responsibility and interim compensation.

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

Claimant, age 53 at the time of hearing, compensably injured his neck on February 13, 1991. He was treated by Dr. Rosenbaum, who diagnosed a soft disc extrusion, C6-7, left with radiculopathy as a result of the industrial injury and preexisting degenerative changes at C4-5 and C5-6. On March 18, 1991, Dr. Rosenbaum performed a microposterior cervical foraminotomy at C5-6 and C-6-7 bilaterally and removed the left extruded disc at C6-7. (Ex.. 3-9)

The employer accepted C5-6/C6-7 herniated disc. On March 20, 1991, Dr. Rosenbaum reported that claimant's herniated disc occurred as a result of the February 13, 1991 incident and that his preexisting condition did not play a significant role. (Ex. 6). The claim was closed by a September 10, 1991 Determination Order awarding 11 percent (35.20 degrees) unscheduled permanent disability and 7 percent (13.44 degrees) scheduled permanent disability for loss of use or function of the left arm. (Ex. 9).

Three years later, in October 1994, claimant sought treatment for left-sided headaches, which he initially related to sinusitis. Claimant reported to Dr. Ford that the headaches had been a problem for about a month, and had worsened in the last couple of weeks. (Ex. 11). Dr. Ford referred claimant to Dr. Cline, a neurologist.

On October 25, 1994, claimant advised Dr. Cline that since mid-September, he had had a constant headache which fluctuated in intensity. (Ex. 12). Noting that all studies conducted to date were unrevealing, Dr. Cline diagnosed headaches of the left temporal region of unknown origin. In a November 14, 1994 chart note, Dr. Cline questioned whether degenerative changes were responsible for claimant's left sided headache. (Ex. 13)

In a December 4, 1994, letter to his health insurer, claimant provided a history of his then-current complaints. He stated that he started having severe headaches in the later half of September 1994 and that, after diagnostic studies and testing, Dr. Cline prescribed physical therapy. He reported that the physical therapy resulted in an increase in his headaches as well as increased discomfort in his neck, shoulders and arms. He further noted that: "The discomfort and pain in the neck, shoulders and arms had been going on for some time for the past couple of years, but I only associated these with just a part of life. This discomfort and pain in my neck, shoulders and arms did not happen that often and only became more frequent after the headaches had been going on for a while." (Ex. 18).

In a post-script to the letter, claimant added: "The only thing that I can think of that may have been a factor in the reactivation of the old injury sustained in 1991 was the following and I am unsure of the exact date at this time, but it was sometime in August 1994, I believe." Claimant then related a history of an on-the-job incident in which he assisted ambulance personnel extricate an injured woman from the sleeper compartment of a semi-truck. The ambulance driver had placed the woman on a back board while in the truck, and claimant and the other emergency medical technician had to catch the

woman with their arms outstretched upward and transfer her to the ambulance. Claimant explained that he felt only a little discomfort and no pain at the time.[1] (Ex. 18)

On December 22, 1994, claimant saw Dr. Leonard on referral from Dr. Cline. Consistent with what he related to Dr. Cline, claimant reported to Dr. Leonard that he developed a left-sided headache in mid-September without a known precipitating event, which had been chronic and persistent since that time. Dr. Leonard also reported that claimant had experienced chronic neck and aching discomfort "since August 1994, after a prolonged period of lifting." Dr. Leonard determined that claimant's chronic neck and shoulder problems could not adequately explain the daily persistent headaches. (Ex. 23-2)

Claimant returned to Dr. Rosenbaum on January 9, 1995, complaining primarily of a grating and popping sensation in his neck. Dr. Rosenbaum diagnosed musculoskeletal versus radicular symptoms. (Ex. 24). In February 1995, after reviewing claimant's entire history and diagnostic studies, Dr. Rosenbaum noted that claimant did not have any significant neurologic findings, and recommended against any surgical procedure. (Ex. 28).

Meanwhile, claimant continued to treat with Dr. Cline for headaches, neck pain and left arm pain. On February 2, 1995, claimant advised Dr. Cline of the incident in which he assisted in removing the injured woman from the truck. Claimant also reported to Dr. Cline that he had experienced immediate discomfort in his neck and arms following this incident, and that his intense headaches began two weeks thereafter. (Ex. 26). Based this history, Dr. Cline opined that claimant's condition was job-related, due to the recent incident as well as his prior 1991 neck injury.

On March 1, 1995, claimant was examined by Dr. Mason at Dr. Cline's request. (Ex. 29). Dr. Mason reported that claimant's current symptoms were secondary to "persisting nerve root deformity seen on his studies" although these deformities were relatively subtle. Dr. Mason recommended a bilateral nerve root decompression. (Exs. 29, 33).

On March 13, 1995, claimant made claim for a cervical spine injury arising out of the July 1, 1994 incident. The SAIF Corporation issued a disclaimer of responsibility, followed by a compensability denial. On August 28, 1995, Alexis Risk Management issued a denial on the employer's behalf, denying that claimant's current symptoms were compensably related to his 1991 injury.[2]

On August 16, 1995, claimant was examined by Drs. Strum and Wilson at SAIF's request. Drs. Strum and Wilson diagnosed degenerative disc disease at C5-6 and C6-7. They found no objective neurological evidence of a focal neurological deficit which would indicate a compromise of the cervical nerve roots. Drs. Strum and Wilson also reported that claimant's current condition was not related to the incident of July 1, 1994, as the incident was not consistent with the type of mechanism that would produce a pathological worsening of his preexisting degenerative disc disease. (Ex. 37A). Dr. Rosenbaum concurred with the findings and report of Drs. Strum and Wilson.

Claimant was reexamined by Dr. Mason on February 6, 1996. Dr. Mason noted that claimant continued to be symptomatic, experiencing bilateral upper extremity pain, numbness and tingling, greater on the left but present on the right and that he has developed weakness of the left hand. Dr. Mason found a change in claimant's objective neurological exam since March 1, 1995, noting that he had essentially an absence of tendon reflexes on the right upper extremity and a reduction of reflex activity on the left. Dr. Mason concluded that claimant's symptoms were secondary to nerve root involvement, due to his cervical spondylosis. (Ex. 44).

Dr. Mason performed a cervical laminectomy with nerve root decompression, bilateral multiple level on February 15, 1996. His post-operative diagnosis was cervical spondylosis with root compression, C5-6, C6-7, bilateral. Dr. Mason noted that after complete exposure of the body edge, it was clear that the lamina had largely regrown since claimant's previous partial laminectomies. (Ex. 46).

At hearing, claimant argued that he sustained a new injury on July 1, 1994 which was the major cause of his combined condition and need for treatment. Alternatively, claimant asserted that his

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[1] Contrary to claimant's belief, this incident occurred on July 1, 1994. (Ex. 10).

[2] The employer was self-insured at the time of claimant's 1991 injury.

condition was a compensable aggravation of his 1991 injury. The ALJ found that claimant failed to prove that the July 1, 1994 incident or his 1991 industrial injury was the major contributing cause of his bilateral cervical spondylosis at C5-7 or a worsening thereof. The ALJ concluded that, based on inconsistencies in the record as well as claimant's demeanor at hearing, claimant was not a reliable witness. In addition, the ALJ was persuaded by the expert medical opinions of Drs. Rosenbaum, Strum and Wilson, who related claimant's symptoms to his noncompensable, preexisting degenerative cervical spondylosis.

On review, claimant urges us to rely on the opinion of Dr. Mason over that of his former treating surgeon, Dr. Rosenbaum. Claimant contends that Dr. Mason's reports persuasively establish that claimant suffered a new injury on July 1, 1994 which is the major cause of his current condition.[3] We disagree.

Like the ALJ, we find Dr. Mason's opinion, to the extent it supports the compensability of claimant's upper extremity symptoms,[4] to be based on an inaccurate history. Dr. Mason opined that claimant reinjured himself in July 1994 and that this injury worsened his nerve root pathology. This opinion was based on a history of claimant having the onset of cervical and shoulder symptoms during the July 1, 1994 incident, which continued to worsen while he was on vacation, at which time he also experienced the left temporal headache. (See Ex. 29-1). According to the employer's records and the contemporaneous medical evidence, however, claimant worked through July 12 without difficulty, then went on military leave until July 31, 1994, then returned to work for the entire month of August without any problems, and took vacation through mid-September 1994 before his left-sided headaches began without a known precipitating event. (Exs. 9A, 12, 23). In addition, according to claimant's December 1994 correspondence, he did not experience any pain, but only a "little discomfort" at the time of the July 1, 1994 incident. (Exs. 18, 20). Lastly, according to claimant's letters as well as the contemporaneous records, claimant did not complain of increasing pain in his neck, shoulders and arms until after his headaches began, when he underwent physical therapy. (Exs. 15, 18).

Because Dr. Mason's causation opinion is based on an unreliable and inaccurate history, it is entitled to little weight.[5] See Miller v. Granite Construction Co., 28 Or App 473 (1977). Accordingly, we agree with the ALJ that a preponderance of the evidence establishes that claimant's condition, diagnosed as bilateral cervical spondylosis with nerve root compression at C5-6 and C6-7, is caused in major part by his noncompensable, preexisting degenerative disc disease rather than any work injury.[6] We therefore uphold both SAIF's and Alexis' denials.

ORDER

The ALJ's order dated April 16, 1996 is affirmed.

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[3] Although claimant also raises his alternative "aggravation" argument on review, he does not cite to, nor do we find, any medical evidence indicating that claimant's 1991 industrial injury is the major contributing cause of his cervical spondylosis and need for decompression surgery in 1996. Therefore, we limit our discussion to claimant's "new injury" argument.

[4] Dr. Mason never expressly related claimant's headaches to the incident of July 1, 1994. Rather, in his July 14, 1995 report, Dr. Mason opined that the July 1994 work incident produced further irritability of the cervical nerve roots, which caused claimant's arm pain. (Ex. 35). Dr. Mason related claimant's local neck discomfort to his preexisting cervical spondylosis.

[5] The same is true of Dr. Cline's causation opinion, as Dr. Cline understood that claimant's intense headaches and neck and arm symptoms began within two weeks of the incident in which claimant assisted in removing the injured woman from the truck. (Ex. 26). A preponderance of the evidence establishes, however, that claimant's headaches began approximately two and a half months after the July 1, 1994 incident.

[6] Indeed, Dr. Mason's surgical findings of cervical spondylitic changes and root compression at C5-6 and C6-7, bilaterally are not inconsistent with Dr. Rosenbaum's (and Drs. Strum and Wilson's) attribution of claimant's symptoms to the progression of his degenerative condition. (See Exs. 37A, 46, 52)

In the Matter of the Compensation of
OLIVE B. LYONS, Claimant
WCB Case No. 96-00853
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's right wrist tendinitis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has been performing primarily janitorial work for the employer for 18 years. On July 19, 1995, claimant "overdid" mopping floors and her right arm started aching. Claimant sought medical treatment on August 3, 1995 and she was diagnosed with right wrist tendinitis.

The ALJ found that claimant has several preexisting conditions: osteoarthritis, osteoporosis and polymyalgia rheumatica. Nevertheless, the ALJ found that no physician had opined that the preexisting conditions combined with the July 19, 1995 work incident to cause a need for treatment or disability of any combined condition. Relying on Dr. Saddoris' opinion, the ALJ concluded that claimant's work activities on July 19, 1995 were the major contributing cause and the sole cause of claimant's right wrist tendinitis.

SAIF argues that claimant failed to prove that she has a compensable right wrist tendinitis condition. SAIF asserts that claimant's wrist condition was the result of a combination of her preexisting conditions and her work activity and it contends that Dr. Saddoris' opinion is not persuasive.

The ALJ found that claimant had satisfied her burden of proof under the legal test of an injury claim or an occupational disease claim. Claimant contends that this is an injury claim and the material contributing cause standard applies.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's right wrist tendinitis was an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. Mathel v. Josephine County, 319 Or 235, 240 (1994); James v. SAIF, 290 Or 343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982).

Claimant had been treated for pain and stiffness in her shoulders, upper arms, elbows and wrists before the July 19, 1995 work incident and she had been diagnosed with osteoarthritis, osteoporosis and polymyalgia rheumatica. On July 19, 1995, claimant "overdid" mopping floors and her right arm started aching. Claimant testified that she had a different kind of pain than she had previously experienced. (Tr. 12). Claimant sought medical treatment on August 3, 1995 and she was diagnosed with right wrist tendinitis. (Ex. 13I-4A). Claimant was treated conservatively. Claimant filed a claim when the pain kept getting worse. (Tr. 13).

The record supports the occurrence of an injury on July 19, 1995. The injury was unexpected, as claimant had not had the same kind of pain with her right wrist and forearm. Moreover, claimant's tendinitis condition was "sudden in onset" in that it occurred over a discrete, identifiable period of time. The fact that claimant's pain grew progressively worse over a short period of time does not make it "gradual in onset." Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984) (the claimant's back trouble coincided precisely with jolting of the faulty loader; the fact that the claimant's back pain grew worse over his six-week employment did not make it "gradual in onset"); Rickey C. Amburgy, 48 Van Natta 106 (1996). Therefore, we analyze the claim as an accidental injury, rather than an occupational disease.

SAIF argues that Dr. Saddoris' general diagnosis of tendinitis is not sufficient to establish a distinct condition in light of claimant's preexisting osteoarthritis and polymyalgia rheumatica. SAIF contends that Dr. Nathan persuasively rebutted Dr. Saddoris' theory that claimant showed any signs of tendinitis. For the following reasons, we conclude that, even if we assume that Dr. Saddoris' diagnosis of right wrist tendinitis is correct, his causation opinion is not persuasive.

Dr. Saddoris diagnosed claimant with polymyalgia rheumatica, right wrist tendinitis and erosive osteoarthritis of her hands. (Ex. 25). Dr. Saddoris explained:

> "Given [claimant's] history and reasonable medical probability, it is more likely than not, that her work activities are aggravating a pre-existing condition of osteoarthritis and her work activities are the major contributing factor in her right wrist tendinitis. Based upon the history that you refer to in my progress notes, and reasonable medical probability, her work activities are a major contributing factor in her current need for care and treatment, in that her erosive osteoarthritis at the present time is limiting her work capability and this capability needs to be reassessed as she responds to medication and physical therapy." (Id.)

Dr. Saddoris explained that treatment for claimant was "aggressive anti-inflammatory therapy with Prednisone for her polymyalgia rheumatica and right wrist tendinitis and Plaquenil and Indocin with a gastric cytoprotective agent, Cyotec, for her erosive osteoarthritis." (Id.)

Assuming, without deciding, that Dr. Saddoris' diagnosis of right wrist tendinitis is correct, we construe his opinions to establish that claimant's July 19, 1995 work incident combined with her preexisting polymyalgia rheumatica and erosive osteoarthritis. Dr. Saddoris reported that claimant's work activities were aggravating the preexisting osteoarthritis and were also the major contributing factor in her right wrist tendinitis. (Ex. 25). Dr. Saddoris was treating claimant's polymyalgia rheumatica and right wrist tendinitis with the same medication. Furthermore, Dr. Saddoris' statement that claimant's work activities were "a major contributing factor in her current need for care and treatment, in that her erosive osteoarthritis at the present time is limiting her work capability" indicates that the July 19, 1995 work incident combined with her preexisting erosive osteoarthritis. Therefore, in light of claimant's preexisting conditions, she must establish that her work activities were the major contributing cause of the disability or need for treatment of the right wrist tendinitis. ORS 656.005(7)(a)(B).

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). Here, we find persuasive reasons not to defer to Dr. Saddoris' opinion. Even if we defer to Dr. Saddoris' diagnosis of a separate condition of tendinitis, his reports do not establish that claimant's July 19, 1995 work incident was the major contributing cause of her right wrist tendinitis. Although Dr. Saddoris opined that claimant's "work activities are the major contributing factor in her right wrist tendinitis[,]" he also stated that claimant's "work activities are a major contributing factor in her current need for care and treatment, in that her erosive osteoarthritis at the present time is limiting her work capability and this capability needs to be reassessed as she responds to medication and physical therapy." (Ex. 25).

Dr. Saddoris' opinion is, at best, confusing. Dr. Saddoris apparently assumes that, because claimant's preexisting erosive osteoarthritis was limiting her work capability, it follows that her work was the major cause of the need for treatment. 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. Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995). Dr. Saddoris' opinion does not properly evaluate the relative contribution of each cause, including the preexisting conditions and the precipitating cause. Moreover, Dr. Saddoris' opinion indicated that claimant's preexisting osteoarthritis was the major cause of the need for treatment. None of the other medical opinions support compensability. We conclude that claimant has failed to establish that her work activities were the major contributing cause of her right wrist tendinitis.

ORDER

The ALJ's order dated April 23, 1996 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Chair Hall dissenting.

Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time. See Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, there are no persuasive reasons to reject the opinion of claimant's attending physician.

Dr. Saddoris has treated claimant's upper extremity problems since November 1994 and he diagnosed right wrist tendinitis after claimant's July 19, 1995 injury. Unlike Dr. Nathan, who examined claimant on one occasion, Dr. Saddoris had the opportunity to observe the difference between claimant's osteoarthritis symptoms and her tendinitis symptoms. Even Dr. Nathan could not rule out the possibility that claimant may have had tendinitis before the date Dr. Nathan examined claimant. (Ex. 24C-1). Thus, Dr. Saddoris' observations of claimant are critical. Further, contrary to the majority's conclusion, Dr. Saddoris' opinion is not confusing. I agree with the ALJ that Dr. Saddoris' opinion persuasively establishes that claimant's work activities on July 19, 1995 were the major contributing cause of her right wrist tendinitis.

In the Matter of the Compensation of
BETTY F. SANGER, Claimant
WCB Case No. 94-04740
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

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

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

Claimant, age 49 at the time of hearing, developed acute pain in her left heel, causing her to seek treatment from a podiatrist on January 12, 1994. At that time, claimant was working for the employer, a hotel/restaurant, as a restaurant manager. Claimant had been hired by the employer in September 1993.

The podiatrist, Dr. Hoyal, diagnosed a plantar fascial tear. Claimant was eventually referred to Dr. Grant for electrodiagnostic evaluation. Dr. Grant found no specific neurophysiologic abnormalities to correlate with claimant's complaints, and diagnosed chronic and severe left plantar fasciitis and mild to moderate right plantar fasciitis. He ruled out tarsal tunnel syndrome.

On May 10, 1994, Dr. Hoyal operated on claimant's left foot and removed a heel spur, released the medial fibers of the plantar fascia and removed a bursal mass with nerve involvement or a possible tumor. He also performed a tarsal tunnel release on the distal tunnel.

Claimant continued to complain of left foot pain post-surgery. In August 1994, claimant returned to Dr. Hoyal complaining of a tearing or burning sensation in her left heel. In late September 1994, claimant complained of weakness in her left ankle. In January 1995, claimant returned to Dr. Grant for further testing. At that time, he diagnosed left lateral plantar sensory neuropathy, although he could not determine the significance of the electrodiagnostic abnormalities because claimant's symptomatology did not match up with the diagnosis.

In March 1995, claimant was examined by Dr. Woolpert at the carrier's request. Dr. Woolpert diagnosed two separate conditions: plantar fasciitis and possible tarsal tunnel syndrome of the left foot. On March 17, 1995, Dr. Hoyal performed a second surgery on claimant's left foot. He removed a mass, possible ganglion and/or lipoma, and performed an adhesiolysis of the scar tissue from the medial aspect of the left foot, including the retinaculum. Dr. Hoyal found no involvement of the tarsal tunnel.

At hearing, claimant argued that her left foot condition is compensably related to her work activity for the employer, which required long hours on her feet. The ALJ found, based on claimant's demeanor at hearing as well as the written record, that claimant was not a credible witness. The ALJ therefore rejected claimant's testimony that her feet were completely asymptomatic prior to her work activities with the employer, and relied instead on the testimony of claimant's supervisor, who reported that claimant admitted to him that she had a long-standing problem with painful feet. The ALJ also rejected the opinions of claimant's treating doctors, finding that they were based on an inaccurate, unreliable history.

After considering the record, we agree with the ALJ that claimant is not a credible witness, and that her lack of credibility undermines the accuracy of the history relied on by the medical experts. We also conclude, however, that even assuming claimant's treating doctors had an accurate history of claimant's symptoms, their opinions are insufficient to sustain claimant's burden of proof on compensability.

Both Dr. Hoyal and Dr. Grant related claimant's plantar fasciitis and left foot condition to her work activity with the employer, although neither doctor weighed the relative contribution of other known causes or predisposing factors, such as claimant's foot structure, her naturally tight plantar fascia and her long history of working on her feet.[1] See Dietz v. Ramuda, 130 Or App 397 (1994) (persuasive medical opinion must evaluate the relative contribution of different causes and explain why work exposure or injury contributes more to the claimed condition than all other causes or exposures combined). Further, neither doctor addressed why, when claimant spent the same amount of time on both feet, her left foot was so much more symptomatic than her right, or why claimant presented with symptoms atypical of plantar fasciitis. In addition, neither doctor discussed the significance of the bursal mass found and removed from claimant's left heel in May 1994, or the mass excised in March 1995. Because these two medical opinions are incomplete and conclusory, we find them insufficient to establish that claimant's work activities with the employer are the major contributing cause of her left foot condition. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Consequently, we affirm the ALJ's order upholding the insurer's denial based on claimant's lack of credibility as well as on the lack of persuasive medical evidence supporting compensability.

ORDER

The ALJ's order dated March 7, 1996 is affirmed.

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[1] Dr. Hoyal testified that claimant's foot structure and tight plantar fascia may have predisposed her to developing plantar fasciitis. Dr. Grant similarly acknowledged that a naturally tight plantar fascia was a predisposing factor that would affect the development of symptoms.

In the Matter of the Compensation of
NATALIE M. ZAMBRANO, Claimant
WCB Case No. 95-10599
ORDER ON RECONSIDERATION
Coughlin, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Claimant requests reconsideration of that portion of our September 16, 1996 Order on Review that awarded an attorney fee. In our order, we stated: "For services on review concerning the unscheduled permanent disability award, claimant is awarded $1,000, payable by the insurer." Claimant correctly asserts that sentence should be changed to read: "For services on review concerning the unscheduled permanent disability award, claimant's counsel is awarded $1,000, payable by the insurer."

Accordingly, we withdraw our September 16, 1996 Order on Review. On reconsideration, as supplemented herein, we adhere to and republish our September 16, 1996 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
WILLIAM D. ZIMMERMAN, Claimant
Own Motion No. 96-0442M
OWN MOTION ORDER
Flaxel & Nylander, Claimant Attorneys
SAIF Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable possible fracture right arm radial head injury. Claimant's aggravation rights expired on May 15, 1992. SAIF recommends that we authorize the payment of temporary disability compensation. SAIF further advises that claimant is receiving temporary disability compensation under another compensable claim, and requests that the Board "indicate the amount due and payable to [claimant] out of this 1987 claim."

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

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

SAIF requested that the Board determine the amount of temporary disability benefits payable under claimant's 1987 injury claim. An injured worker in not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Therefore, if any concurrent temporary disability compensation is due claimant as a result of this order, SAIF may petition the Workers' Compensation Division of the Department of Consumer and Business Services for a pro rata distribution of payments. OAR 436-060-0020(8) and (9); Michael C. Johnstone, 48 Van Natta 761 (1996); William L. Halbrook, 46 Van Natta 79 (1994).

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

Cite as 323 Or 520 (1996) July 11, 1996

IN THE SUPREME COURT OF THE STATE OF OREGON

Helen Jean KRUSHWITZ, Personal Representative of the Estate of Matthew Allen Theurer,
Petitioner on Review,
v.
McDONALD'S RESTAURANTS OF OREGON, INC., an Oregon corporation, *Respondent on Review,*
and McDONALD'S CORPORATION, a Delaware corporation, *Defendant.*
(CC 9104-02047; CA A73926; SC S41757)

In Banc
On review from the Court of Appeals.*
Argued and submitted September 5, 1995.
Kathryn H. Clarke, Portland, argued the cause and filed the petition for petitioner on review. With her on the briefs were Maureen Leonard and Lawrence Wobbrock, Portland.
I. Franklin Hunsaker, III, of Bullivant, Houser, Bailey, Pendergrass & Hoffman, Portland, argued the cause for respondent on review. With him on the brief were Douglas G. Houser, Ronald G. Stephenson, and Ronald J. Clark.
David F. Sugerman, of Paul & Sugerman, PC; John Paul Graff, of Graff & O'Neil; and Kevin N. Keaney, Portland, filed briefs on behalf of *amicus curiae* Oregon Trial Lawyers Association.
Chess Trethewy, of Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C., Salem, and Jerald P. Keene, of Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland, filed a brief on behalf of *amicus curiae* Associated Oregon Industries.
Jonathan M. Hoffman and Julie K. Bolt, Portland, filed a brief on behalf of amicus *curiae* Oregon Association of Defense Counsel.
Before Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Graber, and Durham, Justices.**
CARSON, C. J.
The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed, and the case is remanded to the circuit court for further proceedings.

* Appeal from Multnomah County Circuit Court, Ancer L. Haggerty, Judge. 129 Or App 621, 880 P2d 483 (1994).

** Unis, J., retired June 30, 1996, and did not participate in this decision.

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323 Or 523> In this action for wrongful death, we decide two issues: (1) whether an employee who was killed in an automobile accident while driving home from work suffered a "compensable injury" as that term is defined by the Workers' Compensation Law; and (2) whether the exclusivity provisions contained in the Workers' Compensation Law preclude plaintiff's wrongful death action. We answer both questions in the negative.

Because the circuit court dismissed this action pursuant to ORCP 21, for the purposes of appellate review, we accept all well-pleaded allegations contained in plaintiff's complaint and give plaintiff the benefit of all favorable inferences that may be drawn therefrom. *Stringer v. Car Data Systems, Inc.*, 314 Or 576, 584, 841 P2d 1183 (1992).

Matthew Theurer, an 18-year-old high school student, worked part time at a restaurant owned by McDonald's Restaurants of Oregon, Inc. (defendant). On April 4, 1988, Theurer worked from 3:30 p.m. to 8:00 p.m., which was his normal after-school shift. In order to make some extra money, Theurer volunteered to work an additional shift later that night. He returned to McDonald's at midnight and worked from midnight until 8:21 a.m. on April 5, 1988. Upon completing that shift, Theurer told his supervisor that he was too tired to work his upcoming afternoon shift and asked that another employee replace him. Theurer then left the restaurant to drive home. His automobile crossed the center line on the highway, after he fell asleep at the wheel, and struck another automobile head-on. Theurer was killed in that collision.

Plaintiff, who is Theurer's mother and the personal representative of his estate, filed this wrongful death action against defendant and McDonald's Corporation, defendant's parent company.[1] Plaintiff alleged that defendant negligently caused Theurer's death, in that defendant: (1) knew or should have known that Theurer had worked too many hours without adequate sleep to drive home safely; (2) should have **<323 Or 523/524>** foreseen that driving with inadequate sleep posed a risk of harm to Theurer and to others; and (3) was negligent in scheduling Theurer to work more hours than was reasonable in the circumstances. Plaintiff also alleged that, because defendant required Theurer to work more than 10 hours in one day, defendant was negligent *per se* and also was subject to statutory liability. Plaintiff sought compensation for economic damages suffered by Theurer's estate, noneconomic damages for pain and suffering suffered by both Theurer and plaintiff, and punitive damages.

Defendant filed several motions under ORCP 21 to dismiss plaintiff's complaint. The trial court dismissed plaintiff's claims for negligence and statutory liability, both for failure to state a claim. Plaintiff then filed an amended complaint, which essentially restated the allegations contained in the original complaint and further alleged that defendant was negligent in failing to arrange alternative transportation for Theurer's commute home. Defendant again moved to dismiss, arguing that, because defendant's potential liability was based solely upon the employer-employee relationship between defendant and Theurer, the exclusivity provisions of the Workers' Compensation Law barred plaintiff's wrongful death action. Defendant further argued that Theurer's death was a "compensable injury" under the Workers' Compensation Law, because the "special errand" exception to the "going and coming" rule applied to Theurer's accident. The trial court agreed with defendant that the Workers' Compensation Law provided an exclusive remedy and, consequently, granted defendant's motion to dismiss and entered judgment against plaintiff.

Plaintiff appealed to the Court of Appeals, arguing that Theurer's death was not a compensable injury and, therefore, that the exclusivity provisions contained in the Workers' Compensation Law did not bar her wrongful death action. Plaintiff also argued that the trial court's ruling deprived her of a remedy and conferred an unequal privilege upon defendant, in violation of Article I, sections 10 and 20, of the Oregon Constitution.[2] The Court of Appeals determined **<323 Or 524/525>** that Theurer had suffered a compensable injury under the "general hazard" exception to the going and coming rule and, consequently, that the exclusivity provision of the Workers' Compensation Law barred plaintiff's wrongful death action. *Krushwitz v. McDonald's Restaurants,* 129 Or App 621, 627, 880 P2d 483 (1994). That court further held that, because Theurer's death was compensable under the Workers' Compensation Law, plaintiff had a remedy and, therefore, dismissal of the complaint violated no constitutional provisions. *Ibid.*

Plaintiff petitioned this court for review. We allowed review and now reverse the decision of the Court of Appeals.

The first issue, which relates to the scope of the workers' compensation statutes, is whether Theurer's accident resulted in a "compensable injury" under the Workers' Compensation Law. If Theurer's death were a compensable injury, plaintiff's wrongful death action would be barred by the exclusivity provision contained in ORS 656.018(1)(a), which provides, with exceptions not alleged to apply here, that the Workers' Compensation Law is an exclusive remedy and replaces any other liability on the employer's part. If Theurer's death was not a compensable injury, however, plaintiff may be able to pursue her wrongful death action against defendant, as discussed below.[3]

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[1] McDonald's Corporation is not a party to this action on review.

[2] Article 1, section 10, provides, in part, that "every man shall have remedy by due course of law for injury done him in his person, property, or reputation." Article I, section 20, provides that "[n]o law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

[3] We note that, in the course of deciding this case, we have considered whether this court should dismiss or abate this proceeding and allow the parties to resort to the workers' compensation system. However, we have concluded that such a result would serve no constructive purpose and, accordingly, proceed to determine the issues presented by the parties.

ORS 656.005(7)(a) provides, in part:

> "A 'compensable injury' is an accidental injury * * * *arising out of and in the course of* employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means * * * [.]" (Emphasis added.)

The "arising out of" prong of the compensability test requires that some causal link exist between the employee's injury **<323 Or 525/526>** and his or her employment. *Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 366, 867 P2d 1373 (1994).' The "in the course of" prong requires that the time, place, and circumstances of the employee's injury justify connecting that injury to the employment. *Ibid.* This court views the two prongs as two parts of a single "work-connection" analysis, in order to determine whether an employee suffered a compensable injury. *Rogers v. SAIF,* 289 Or 633, 643, 616 P2d 485 (1980).

In this case, the first prong of the compensability test, "arising out of," is met, because plaintiff alleges that, by permitting Theurer to work long hours on a school day, defendant effectively caused Theurer's death. The main disagreement between the parties is whether plaintiff has satisfied the second prong, "in the course of."

Plaintiff contends that, because the accident occurred after Theurer had finished working and had left defendant's premises, his death did not occur in the course of his employment. Defendant, on the other hand, contends that the "special errand" exception to the going and coming rule applies to the facts of this case, bringing Theurer's death within the course of his employment and, consequently, resulting in a compensable injury. Defendant also contends that, under Oregon's work-connection test for determining compensability, a sufficient nexus existed between Theurer's death and his employment to result in a compensable injury. For the following reasons, we agree with plaintiff that Theurer's death did not occur in the course of his employment and, therefore, that Theurer did not suffer a compensable injury under ORS 656.005(7)(a).

We first address the issue of whether Theurer's death falls within an exception to the going and coming rule. The general rule in Oregon--the "going and coming" rule--is that injuries sustained while an employee is traveling to or from work do not occur in the course of employment and, consequently, are not compensable. *Cope v. West American Ins. Co.,* 309 Or 232, 237, 785 P2d 1050 (1990). The reason for the going and coming rule is that "[t]he relationship of employer and employee is ordinarily suspended from the time the employee leaves his work to go home until he resumes his work, since the employee, during the time that he is going to **<323 Or 526/527>** or coming from work, is rendering no service for the employer." *Heide/Parker v. T C.I. Incorporated,* 264 Or 535, 540, 506 P2d 486 (1973) (internal quotation marks omitted). This court has recognized a number of exceptions to the general rule, however, that justify treating the employee as if he or she continued in the course of employment at the time of an injury that occurred while the employee was going to or coming from work.

Defendant argues that the "special errand" exception to the going and coming rule applies in this case. The Court of Appeals disagreed, but concluded that the "greater hazard" exception applies. As we shall explain, we conclude that neither the special errand nor the greater hazard exception applies in this case and, consequently, that Theurer's death falls within the going and coming rule.

The "special errand" exception to the going and coming rule applies when an employee sustains an injury while off the employer's premises, "but while [the employee was] proceeding to perform, or while proceeding from the performance of, a special task or mission." *Philpott v. State Ind. Acc. Com.,* 234 Or 37, 41, 379 P2d 1010 (1963). In *Heide/Parker,* this court considered whether the special errand exception applied when an employee was killed in an automobile accident while traveling home to Salem from her place of employment in Portland. In that case, the employee had stopped at a bar with a customer before leaving for home. The employee had been performing some public relations work for the opening of that customer's new facility, which had occurred a few days before, and still was tired from the time spent on that event. She also was carrying some work-related items in her vehicle at the time of the accident. 264 Or at 538. This court declined to apply the special errand exception, stating:

> "In the instant case we cannot see how it can be said that [the employee] was *in the furtherance of her employer's business* after she left the bar and started for her home in Salem. Neither can we see that *her employer had any right to control [the employee]* in traveling from Portland to Salem. Her employer had no right to dictate the manner of travel, the route to be taken, her speed, or that she use her car to drive home as compared to other modes of travel." *Id.* at 545-46. (Emphasis added.)

323 Or 528> In view of this court's decision in *Heide/Parker,* it is clear that Oregon's special errand exception applies only when *either* the employee was acting in the furtherance of the employer's business at the time of the injury *or* the employer had a right to control the employee's travel in some respect. Under that definition, Theurer's death does not fall within the special errand exception to the going and coming rule. Theurer was not acting in behalf of defendant at the time of his death. Neither was Theurer under defendant's control when the accident occurred.[4] Instead, at the time of his death, Theurer had completed his shift and left his place of employment, and merely was coming home from work. That is precisely the type of situation to which the going and coming rule was intended to apply.

Defendant contends that the special errand exception should be expanded and applied here, because plaintiff alleged that defendant contributed to Theurer's fatigue, thereby causing his death. Defendant reasons that the danger presented by Theurer's driving home in that condition was sufficiently substantial to justify considering Theurer's commute home as part of his employment. We acknowledge that defendant is not alone in asserting that view of tho special errand exception. *See, e.g.,* Arthur Larson and Lex K. Larson, 1 *The Law of Workmen's Compensation* § 16.14, 4-208.35 (1995) ("When the amount of overtime work becomes so great as to increase markedly the factor of fatigue, and when this factor contributes to the accident, there is an even more cogent case for finding that the longer hours of work made the homeward trip more hazardous," thereby bringing the accident within the special errand exception.). However, in this case, we decline to expand this court's definition of the special errand exception as defendant urges. The facts alleged here do not rise to the level of *excessive* work-related fatigue, referred to in the Larson treatise. Rather, this case concerns work-related fatigue *coupled with* **<323 Or 528/529>** the fact that Theurer already had attended school all day. In the light of those allegations, and in view of this court's traditionally narrow approach to applying the exceptions to the going and coming rule, we conclude that the special errand exception does not apply in this case.[5]

Turning to the "greater hazard" exception, we note that, according, to prior decisions of this court, that exception to the going and coming rule applies "[i]f the employee's employment requires [the employee] to use an entrance or exit to or from * * * work which exposes [the employee] to hazards in a greater degree than the common public." *Nelson v. Douglas Fir Plywood Co.,* 260 Or 53, 57, 488 P2d 795 (1971). This court has applied that exception only in certain limited circumstances, in which an employee is injured while traveling upon the only means of ingress to or egress from the employer's premises and some "greater hazard" existed upon that route. *See id.* at 57-58 (greater hazard exception applied when employee was injured while traveling upon the only road that led to employer's plant and dangerous, heavy traffic subjected employee to hazards "peculiar and directly attributable to her employment"); *Montgomery v. State Ind. Acc. Com.,* 224 Or 380, 387-89, 393-94, 356 P2d 524 (1960) (greater hazard exception applied when employee was injured while traveling upon a public road with heavy traffic that was the only means of entering employer's plant and employer had had traffic light installed and had gained right to operate light, because of the heavy traffic).

Based upon the definition of the greater hazard exception described above, we conclude that that exception does not apply in this case. Theurer's accident did not occur upon a route that was the sole means of ingress to or egress from defendant's restaurant. Moreover, no specific hazard existed at a particular off-premises point, such as heavy, dangerous traffic or a railroad-crossing. The "hazard"

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[4] We note that the issue of whether Theurer was under defendant's control at the time of the accident, for the purpose of determining the applicability of the special errand exception, is a different question from the issue of whether defendant was *negligent* in failing to provide Theurer with alternative transportation for his commute home, as plaintiff alleged in her amended complaint. We do not address any negligence issues in this opinion.

[5] We leave for another day the issue of whether *excessive* work-related fatigue may qualify under some exception to the going and coming rule, as the Larson treatise suggests.

alleged in this case was that Theurer was tired after working two shifts and attending school within the same 24-hour period. That is <323 Or 529/530> not the type of situation to which the "greater hazard" exception to the going and coming rule was meant to apply. Consequently, the Court of Appeals erred when it held that "Theurer was subjected by his employment to a greater hazard than the traveling public generally confronts, and the hazard persisted throughout and excepted the entire trip from the going and coming rule." 129 Or App at 627.

Because Theurer's death occurred while he was coming home from work, and because neither the special errand nor the greater hazard exception applies in this case,[6] we conclude that Theurer's death did not occur in the course of his employment. Consequently, under the definition set forth in ORS 656.005(7)(a), Theurer did not suffer a compensable injury.

We next address defendant's contention that a sufficient nexus existed between Theurer's death and his employment such that, nevertheless, a compensable injury resulted from his accident. Defendant is correct that, in *Rogers*, this court adopted a work-connection approach to determining whether an employee suffered a compensable injury. That is, instead of applying the "arising out of" and "in the course of" prongs of ORS 656.005(7)(a) rigidly, this court focuses upon whether the relationship between the injury and the employment is sufficient for the injury to be compensable. 289 Or at 642. According to the *Rogers* court:

> "The statutory phrase 'arising out of and in the course of employment' must be applied in each case so as to best effectuate the socioeconomic purpose of the Worker's Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer * * *. [T]here is no formula for decision. Rather, in each case, every pertinent factor must be considered as a part of the whole. It is the basic purpose of the Act which gives weight to particular facts and direction to the analysis of whether an injury arises out of and in the course of employment." *Id.* at 643 (internal case citations and quotation marks omitted).

323 Or 531> This court concluded that, "[i]f the injury has sufficient work relationship, then it arises out of and in the course of employment and the statute is satisfied." *Ibid.*

Defendant contends that, under the work-connection test, an injury does not have to satisfy both traditional requirements of "arising out of" and "in the course of" in order to be compensable. Instead, the two requirements are merged into a single concept of "work-connection"; that is, if a sufficient nexus exists between the accident and the employment, any resulting injury is "work-connected" and, therefore, compensable. Defendant's argument is not well taken.

Despite this court's adoption of the work-connection test, prior case law makes it clear that both elements of the compensability test, "arising out of" and "in the course of," still must be satisfied to some degree. That principle is illustrated by this court's decision in *Phil A. Livesley Co. v. Russ*, 296 Or 25, 672 P2d 337 (1983). In that case, which was decided after *Rogers*, an employee applied for workers' compensation benefits after sustaining injuries from an unexplained fall that occurred at work. The "in the course of" prong easily was satisfied, because the injury occurred while the employee was engaged in work-related activity on his employer's premises. However, because the cause of the injury was unknown, the factors supporting the "arising out of" prong were weak. 296 Or at 27-29. This court first noted that the work-connection test may be satisfied if the factors supporting one prong are minimal while the factors supporting the other prong are many. *Id.* at 28. The court also emphasized, however, that adoption of the work-connection test "was not intended to substantially change existing law" governing compensable injuries. *Ibid.* (internal quotation marks omitted). In that employee's case, the court determined that, because the employee had eliminated any idiopathic causes of his injury, that is, causes unrelated to his employment, the work-connection test was satisfied. The court concluded: "Because the 'course of employment' elements are strong * * *, *and because the 'arising' elements are incapable of direct determination,* we hold that the administrative agency and the Court of Appeals could find that * * * the unitary work-connection test is sufficiently satisfied to allow compensation for this

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[6] Neither party has argued that any other exception to the going and coming rule applies to Theurer's death.

unexplained fall." *Id.* at 32. (Emphasis added.) *See also Norpac Foods*, 318 Or at 366 ("In assessing the compensability of an injury, we must evaluate the work-connection of *both elements*; neither is dispositive." (Emphasis added.)).

The situation in *Livesley* is different from the situation before us now. In the present case, the factors supporting the "arising out of" requirement are strong, because plaintiff alleged that defendant's negligence caused Theurer's death. Under this court's traditional definition of "course of employment," however, that *requirement is not satisfied at all*, because Theurer had completed his work and was returning home at the time of his death, bringing his commute squarely within the going and coming rule. Consequently, the work-connection test is not satisfied in this case.

Having determined that Theurer did not suffer a compensable injury under ORS 656.005(7)(a), we now turn to the issue of whether the exclusivity provisions contained in the Workers' Compensation Law nonetheless preclude plaintiff's wrongful death action. Defendant contends that the Workers' Compensation Law provides an exclusive remedy in this case, because plaintiff's allegations of negligence arise out of the employer-employee relationship between defendant and Theurer. We disagree.

ORS 656.018 provides, in part:

> "(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of injuries * * * *arising out of and in the course of employment* that are sustained by subject workers * * *.
>
> " * * * * *
>
> "(2) The rights given to a subject worker and the beneficiaries of the subject worker under this chapter for injuries * * * *arising out of and in the course of employment* are in lieu of any remedies they might otherwise have for such injuries * * * against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury * * *."[7] (Emphasis added.)

323 Or 533> As is clear from the statutory text, the Workers' Compensation Law provides an exclusive remedy only for injuries "arising out of and in the course of employment." We already have determined that Theurer's injury did not occur in the course of his employment for the purposes of the Workers' Compensation Law. Consequently, the exclusivity provisions contained in ORS 656.018(1)(a) and (2) do not preclude plaintiff's wrongful death action.

Defendant also points to ORS 656.018(6) to support its contention that the Workers' Compensation Law provides the exclusive remedy in this case. That subsection provides:

> "The exclusive remedy provisions and limitation on liability provisions of this chapter apply to all injuries * * * *arising out of and in the course of employment* whether or not they are determined to be compensable under this chapter."[8] (Emphasis added.)

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[7] The operative text of ORS 656.018(1)(a) and (2) was revised by the legislature in 1995. Or Laws 1995, ch 332, § 5. The 1995 legislature also determined that the textual revisions to ORS 656.018 should apply retroactively to "all claims or causes of action existing or arising on or after the effective date of [the 1995 revisions], regardless of the date of injury or the date a claim is presented." Or Laws 1995, ch 332, § 66. In the course of deciding this case, we have reviewed both the old and new versions of ORS 656.018 and have concluded that the result here would be the same under either version of that statute. We note that, although we follow the 1995 text for the purposes of this opinion, we need not, and do not, decide any issues concerning the legislature's decision to make the 1995 amendments retroactive.

[8] The legislature enacted subsection (6) to ORS 656.018 in 1995. Or Laws 1995, ch 332, § 5. That subsection also applies retroactively to claims existing or arising on or after the effective date of the 1995 revisions. Or Laws 1995, ch 332, § 66. Again, because the result here would be the same without subsection (6), for the purposes of this opinion, we need not, and do not, decide any issues concerning the legislature's decision to make subsection (6) retroactive, or the effect of subsection (6) upon pre-existing law.

We disagree that ORS 656.018(6) precludes plaintiff's wrongful death action, for the same reason stated above: The text of ORS 656.018(6) specifically states that the workers' compensation exclusivity provisions apply to all injuries "arising out of and in the course of employment." Because Theurer's death did not occur in the course of his employment, the exclusivity provisions contained in the Workers' Compensation Law do not apply to this case.

In summary, we conclude that Theurer's death falls within the going and coming rule and, consequently, did not occur in the course of his employment with defendant. Because Theurer's death did not occur in the course of his employment, he did not suffer a compensable injury under ORS 656.005(7)(a), and the exclusivity provisions of the Workers' Compensation Law contained in ORS 656.018 do not bar plaintiff's wrongful death action.

The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed, and the case is remanded to the circuit court for further proceedings.

Cite as 323 Or 618 (1996) July 18, 1996

IN THE SUPREME COURT OF THE STATE OF OREGON

Virginia KILMINSTER, Curtis Irwin, Sr., and Curtis Irwin, Sr., as personal representative of the Estate of Curtis Irwin, Jr., (the decedent), *Petitioners on Review,*

v.

DAY MANAGEMENT CORPORATION, an Oregon corporation, dba Clackamas Communications, and Gordon Day, *Respondents on Review,* and KSGO/KGON, INC., a Washington corporation; Motorola, Inc., a Delaware corporation; Skilling Ward Magnusson Barkshire, Inc., a Washington corporation, *Defendants.*

(CC 9301-00574; CA A82220; SC S42217)

On review from the Court of Appeals.*

Argued and submitted January 10, 1996.

Tom Steenson, of Steenson & Schumann, P.C., Portland, argued the cause for petitioners on review. With him on the briefs was Zan Tewksbury.

Larry K. Amburgey, Portland, argued the cause for respondents on review. On the briefs were Howard Rubin and Patricia Ann Haim, Portland.

Richard S. Yugler, Portland, filed a brief on behalf of amicus *curiae* Oregon Trial Lawyers Association.

Jerald P. Keene, of Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland, and Chess Trethewy, of Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C., Salem, filed a brief on behalf of *amicus curiae* Associated Oregon Industries.

Jonathan M. Hoffman and Julie K. Bolt, Portland, filed a brief on behalf of *amicus curiae* Oregon Association of Defense Counsel.

James W. Moller, Special Assistant Attorney General, with Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, Salem, filed a brief on behalf of *amicus curiae* SAIF Corporation.

Jackie Sanders, Portland, filed a brief on behalf of *amicus curiae* Fred Tyacke.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Graber, and Durham, Justices.**

GRABER, J.

The decision of the Court of Appeals is affirmed in part and reversed in part. The judgment of the circuit court is affirmed in part and reversed in part, and the case is remanded to the circuit court for further proceedings.

Durham, J., concurred in part and dissented in part and filed an opinion.

* Appeal from Multnomah County Circuit Court, Nely M. Johnson, Judge. 133 Or App 159, 890 P2d 1004 (1995).

** Fadeley, J., did not participate in the consideration or decision of this case; Unis, J., retired June 30, 1996, and did not participate in this decision.

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323 Or 621> This is an action involving claims for negligent wrongful death, intentional wrongful death, and violation of the Oregon Racketeer Influenced and Corrupt Organization Act (ORICO), brought against decedent's employer and that employer's president.

The individual plaintiffs are decedent's parents. Decedent's father is the personal representative of decedent's estate and is a plaintiff in that capacity. Decedent was an employee of defendant Day Management Corporation (DMC). Defendant Gordon Day is the president of DMC.

The case comes to us on review of a trial court's grant of defendants' motion to dismiss three of plaintiffs' claims. Accordingly, we assume the truth of all well-pleaded facts alleged in the complaint and give plaintiffs the benefit of all favorable inferences that may be drawn from those facts. *Stringer v. Car Data Systems, Inc.*, 314 Or 576, 584, 841 P2d 1183 (1992). Plaintiffs allege, as pertinent:

On January 6, 1992, decedent died in the course and scope of his employment with DMC, when he fell 400 feet while working on a radio tower. Before his death, decedent frequently had complained to DMC about the inadequate equipment that he was forced to use when climbing. Decedent was apprehensive about climbing with the equipment that DMC had provided, and he had asked that he not be required to climb anymore. DMC refused that request and, according to the complaint, told decedent "to climb or leave his employment."

DMC deliberately did not provide its workers, including decedent, with legally required safety equipment. DMC deliberately did not instruct decedent and its other workers how to use legally required safety equipment, how to engage in safe work practices, or how to follow state fall-protection regulations. DMC encouraged its workers not to use available safety equipment and not to take legally mandated safety precautions. DMC refused to develop a system or plan to ensure the safety of its workers at the tower or to provide adequate supervision to ensure the safety of those workers. **<323 Or 621/622>** As a result of DMC's actions, those workers were not adequately protected from fall, injury, and death.

DMC knew, before decedent's death, that if it did not provide the workers in decedent's work location with the requisite safety equipment and training, a worker would fall from the tower and that such a fall would result in serious injury or death.

After decedent's death, plaintiffs filed a complaint against DMC. Decedent's personal representative first alleged that, under ORS 30.020, DMC's negligence had led to the wrongful death of decedent.[1] In the second claim, decedent's personal representative alleged that DMC had acted with a "deliberate intention" to produce decedent's injury or death, within the meaning of ORS 656.156(2), and that decedent, had he lived, would have had cause for action against DMC for its wrongful acts.[2] Plaintiffs also alleged that defendants Day and DMC had engaged in a pattern of racketeering activities in violation of ORICO, ORS 166.715 to 166.735, and that those activities had resulted in decedent's death.

Day and DMC moved to dismiss all three claims, pursuant to ORCP 21 A(8).[3] The trial court ruled that ORS 656.018 was the exclusive remedy for all three claims and that application of that statutory provision was constitutional. The trial court concluded that, as to those three claims, plaintiffs failed to state ultimate facts sufficient to constitute a claim. Accordingly, the trial court granted that motion.[4]

323 Or 623> Plaintiffs appealed to the Court of Appeals, arguing that ORS 656.018 did not bar the negligent wrongful death claim against DMC and, alternatively, that such an application of ORS 656.018 would violate Article I, section 10, of the Oregon Constitution. Plaintiffs also argued that the complaint stated facts sufficient to meet the deliberate-intention-to-injure standard of ORS 656.156(2) and to state a claim against DMC and Day under ORICO. The Court of Appeals affirmed the order of the trial court. *Kilminster v. Day Management Corp.*, 133 Or App 159, 171, 890 P2d 1004 (1995). For the following reasons, we affirm the decision of the Court of Appeals with respect to the negligent wrongful death and ORICO claims but reverse with respect to ORS 656.156(2).

NEGLIGENT WRONGFUL DEATH

We begin with the negligent wrongful death claim. Plaintiff[5] argues that the exclusivity provision of the Workers' Compensation Act, ORS 656.018, does not preclude a wrongful death claim

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[1] Plaintiff describes the first claim as follows: "Plaintiff['s] First Claim alleged DMC's negligence caused decedent's wrongful death."

[2] Plaintiffs did not incorporate those allegations into the negligent wrongful death claim or into the ORICO claim, nor did they cite ORS 656.156(2) except in the deliberate-intention (second) claim.

[3] ORCP 21 A(8) provides:

> "Every defense, in law or fact, to a claim for relief in any pleading, whether a complaint, counterclaim, cross-claim or third party claim, shall be asserted in the responsive pleading thereto, except that the following defenses may at the option of the pleader be made by motion to dismiss: failure to state ultimate facts sufficient to constitute a claim."

[4] In their complaint, plaintiffs alleged other claims against other defendants. After the trial court granted Day's and DMC's motions to dismiss, the trial court entered ajudgment pursuant to ORCP 67 B as to the claims against Day and DMC only. Plaintiffs' other claims against other defendants are not before us.

[5] In our discussion of the negligent wrongful death claim and the intentional wrongful death claim, we use "plaintiff" in the singular to refer to the personal representative of decedent's estate.

brought under ORS 30.020 and that, if ORS 656.018 were read to preclude that claim, such a reading would violate Article I, section 10, of the Oregon Constitution.

ORS 656.018 provides in part:

> "(1)(a) The liability of every employer who satisfies the duty required by [the Workers' Compensation Act] is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom * * *.
>
> "* * * * *
>
> "(2) The rights given to a subject worker and the beneficiaries of the subject worker under this chapter for injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment are in lieu of **<323 Or 623/624>** any remedies they might otherwise have for such injuries, diseases, symptom complexes or similar conditions against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury, disease, symptom complex or similar conditions."[6]

The meaning of that statutory provision, as it relates to the issue in this case, is clear from its text and context. See *PGE v. Bureau of Labor and Industries*, 317. Or 606, 610-12, 859 P2d 1143 (1993) (describing this court's method of statutory analysis). An employer that satisfies certain duties of the Workers' Compensation Act will be liable for on-the-job injuries suffered by a worker only to the extent that that liability is provided for in the Act itself.[7] A worker who is injured in the course and scope of employment is entitled to receive, from the worker's employer, only the remedies provided for in the Act. *See Nicholson v. Blachly*, 305 Or 578, 581, 753 P2d 955 (1988) ("[t]he exclusive remedy of injured employes against their employers for injuries suffered in the course and scope of employment is to receive workers' compensation benefits"); *Fields v. Jantec, Inc.*, 317 Or 432, 438-39, 857 P2d 95 (1993) (same).

Plaintiff alleges that decedent was injured in the course and scope of his employment and that DMC had satisfied the duties required of it by the Workers' Compensation Act. In other words, plaintiff alleges facts that make ORS 656.018 operative in this case.

ORS 656.018 precludes plaintiff's wrongful death claim based on a theory of negligence. ORS 30.020(1) provides a decedent's representative with the right to bring a wrongful death action only *"if the decedent might have maintained an action, had the decedent lived."*[8] (Emphasis added.) A decedent who is

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[6] The legislature amended ORS 656.018 in 1995. Or Laws 1995, ch 332, § 5. Those amendments became effective on June 7, 1995, *id.* at § 69, and the legislature made those amendments applicable to "all claims or causes of action existing or arising on or after the effective date of" those amendments. *Id.* at § 66(l). Decedent's death occurred before the enactment of those amendments. The 1995 amendments to ORS 656.018 do not alter the wording or meaning of that provision in a way that affects our analysis in this case, however. Therefore, we quote and refer to the current version of ORS 656.018, but nothing in our decision today should be read as deciding whether those amendments apply retroactively.

[7] With respect to the negligent wrongful death claim, plaintiff does not rely on ORS 656.156(2) or on the exception clause in ORS 656.018(2).

[8] ORS 30.020(l) provides in part:

> "When the death of a person is caused by the wrongful act or omission of another, the personal representative of the decedent, for the benefit of the decedent's * * * surviving parents * * * who under the law of intestate succession of the state of the decedent's domicile would be entitled to inherit the personal property of the decedent * * * may maintain an action against the wrongdoer, if the decedent might have maintained an action, had the decedent lived, against the wrongdoer for an injury done by the same act or omission."

ORS 656.156(2) provides that a worker who is injured or killed as a result of the "deliberate intention of the employer * * * to produce such injury or death" may "have cause for action against the employer." That provision is discussed in the text, below. 323 Or at 628-32.

injured in the course of the decedent's employment and whose injury is covered under the exclusivity provisiion of the Workers' Compensation Act could not have maintained an action against the employer had he lived. ORS 656.018 is an explicit limitation on the right of covered employees to bring such actions. ORS 30.020(1), by its own terms, does not give a decedent's personal representative a right to sue the decedent's employer for negligent wrongful death when the decedent never had that right in the first place.

Plaintiff argues that such an application of ORS 656.018 to the wrongful death claim against DMC violates Article I, section 10, of the Oregon Constitution, because "it *takes away* the parents' claim for the wrongful death of their son." (Emphasis added.) We disagree.

Article I, section 10, of the Oregon Constitution, provides in part: "[E]very man shall have remedy by due course of law for injury done him in his person, property, or reputation." Recent cases from this court have addressed whether a statute deprived a litigant of a remedy, within the meaning of Article I, section 10, for a recognized common law or statutory right. *See, e.g., Greist v. Phillips,* 322 Or 281, 290-91, 906 P2d 789 (1995) (holding that a $500,000 statutory cap on the amount of noneconomic damages that a party may recover in a statutory wrongful death action does not deprive that party of a "Substantial remedy"); *Neher v. Chartier,* 319 Or 417, 420, 879 P2d 156 (1994) (holding that statutory immunity for public bodies and their officers, employees, and agents in the **<323 Or 625/626>** Oregon Tort Claims Act (OTCA) violated Article I, section 10, "because it purports to immunize public bodies from tort liability" and deprives the personal representative of a decedent's estate of a "substantial remedy"); *Hale v. Port of Portland,* 308 Or 508, 523-24, 783 P2d 506 (1989) (holding that the damages limitation in the OTCA as applied to cities and port districts did not violate Article I, section 10). Plaintiff relies on those cases, and especially on this court's decision in *Neher,* as supporting the argument that application of ORS 656.018 to plaintiff's statutory wrongful death claim in this case deprives decedent's parents of a "substantial remedy" in violation of Article I, section 10. Plaintiff's reliance on those cases is misplaced.

The Article I, section 10, remedy guarantee is implicated only if a person suffers injury to person, property, or reputation. This court recognized that proposition in *Noonan v. City of Portland,* 161 Or 213, 249, 88 P2d 808 (1939):

> "Article I, § 10, Oregon Constitution, was not intended to give anyone a vested right in the law either statutory or common; nor was it intended to render the law static. Notwithstanding similar constitutional provisions in other states, the courts have sustained statutes which eliminated the husband's common law liability for the torts of his wife and which placed the wife upon an economic level with her husband. They have likewise sustained statutes which have abolished actions for alienation of affections, actions for breach of promise, etc. The legislature cannot, however, abolish a remedy and at the same time recognize the existence of a right."

In recent cases, this court has adhered to the foregoing proposition. *See Neher,* 319 Or at 427 (quoting the above passage from *Noonan* with approval); *Hale,* 308 Or at 521 (same).

As explained above, the Workers' Compensation Act does not give decedent or plaintiff a statutory right to bring a negligence-based wrongful death action. Similarly, ORS 30.020 does not provide that right, because it gives a party a right to bring a wrongful death action only "if the decedent might have maintained an action, had the decedent lived." In other words, ORS 30.020 gives plaintiff a *derivative* right; but none of these plaintiffs has an independent basis from which to derive such a right.

323 Or 627> The legislature has chosen not to provide decedent's parents with a negligence-based wrongful death action in this case. Because the legislature has chosen not to provide decedent's parents with a wrongful death action based on a theory of negligence, and because Oregon has no common law action for wrongful death, *see Greist,* 822 Or at 294 (so stating), they have suffered no legally cognizable injury to their person, property, or reputation. Therefore, application of ORS 656.018 to this wrongful death action brought under ORS 30.020(l) does not violate Article I, section 10.

Neher does not support a different conclusion. In *Neher,* the decedent was killed when she was struck by a TriMet bus while she was engaged in activities covered by the Workers' Compensation Act.

The plaintiff, the personal representative of the decedent's estate, sought damages against Tri-Met and the bus driver. Those defendants claimed immunity under a provision of the OTCA that granted immunity to the public body and its employees if the person injured or killed was covered by the Workers' Compensation Act. 319 Or at 420-21. This court held that the application of statutory immunity violated Article I, section 10. *Id.* at 428.

The issue presented in Neher contained a feature not present in this case. In *Neher,* the OTCA provided immunity to a public body and its employees if the person injured or killed was covered under the exclusive remedy provision of the Workers' Compensation Act. The challenge was to the application of the *OTCA's* grant of immunity to the defendants when those defendants' relationship to the decedent was *unrelated* to the decedent's relationship with her employer; the defendants were not the decedent's employer. In *Neher,* then, the defendants' lack of an employment relationship with the decedent precluded the defendants from asserting directly that they were immune from liability under ORS 656.018. In other words, in *Neher,* the challenged grant of governmental immunity was "piggy backed" atop ORS 656.018. Further, because ORS 656.018 was not available to the defendants *vis-a-vis* the plaintiffs, the plaintiffs did not challenge the exclusive remedy bar of ORS 656.018. The scenario in this case, wherein plaintiffs negligent wrongful death claim against decedent's employer is controlled **<323 Or 627/628>** directly by ORS 656.018, is readily distinguishable from the scenario presented to this court in *Neher.*

Moreover, in *Neher,* the parties did not raise, and the court did not address, the question whether the statutes at issue there gave the plaintiff a derivative (as distinct from an independent) right. Here, that question is before us. As noted, none of the plaintiffs has an independent right to bring a wrongful death action against DMC, and decedent's personal representative has no derivative right.

The trial court did not err in dismissing the negligent wrongful death claim against DMC. The Court of Appeals did not err when it affirmed that ruling.

DELIBERATE INTENTION TO INJURE

Plaintiff next argues that the trial court erred when it dismissed the second claim for failure to state ultimate facts sufficient to constitute a claim. In the second claim, plaintiff incorporates the allegations of the wrongful death claim and, in addition, alleges that defendants deliberately intended to injure or kill decedent, citing ORS 656.156(2). We interpret the allegations of deliberate intention to injure or kill decedent to serve two functions: first, to allege that the usual bar of ORS 656.018 does not apply to this claim and, second, to allege affirmatively a claim for intentional wrongful death. The only issue brought to us for decision on this claim is the adequacy of the allegations of deliberate intention to injure or kill decedent. We agree with plaintiff's argument in that regard.

ORS 656.156(2) provides in part:

> "If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker, the widow, widower, child or dependent of the worker may take under this chapter, and also have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes."

ORS 656.156(2) is an exception to the exclusivity provision, ORS 656.018. ORS 656.156(2) gives a worker who is injured or killed in the course and scope of employment the right to bring an "action against the employer * * * for damages over **<323 Or 628/629>** the amount payable" under the Workers' Compensation Act if, but only if, the employee's injury or death "results from the deliberate intention of the employer to produce such injury or death."

Defendants argue, "[a]s a threshold matter, [that p]laintiff[] lack[s] standing to maintain a claim under" ORS 656.156(2), because that statute explicitly gives a right to bring an action under that subsection only to the worker, widower, child, or dependent of the worker. Defendants reason that, because a personal representative is not in any of those listed categories, plaintiff may not maintain this action. That argument is not well taken.

Under ORS 656.156(2), in the event of a worker's death resulting from the employer's deliberate intention to produce such death, "the worker * * * may * * * have cause for action against the employer, as if such [workers' compensation] statutes had not been passed, for damages over the amount payable under those statutes." That statute thus removes the bar that otherwise would prevent a worker from maintaining an action for damages against the employer, even though the worker is dead. Logically, the only party who can pursue that action, and thereby effectuate the substantive right afforded the deceased worker by ORS 656.156(2), is the worker's personal representative. Plaintiff is a person who may bring a claim, the bar to which has been removed by ORS 656.156(2), in the circumstances.

The trial court held that plaintiff failed to allege facts sufficient to state a claim, however. The Court of Appeals affirmed, stating that "[p]laintiff['s] allegations do not meet the stringent test for 'deliberate intent' to cause injury or death under ORS 656.156." 133 Or App at 167. Plaintiff argues that the complaint adequately pleads that DMC deliberately intended to produce decedent's injury or death.

Plaintiff's argument requires us to interpret ORS 656.156(2) to determine the meaning of the phrase "result[ing] * * * from the deliberate intention of the employer of the worker to produce such * * * death." Our analysis begins with the text and context of ORS 656.156(2). *PGE*, 317 Or at 610. A prior interpretation of a statute by this **<323 Or 629/630>** court becomes part of the statute itself, as if it were written into the statute at the time of the statute's enactment. *Holcomb v. Sunderland*, 321 Or 99, 105, 894 P2d 457 (1995).

The operative wording in ORS 656.156(2) was part of the original Oregon Workers' Compensation Act that was passed by the people in a referendum in 1913.[9] *See* General Laws of Oregon, p 8 (1915) (providing results of referendum vote). That wording has remained unchanged since adoption of the Act--a period of more than 80 years. Accordingly, this court's interpretations of that wording since adoption of the Act control its meaning.

Jenkins v. Carman Mfg. Co, 79 Or 448,453-54,155 P 703 (1916), is the first case from this court to interpret the phrase "deliberate intention to produce such injury or death." The court stated:

> "We think by the words 'deliberate intention to produce the injury' that the lawmakers meant to imply that the employer must have determined to injure an employee and used some means appropriate to that end; that there must be a specific intent, and not merely carelessness or negligence, however gross."

This court repeatedly has adhered to that definition. In *Heikkila v. Ewen Transfer Co.*, 135 Or 631, 634, 297 P 373 (1931), the court quoted with approval the definition from *Jenkins* and then said:

> "Under our authorities, recovery by a workman of his employer, where * * * recovery is sought in addition to any payment from the accident fund, where the injury results from the deliberate intention of the employer to produce the injury, 'deliberate intention' implies that the employer **<323 Or 630/631>** must have determined to injure the employee. It is not sufficient to show that there was mere carelessness, recklessness, or negligence, however gross it may be. Reckless disregard of the consequence * * * does not charge an intent to injure plaintiff."

See also Caline v. Maede, 239 Or 239, 240, 396 P2d 694 (1964) (relying on and applying *Jenkins* and *Heikkila); Bakker v. Baza'r*, Inc., 275 Or 245, 253, 551 P2d 1269 (1976) (stating that "[t]his court has consistently adhered to a strict construction of this statutory exception" and applying the above quotation from *Jenkins*); *Duk Hwan Chung v. Fred Meyer*, Inc., 276 Or 809, 813, 556 P2d 683 (1976) (quoting the above-quoted passage from *Heikkila* with approval, citing *Jenkins* and *Caline* with approval, and stating, "[i]n order to come within the exception [provided in ORS 656.156(2)] it is incumbent upon the injured workman to establish that his employer had a deliberate intention to injure him or someone else and that he was in fact injured as a result of that deliberate intention").

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[9] The pertinent section of the original version of the Workers' Compensation Act provided in part:

"If injury or death results to a workman from the deliberate intention of his employer to produce such injury or death, the workman, the widow, widower, child or dependent of the workman shall have the privilege to take under this act, and also have cause of action against the employer, as if this act had not been passed, for damages over the amount payable hereunder." General Laws of Oregon, ch 112, § 22, p 204 (1913).

The meaning of the provision at issue in this case is clear from this court's prior interpretations. In order for a worker to show that an injury that occurred during the course and scope of the worker's employment "result[ed] * * * from the deliberate intention of the employer * * * to produce" that injury, the worker must show that the employer determined to injure an employee, that is, had a specific intent to injure an employee; that the employer acted on that intent; and that the worker was, in fact, injured as a result of the employer's actions.

This court has, on six occasions, considered a claim brought under ORS 656.156(2). In the five cases cited above, the court held that the plaintiffs did not meet the requisite burden of pleading or proof.

Only one case from this court has held that a plaintiff met that burden. *Weis v. Allen,* 147 Or 670, 35 P2d 478 (1934), illustrates what a worker must establish. In *Weis,* the plaintiff brought an action to recover damages from his employer for injuries suffered when he was shot by a spring gun that the employer had set on the employer's property where the plaintiff was working. The plaintiff claimed that **<323 Or 631/632>** his injuries were a result of the employer's "deliberate intention * * * to produce such injury." The employer appealed from a jury verdict in the plaintiff's favor. 147 Or at 672. This court held that the evidence in the record was sufficient to support the verdict:

> "The record discloses that the guns * * * were so arranged that their contents would be discharged into the person for any one who might come in contact with the wires operating them. This change was made at the insistence and with the knowledge of the defendant, and the guns, set to inflict serious injury, were so maintained by him even after he had been ordered by the police to discontinue their use as dangerous and unlawful. There can be, therefore, no question but that these guns were kept and used by the defendant with the deliberate intention of injuring any one who might inadvertently cause them to be discharged.
>
> "It was not necessary here to prove that the defendant had singled the plaintiff out and set the gun with the express purpose of injuring him and no one else. The act which the defendant did was unlawful and was deliberately committed by him with the intention of inflicting injury." 147 Or at 680-82.

In this case, plaintiff has alleged facts sufficient to meet the foregoing standard for deliberate intention to injure or kill. Plaintiff alleges that DMC *knew* that decedent or someone who did the same work as decedent *would* be injured from a fall from the tower; that DMC decided to forego taking safety procedures, *knowing* that, by so doing, serious injury or death *would* result; and that DMC told decedent to climb the tower or lose his job. The second claim also cites ORS 656.156(2) and asserts specifically that DMC intended to produce decedent's injury and death:

> "The injury to and death of decedent resulted from the deliberate intention of Defendant DMC to produce such injury and death."

Reading all the allegations together, in the light most favorable to plaintiff, a finder of fact reasonably could infer that DMC determined to injure an employee, that is, specifically intended, "to produce [decedent's] injury or **<323 Or 632/633>** death." The underlying facts pleaded by plaintiff do not describe when or how DMC determined to injure decedent. However, a specific intent to produce an injury may be inferred from the circumstances. *Cf State v. Elliott,* 234 Or 522, 528-29, 383 P2d 382 (1963) (specific intent to commit a crime is a "subjective fact * * * seldom susceptible of direct proof [and] * * * usually established by a consideration of objective facts, and from th[osel objective facts an ultimate conclusion is drawn"). Taking all the allegations of the second claim together, plaintiff alleges more than gross negligence, carelessness, recklessness, or conscious indifference to a substantial risk of injury. Plaintiff alleges that serious injury to or death of a worker was *certain to occur,* that DMC failed to take requisite safety precautions or buy requisite safety equipment, and that DMC instructed decedent to climb the tower while *knowing* that a worker who climbed the tower *would* fall and be hurt. A reasonable finder of fact could infer that DMC acted as it did because it wished to injure or kill decedent. A specific intent to injure or kill decedent certainly is not the only state of mind that could be inferred, but it is a permissible inference. We need not consider whether plaintiff can *prove* that defendants had the alleged specific intent to injure or kill decedent; in the procedural posture of this case, we consider only the sufficiency of the complaint.

The trial court erred when it dismissed plaintiff's second claim for failure to state facts sufficient to constitute a claim. The Court of Appeals erred in affirming that ruling.

ORICO

Finally, plaintiffs argue that the trial court erred by dismissing their claim against DMC and Day under ORICO, ORS 166.715 to 166.735. The trial court concluded that ORS 656.018 barred plaintiffs' ORICO claim and, alternatively, that plaintiffs had failed to allege ultimate facts sufficient to constitute a claim under ORICO. The Court of Appeals did not address the applicability of ORS 656.018 to plaintiffs' ORICO claim, but affirmed the judgment of the trial court, concluding that plaintiffs failed to allege ultimate facts sufficient to state a claim. *Kilminster*, 133 Or App at 167-71. We hold that ORS 656.018 bars plaintiffs' ORICO claims. Accordingly, we do not address the sufficiency of plaintiffs' factual allegations.

323 Or 634> Plaintiffs allege that defendants'[10] engaged in a pattern of racketeering activity[11] and that defendants received proceeds or income resulting from that pattern of racketeering activity, in violation of ORS 166.720(1) to (3).[12] Plaintiffs allege that, "[a]s a result of the prohibited conduct of Defendants DMC and Day under ORICO, [decedent] suffered injury and death."

With respect to the underlying facts, plaintiffs' ORICO claim incorporates by reference the facts alleged in the first claim--the wrongful death claim based on a theory of negligence. Plaintiffs do not incorporate by reference the facts alleged in their second claim. That is, in the ORICO claim, plaintiffs do not cite ORS 656.156(2) and do not allege that "[t]he injury to and death of decedent resulted from the **<323 Or 634/635>** deliberate intention of Defendant DMC to produce such injury and death" or that decedent, had he lived, would have had cause for action against DMC for its wrongful acts.

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[10] Plaintiffs alleged that DMC is an "enterprise," as that term is used in ORS 166.715(2), and that DMC is subject to liability under ORICO. Plaintiffs also alleged that Day was a "person," under ORS 166.715(5), and that Day is subject to liability under ORICO.

[11] ORS 166.715(6)(a)(G) provides:

" 'Racketeering activity' means to commit, to attempt to commit, to conspire to commit, or to solicit, coerce or intimidate another person to commit:

"(a) Any conduct that constitutes a crime, as defined in ORS 161.515, under any of the following provisions of the Oregon Revised Statutes (G)163.160 to 163.205, relating to assault and related offenses."

Plaintiffs assert that defendants engaged in a pattern of racketeering activity by committing acts prohibited by ORS 163.195. ORS 163.195 provides:

"(1) A person commits the crime of recklessly endangering another person if the person recklessly engages in conduct which creates a substantial risk of serious physical injury to another person.

"(2) Recklessly endangering another person is a Class A misdemeanor."

[12] ORS 166.720 provides in part:

"(1) It is unlawful for any person who has knowingly received any proceeds derived, directly or indirectly, from a pattern of racketeering activity or through the collection of an unlawful debt to use or invest, whether directly or indirectly, any part of such proceeds, or the proceeds derived from the investment or use thereof, in the acquisition of any title to, or any right, interest or equity in, real property or in the establishment or operation of any enterprise.

"(2) It is unlawful for any person, through a pattern of racketeering activity or through the collection of an unlawful debt, to acquire or maintain, directly or indirectly, any interest in or control of any real property or enterprise.

"(3) It is unlawful for any person employed by, or associated with, any enterprise to conduct or participate, directly or indirectly, in such enterprise through a pattern of racketeering activity or the collection of an unlawful debt."

In the first claim, plaintiff alleges that serious injury to or death of a worker was certain to occur, that DMC failed to take requisite safety precautions or buy requisite safety equipment, and that DMC instructed decedent to climb the tower while knowing that a worker who climbed the tower would fall and be hurt. Plaintiff also alleges in the first claim that DMC "ratified its deliberate behavior described herein which was intended to cause decedent's death by asking employs [sic] of DMC to sign affidavits containing false information concerning the facts and circumstances of decedent's death." It might be possible to read the first claim (and thus the ORICO claim) as alleging a deliberate intention to kill decedent, even without the additional allegations of the second claim, but for the positions that plaintiffs have taken in this litigation.

First, as noted, plaintiffs chose to incorporate the first claim by reference into the ORICO claim, but they chose not to incorporate by reference the second claim. In the trial court, plaintiffs described the "nature" of the first claim as one "alleging that DMC's negligence * * * caused the death of [decedent]." That is a characterization of the first claim to which plaintiffs have adhered expressly on appeal and review as well. They are bound by that characterization. See *McGanty v. Staudenraus*, 321 Or 532, 544 n 6, 901 P2d 841 (1995) (in a case involving the sufficiency of a complaint to plead certain theories, issues were decided on the basis of what the plaintiff's lawyer said could be proved, notwithstanding the broader wording of the complaint).

Second, plaintiffs' legal arguments concerning the relationship between ORS 656.018 and their ORICO claim do not rely on application of the deliberate-intention-to-injure exception of ORS 656.156(2). In response to defendants' assertion that their ORICO claim is barred, plaintiffs argued to the trial court that, because of "the unique remedial nature of ORICO," the workers' compensation statutes "should not bar a person from pursuing all available civil remedies under **<323 Or 635/636>** ORICO." Plaintiffs also incorporated by reference their arguments that application of ORS 656.156(2) to the facts of this case would be unconstitutional. Significantly, plaintiffs did not incorporate by reference the argument, made in connection with the second claim, that the allegations of the amended complaint suffice to establish a deliberate intention to injure or kill decedent. Likewise, on appeal and review, plaintiffs' argument has been limited to the assertion that ORS 656.018 does not apply to ORICO claims at all:

> "Plaintiffs' ORICO claim is separate from and completely independent of Oregon's Workers' Compensation Act. ORICO's purpose, goals, and remedies, which address injury resulting from prohibited racketeering activity, make it an available remedy notwithstanding ORS 656.018."

To summarize, plaintiffs themselves characterize the ORICO claim as one that does not seek to establish that defendants specifically intended to injure or kill decedent.[13] We analyze the applicability of the exclusivity provision in the workers' compensation statutes accordingly.

As discussed above, ORS 656.018(2) explicitly provides that the remedies provided in the Workers' Compensation Act "are in lieu of any remedies [the injured worker] might otherwise have for such injuries * * * against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute." An employer that satisfies certain duties of the Workers' Compensation Act will be liable for an employee's on-the-job injuries only to the extent that that liability is provided for in the Act itself. The liability provided for in the Act is "exclusive and in place of all other liability." ORS 656.018(l)(a). *See also Nicholson*, 305 Or at 581 (so stating); *Fields*, 317 Or at 438-39 (same).

In the ORICO claim, plaintiffs allege that the events that led to decedent's death occurred in the course and scope **<323 Or 636/637>** of decedent's employment. There is no allegation in the ORICO claim that places the events that gave rise to decedent's injuries outside the course and scope of decedent's employment. Similarly, there is no allegation in the ORICO claim that places Day's or DMC's actions outside their roles as decedent's employer.

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[13] In connection with their assertion of entitlement to punitive damages, plaintiffs do allege (among other things) that defendants deliberately intended to injure decedent. But that allegation is not made in connection with the *underlying* ORICO claim. Plaintiffs are not offering to prove, in order to be entitled to recover under ORICO at all, that defendants had that state of mind. Instead, plaintiffs are asking that, if they can establish that state of mind, they be allowed to recover an additional measure of damages not normally available on their underlying claim.

Plaintiffs attempt to use ORICO as a back door through which to seek a remedy for a workplace injury that otherwise is barred by ORS 656.018(2). Plaintiffs allege safety violations that would give rise to a claim under ORS 654.305 to 654.335; but such a claim is barred expressly by ORS 656.018(2). Similarly, ORS 656.018(2) explicitly states that no "other laws * * * or statute[s]" provide a worker, who is injured in the course and scope of employment, with a remedy not provided in the Workers' Compensation Act. When a worker attempts to use ORICO to impose liability on the worker's employer for a workplace injury suffered by the worker, ORICO constitutes "other laws * * * or statute[sl." ORS 656.018 bars a worker's ORICO claim against the worker's employer when the injury to the worker that gave rise to the ORICO claim occurred in the course and scope of the worker's employment and is covered by the Workers' Compensation Act.

In their ORICO claim against defendants DMC and Day, plaintiffs allege that decedent was killed in the course and scope of his employment. Their claim, therefore, is barred by ORS 656.018.

The trial court did not err when it dismissed the ORICO claim. The Court of Appeals did not err when it affirmed that ruling.

CONCLUSION

In summary, we hold:

(1) ORS 656.018 bars the personal representative's wrongful death claim, based on a theory of negligence, and that application of ORS 656.018 does not violate Article I, section 10, of the Oregon Constitution.

323 Or 638> (2)The personal representative alleges ultimate facts sufficient to meet the deliberate-intention-to-injure standard established in ORS 656.156(2).

(3) ORS 656.018 bars plaintiffs' ORICO claim against decedent's employer for injuries that arose in the course and scope of decedent's employment.

The decision of the Court of Appeals is affirmed in part and reversed in part. The judgment of the circuit court is affirmed in part and reversed in part, and the case is remanded to the circuit court for further proceedings.

DURHAM, J., concurring in part, dissenting in part.

I agree with the majority that the exclusivity provision of the Workers' Compensation Act, ORS 656.018, bars plaintiff's[1] first claim, which he argues is a "negligent" wrongful death claim, and that application of ORS 656.018 to that claim does not violate Article I, section 10, of the Oregon Constitution.[2] The trial court did not err in dismissing that claim. I also agree that, with respect to the second claim for "deliberate" wrongful death, plaintiff alleges ultimate facts that are sufficient to meet the deliberate-intention-to-injure standard set forth in ORS 656.156(2)[3] and that the trial court, therefore, erred in dismissing that claim. However, for the reasons that follow, I disagree with the majority's conclusion that ORS 656.018 bars plaintiffs' ORICO claim.

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[1] In discussing the negligent wrongful death claim, I use the term "plaintiff" in the singular, as does the majority, 323 Or at 623 n 5, to refer to the personal representative of decedent's estate.

[2] Plaintiff allege in the first claim that defendant DMC "deliberately" engaged in a number of acts that caused decedent's death. However, he argues, apparently for tactical reasons, that the first claim is a viable claim for *negligent* wrongful death. Plaintiff is bound by that characterization. Because plaintiff's characterization of the first claim is not consonant with the right of action described in ORS 656.156(2), ORS 656.018 bars that claim.

[3] ORS 656.156(2) provides:

> "If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker, the widow, widower, child or dependent of the worker may take under this chapter, and also have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes."

323 Or 639> Plaintiffs base the ORICO claim on allegations that defendants' repeated violations of Oregon's worker safety laws, ORS 654.305 to 654.335, and regulations promulgated pursuant to those statutes, resulted in decedent's death. I assume, without deciding, that ORS 656.018 and 656.156(2) apply to that claim. The majority concludes that plaintiffs do not allege deliberate intent to injure in connection with the ORICO claim and, as a result, ORS 656.018 bars that action. The majority is incorrect.

The ORICO claim incorporates the following factual allegations:

"7.

"The work in which the decedent was employed at the time of his death involved an extreme risk of death and danger to employees. The Tower is 603 feet tall. It presents life threatening conditions of fall hazard.

"* * * * *

"10.

"Defendant DMC was aware of said falls, of decedent's previous injury, and that decedent fell because he was not supplied with required fall protection equipment. Defendant DMC *deliberately* took no steps to prevent decedent from falling again.

"* * * * *

"12.

"Decedent was nervous and apprehensive about climbing. He requested that he not climb anymore. Defendant DMC refused this request and ordered decedent to climb or leave his employment.

"* * * * *

"16.

"Prior to decedent's death, DMC *deliberately* did not instruct decedent and other workers to use required safety equipment or to follow safe work practices and OR-OSHA's fall protection regulations. Decedent and other workers **<323 Or 639/640>** were allowed and encouraged by Defendant DMC to 'free climb'the Tower which they often did.

"17.

"Defendant DMC *deliberately* allowed and encouraged decedent and other workers not to use required ladder devices, not to always 'tie off' as required, and not to use other required fall protection equipment and safe procedures. Defendant DMC *deliberately* did not supply nor require necessary fall protection equipment.

"18.

"Defendant DMC *deliberately* allowed and encouraged decedent and other workers to not wear required hard hats.

"19.

"Defendant DMC *deliberately* refused and failed to develop a system or plan to ensure the safety of its workers at the Tower.

"20.

"Defendant DMC *deliberately* failed to provide adequate supervision to ensure that DMC workers on the Tower, including decedent, followed safe work practices and fall protection regulations.

"21.

"As a result of Defendant DMC's *deliberate conduct* as alleged above, workers on the Tower, including decedent, were not adequately protected from fall:

"(a) When they were allowed to free climb the Tower.

"(b) When they were not supplied and therefore did not use approved devices compatible with the Tower ladder safety cable.

"(c) When they stepped off the ladder to their work position at the Tower cable tray area.

"(d) When they were allowed to rappel down the Tower center tube.

323 Or 641> "(e) When they were connected to the Tower ladder safety cable by a four-foot lanyard, against the manufacturer's specifications and ANSI A14.3.

"(f) When they used fall-protection equipment against manufacturer's instructions, including using positioning belts for fall-arrest protection, connecting both snap locks of pole straps into the hip ring, using pole straps as lanyards, and wrapping pole straps lanyards around sharp objects.

"* * * * *

"26.

"Defendant DMC has *ratified its deliberate behavior* described herein *which was intended to cause decedent's death* by asking employs *[sic]* of DMC to sign affidavits containing false information concerning the facts and circumstances of decedent's death." (Emphasis added.)

ORCP 12 provides:

"A. Liberal Construction. All pleadings shall be liberally construed with a view of substantial justice between the parties.

"B. Disregard of Error or Defect Not Affecting Substantial Right. The court shall, in every stage of an action, disregard any error or defect in the pleadings or proceedings which does not affect the substantial rights of the adverse party."

This court is obliged to review the allegations quoted above, and all inferences that they create, in the light most favorable to the nonmoving party. *Stringer v. Car Data Systems, Inc.*, 314 Or 576, 584, 841 P2d 1183 (1992).

Viewed in that light, the ORICO claim is susceptible of a reasonable interpretation that satisfies the deliberate-intention-to-injure standard in ORS 656.156(2). The complaint alleges facts showing the risk of death and danger that decedent faced in working on the tower and describes a long list of deliberate actions and failures to act by defendant DMC that caused decedent's death. Significantly, paragraph 26, last quoted above, refers to defendant DMC's deliberate behavior that caused the death and states that such behavior "was intended to cause decedent's death."

323 Or 642> ORS 656.156(2) removes the bar to liability in ORS 656.018 if the worker is injured or killed due to the "deliberate intention of the employer * * * to produce such injury or death." This court's cases require a pleading, under ORS 656.156(2), to allege an employer's specific intent to injure the worker, in contrast to a state of mind characterized by recklessness or simple negligence. *See Jenkins v. Carman Mfg. Co.*, 79 Or 448, 453-54, 115 P 703 (1916) ("there must be a, specific intent, and not merely carelessness or negligence, however gross"); *Heikkila v. Ewen Transfer Co.*, 135 Or 631, 634, 297 P 373 (1931) ("the employer must have determined to injure an employee").

Plaintiffs' ORICO claim does not allege that defendant DMC acted negligently or recklessly. Instead, it alleges that defendant DMC's deliberate behavior "was intended to cause decedent's death." In contrast to plaintiff's argument about the first claim, the ORICO claim does not state that defendant DMC's behavior "negligently" caused decedent's death.

In their ORICO claim, plaintiffs incorporate by reference the facts alleged in their claim for negligent wrongful death. Those allegations describe a pattern of deliberate conduct that plaintiffs expressly allege "was intended to cause decedent's death." The fact that plaintiff characterizes the first claim as based on a theory of negligence has no bearing on the question whether those factual allegations, when incorporated into the ORICO claim, are sufficient to satisfy the deliberate-intention-to-injure standard of ORS 656.156(2).

In concluding that ORS 656.018 does not bar plaintiff's second claim, the majority relies on plaintiff's allegations that "serious injury to or death of a worker was *certain to occur*, that DMC failed to take requisite safety precautions or buy requisite safety equipment, and that DMC instructed decedent to climb the tower while *knowing* that a worker who climbed the tower *would* fall and be hurt." 323 Or at 633 (emphasis supplied by the majority). What the majority fails to mention is that *plaintiffs also incorporate each of those same allegations into their ORICO claim.*

323 Or 643> The majority rests its conclusion that ORS 656.018 bars plaintiffs' ORICO claim on the following reasoning:

> "[I]n the ORICO claim, plaintiffs do not cite ORS 656.156(2) and do not allege that '[t]he injury to and death of decedent resulted from the deliberate intention of Defendant DMC to produce such injury and death' or that decedent, had he lived, would have had cause for action against DMC for its wrongful acts." 323 Or at 634-35.

The majority does not explain why plaintiffs' failure to include a citation to ORS 656.156(2) in connection with their ORICO claim precludes plaintiffs from obtaining the benefit of that statute. The absence of a citation to ORS 656.156(2) is of no moment in determining whether plaintiffs have alleged sufficient facts in their ORICO claim to r6move the bar of ORS 656.018.

Finally, the majority ignores paragraph 96 of the complaint, which is part of the ORICO claim, which alleges that defendants

> "willfully ignored the public policy in favor of worker safety laws *[see* ORS chapter 654], knowingly violated [their] duty to provide a safe work environment [see ORS 654.101 and 654.305] without regard to the cost of safety measures, wantonly failed to comply with state safety standards [see ORS 654.022, 654.310, and OAR 437-3-040(l)], and *deliberately intended to cause worker injury and death.* Such wrongful acts are reprehensible and are of the type from which the community deserves protection; accordingly, punitive damages should be assessed against Defendants DMC and Day in the amount of $20,000,000.00." (Emphasis added.)

The majority explains its unwillingness to give effect to the allegations in that paragraph as follows:

> "Plaintiffs are not offering to prove, in order to be entitled to recover under ORICO *at all*, that defendants had that state of mind [i.e., a deliberate intention to injure]. Instead, plaintiffs are asking that, if they can establish that state of mind, they be allowed to recover an additional measure of damages not normally available on their underlying claim." 323 Or at 636 n 13 (emphasis supplied by the majority).

323 Or 624> The majority may or may not be correct that plaintiffs incorporated an allegation that defendants "deliberately intended to cause worker injury and death" as part of their ORICO claim for the sole purpose of supporting a claim for punitive damages. However, even assuming that the majority's speculation is correct, we may not overlook that allegation in assessing the sufficiency of the complaint. The majority cites to no legal authority in support of its decision to do so. The majority's unwillingness to give effect to that allegation is a misapplication of this court's standard of review and a departure from settled legal principles.

In sum, the majority's conclusion that plaintiffs do not allege a deliberate injury in their ORICO claim is incorrect. The ORICO claim alleges facts that describe a deliberate injury, not the result of mere negligence. Plaintiffs incorporate into the ORICO claim the very same allegations upon which the majority relies in concluding that plaintiffs second claim does allege a deliberate intention to injure and is not barred by ORS 656.018. Moreover, plaintiffs allege, in paragraph 96 of the complaint, which is part of the ORICO claim, that defendants "deliberately intended to cause worker injury and death." Those allegations plainly are sufficient to remove the bar of ORS 656.018. Accordingly, the ORICO claim is not subject to dismissal for the reason expressed by the majority.

For the foregoing reasons, I dissent from the majority's analysis and conclusion regarding the sufficiency of the ORICO claim.

Cite as 141 Or App 467 (1996) June 19, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON OCCUPATIONAL SAFETY & HEALTH DIVISION, *Petitioner,*

v.

PORT OF PORTLAND, *Respondent.*

(SH-93-297; CA A85884)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 1, 1995.

Janie M. Burcart, Assistant Attorney General, argued the cause for petitioner. With her on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

George Goodman argued the cause for respondent. With him on the brief was Cummins Goodman Fish & Peterson, P.C.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LANDAU, J.

Reversed and remanded for reconsideration.

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141 Or App 469> Petitioner Oregon Occupational Safety and Health Division (Or-OSHA)[1] appeals a final order of the Workers' Compensation Board (the Board) granting employer Port of Portland's (the Port) motion to dismiss as untimely a citation Or-OSHA issued for violations of the Oregon Safe Employment Act (OSEA).[2] *See* ORS 654.071(l). We reverse and remand for reconsideration.

The relevant facts are not disputed. On Saturday, April 17, 1993, at 8:20 p.m., longshoreman Michael Cork was struck and killed by a top loader at a Port of Portland terminal. Marine security notified the Port, and the Port's risk manager, Catherine Brown, went to the scene. She arrived at the scene of the accident at 8:53 p.m. She saw the body and ordered the area secured. Sometime before 9:30 p.m., Brown telephoned Or-OSHA. She reached a recorded message that instructed her to call the agency's emergency number. Brown called the emergency number and reported that a worker had been struck by a top loader and killed instantly. The emergency operator who took the call contacted the Or-OSHA officer on duty, Terry DeForest, and reported that a worker had been hit by a top loader at the Port and had been killed.

DeForest had some difficulty contacting Brown, but eventually she called him from the accident scene. Brown told DeForest that a worker had been hit and killed by a top loader, that an emergency crew and medical examiner were on the scene and that she needed permission to have the body removed. DeForest permitted removal of the body but requested that the scene otherwise remain secured until Or-OSHA could investigate the following day.

On Sunday, April 18, 1993, DeForest telephoned Or-OSHA investigator John Murphy and told him that a worker had been struck and killed by a top loader at the Port and requested that he investigate. Murphy arrived at the scene **<141 Or App 469/470>** that afternoon and began an opening conference. Following the opening conference, Murphy encountered difficulty identifying or contacting all the potential witnesses. He also was off work during June and much of August for personal reasons. Or-OSHA held a closing conference on October 12, 1993, and issued a citation for violations of five standards on October 15 , 1993, 181 days after the April 17, 1993 accident.

Employer moved to dismiss the citation as untimely under ORS 654.071(3), which provides:

> "No citation or notice of proposed civil penalty may be issued under this section after the expiration of 180 days following the director's knowledge of the occurrence of a violation * * *."

A hearing was conducted on the extent of the information available to Or-OSHA on the night of April 17, 1993. In the course of that hearing, DeForest testified as follows:

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[1] Both petitioner and respondent, as well as the Workers' Compensation Board, refer to the Oregon Occupational Safety and Health Division as "OrOSHA," so we do also.

[2] The OSEA is codified at ORS 654.001 through ORS 654.295, ORS 654.750 through ORS 654.780, and ORS 654.991.

"Q. Well, did you believe that there was sufficient evidence to determine that a violation had occurred? Based on what you knew from the ORS people * * * did you form any opinion that a violation had occurred?

"A. No. I didn't know if there was a violation yet or not. I knew that there was a fatality.

"Q. Does a fatality equate to a violation?

"A. No, sir."

On cross-examination, DeForest further testified:

"Q. Now, lets assume it's a worker who's killed and you learn about it, and he's struck by a top loader. Can a top loader at a place of employment strike an employee at that place of employment without violating any OSHA regulation or standard, to your knowledge?

"A. I wouldn't be able to answer that question without an investigation.

" * * * * *

"Referee: Let's just talk about whether it's a violation--whether it could be a violation. Can you answer that?

141 Or App 471> "A. Really, no. Not with the information you have here. I have to--That's why I send out Mr. Murphy to decide whether I have a violation or not.

" * * * * *

"Q. On the face of it, just on the surface, when you received information indicating that The Port of Portland had an employee who had driven a top loader into and killed another employee, wouldn't you agree that that information alone, absent mitigating facts, appears to violate [ORS] 654.010?

"A. On the surface, yes."

After the hearing, the Board found and concluded as follows:

"While not all the information necessary for issuing a citation was available on the 17th, the * * * elements of a violation were sufficiently clear to say that on April 17th, Or-OSHA knew or with the exercise of reasonable diligence, should have known, that a violation had occurred and that the Port was the employer involved. The 180 days began to run on April 17th.

" * * * * *

"Employers have a duty to attempt to prevent workers from being killed by machinery on the job, under the general duty clause as well as more specific safety rules. As acknowledged by Mr. DeForest, 'on the surface, the fact that a top loader hit and killed someone looks like a violation of some [safety] rule.'

" * * * * *

"The issue is not whether on April 17 Or-OSHA had all the information it wanted or needed in order to issue a citation. It had six months to complete its investigation and issue its citation. The question is whether it had sufficient notice on April 17 to believe that some violation of its safety regulations, general or specific, had occurred * * *. * * * [I]t did."

The Board then dismissed the citation as not timely issued.

On appeal, Or-OSHA argues that the Board erred in dismissing the citation. Or-OSHA contends that ORS 654.071(3) provides that a citation may not be issued more than 180 days following "the director's knowledge of the **<141 Or App 471/472>** occurrence of a violation." According to Or-OSHA, the director did not know that a violation occurred until at least April 18, 1993, which was 180 days before

the citation was issued. The Port defends the Board's decision, arguing that it is not necessary that the director have actual knowledge of a violation and that, on April 17, 1993, the director had sufficient information that he at least should have known that a violation occurred. That, the Port argues, is sufficient to commence the running of the 180-day limitation period.

The disposition of the appeal requires us to determine whether the Board correctly interpreted and applied ORS 654.071(3), an issue that we review for errors of law. ORS 183.482(8)(a); *Oregon Occupational Safety v. Fall Creek Logging*, 137 Or App 506, 508, 905 P2d 241 (1995). In reviewing the Board's construction of the statute, we apply the principles of construction set out in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993), looking first to the text of the statute in its context. In construing the language of the statute, we are constrained both by constitutional principles and statutory command neither to insert what has been omitted by the legislature nor to omit what the legislature inserted. ORS 174.010; *Fernandez v. Board of* Parole, 137 Or App 247, 252, 904 P2d 1071 (1995). Instead, we are to construe fairly the terms as enacted, giving the words their plain, natural and ordinary meaning, unless there is evidence that the legislature intended otherwise. *PGE*, 317 Or at 611.

ORS 654.071(3) provides that a citation may not be issued more than 180 days "following the director's knowledge of a violation." Two key conditions are expressed by that phrasing: first, that the 180-day period is triggered by the director's *knowledge*, and second, that what the director must have knowledge of is a *violation*. We begin our analysis of the statute with the intended meaning of the reference to the director's knowledge.

The term "knowledge" generally refers to

> "the fact or condition of knowing **a(1):** the fact or condition of knowing something with a considerable degree of familiarity gained through experience of or contact or association with the individual or thing so known * * * **b(1):** the fact or **<141 Or App 472/473>** condition of being cognizant, conscious, or aware of something * * * (2): the particular existent range of one's information or acquaintance with facts * * *."

Webster's Third New International Dictionary 1252 (1976). In the law, however, it cannot be gainsaid that the term sometimes refers to actual knowledge--consistent with the foregoing definition--and sometimes to constructive knowledge, referring to the extent to which information merely gives one reason to have known a fact, whether or not actual knowledge occurs. *See Black's Law Dictionary* 784 (5th ed 1979).

Examining the text of ORS 654.071(3) in its context, however, it is clear that the legislature understood the distinction between the two types of knowledge and used language accordingly. Thus, in ORS 654.071(l), the director or an authorized representative of the director is authorized to issue a citation if either

> *"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 * * *."

ORS 654.071(1) (emphasis supplied); *see also* ORS 654.031 (director shall issue citation when he or she "has reason to believe" that any place of employment is unsafe). Similarly, in ORS 654.071(4), the director is authorized to consider failure to correct a violation as a separate violation if he or she

> *"has reason to believe* that an employer has failed to correct a violation within the period of time fixed for correction, or within the time fixed in a subsequent order granting an extension of time to correct the violation * * *."

ORS 654.071(4) (emphasis supplied).

In contrast, ORS 654.071(3) provides that no citations may issue more than 180 days from the "director's knowledge of the occurrence of a violation." The statute does not say 180 days from the date the director "has reason to believe" a violation has occurred. To construe the reference to "knowledge" in ORS 654.071 to mean "has reason to believe," would require us to ignore the distinction that the legislature has drawn in that section between the two different terms without any evidence that the legislature so intended. We **<141 Or App 473/474>** reject the Port's proposed construction of the statutory term "knowledge" and turn to the question of the intended meaning of the "violation" of which the director must have knowledge to trigger the 180-day period.

At the outset, we note that the statute refers to knowledge of a "violation," not merely an accident. The distinction is important, for it does not necessarily follow that all accidents--even fatal ones--constitute violations within the meaning of the statute. ORS 654.071(3) does not define the term "violation," nor does it spell out what must be violated to implicate the statute. Other sections of the statute, however, repeatedly refer to "violations"' in terms of violations of any laws, regulations or standards pertaining to occupational safety and health. *See, e.g.,* ORS 654.062. Moreover, ORS 654.035 authorizes the director to fix standards by which it may be determined that violations have occurred. The director has done that, and by rule has defined a "violation" to be a

> "breach of a person's duty to comply with an Oregon occupational safety or health statute, regulation, rule, standard or order."

OAR 437-01-015(53). Neither the Port nor Or-OSHA challenges the validity of that definition, and, at least for the purposes of this opinion, we adopt it.

The question, then, is precisely what violation the director knew about, if any, on April 17, 1993. The Board did not cite any particular violation. It did refer generally to the duty of all employers to maintain a safe place of employment. The Port asserts that the duty to maintain a safe workplace forms the basis of the Board's decision, and Or-OSHA appears to argue under the same assumption.

The duty to which the parties refer, known as the "general duty clause," is expressed in ORS 654.010:

> "Every employer shall furnish employment and a place of employment which are safe and healthful for employees therein, and shall furnish and use such devices and safeguards, and shall adopt and use such practices, means, methods, operations and processes as are reasonably necessary to render such employment and place of Oregon employment **<141 Or App 474/475>** safe and healthful, and shall do every other thing reasonably necessary to protect the life, safety and health of such employees."

The statute does not, by its terms, describe particular elements that constitute a violation. The Board held that, to make out a violation of the general duty clause, it must be established that

> "(1) The standard alleged to have been violated must apply to the cited conditions; and
>
> "(2) The employer's conduct must be out of conformance with the requirements of the standard; and
>
> "(3) Employees must have been exposed to the cited conditions; and
>
> "(4) The employer knew or could have known of the conditions."

Or-OSHA does not contest the four-part test the Board applied. The Port does, although it does not cross-assign error to the Board's decision in that regard. According to the Port, employer knowledge is not an element of a general duty clause violation. We need not resolve that particular dispute, because there is a complete absence of evidence as to two other elements.

It is apparently undisputed that the general duty standard applies to the Port. What is disputed is whether the director knew that the Port's conduct was out of conformance with the standard and that its employees were exposed to "cited conditions." Or-OSHA argues that there simply is no evidence that the director knew anything about either element on April 17, 1993. All the director knew at that time, Or-OSHA contends, is that someone was killed by a top loader. As Or-OSHA argues:

> "[T]he deceased could have had a heart attack and fallen or intentionally thrown himself beneath the wheels of the top loader or the loader itself could have malfunctioned despite perfect maintenance. None of these things was or could have been known by Or-OSHA the night the longshoreman died."

141 Or App 476> The Port insists that the fact of the accident itself demonstrated a violation of the general duty clause:

> "On April 17, 1993, the employer reported and Or-OSHA knew of the *occurrence* of a work related fatality. This fatality, *standing alone,* constituted a breach of the employer's duty to provide one of its employees with a safe place of employment * * *."

(Emphasis in original.)

The Port cites no authority for its reading of the statute, and we are aware of none. The language of the law certainly does not support that construction. The statute, on its face, requires employers to adopt such practices *"as are reasonably necessary"* to make the place of employment safe and to do every other thing *"reasonably necessary"* to protect the life, safety and health of the employees. ORS 654.010. The statute does not impose the standard of absolute safety that the Port asserts; merely because an accident has occurred does not necessarily mean that a violation has occurred as well. To the contrary, the statute speaks in terms of "reasonably necessary" precautions, which requires an examination of the facts of each case to determine whether a general duty violation has occurred.

Our reading of the language of ORS 654.010 is consistent with federal case law interpreting the federal general duty standard,[3] on which ORS 654.010 is based. *See Skirvin v. Accident Prevention Division*, 32 Or App 109, 111 n 1, 573 P2d 747, *rev den* 282 Or 385 (1978) (Oregon Safe Employment Act based on federal Occupational Safety and Health Act of 1970); *see also Marks v. McKenzie High School Fact-Finding Team*, 319 Or 451, 457-58, 878 P2d 417 (1994) (federal cases can give insight to the meaning of state statutes based upon federal statutes); *Loewen v. Galligan*, 130 Or App 222, 231, 882 P2d 104, *rev den* 320 Or 493 (1994) (same). Under those cases, the fact of an accidental injury is relevant **<141 Or App 476/477>** to a showing that there has been a violation, but it is not dispositive. In *Bethlehem Steel Corp v. Occ. Saf & H.R. Comm.*, 607 F2d 871, 874 (3d Cir 1979), for example, the court explained:

> "[A]lthough the occurrence of a death or serious injury may be relevant to proving a violation of the general duty clause, the statute is violated when a recognized hazard is maintained, whether or not an injury occurs. * * * Moreover, an employer may be found not to have violated the general duty clause notwithstanding the occurrence of a death if the hazard was unforeseeable."

See also Donovan v. Royal Logging Co., 645 F2d 822, 829 (9th Cir 1981) (violation occurs on evidence of a practice that could cause serious harm upon other than "freakish" or "implausible" circumstances); *Titanium Metals Corp. of America v. Usery*, 579 F2d 536, 542 (9th Cir 1978) ("OSHA was never designed, nor could it have been, to eliminate all occupational accidents").

With the foregoing construction in mind, it is clear to us that the record is devoid of any evidence as to the director's knowledge, on April 17, 1993, of the reasonableness of the employer's conduct that night. The only information that Or-OSHA had received was that a longshoreman had died when struck and killed by a top loader. That does not speak to the reasonableness of an employer practice or condition at the time, much less the extent to which the employees were exposed to such practice or condition.

The Port insists that the Board found as a matter of fact that the director knew of a violation, based on DeForest's testimony that "on the surface, the fact that a top loader hit and killed someone looks like a violation of some [safety] rule." That argument, however, is based on a misquoting of DeForest's testimony. DeForest simply did not say the words that are quoted in the Board's opinion. To the contrary, he repeatedly asserted that, the occurrence of an on-the-job fatality, by itself, does not establish a violation of any applicable standard. On cross-examination, DeForest was asked whether, "just on the surface," knowledge that one employee had driven a top loader on top of another, *"absent mitigating facts,"* appeared to violate, the general duty clause. To that **<141 Or App 477/478>** qualified question, he replied: "On the surface, yes." The qualification was, however, that there were no mitigating circumstances. As DeForest repeatedly testified, it could not be determined without an investigation whether such circumstances existed on the night of April 17, 1993.

The Board erred in concluding that the citation had been untimely issued in violation of ORS 654.071(3) and in granting the Port's motion to dismiss.

Reversed and remanded for reconsideration.

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[3] 29 USC §§ 651-678 (1970). The federal "general duty" is found at 29 USC section 654(a)(1):

> "Each employer * * * shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees."

Cite as 141 Or App 578 (1996) June 26, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Clifton Edwards, Claimant.
Clifton EDWARDS, DCD, *Petitioner,*
v.
CHERRY CITY ELECTRIC, INC., and SAIF Corporation, *Respondents.*
(94-04160; CA A88095)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 11, 1995.
Darrell E. Bewley argued the cause for petitioner. With him on the brief was Vick and Gutzler.
Julene Quinn argued the cause for respondents. On the brief were Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and James W. Moller, Special Assistant Attorney General.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

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141 Or App 580> Claimant suffered a compensable, work-related injury. He died of causes unrelated to the injury before receiving a compensation award. He had no spouse or dependents who survived him. The issue is whether claimant's personal representative could pursue an award of permanerit disability benefits that accrued before claimant's death when claimant left no surviving spouse or dependents. The Workers' Compensation Board concluded that the personal representative could not and, further, that the personal representative could not collect a burial allowance under ORS 656.218(5) because there was not an unpaid award of permanent disability benefits. We affirm.

Claimant's injury occurred on September 21, 1991. He filed a claim with SAIF in November 1991, which SAIF denied. On April 10, 1992, a board referee set aside SAIF's denial. SAIF requested review. The board affirmed the referee's order. Finally, in February 1993, SAIF sent a letter to claimant stating that his claim had been accepted and that benefits would be determined.

Claimant died on August 29, 1993. On October 19, 1993, the Department of Insurance and Finance[1] issued a determination order that awarded claimant temporary partial disability benefits but no permanent benefits. Claimant's personal representative sought reconsideration of that order, arguing that claimant should have been awarded permanent partial disability benefits. The department agreed and issued an order on reconsideration that awarded claimant 17 percent unscheduled permanent disability.

In response, SAIF requested a hearing and argued that the order on reconsideration was void because the personal representative lacked authority to request reconsideration by the department. The board concluded that the order on reconsideration was void. It reasoned as follows: The legislature amended ORS 656.268 in 1990 to add a requirement **<141 Or App 580/581>** that a party seek reconsideration by the department of a disability award in order for the party to request a hearing on the award with the board. *See* Or Laws 1990, ch 2, § 16. ORS 656.218(4), in turn, was last amended in 1987. It authorizes certain beneficiaries of a worker to request a hearing on a permanent disability award, but it does not authorize them to seek reconsideration of the award under ORS 656.268. Therefore, the beneficiaries cannot request a hearing because they cannot satisfy a condition that must be met to do that, which is to request reconsideration under ORS 656.268.

As an alternative ground for its decision, the board held that the personal representative was not a person who could request reconsideration or a hearing because he was not among the parties identified in ORS 656.218(4) who could request a hearing on a permanent disability award for a deceased worker. It relied on *Trice v. Tektronix,* 104 Or App 461, 801 P2d 896 (1990), as support for that conclusion. Finally, it held that the personal representative could not collect a burial allowance under

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[1] The Department of Insurance and Finance is now the Department of Consumer and Business Services. Or Laws 1993, ch 744, § 1.

ORS 656.218(5) because the amount of the allowance is the lesser of any unpaid permanent disability award or the amount payable under ORS 656.204(1), and the amount of the permanent disability award due claimant under the original determination order is $0. As a result, the board reversed the referee's decision and vacated the order on reconsideration. The personal representative now seeks judicial review.

ORS 656.218 provides in relevant part:

"(1) In case of the death of a worker *entitled to compensation*, whether eligibility therefor or the amount thereof [has] been determined, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto.

"(2) If the worker's death occurs prior to issuance of a notice of closure or making of a determination under ORS 656.268, *the insurer*, or the self-insured employer *shall proceed under ORS 656.268 and determine compensation for permanent partial disability*, if any.

"* * * * *

141 Or App 582> "(4) If the worker dies before filing a request for hearing, *the persons described in subsection (5) of this section shall be entitled to file a request for hearing and to pursue the matter to final determination* as to all issues presented by the request for hearing.

"(5) The payments provided in this section shall be made to *the persons who would have beenentitled to receive death benefits* if the injury causing the disability had been fatal. *In the absence of persons so entitled, a burial allowance may be paid not to exceed the lesser of either the unpaid award or the amount payable by ORS 656.204.*"

(Emphasis supplied.)

Claimant died from causes unrelated to his injury before issuance of a notice of closure. Thus, pursuant to ORS 656.218(2), SAIF was required to proceed under ORS 656.268 and determine whether decedent was owed compensation for permanent partial disability. SAIF complied with that requirement by submitting decedent's claim to the department for evaluation and closure. The department issued a determination order that awarded no permanent disability.

Claimant's personal representative argues that, at that point, he was entitled to request a hearing pursuant to ORS 656.218(4) to pursue the matter to a final determination. As explained, the board held that he could not because ORS 656.218(4) includes no right to seek reconsideration. We disagree with that analysis. The authority to request a hearing under ORS 656.218(4) implies the authority to satisfy any condition that must be met to file such a request, including the authority to request reconsideration. Thus, any person who is entitled to request a hearing under ORS 656.218(4) is authorized to request reconsideration under ORS 656.268.

SAIF argues, however, that only those individuals who would have been entitled to receive death benefits had the injury been fatal are entitled to request a hearing under ORS 656.218(4). Because decedent left no statutory beneficiaries who were entitled to pursue review of his claim, SAIF contends that the initial award denying permanent disability benefits was final. It argues that its position is supported by our decision in *Trice*.

141 Or App 583> In *Trice*, the claimant had requested a hearing on her entitlement to temporary disability benefits. She died of a cause unrelated to her injury before the hearing could take place. 104 Or App at 463. The claimant's personal representative moved to be substituted for the claimant in the proceeding. The board denied the motion and dismissed the hearing request because it concluded that the personal representative was not an individual entitled under ORS 056.218 to pursue the claim. *Id.* at 465. We affirmed that decision, holding that the only people who could file and pursue a hearing request involving a deceased claimant are the claimant's surviving spouse and dependents. That conclusion controls the decision in this case. Claimant's personal representative is not a person who is entitled to pursue a hearing under ORS 656.218 on claimant's award, so he is not someone who could request reconsideration of the department's detentination award, as the board correctly held.

That conclusion may appear anomalous because it seems to leave no one in a position to pursue the burial benefits that ORS 656.218(5) authorizes. It is not as anomalous as it appears, however, when one examines the history of the provision in ORS 656.218(5) authorizing payment of a burial allowance.

The provision was adopted in 1959 when the workers' compensation system was administered by a state agency, the State Industrial Accident Commission.[2] As adopted, it gave the agency the discretion to award a burial allowance to the estate of a deceased worker from the trust fund that it administered. Nothing suggests that the agency was required to make such an award. Moreover, it is unclear the extent to which a decision to deny a burial award could have been challenged on review as an abuse of discretion by the agency.[3]

With the changes made to the workers' compensation system since 1959, there now is no state agency to which **<141 Or App 583/584>** a worker's personal representative can make a request for discretionary payment of a burial allowance. If such a benefit is to be paid the discretion to make the payment now appears to rest with the insurers and self-insured employers who are responsible for paying workers' compensation benefits. Under that circumstance, there is no need to give personal representatives the right to pursue claims under ORS 656.218, because there is no basis for the department or the board to order an insurer or self-insured employer to pay a burial allowance under ORS 656.218(5), which is the only award that a claimant's personal representative could seek under the statute. Thus, the personal representative was not a person entitled to request a hearing and the board lacked the authority to consider the personal representative's request for a burial allowance.[4]

Affirmed.

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[2] *See* Or Laws 1959, ch 450, § 3; former ORS 656.002(3) (1959) (repealed by Or Laws 1975, ch 556, § 1); *former* ORS 656.410(2) (1959) (renumbered as ORS 656.726).

[3] *See former* ORS 656.282 to 656.290 (1959) (repealed by Or Laws 1965, ch 285, § 95).

[4] The personal representative raised no issue on appeal about whether he could collect a burial allowance based on an unpaid award of temporary disability benefits, as opposed to an award of permanent disability benefits. *See Trice*, 104 Or App at 464-65. Therefore, we do not reach the issue whether the board erred in holding that the personal representative could not collect such an allowance because permanent benefits had not been awarded to claimant.

Cite as 142 Or App 21 (1996) July 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard A. Johnson, Claimant.
LIBERTY NORTHWEST INSURANCE CORP. and Brod & McClung-Pace Co., *Petitioners,*
v.
Richard A. JOHNSON, *Respondent.*
(WCB No. 94-06893; CA A89998)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 12, 1996.
John Klor argued the cause for petitioners. With him on the brief was Marjie Masters-Gittins.
Phil H. Ringle, Jr., argued the cause and filed the biief for respondent.
Before Deits, Presiding Judge, and Landau and Leeson, Judges.
DEITS, P. J.
Affirmed.

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142 Or App 23> Employer seeks review of an order of the Workers' Compensation Board (Board) concluding that claimant's injury was compensable. We affirm.

We quote the material facts, which are undisputed, from the order of the Administrative Law Judge (ALJ):

> "Claimant is a 28-year-old male. During times relevant to this proceeding, he worked for the employer as a receiving clerk.
>
> "On September 7, 1994, near the end of his unpaid lunch period, he was smoking a cigarette in a smoking area. He heard the 'one-minute' buzzer, which is sounded to give workers notice that they have one minute to return to their work stations. Claimant took a few puffs on his cigarette and then began walking back to his station. He passed two co-workers.
>
> "One of the men claimant passed was a lead person and the other was a man who worked under the lead person. Claimant commented to the latter man something to the effect that it would be of no benefit to the man to 'brownnose' his lead person. Claimant spoke the words in jest. It is apparently common for the employees to 'kid' one another and to engage in jocular comments, some of which might appear barbed. It is not common for employees to engage in physical contact with one another.
>
> "Immediately following the comment that claimant made to the co-worker, the man rose and came toward claimant. The co-worker grabbed claimant in a spirit of fun and twisted him down to the ground. Claimant experienced a pop and pain in his left knee. Claimant at some point had put up his hands to ward off physical contact, but did not strike the man who grabbed him.
>
> "Claimant could not rise immediately and required assistance. He did finish his day's work, but continued to have difficulty with the knee.
>
> "Claimant saw [an orthopedic surgeon], who referred him for an MRI scan. Claimant was taken off work. The MRI indicated that claimant had a torn anterior cruciate ligament, and claimant was started on physical therapy.
>
> **142 Or App 24>** "On May 18, 1994, the insurer denied the compensability of the injury on the grounds that the injury did not occur within the course and scope of employment."

The ALJ affirmed employer's denial of compensability and rejected employer's defense that claimant was an active participant in an assault or combat under ORS 656.005(7)(b)(A). However, he concluded that claimant's injury resulted from horseplay and that there was not a "sufficient work connection" between that injury and conditions of claimant's employment. Thus, he denied compensability of claimant's injury.

The Board adopted the ALJ's findings of fact, but a majority of the Board reversed the decision pertaining to the compensability of claimant's injury. The majority first concluded that claimant's injury took place on employer's premises and, therefore, occurred in the course of his employment. *See Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 867 P2d 1373 (1994). The majority then concluded that claimant's injury arose out of his employment, because the conditions of claimant's employment put him in a position to be injured:

> "As found by the ALJ, there was evidence that it was common for employees to verbally tease and taunt one another. Under such circumstances, we find that the conditions of claimant's employment put him in a position to be the target of retaliatory actions resulting in physical injury. Hence, claimant satisfied the 'arising out of employment' element."

The Board also noted that the employer's policy prohibiting horseplay had "little relevance' to the analysis, because claimant was a "victim" of his coworker's horseplay.

Employer contends that the Board erred in concluding that claimant's injury "[arose] out of and in the course of employment" under ORS 656.005(7)(a). An injury is compensable if it "aris[es] out of and in the course of employment." ORS 656.005(7)(a). Both the "arising out of" and "in the course of" elements are part of a single inquiry: "whether the relationship between the injury and the employment is sufficient that the injury should be compensable." *Andrews v. Tecktronix,* Inc., 323 Or 154, 161, ___ P2d ___ (1996) (citing **<142 Or App 24/25>** *Norpac Foods,* 318 Or at 366). The "in the course of" requirement focuses on the "time, place, and circumstances of the injury." *Id.* It "demands that the injury be shown

to have arisen within the time and space boundaries of the employment, and in the course of an activity whose purpose is related to the employment." Larson, 1 *Workmen's Compensation Law*, § 14.00, 4-1 (1995). The "arising out of" element concerns "the causal connection between the injury and the employment." *Andrews*, 323 Or at 161.

We turn first to employer's assertion that the Board erred in concluding that claimant's injury occurred "in the course of" his employment. Employer argues that, because claimant was injured during an unpaid lunch break, the Board's conclusion was wrong. We disagree. Generally, an injury to an employee on the employer's premise during a lunch break occurs in the course of the employment. *Olsen v. SAIF*, 29 Or App 235, 562 P2d 1234, *rev den* 280 Or 1 (1977). Under these circumstances, the Board properly concluded that claimant's injury was "in the course of" his employment.

We next address plaintiff's assertion that the Board erred in concluding that claimant's injury arose out of his employment. In *Kammerer v. United Parcel Service*, 136 Or App 200, 901 P2d 860 (1995), an opinion issued on the same day as the Board's order here, we discussed the compensability of injuries caused by horseplay. In that case, the claimant was walking through a designated employee parking lot when one of her coworkers "flicked" a plastic tag at her. The tag struck her in the eye causing an injury. The employer denied compensability and the referee affirmed the denial on the ground that there was no evidence that the employer had acquiesced in the tag flicking behavior. The Board affirmed, adopting the referee's order. We reversed the Board and held that the claimant's injury was compensable.

On judicial review, the only issue was whether the claimant's injury arose out of her employment. We explained that compensability depends primarily on whether the claimant was a participant in the horseplay. With respect to active participants, we stated:

> "Under Oregon case law, an active participant or instigator in horseplay who is injured may not receive compensation **<142 Or App 25/26>** unless the employer knew or should have known of and acquiesced in the behavior." *Id.* at 204.

That rule is based on the idea that a participant in horseplay has "voluntarily stepp[ed] aside from the employment," unless, through employer acquiescence, horseplay is considered "an aspect of the work environment." *Id.* With respect to nonparticipating victims of horseplay, we stated:

> "Oregon courts have not directly addressed whether a nonparticipant in horseplay may recover workers' compensation. Professor Larson has stated that '[i]t is now clearly established that the non-participating victim of horseplay may recover compensation.' Larson, IA *Workmen's Compensation Law* § 23. 10, at 5-178. Indeed, a majority of states allow recovery by an innocent bystander without a showing of knowledge or acquiescence by the employer. *See id.* at 5-178 n 1. The reason for the difference in treatment between a participant and a nonparticipant is that there is no voluntary deviation from employment on the part of an innocent bystander.
>
> "[A] claimant who is not the initiator nor an active participant in an assault or combat may recover compensation. *See Irvington Transfer v. Jasenosky*, 116 Or App 635, 63940, 842 P2d 454 (1992) (claimant assaulted by coworker entitled to compensation). An innocent bystander engaged in normal work activities cannot be understood to have 'stepped aside' from employment, and may recover when assaulted on the job. Similar reasoning applies to an innocent victim of horseplay. Thus, employer acquiescence in the horseplay should have no bearing on whether such a bystander is entitled to compensation." (Footnote omitted.) *Id.* at 204-05.

Thus, under *Kammerer*, the key issue here is whether claimant was an active participant in the horseplay incident that caused his injury. The Board determined that claimant was a victim of his coworker's horseplay. Employer, relying on *Kessen v. Boise Cascade Corp.*, 71 Or App 545, 693 P2d 52 (1984), argues that claimant was not a nonparticipating victim of horseplay, because he "initiated the horseplay by verbally teasing his co-worker." We disagree.

In *Kessen*, the claimant, a truck driver, was angered when his supervisor refused to give him a night off from **<142 Or App 26/27>** work. The claimant stormed out of his supervisor's office and slammed the door. The supervisor called the claimant back, and told him to close the door properly. The claimant came back and began complaining to his supervisor, claiming that he favored the day shift drivers. We described the facts immediately preceding claimant's injury as follows:

> "Suddenly, claimant turned his anger directly at Huff, another truck driver, who had just completed a 12-hour shift and was seated in a swivel chair with one foot propped up on the driver's desk where claimant had signed in. In anger, claimant began pointing and shaking his finger at Huff. Speaking in a loud voice, he moved toward Huff, accusing him of being one of those 'favored few.' He then grabbed Huff's wrapped and bandaged left arm, which had only recently been removed from a cast. (Huff had broken the arm two and a half weeks before.) Huff rose from his chair and nailed claimant with a right to the jaw, causing the injuries resulting in this proceeding." *Id.* at 547.

We affirmed the Board's conclusion that the claimant's injuries were not compensable on the ground that he was an "active participant" in an assault under former ORS 656.005(8)(a).[1] We stated:

> "Claimant was an active participant in the altercation. Although he was the recipient of the only blow struck, he was the one who, because of his anger, vocal tirade and threatening gestures, actually initiated the fight. We agree with the referee in his characterization of claimant as being the aggressor." *Id.* at 548.

The facts of *Kessen* are a far cry from those here. In *Kessen,* the claimant's aggressive conduct, including pointing and shaking his finger and grabbing his coworker's broken arm, was not only itself physical but also invited a physical response. Claimant's comment here to the effect that his coworker was a "brown-noser" was made in jest and not intended to incite the resulting playful physical attack. The Board adopted the ALJ's finding that there was no credible evidence that claimant initiated the physical contact with his **<142 Or App 27/28>** coworker, that he had any reason to expect that physical conduct would result from his remark, or that he actively participated in the wrestling incident. Those findings are supported by substantial evidence and support the Board's determination that claimant was a victim of his coworker's horseplay. Thus, as in *Kammerer,* the fact that claimant's injury was the result of his coworker's horseplay does not preclude him from receiving compensation for his injury. We conclude that there was a sufficient causal connection between the injury and the employment. Accordingly, the Board properly concluded that claimant's injury was compensable.

Affirmed.

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[1] That provision has since been renumbered ORS 656.005(7)(b)(A).

Cite as 142 Or App 62 (1996) July 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Todd E. Moe, DCD, Claimant.
SAIF CORPORATION, *Petitioner,*
v.
Brenda MOE, Beneficiary of Todd E. Moe, Deceased, and Jet Logging, Inc., *Respondents.*
(92-15393; CA A85828)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 8, 1995.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

David C. Force argued the cause and filed the brief for respondent Brenda Moe, Beneficiary of Todd E. Moe, Deceased.

Robert J. Thorbeck filed the brief for respondent Jet Logging, Inc.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

DE MUNIZ, J.

Affirmed.

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142 Or App 64> SAIF seeks review of an order of the Workers' Compensation Board (board) holding that decedent was a subject Oregon worker at the time he sustained a fatal injury in Montana and that his widow was therefore entitled to survivor benefits. ORS 656.126(1). We affirm.

Decedent was killed in a logging accident while working for Jet Logging, Inc. (employer) in Montana on September 2, 1992. Employer is a small, family-owned Oregon logging company that hired decedent in 1989. Employer had a contract to perform work in Oregon until March 1992, when the Oregon company with which employer had contracted could no longer guarantee employer sufficient work. At that time employer accepted a logging contract in Montana. On March 16, employer told SAIF that it was taking its employees temporarily to Montana, and requested an "Extraterritorial Certificate of Insurance," which SAIF issued March 18, 1992. Employer submitted that certificate to the Montana Employment Relations Division, which approved coverage through October 3, 1992. While in Montana, employer submitted payroll reports to SAIF and continued to pay premiums to SAIF through September 30, 1992. Employer paid no payroll taxes in either Oregon or Montana.

Employer moved a large portion of its logging equipment to Montana but left other equipment in Oregon. Employer had opened a checking account in Montana in 1991, when its owners had purchased Montana acreage known as the Dry Creek Property, which was not connected to the Montana logging job. Employer used the Montana account to pay its employees and meet expenses for that job, but it continued to maintain an Oregon bank account after March 1992. It also kept an Oregon accountant and lawyer and maintained a business address, telephone number, auto insurance and supplier accounts in Oregon.

Before the move, decedent had separated from his wife, moved in with his mother and closed his Oregon bank account. In March, he went to Montana with employer and lived in a trailer parked near the rental housing occupied by **<142 Or App 64/65>** employer's owners, other employees and their family members. Decedent registered his vehicle in Montana but retained his Oregon driver's license and automobile insurance. In April, he began receiving paychecks from employer for the Montana work.

In August 1992, employer negotiated with a Wyoming company to do logging work in Wyoming. On August 24, those negotiations fell through and employer signed a contract with another Montana company to perform work in Montana from August 24 to October 30, 1992. On September 1, the night before his death, decedent wrote to his girlfriend, who resided in Brownsville, Oregon. His letter stated:

> "[I]f I don't get a raise here pretty soon, I might just move there with you, and find a better job. * * * They have been promising me and Greg raises for 6 months and we haven't seen any more money. But even if they don't[,] I will probably stay anyways. Unless you do decide to move up here and after a few months or years we don't like it we can move."

Decedent was killed the next day. In November 1992, a son of employer's president was also killed in a logging accident. Because of the son's death, the president testified, employer decided to stay in Montana.

Decedent's widow filed a claim for survivor's benefits in Oregon. SAIF denied the claim, and a referee affirmed. The board reversed, reasoning that both employer and decedent had intended to remain in Montana only temporarily at the time of decedent's death. SAIF seeks review from that order. We review for errors of law and substantial evidence.[1] ORS 183.482(8)(a), (c); *Berkey v. Dept. of Ins. and Finance,* 129 Or App 494, 498, 879 P2d 240 (1994); *Power Master, Inc. v. National Council on Comp. Ins.*, 109 Or App 296, 301, 820 P2d 459 (1991) *(Power Master II).*

142 Or App 66> Whether workers injured out of state are entitled to benefits under Oregon's Workers' Compensation system is governed by ORS 656.126, which provides, in part:

> "(1) If a worker employed in this state and subject to this chapter temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and

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[1] Substantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make that finding. ORS 183.482(8)(c). A court must consider "all the evidence in the record." *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990).

> in the course of employment, the worker, or beneficiaries of the worker if the injury results in death, is entitled to the benefits of this chapter as though the worker were injured within this state."

Under that section, "subject workers" (i.e. workers subject to ORS chapter 656) who work outside Oregon generally continue to be covered by this state's workers' compensation system if Oregon is the place of their permanent employment and if their presence out of state is "incidental"[2] to that employment. *Berkey*, 129 Or App at 498; *Northwest Greentree, Inc. v. Cervantes-Ochoa*, 113 Or App 186, 188, 830 P2d 627 (1992); *Power Master II*, 109 Or App at 299. "Subject workers" include all workers who work in Oregon, with certain exceptions not relevant here. ORS 656.005(28); ORS 656.027; *Northwest Greentree*, 113 Or App at 188; *Power Master II*, 109 Or App at 299.

SAIF argues that decedent was not a "subject worker" because, at the time of decedent's death, employer had moved to Montana and there was no more Oregon employment. SAIF relies on *Hobson v. Ore Dressing, Inc.*, 87 Or App 397, 742 P2d 675, *rev den* 304 Or 437 (1987). There we held that the claimant, who was president and 50 percent shareholder of the employer corporation, was not a "subject worker" because when the claimant moved to California the **<142 Or App 66/67>** employer moved with him. 87 Or App at 400. After the move, the corporation's headquarters were in the claimant's California home, the company paid payroll taxes to California, the former Portland site was effectively inactive, and the corporation's contacts in Oregon were limited to the claimant's trips to negotiate future projects and consult with accountants, lawyers and financial institutions. *Id.* The similarity of facts here, SAIF contends, compels a similar conclusion.

However, as we noted in *Hobson*, the key inquiry under ORS 656.126(1) is "the extent to which the claimant's work outside the state is temporary." 87 Or App at 400.[3] To determine whether a worker has temporarily left Oregon incidental to Oregon employment, we apply the "permanent employment relation test." *Berkey*, 129 Or App at 498 (1994); *Northwest Greentree*, 113 Or App at 189; *Power Master II*, 109 Or App at 299.

In *Hobson*, we concluded that the claimant had not left Oregon temporarily, primarily because the employer itself had moved its operations out of state. 87 Or App at 400. However, under the "permanent employment relation test," no single factor is dispositive; rather, all circumstances are relevant. Those circumstances include the employer's intent, the employee's understanding, the location of the employer and its facilities, the circumstances surrounding the employee's work assignment, state laws and regulation to which the employer is otherwise subject and the residence of the employees. *Berkey*, 129 Or App at 498 (1994); *Northwest Greentree*, 113 Or App at 189-90; *Power Master II*, 109 Or App at 300; *Phelan*, 84 Or App at 635. Unlike *Hobson*, there are other factors here, apart from employer's apparent movement of its operations out of state, supporting the board's determination that decedent was a subject worker.

The board found that it was employer's intent, at the time of decedent's death, to remain in Montana only temporarily. That finding is supported by substantial evidence in the record. In applying for the "Extraterritorial Certificate of Insurance," employer informed SAIF that it was taking its **<142 Or App 67/68>** employees to Montana temporarily. It left some of its equipment in Oregon, and after the move maintained, in Oregon, a bank account, an accountant, a lawyer, a business address, a telephone, automobile insurance and supplier accounts. While in Montana, employer continued to identify itself to SAIF as an Oregon employer and continued to pay SAIF insurance premiums. It was only after

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[2] SAIF urges us to construe the term "incidental" under the statutory construction template of *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). There is no need for us to reexamine the meaning of that term; for nearly two decades, we have consistently adhered to a single interpretation of ORS 656.126(1). *Berkey*, 129 Or App at 498; *Northwest Greentree, Inc. v. Cervantes-Ochoa*, 113 Or App 186, 189-90, 830 P2d 627 (1992); *Power Master II*, 109 Or App at 300-01; *Power Master, Inc., v. Blanchard*, 103 Or App 467, 471, 798 P2d 691 (1990) (*Power Master I*); *Phelan v. H.S.C. Logging, Inc.*, 84 Or App 632, 634-35, 735 P2d 22, *rev den* 303 Or 590 (1987); *Langston v. K-Mart*, 56 Or App 709, 711-12, 642 P2d 1205, *rev den* 293 Or 235 (1982); *Jackson v. Tillamook Growers Co-op*, 39 Or App 247, 250, 592 P2d 235 (1979); *Kolar v. B & C Contractors*, 36 Or App 65, 69-70, 583 P2d 562 (1978).

[3] *See also Northwest Greentree*, 113 Or App at 189; *Power Master I*, 103 Or App at 471; *Phelan*, 84 Or App at 635; *Langston*, 56 Or App at 711; *Jackson*, 39 Or App at 250; *Kolar*, 36 Or App at 69-70.

decedent's death, when a son of employer's president died, that employer decided to remain in Montana. There was apparently no similar evidence of employer intent in *Hobson*.[4]

The record also contains evidence from which a reasonable person could conclude that decedent understood his stay in Montana to be temporary. Decedent was hired by employer in 1989 and was working for employer in Oregon in the months before the March 1992 move to Montana. After moving, decedent retained his Oregon driver's license and automobile insurance. The board could properly interpret decedent's letter to his girlftiend as expressing an intent to stay with employer, *unless* his girlfriend decided to move to Montana, in which case decedent would have stayed in Montana for "a few months or years." Because employer at that time intended to return to Oregon, and decedent intended to remain with employer, we conclude that decedent understood his stay in Montana to be temporary.

The fact that employer moved much of its equipment to Montana does not compel the conclusion that its facilities were "located" there. The record supports the inference that it is the nature of a small logging operation to move the bulk of the equipment to the logging site. Simply because the logging *job* is out of state does not mean that employer has moved its *facilities* out of state. This is especially true considering that employer left some equipment in Oregon, continued to buy supplies from Oregon companies and maintained the vestiges of a business here, including a bank account, business address, and telephone. Unlike in *Hobson*, where **<142 Or App 68/69>** the corporation's headquarters were in the claimant's California home, the record here indicates that the employer's headquarters remained in Oregon.

We find no significant evidence in the record as to the circumstances surrounding decedent's Montana work assignment, other than the inference that a logging job requires employees to live, at or near the site. Simply because decedent moved to Montana for a single logging contract, and intended to remain for another possible job, does not mean his move was permanent.

Furthermore, although employer withheld neither Oregon nor Montana income tax from his employee's paychecks, it sent payroll reports and paid premiums to SAIF, not to a Montana workers' compensation insurer, raising the inference that employer remained subject to Oregon laws and regulations.

Finally, although the employees lived in Montana during the operation, they lived in rental housing, and decedent lived in a trailer parked nearby. As noted above, due to the nature of a logging operation, where the employees resided does not necessarily indicate whether the move was permanent or temporary.

We find substantial evidence in the record supporting the board's conclusion that decedent was working temporarily out of state at the time of his work-related fatality. Although there is some evidence to the contrary, viewed as a whole, the record permits a reasonable person to reach the board's conclusion. ORS 183.482(8)(c).

Affirmed.

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[4] The employer in *Hobson* also claimed that it intended to return to Oregon, but we found that argument unpersuasive in the light of evidence indicating a permanent move. 87 Or App 400. Unlike *Hobson*, the evidence here supported employer's claim that it intended to return to Oregon.

Cite as 142 Or App 98 (1996) July 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Darron A. Arnold, Claimant.
FREIGHTLINER CORPORATION, *Petitioner,*
v.
Darron A. ARNOLD, *Respondent.*
(93-04313; CA A86953)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 4, 1995.
Deborah L. Sather argued the cause for petitioner. With her on the briefs were Tracy J. White and Stoel Rives Boley Jones & Grey.
John F. Hogan argued the cause for respondent. On the brief was Donald M. Hooton.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed.

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142 Or App 100> Employer seeks review of an order of the Workers' Compensation Board (Board) holding that claimant's workers'compensation claim is compensable. We affirm.

The Board found the following facts. Claimant worked for employer, a truck cab manufacturer, as a painter's helper. His job required regular use of sprayed acid primer and other organic compounds that are capable of causing respiratory irritation. Claimant and other workers did not regularly use respiratory protective equipment while spraying primers in the open work area, which had fresh air ventilation. Claimant's job also required him to work in close proidmity to an enclosed paint booth. He had access to the interior of the booth but was neither trained nor authorized to use it, nor had he been fitted for a fresh air supply mask to be used while inside the booth.

On March 15, 1993, claimant brought a helmet to work. During his shift, he sanded the helmet and prepared it for painting. Employer had a practice of allowing employees to complete personal work during work hours if the nature of the personal work was of the type the employees typically performed on the job and a policy of requiring a work order to do this. Claimant and his supervisor, Allen, spoke briefly about the helmet while claimant was sanding it during a break. Allen told claimant to hurry up and to do the work on claimant's own time. Between that break and the lunch break that followed, claimant painted the helmet with acid primer. While doing so, claimant did not wear a respirator. In the course of spraying the primer, claimant shot a burst of primer that surrounded him with a cloud of spray exceeding by four times his normal exposure to acid spray.

Claimant then obtained permission from a coworker to use the paint booth and related equipment to finish painting the helmet. He used the coworker's equipment, including the coworker's respirator, which did not fit well, and he completed the painting on his next break. He returned to his rogular work and completed painting one or two more truck cabs before leaving.

142 Or App 101> On the way home, claimant began experiencing chills. Other symptoms developed during the night. The next day, he sought medical treatment. His physician authorized modified work without exposure to hydrocarbon fumes. Employer denied. his claim for workers' compensation benefits.

The Board set aside the denial. The Board concluded that claimant had established that his occupational disease claim arose out of and in the course of his employment and that his work-related exposures were the major contributing cause of his respiratory condition. In evaluating whether the claim arose out of and in the course of employment, the Board cited the unitary work-connection test articulated by the Supreme Court in *Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 366, 867 P2d 1373 (1994), but it also discussed the facts in the light of the seven factors we listed in *Mellis v. McEwen, Hanna, Gisvold,* 74 Or App 571, 574, 703 P2d 255, *rev den* 300 Or 249 (1985). The Board found that claimant's activities in sanding, priming and painting his own motorcycle helmet did not benefit employer and that

claimant had failed to obtain employer's permission to work on his helmet with employer's equipment. Nevertheless, the Board also found that employer had acquiesced in claimant's use of employer's equipment to sand and prime the helmet and that the use of employer's equipment for personal projects was typically allowed with permission during regular work hours. It further found that claimant's exposure to various irritating gases was an ordinary risk of his work with sanding and priming equipment and that some exposure to paint spray from the painting booth also was a risk associated with his work. The Board also found, however, that the same could not be said of claimant's own use of the painting equipment, which was not an ordinary part of his job. The Board finally noted that claimant's activities took place on employer's premises and were paid for by employer. The Board then concluded as follows:

> "Considering all the above factors, without any one factor being dispositive, we are persuaded that claimant's activities in sanding and priming his helmet did arise out of **<142 Or App 101/102>** his employment. We note in particular that although claimant's work on his helmet was a personal mission, we conclude that the employer acquiesced in its employees' activities on personal projects, at least to the extent that those activities were part of the employee's regular duties[.]"

As to medical causation, the Board found that the testimony of employer's own physician, Dr. Montanaro, established that claimant's work-related exposures were the major contributing cause of claimant's need for medical treatment. The Board acknowledged that Montanaro used the term "material" cause in his opinion. Nevertheless, it concluded that, because Montanato had identified no other causes of claimant's need for treatment, it is clear that the gravamen of his testimony was that the "major" contributing cause of the need for treatment was claimant's work-related exposure.

On review, employer first assigns error to the Board's conclusion that claimant's occupational disease arose out of and in the course of employment. Employer argues that the Board applied the wrong legal standard when it evaluated the facts in the light of the seven factors described in our opinion in *Mellis*. According to employer, the exclusive test for determining whether a claim arises out of and in the course of employment is the unitary work-connection test the Supreme Court set forth in *Norpac Foods*. Claimant argues that it was not reversible error to have applied the analysis described in *Mellis*. We agree with claimant.

For an injury or occupational disease to be compensable, it must "aris[e] out of and in the course of employment * * *." ORS 656.005(7)(a). In *Mellis*, we held that, in determining whether an injury or disease satisfies those statutory requirements, courts should consider seven factors: (1) whether the employment activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and the employee; (3) whether the activity was an ordinary risk of, and incidental to, employment; (4) whether the employer paid for the activity; (5) whether the activity occurred on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; **<142 Or App 102/103>** and (7) whether the employee was on a personal mission. *Mellis*, 74 Or App at 574.

In *Norpac Foods*, the Supreme Court explained that ORS 656.005(7)(a) creates a "unitary approach," in which the "arising out of" and "in the course of" references are but two components of a single inquiry:

> "Each element of the inquiry tests the work-connection of the injury in a different manner. The requirement that the injury occur 'in the course of employment' concerns the time, place, and circumstances of the injury. The requirement that the injury 'arise out of' the employment tests the causal connection between the injury and the employment. In assessing the compensability of an injury, we must evaluate the work-connection of both elements; neither is dispositive."

Norpac Foods, 318 Or at 366 (citations omitted). The court did not address whether the seven-factor analysis we described in *Mellis* continues to be a valid approach in evaluating the work-connection issue.

We addressed that issue in *First Interstate Bank v. Clark*, 133 Or App 712, 894 P2d 499, *rev den* 321 Or 429 (1995). In that case, the Board analyzed the issue of work connection in terms of the *Mellis* factors. We held:

> "The analytical framework set out in *Norpac Foods* does not significantly change the nature of our inquiry * * *; it essentially incorporates the tests for work-connection that have been established through case law. However, we believe that reliance on the *Mellis* test, as *the* test of work-connection, is inconsistent with the *Norpac Foods* framework, because the *Mellis* test does not necessarily allow a meaningful consideration of each of the two elements of the inquiry. Strict adherence to the seven-factor test also does not allow consideration of the totality of the circumstances, as required by *Norpac Foods.* Accordingly, we conclude 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, some or all of those factors will remain helpful inquiries under the *Norpac Foods* two-prong analysis."

Clark, 133 Or App at 717 (emphasis in original). We evaluated the Board's decision in that light and concluded that, **<142 Or App 103/104>** although it had framed its analysis under the seven *Mellis* factors, the Board had adequately addressed the inquiries required under the unitary work-connection analysis of *Norpac Foods*. *Clark*, 133 Or App at 717-20. In other words, although *Mellis* no longer correctly frames the analysis for evaluating the issue of work connection, it is not necessarily error for the Board to have relied on the seven *Mellis* factors in reaching a decision on the issue. The determinative question is whether the Board's work-connection analysis--by reference to seven factors or otherwise--adequately addresses both the "arising out of" and the "in the course of" components of the unitary work-connection test. With that in mind, we turn to the Board's decision in this case.

We conclude that, as in *Clark*, although the Board applied the seven-factor *Mellis* analysis, its decision nevertheless adequately addressed both components of the unitary analysis required in *Norpac Foods*. As to the "arising out of" component, the Board found that the risks associated with claimant's employment included exposure to irritating vapors from sanding and priming work. The Board further found that claimant's occupational disease was caused in major part by his exposure to those vapors. As to the "in the course of" component, the Board found that the activities that caused claimant's occupational disease occurred on employer's premises, were paid for by employer and occurred with employer's acquiescence. In reaching the conclusion that claimant's occupational disease arose out of and in the course of his employment, the Board clearly considered the totality of the circumstances; it cited *Norpac Foods* and expressly evaluated all relevant factors, without giving any one dispositive weight. *Norpac Foods* requires no more than that.

Employer insists that, even if the Board did not commit reversible error in referring to the seven *Mellis* factors, it erred in finding that claimant had acted within the boundaries of his employment and that employer had acquiesced in claimant's use of its sanding and priming equipment for a personal project. After carefully reviewing the record as a whole, we conclude that substantial evidence supports the Board's findings.

142 Or App 105> In its second assignment of error, employer argues that the Board erred in relying on the opinion of Montanaro, because he testified only that claimant's need for treatment was caused in "material" part by his work activities. Claimant argues that the Board was not precluded from relying on the opinion of Montanaro merely because his opinion did not include the words "major contributing cause." Again, we agree with claimant. An expert's testimony need not be ignored merely because it fails to include "magic words" such as "major contributing cause." *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412, 417, 713 P2d 647 (1986). In this case, despite the fact that Montanaro used the term "material" in reference to causation, his testimony as a whole reasonably may be read as concluding that the "major" cause of claimant's need for treatment was his occupational exposure.

In its final assignment of error, employer argues that the Board's finding that claimant's occupational exposure was the major contributing cause of his need for treatment is not supported by substantial evidence. We reject that argument without further discussion.

Affirmed.

Cite as 142 Or App 121 (1996) July 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Marvin Taylor, Claimant.
MARVIN TAYLOR, *Petitioner,*
v.
CABAX SAW MILL and Industrial Indemnity, *Respondents.*
(94-00753; CA A87505)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 18, 1995.
Susan L. Frank argued the cause for petitioner. With her on the brief was Pozzi Wilson Atchison.
John E. Snarskis argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed.

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142 Or App 123> Claimant petitions for review of an order of the Workers' Compensation Board (Board) upholding Industrial Indemnity's (carrier) denial of medical services benefits. We affirm.

The facts are not in dispute. Claimant sustained a compensable injury in 1967, and his treatment included chiropractic procedures. On December 1, 1987, carrier refused to pay for more than two chiropractic treatments per month. On June 20, 1988, the parties entered into a disputed claims settlement (DCS), which provided, among other things:

> "The carrier's denial limiting claimant's medical treatment to two times per month shall remain valid and in full force and effect unless and until claimant should establish that his accepted condition has worsened to reasonably require either hospitalization or in-patient or out-patient surgical procedures * * *. Treatments in excess of two times per month are therefore per se unreasonable unless claimant should establish such qualification for reopening under these rules of the Board's Own Motion jurisdiction."

In 1990, the Oregon legislature amended the workers' compensation statutes, and those amendments included a new provision requiring that the availability of medical services benefits is to be determined, in part, based on whether a worker and his or her physician are members of a managed care organization (MCO). ORS 656.245.[1] The amendments apply to this case. *Id.*, Or Laws 1990, ch 2, § 54; *Carlson v. Valley Mechanical,* 115 Or App 371, 374-75, 838 P2d 637 (1992), *rev den* 315 Or 311 (1993); *SAIF v. Herron,* 114 Or App 64, 836 P2d 131, *rev* den 315 Or 271 (1992).

On September 21, 1993, claimant saw a neurosurgeon, Dr. Dunn, who was not subject to an MCO contract. Carrier advised claimant that he was subject to an MCO contract, and that, under ORS 656.245, to receive medical services benefits, he must be treated by an MCO physician. Claimant requested a hearing on the denial, arguing that the 1988 DCS, in effect, guaranteed him two medical treatments **<142 Or App 123/124>** per month, regardless of whether the treating physician was an MCO member. The administrative law judge (ALJ) upheld the denial:

> "Carrier has denied Dr. Dunn's treatment * * * because he is not an MCO member. Membership is a prerequisite to compensability.
>
> "Contrary to claimant's position * * * I do not agree that the 1988 stipulation forever binds carrier to provide at least two treatments per month without regard to compensability. The stipulation only deals with the issue of reasonableness and necessity.

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[1] Or Laws 1990, ch 2, § 10 (Spec Sess).

> "On the merits, the 1990 Legislature retroactively changed the definition of compensability insofar as treatment under ORS 656.245 is concerned. Under the new statute, until Dr. Dunn becomes an MCO physician, his treatment is not compensable."

(Citations omitted.) Claimant requested Board review. The Board adopted the opinion of the ALJ and upheld the denial.

On review, claimant argues that the Board erred, because the language of the DCS

> "clearly demonstrates that the parties agreed that claimant was entitled to two medical treatments per month with no limitation on his choice of physician."

Claimant identifies no language in the DCS stating such an entitlement; his argument instead appears to be based on the fact that the language does not say anything to the contrary. According to claimant, the DCS contains no limitations on his choice of doctors, and allowing the statute to apply retroactively to him would unfairly amount to rewriting the terms of the agreement. Carrier argues that the DCS says nothing at all about claimant being entitled to any particular treatment; it only establishes the reasonableness of its denial of any treatments in excess of two per month.

We review the Board's construction of a DCS as we would its construction of any written agreement, applying standard rules of contract construction. *Trevitts v. Hoffman-Marmolejo,* 138 Or App 455, 459, 909 P2d 187 (1996); *see* **<142 Or App 124/125>** *Good Samaritan Hospital v. Stoddard,* 126 Or App 69, 72, 867 P2d 543, *rev den* 319 Or 572 (1994). Generally, that review consists of two steps, beginning with a determination whether, as a matter of law, the terms of the agreement are ambiguous and, if so, proceeding to a determination of the "objectively reasonable construction of the terms" in the light of the parties' intentions and other extrinsic evidence. *Williams v. Wise,* 139 Or App 276, 281, 911 P2d 1261 (1996). If we proceed to the second step in the analysis, we review the factfinders' determination of the parties' intentions for any evidence. *See Timberline Equip. v. St. Paul Fire and Mar. Ins.,* 281 Or 639, 643, 576 P2d 1244 (1978); *Williams,* 139 Or App at 279; *Trevitts,* 138 Or App at 459-60.

In this case, we conclude that the Board correctly determined that the terms of the 1988 DCS are unambiguous and do not create an entitlement to treatment from the medical services provider of claimant's choice. The DCS addresses only one issue: the reasonableness of carrier's denial of more than two treatments per month. The agreement does not, by its terms, guarantee claimant two treatments, regardless of who provides them. In other words, even assuming that the DCS entitles claimant to two medical treatments per month, those services must otherwise be compensable. Under the applicable statute, to be compensable, claimant's treatment must be provided within the MCO contracted by the carrier and the terms of that contract. ORS 656.245(4). Enforcement of the statute does not alter the terms of the DCS; the agreement does not address that issue. Because Dunn was not an MCO member, the Board did not err in upholding the carrier's denial.

Affirmed.

Cite as 142 Or App 137 (1996) July 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Glenn E. Whitlock, Claimant.
Glenn E. WHITLOCK, *Petitioner,*
v.
KLAMATH COUNTY SCHOOL DISTRICT and Samis, *Respondents.*
(93-13776; CA A87326)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 17, 1996.
Sean Lyell argued the cause for petitioner. On the brief were Ralph E. Wiser III and Bennett & Hartman.
Elliott C. Cummins argued the cause for respondents. On the brief were George W. Goodman and Cummins, Goodman, Fish & Peterson, P.C.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Reversed and remanded for reconsideration.

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142 Or App 139> Claimant petitions for review of an order of the Workers' Compensation Board that determined that his stress-related disorder was not compensable because it arose from "conditions generally inherent in every working situation." ORS 656.802(3)(b). We review for errors of law and for substantial evidence, ORS 183.482(7) and (8), and remand for reconsideration.

Claimant taught music to elementary school children in the Klamath School Distiict from 1981 until 1993. At the end of the 1992-93 school year, in the wake of Ballot Measure 5,[1] the employer District eliminated all elementary school music positions. Consequently, claimant exercised his "bumping" rights under a collective bargaining agreement and secured a secondary school social studies teaching position. Although claimant had a secondary social studies certification, he had never actually taught that subject.

For the 1993-94 school year, the District assigned claimant either six or seven class periods a day, in four subject areas: 7th grade social studies, 10th grade global history, 12th grade economics, and 12th grade federal government. Claimant, like all teachers in the District, was allotted one 49-minute preparation period a day.

Claimant felt overwhelmed and stressed by his new duties. He worked 12 to 14 hours a day, including spending four to six hours a night preparing for the next day's classes. Nevertheless, he received "considerable" criticism from his students and some criticism from the school administration.[2] Claimant became very despondent and, at the urging of family and friends, sought treatment from his physician, who referred him for psychiatric treatment. The psychiatrist diagnosed "a single episode of nonpsychotic major depression due to stress at work."

142 Or App 140> In October 1993, claimant filed a claim for workers' compensation. Employer denied coverage. The administrative law judge set aside employer's denial and awarded claimant attorney fees. The Board, with one dissenting member, reversed, concluding that claimant had failed to prove a compensable psychological claim under ORS 656.802, because "the stressors that claimant cites are all conditions which are generally inherent in every working situation." The Board based its decision on the following "conclusions of law:"

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[1] Ballot Measure 5 was adopted by the electorate in 1990 and incorporated into the Oregon Constitution at Article XI, section 11b-11f.

[2] The parties stipulated that claimant's interaction with school administrators "falls into the category of reasonable disciplinary, corrective, or job-performance activities," and are not the basis of his claim.

"The element in contention is whether stressors associated with claimant's social studies teaching job are conditions other than conditions generally inherent in every working situation. ORS 656.802(3)(b). The stressors include no training or experience in a job outside his area of expertise (music), and the number of different classes he had to teach coupled with overwhelming class preparation time, including four to six hours in the evening.

"* * * * *

"As with legal parameters, financial constraints (budget cuts) are also everchanging. Employers are constantly required to maintain the operation of their businesses within budgetary parameters. Therefore, we conclude that operating within financial constraints is a condition generally inherent in every work place.

"Due to financial constraints, claimant knew there was the possibility that his music teaching program would be eliminated. Thus, to remain employed as a teacher, claimant became certified to teach social studies, a subject area that was less likely to be eliminated from the curriculum. When the music program was eliminated, claimant chose, rather than being laid off, to accept a position teaching social studies. Claimant subsequently developed a mental condition. Because claimant's change of position was the result of budget cuts, we find that claimant's subsequent mental problems were caused by a condition that is generally inherent in every work place.

"Claimant contends that he lacked training to teach social studies, and that lack of training is not a condition that is generally inherent in every working situation. Because of claimant's eleven years' experience as a teacher, **<142 Or App 141>** and his demonstrated proficiency in social studies (sufficient to warrant certification in that subject area), we are not persuaded that, in claimant's case, there was such a lack of training.

"* * * Additionally, although claimant contends, and the Referee found, that the Collective Bargaining Agreement is not generally inherent in every work situation, we conclude that employment contracts, written or otherwise, are certainly inherent in every work situation. Moreover, in this instance, claimant freely chose to exercise his option under the contract which resulted in 'bumping' another teacher because of claimant's seniority in the school district."

Claimant, in petitioning for review, raises eight assignments of error. Those assignments reduce to two related propositions: (1) The Board improperly focused on factors that did not directly cause his mental disorder--i.e., school budget cuts and claimant's exercise of bumping rights under the collective bargaining agreement. (2) The Board, consequently, did not meaningfully address the actual employment conditions that produced claimant's mental disorder--i.e., "lack of preparation time," which caused him to spend four to six hours every evening preparing for the next day's classes.[3] Thus, claimant asserts, the Board's "generally inherent" conclusion pertains to the "wrong" employment conditions, rendering its application of ORS 656.802(3)(b) erroneous as a matter of law. ORS 183.482(8)(a).

ORS 656.802 provides, in part:

"(3) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter *unless the worker establishes all of the following:*

"(a) The employment conditions producing the mental disorder exist in a real and objective sense.[4]

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[3] Claimant also asserted that "inadequate training" caused his stress. However, the Board concluded that, because of claimant's certification in social studies, there was no lack of training.

[4] Employer does not dispute that the conditions cited by claimant--i.e., the need to prepare for four distinct classes and the lack of sufficient time for such preparation--exist in a real and objective sense.

> "(b) The employment conditions producing the mental disorder are *conditions other than conditions generally* <**142 Or App 141/142**> *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.
>
> "* * * * *
>
> "(d) There is clear and convincing evidence that the mental disorder arose out of and in the course of employment." (Emphasis supplied.)[5]

Claimant asserts that, in applying ORS 656.802(3)(b), the Board improperly focused on the conditions that led to his change in position from an elementary music teacher to a secondary social studies teacher and not on his "actual stressors." He contends that the Board's extensive discussion of such factors was an analytic *non sequitur* because

> "[w]hether claimant was placed into [the social studies] position because of financial constraints or pursuant to a collective bargaining agreement is of no consequence. What is of consequence is the actual stressors in the social studies position which caused him to decompensate psychologically."

Employer does not dispute--and, indeed, expressly endorses--that proposition. For example, employer acknowledges:

> "ORS 656.802(3)(b) speaks to the 'conditions producing the mental disorder.' Clearly the legislature intended the focus to be upon those conditions that are directly responsible for Claimant's mental disorder. Focusing upon events that led to Claimant's initial placement in the work situation can only serve to make this analysis impossible. Thus, the initial question should be: What is it about the job that caused Claimant's mental disorder?
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> * * * * *
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> **142 Or App 143>** "Whether Claimant chose to bump another teacher is only relevant to explaining how and what led up to Claimant's assignment as a social studies teacher. It has nothing to do with defining the type of stressors Claimant faced in the job." (Footnote omitted.)

However, employer contends that the Board's consideration of such factors was, at worst, harmless error because the Board adequately and properly addressed claimant's actual stressors from his social studies teaching position, specifically including preparation demands.

We agree with both claimant and employer that, in the circumstances presented here, the Board's analysis of the conditions that led to claimant assuming the social studies position was extraneous. Claimant's asserted entitlement to compensation rests, ultimately, on the premise that the major contributing cause of his mental disorder was the stress that claimant experienced once he was in his new position. Thus, on this record, consideration of conditions that antedated claimant's assumption of the social studies position is immaterial.

We disagree, however, with employer that the Board's decision should nevertheless be sustained. That is so for two reasons. First, contrary to employer's assumption, the Board's discussion of immaterial conditions of employment may not be discounted as mere "harmless error." From the tone and tenor of its opinion, it is apparent that the Board was preoccupied with the prevalence of layoffs

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[5] In 1995, the legislature amended ORS 656.802. Or Laws 1995, ch 332, § 56. Those amendments codified principles set forth in pre-1995 decisions by the Board and by this court and do not bear on the disposition of this case. Accordingly, notwithstanding the abstract applicability of those amendments, *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996), we do not remand for reconsideration on the basis of the changed statutory language. *See Baar v. Fairview Training Center,* 139 Or App 196, 204-205, 911 P2d 1232 (1996).

and the dynamics of bumping rights. That emphasis may well have skewed the Board's passing consideration of the preparation demands of the social studies position. *Accord Magana v. Wilbanks International,* 112 Or App 134, 137, 826 P2d 1058 (1992) ("We cannot disregard as surplusage the Board's explicit conclusion that claimant did not prevail *because* he did not prove a fact, that by law, he does not have the burden to prove.") (emphasis in original).

Second, the Board's discussion of the preparation demands associated with the social studies position was so cursory as to preclude meaningful judicial review. The Board **<142 Or App 143/144>** (1) initially identified "the number of different classes [claimant] had to teach coupled with overwhelming class preparation time, including four to six hours in the evening," as being among the pertinent stressors; and (2) ultimately concluded that "the stressors that claimant cites are all conditions which are generally inherent in every working situation." However, nothing in the Board's extended analysis between those statements--a discussion replete with references to budget cuts and collective bargaining agreements--suggests that the Board actually, specifically considered whether the preparation for the social studies position was of a sort "generally inherent in every working situation." Much less does the Board's decision explain why it could, or would, have reached such a conclusion.

We thus conclude that the Board failed to "articulate * * * the rational connection between the facts and the legal conclusion" that the preparation associated with claimant's social studies position was of a sort "generally inherent in every working situation." *See Ross v. Springfield School Dist. No. 19,* 294 Or 357, 370, 657 P2d 188 (1982). Accordingly, we reverse and remand for the Board to address that question.

Reversed and remanded for reconsideration.

Cite as 142 Or App 145 (1996) July 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lori Ann Wages, Claimant.
BANK OF NEWPORT, *Petitioner,*
v.
Lori Ann WAGES, *Respondent.*
(93-04948; CA A89282)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 17, 1996.
Kevin L. Mannix argued the cause for petitioner. On the brief were Patricia Nielsen and Kevin L. Mannix, P.C.
Victor Calzaretta argued the cause and filed the brief for respondent.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Affirmed.

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142 Or App 147> Employer seeks reversal of an order of the Workers' Compensation Board that granted claimant benefits for an adjustment disorder. The Board concluded that claimant's mental disorder was the product of employment conditions other than those "generally inherent in every working situation." ORS 656.802(3)(b). We affirm.

The Board found the following material facts: Claimant worked as a teller for the employer bank for six months, from October 1992 to March 1993. Throughout that time, claimant experienced stress because of various interactions with her supervisor. In particular, claimant believed that the supervisor had unfairly singled her out, was overly critical of her work, and ignored or was unwilling to listen to her explanations. However, claimant's perceptions in that regard were not based on conditions that

"exist[ed] in a real and objective sense." ORS 656.802(3)(a).[1] Claimant also experienced tension because of her belief that her supervisor had given her an unjustifiably negative performance review. However, contrary to claimant's perception, the review was, in fact, favorable, not negative.

Claimant also experienced stress because of what she perceived to be ridicule and harassment based on her physical condition. Throughout her employment, claimant was obese and was very concerned about that condition. Nevertheless, her supervisor made disparaging comments about **<142 Or App 147/148>** obese people in general and claimant's obesity specifically. For example, on one occasion, the supervisor complemented a customer on her weight loss and, in the customer's presence, said to claimant, "See * * *, if she can do it, you can do it too." Another time, the supervisor made a comment in claimant's presence about obese people giving "the impression of being out of control and dirty." On yet another occasion, when claimant was wearing a pink shirt, the supervisor made a "pink elephant" joke but denied that her remarks were directed at claimant.

The most egregious episode pertaining to claimant's obese physical condition occurred in early March 1993, when bank sweatshirts were delivered to the branch where claimant worked. As a "joke," and without claimant's knowledge or permission, her supervisor and another employee jointly put on claimant's sweatshirt and had a third employee take a picture of them in the sweatshirt. The supervisor then showed the picture to several other bank employees, sharing the "joke." About a week later, after claimant asked her supervisor if she could take some vacation time to take a weight reduction cruise, the supervisor gave her the sweatshirt picture and told her that the picture should give her sufficient incentive to lose weight.

Claimant was humiliated both by the sweatshirt photograph and by her supervisor's "incentive" remark. That evening, while in a restaurant with her husband and mother, claimant experienced a panic attack and, when questioned, she explained what had happened at the bank that day. Three days later, claimant saw a physician for anxiety attacks, arm numbness and itching, chest pain, and inability to sleep, which had occurred on and off since the sweatshirt incident. The physician diagnosed work-related anxiety, took claimant off work, and referred her for counseling.

Thereafter, and for a period of two months, Dr. Schumann, a clinical psychologist, treated claimant. Schumann ultimately diagnosed claimant as suffering from a workrelated adjustment disorder. Schumann wrote a report that discussed the full range of potential stressors in claimant's employment, including those conditions that the Board later **<142 Or App 148/149>** determined did not "exist in a real and objective sense," ORS 656.802(3)(a), and then concluded:

> "In my opinion [claimant's] present state of acute anxiety and depression including occasional suicidal thoughts from life being too hard was caused by the stress at work consisting of low level but constant harassment and ridicule from her supervisor * * * and the ultimate insensitivity, if not cruelty of the 'photograph incident.' I believe that this stress constitutes a retraumatization of a young woman who has suffered from emotional problems for a long time.

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[1] ORS 656.802(3) provides:

"Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes all of the following:

"(a) The employment conditions producing the mental disorder exist in a real and objective sense.

"(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles.

"(c) There is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

"(d) There is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

> "* * * [Claimant] had begun to diet and exercise and started to lose weight when she began her new job at the bank. She felt anxious to do a good job but was quickly intimidated by her supervisor's behavior although still enjoying her colleagues. As time went on things became more aggravating and upsetting so that she found herself dreading to get up in the morning and to face having to go back to work and feel humiliated the next morning."

Claimant filed an occupational disease claim for her adjustment disorder. The administrative law judge determined that the claim was not compensable because claimant had failed to prove, via expert medical testimony, that the "major contributing cause" of her adjustment disorder was employment conditions that "exist[ed] in a real and objective sense" and that were "conditions other than those conditions generally inherent in every working situation." ORS 656.802(2)(a) and (3)(a) and (b). In particular, the ALJ concluded that Schumann's opinion that claimant's mental disorder was "caused by the stress at work" did not sufficiently distinguish between stressors that existed "in a real and objective sense" (*e.g.*, the supervisor's remarks about obesity and the "photograph incident") and those that did not (e.g., the supervisor's alleged "singling out" of claimant and the "unfavorable" performance review).

The Board, although adopting the ALJ's findings of fact, reversed. In so holding, the Board agreed with employer that "medical evidence that does not factor out excluded from nonexcluded employment conditions under ORS 656.802(3) cannot satisfy a claimant's burden of proving a compensable **<142 Or App 149/150>** mental disorder." The Board concluded, however, that claimant's medical evidence, particularly Schumann's opinion, satisfied that standard:

> "Dr. Schumann, claimant's treating psychologist, opined that claimant was exhibiting many of the classic symptoms of an adjustment disorder. She concluded that claimant's mental state was caused by stress at work consisting of low level harassment and ridicule from her supervisor and the 'ultimate insensitivity if not cruelty' of the photograph incident. Given the significance to which Dr. Schumann accorded the photograph incident, we conclude that Dr. Schumann's opinion supports a finding that cognizable stressors under ORS 656.802(3) were the major contributing cause of claimant's mental disorder.
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> * * * * *
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> "We recognize that no medical opinion explicitly weighed excluded stressors (such as claimant's performance evaluation and her allegations of being ignored and harassed) against non-excluded stressors (such as the photograph incident and jokes and remarks about obesity) as required by ORS 656.802(3)[.] However, given the emphasis both Dr. Turco and Dr. Schumann placed on the photograph incident (as opposed to the excluded stressors), we are persuaded that it, as well [as] real and objective stress from the ridicule regarding claimant's obesity, played the major causative role in producing an adjustment disorder that required medical services and resulted in disability." (Record citations omitted.)

In petitioning for review, employer reiterates its argument that claimant's medical evidence did not sufficiently distinguish between conditions that are cognizable under ORS 656.802(3), and those that are not, as the major contributing cause of her mental disorder. In so arguing, employer does not dispute the Board's determination that the comments and conduct pertaining to claimant's obesity, including the "photograph incident," existed "in a real and objective sense," and, thus, were cognizable conditions under ORS 656.802(3)(a). Nor does employer dispute that those conditions are conditions "other than conditions generally inherent in every working situation." ORS 656.802(3)(b. Finally, employer acknowledges that a medical opinion may be sufficient proof of causation even if it does not explicitly **<142 Or App 150/151>** employ the "magic words" of "major contributing cause."[2] *See McClendon v. Nabisco Brands*, 77 Or App 412, 417, 713 P2d 647 (1986).

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[2] At oral argument, employer's counsel stated:

> "The [Oregon] Supreme Court and the Court of Appeals have long held that the magic words are not necessary. That what you have to do is take the statement as a whole by the medical practitioner and determine whether or not, in context, that is the essence of what they're saying."

Employer argues, however, that the deficiencies in claimant's proof of causation transcends the mere absence of "magic words." Instead, employer asserts, that proof "did not attempt to factor out" noncognizable conditions and, consequently, the "Board read into medical reports opinions which simply were not there."

Stripped to its essentials, employer's argument is that the Board read too much into the medical reports, particularly Schumann's. The inquiry thus reduces to whether the Board, as a trier of fact, could reasonably read Schumann's opinion as concluding, albeit implicitly, that cognizable stressors were the "major contributing cause" of claimant's adjustment disorder. ORS 183.482(8)(c); ORS 656.802-(2)(a).

We conclude that the Board could reasonably so read Schumann's opinion. That opinion recites that claimant became obese as an adolescent as a result of traumas associated with her father's death, her mother's severe alcoholism, and her own withdrawal and suicidal depression. Schumann further noted that, when claimant began working for the bank, she "had begun to diet and exercise and started to lose weight" and "felt anxious to do a good job." Schumann's opinion is properly construed not only in the light of those circumstances, which explicitly informed her assessment, but also in the context of her references to "ridicule" from the supervisor's obesity-related remarks, her descriptions of "the ultimate insensitivity if not cruelty of the 'photograph incident,'" and her description of claimant's symptomatic "dreading to get up in the morning and to face having to go back to work and feel humiliated the next morning" and "fear [of] running **<142 Or App 151/152>** into [her supervisor] or other bank employees fearing taunting or ridicule." Viewed in its totality, the Board could reasonably read Schumann's opinion as concluding that, given this claimant's particular history, the cognizable, obesity-related workplace conditions were the preponderant cause of her mental disorder. Consequently, the Board did not err in concluding that claimant's medical proof was sufficient to meet her burden or proof under ORS 656.802(3)(a).

Affirmed.

Cite as 142 Or App 182 (1996) July 10, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David W. Winters, Claimant.
David W. WINTERS, *Petitioner,*
v.
WOODBURN CARCRAFT COMPANY and Reliance Insurance Company, *Respondents.*
(94-08266; CA A89787)

Judicial Review from Workers' Compensation Board.
On Respondents' Motion for Sanctions filed March 20, 1996.
Richard D. Barber, Jr., and Bostwick Sheridan & Bronstein for motion.
Before Landau, Presiding Judge, and Richardson, Chief Judge, and Haselton, Judge.
LANDAU, P. J.
Motion for award of sanctions against claimant's attorney allowed in the amounts of $1,510.50 in attorney fees, plus $135.25 in costs.

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142 Or App 184> Employer moves for an order imposing sanctions against claimant's attorney on the ground that claimant's petition for judicial review was frivolous. Claimant did not respond to the motion. We allow it and award attorney fees and costs in the amount of $1,645.75.

ORS 656.390(1) provides, in relevant part:

> "if either party * * * appeals for review of the [workers'compensation] claim to the Court of Appeals or to the Supreme Court * * * and the * * * court finds that the appeal * * * was frivolous or was filed in bad faith or for the purpose of harassment, the * * * court may impose an appropriate sanction upon the attorney who filed the * * * appeal * * *. The sanction may include an order to pay to the other party the amount of the reasonable expenses incurred by reason of the appeal including a reasonable attorney fee."

From the disjunctive wording of the statute, it is apparent that an award of sanctions may be appropriate if a petition for judicial review of an order of the Workers' Compensation Board (Board) was "frivolous" or if the petition was filed in bad faith or if it was filed for the purpose of harassment. In other words, if we find that the petition for review was frivolous, that finding alone warrants the imposition of sanctions. In *Westfall v. Rust International*, 314 Or 553, 840 P2d 700 (1992), the Supreme Court held that an appeal is "frivolous" within the meaning of ORS 656.390

> "if every argument on appeal is one that a reasonable lawyer would know is not well grounded in fact, or that a reasonable lawyer would know is not warranted either by existing law or by a reasonable argument for the extension, modification, or reversal of existing law."

Id. at 559. In 1995, however, the legislature amended the statute to include a definition of "frivolous" in somewhat less forgiving terms:[1]

> **142 Or App 185>** "As used in this section, 'frivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing."

1995 Or Laws, ch 332, § 45 (codified at ORS 656.390(2)).

Employer does not argue that claimant's petition for judicial review was filed in bad faith or for the purpose of harassment. It does argue that the petition was frivolous in that claimant had no reasonable prospect of prevailing. According to employer, the only issue claimant raised, on judicial review was whether the Board had correctly evaluated the conflicting expert testimony of the two physicians who offered testimony on the issue of compensability. Because we review the issue for substantial evidence on the whole record, employer argues, the petition cannot be regarded as anything but frivolous. After carefully reviewing the arguments of the parties, we reach the same conclusion.

Claimant injured his left knee at work in 1994. In his claim fonn, he responded that he had strained his knee about four years earlier. At the hearing, however, he testified that he had injured the knee twice before in motorcycle accidents. He said that the first accident occurred in 1974 and that his injuries were completely resolved. He said that the second accident, in 1987, resulted in only minor soreness. The chart notes from the 1987 examination, however, indicate that claimant complained of knee extension and locking problems for about ten years. Dr. Hoppert gave an opinion that claimant's current need for treatment was caused in major part by the 1994 injury. Dr. Duff stated that the 1994 incident was not the major contributing cause of the need for treatment but was instead only the "straw that broke the camel's back."

After finding the foregoing facts, the administrative law judge (ALJ) found that claimant was not credible, because of inconsistencies in his testimony as to his prior **<142 Or App 185/186>** injuries. He further found that neither doctor's testimony was persuasive:

> "[B]oth of these doctors' opinions are expressed in 'check the block' reports that were written by the respective attorneys. I find neither to be persuasive. Further, it would appear that Dr. Hoppert has an incorrect or incomplete history upon which he has based his opinion. It is certainly clear that the incident at work on February 15, 1994, was the immediate precipitating cause for claimant's surgery. However, the legal test is 'major

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[1] The legislative history suggests that the amendment was drafted in direct response to the court's decision in *Westfall*. As Rep. Kevin Mannix, principal sponsor of the amendment, explained:

> "The term 'frivolous' is defined because there is a Supreme Court case that defines 'frivolous' so poorly that almost nothing will ever be frivolous because a lawyer can make an argument, as you probably know, about just about anything. We tried to come up with a definition of frivolous that's a real world definition that can be applied by reasonable people, not just by lawyers and judges."

Tape Recording, Senate Labor and Government Operations Committee, January 30, 1995, Tape 16, Side B at 185. Mannix offered a similar explanation to the House. Tape Recording, House Labor Committee, March 6, 1995, Tape 46, Side B at 72-135.

> contributing cause[.]'* * * Here, neither doctor has made any analysis of the relative contribution of claimant's prior motorcycle accidents and the February 15, 1994, tripping incident at work. I conclude that claimant has failed in his burden of proof and that there is insufficient evidence to establish that the work incident on February 15, 1994, was the major contributing cause of claimant's resultant left knee condition and need for surgery.."

The Board adopted and affirmed the ALJ's order.

On review, claimant argued that the Board erred "when it rejected the opinion of claimant's treating physician." In support of that assignment he argued:

> "When medical opinions differ greater weight is given to those opinions which are well-reasoned and based on the most complete information. *Somers v. SAIF*, 77 Or App 259, 263, 712 P2d 179 (1986). In this case there are two competing medical opinions, that of Jonathan Hoppert, M.D., claimant's treating physician, and that of William Duff, M.D., who performed an IME on July 1, 1994. Each of these opinions has its strengths, but on balance they weigh in favor of compensability."

Claimant then described Duff's testimony and argued that Duff equivocated somewhat on the issue of compensability. Following that, he described Hoppert's testimony and quoted from the several portions of it in which Hoppert concluded that the need for treatment was occasioned, in major part, by the 1994 incident. Claimant then concluded the argument with the following:

> "Generally greater weight is given to the treating doctor's opinion, unless there are persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814[, 669 P2d 1163] **<142 Or App 186/187>** (1983). There is no persuasive reason in this case to discount the opinion of Dr. Hoppert."

Claimant then argued that the Board also erred in failing to award a penalty, because employer had untimely denied his claim. The argument had not been raised below, and claimant asserted no basis for considering it for the first time on review.

We affirmed without opinion, and employer's motion for sanctions followed. We turn, then, to an examination of whether the assignments of error claimant raised in his petition for judicial review were "frivolous" within the meaning of ORS 656.390(2).

As to the first assignment, claimant contended, purely and simply, that the Board did not weigh the competing testimony of the two physicians to his lil6ng. His only arguments in support were that "on balance" the opinions of the physicians "weigh in favor of compensability" and that "there is no persuasive reason" to give lesser weight to the testimony of his physician. The trouble with claimant's assignment is that it failed to acknowledge, much less apply, this court's standard for reviewing the Board's evaluation of conflicting medical evidence. In appropriate cases, the Board properly may or may not give greater weight to the opinion of a treating physician. On review of the Board's decision, our role is limited to evaluating whether the Board's decision is supported by substantial evidence. ORS 183.482(8)(c). "Substantial evidence" consists of evidence that, when the record is viewed as a whole, would permit a reasonable person to make a finding. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988). Claimant's citations of authority for a different, more favorable standard of review were to cases that we decided under the long-superseded *de novo* standard of review.

Thus, claimant's petition did not dispute that the Board's order is supported by substantial evidence. Instead, invoking an inappropriate standard of review, claimant invited us to second-guess the Board's assessment of conflicting expert testimony. We lack such authority. Accordingly, **<142 Or App 187/188>** with respect to the first assignment of error, claimant's petition was filed "without reasonable prospect of prevailing." ORS 656.390(2).

Claimant's second assignment was similarly deficient. It raised an argument that clearly was not preserved and, as a result, had no reasonable prospect of success on review.

We find, therefore, that claimant's petition for review was frivolous within the meaning of ORS 656.390 and that an award of attorney fees against claimant's attorney is appropriate. Employer has submitted an affidavit in support of its motion establishing that it has incurred fees in the amount of $1,510.50 and costs of $135.25. We find those amounts to be reasonable and appropriate.

Motion for award of sanctions against claimant's attorney allowed in the amounts of $1,510.50 in attorney fees, plus $135.25 in costs.

Cite as 142 Or App 224 (1996) July 24, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

HOLMAN ERECTION CO., INC.,
dba Northwestern Steel Construction Co., a foreign corporation, *Appellant,*
v.
EMPLOYERS INSURANCE OF WAUSAU, a foreign mutual insurance company, *Respondent.*
(9304-02512; CA A85394)

Appeal from Multnomah County, Circuit Court.
Robert W. Redding, Judge.
Argued and submitted January 24, 1996.
Larry Dawson argued the cause and filed the briefs for appellant.
Lisa E. Lear argued the cause for respondent. With her on the brief were I. Franklin Hunsaker, Douglas G. Houser and Bullivant, Houser, Bailey, Pendergrass & Hoffman.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Affirmed.

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142 Or App 226> This is an action by an insured against its insurer. Plaintiff, Northwestern Steel Construction Co. (Northwestern), a construction subcontractor, is seeking recovery against defendant, Employers Insurance of Wausau (Wausau), its comprehensive general liability[1] and workers' compensation insurer, for failing to undertake the defense of two separate lawsuits. First, Wausau refused to accept the tender of defense of *Sorenson v. Mortenson,* an action in which one of Northwestern's own employees sought to recover for personal injuries against Mortenson, the general contractor on one of Northwestern's projects. Second, Wausau refused to accept the tender of defense when Mortenson later sued Northwestern for failing to procure insurance to protect Mortenson. Plaintiff appeals the lower court's judgment for defendant, making eight assignments of error.[2] We write only to address plaintiffs contention that the trial court erred in concluding that defendant did not have a duty to defend Mortenson in the injury action by Northwestern's employee, Sorenson, and did not have a duty to defend Northwestern in the action by Mortenson for failure to procure insurance to protect Mortenson. We affirm.[3]

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[1] The policy is actually entitled "Commercial General Liability Policy." However, we refer to it here as the "Comprehensive General Liability Policy" for the sake of clarity because that is how the parties referred to it in their subcontract and in their briefs on appeal.

[2] Defendant responds and makes two cross-assignments of error. Because of our disposition, we do not need to reach the issues raised by defendant's cross-assignments.

[3] Plaintiff's assignments of error also encompass adverse rulings on two other theories Northwestern asserted below as grounds for relief. (1) "breach of fiduciary duty" and (2) waiver and estoppel. First, plaintiff s breach of fiduciary duty claim is necessarily predicated on a holding that defendant was contractually obligated to undertake the defense of Sorenson's underlying personal injury lawsuit. *Georgetown Realty v. The Home Ins. Co.,* 313 Or 97, 110-11, 831 P2d 7 (1992). That claim then, is subsumed within our disposition of plaintiff's breach of contract claims under its comprehensive general liability and workers' compensation insurance contracts. Second, plaintiff's waiver and estoppel theories go to the threshold question of whether there is coverage for plaintiff's claims. It is well established that waiver and estoppel cannot be invoked to create coverage or to negate an express exclusion in a policy of insurance. ABCD ... *Vision, Inc. v. Fireman's Fund Ins. Companies,* 304 Or 301, 307, 744 P2d 998 (1987). Therefore, we affirm the lower court's rulings on those questions without further discussion.

142 Or App 227> The pertinent facts are not disputed. In 1988, Northwestern entered into a construction subcontract with Mortenson regarding work to be performed on the Portland International Airport parking structure. That contract contained an "indemnity" provision under which Northwestern agreed to indemnify Mortenson for any liability that Mortenson might incur for injuries to Northwestern's employees.[4] The subcontract also included a provision that Northwestern would obtain insurance for Mortenson that protected Mortenson from claims for bodily injury or property damage arising out of Northwestern's work.[5] Northwestem failed to procure the bargained for insurance. In October 1988, Northwestern's employee, Sorenson, sustained injuries in a fall on the job site. In October 1990, he filed an action against Mortenson to recover damages for his personal injuries. Mortenson tendered defense of the action to Northwestern, which, in turn, tendered the claim to Wausau, its insurer. In a letter dated February 21, 1991, Wausau responded that it intended to deny the claim because Northwestern had not named Mortenson as an additional insured on its liability insurance policy. Wausau notified Mortenson of the decision in a letter dated March 7, 1991. On March 13, 1991, Northwestern's attorney wrote Wausau and informed it that Mortenson demanded a defense in the Sorenson lawsuit based on the indemnity provision in the contract. Ultimately, Wausau engaged the services of a Portland attorney, Folliard, who later recommended that Wausau reject the **<142 Or App 227/228>** tender of defense because the indemnification clause in the subcontract was unenforceabe under Oregon's Workers' Compensation Law, ORS 656.018(l)(a). Folliard informed Mortenson of this decision yet remained involved in the depositions of Northwestern's employees conducted for the litigation.

In July 1991, Mortenson filed an action against Northwestem for breach of contract based on Northwestern's failure to name Mortenson as an additional insured under its comprehensive general liability policy. Mortenson sent a copy of the complaint to Wausau's attorney, who immediately informed Northwestern and Wausau of the action and obtained an extension of time for Northwestern to make an appearance in the litigation. Three weeks after Mortenson filed suit against Northwestern, Wausau informed Northwestern that it would not undertake the defense of the action because the breach of contract claim was not covered under either of Northwestern's policies. Mortenson ultimately settled Sorenson's injury action and Northwestem settled Mortenson's action for damages due to Northwestern's failure to procure insurance.

Northwestern then brought this action against Wausau to recover defense expenses and what it paid to settle the lawsuit brought against it by Mortenson arising from Wausau's failure to defend and pay under its workers' compensation insurance and general liability insurance contracts. Before trial, the court dismissed plaintiff's breach of contract claims, holding that defendant had no obligation to

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[4] The contract provided, in part:

"17. INDEMNITY

"17.1 [Plaintiff] agrees to assume entire responsibility and liability for all damages or injury to all persons, whether employees or otherwise, and to all property, including the loss of use therefrom, arising out of, arising from or in any manner connected with the execution of the Work under this Subcontract and, to the fullest extent permitted by law, [plaintiff] shall defend and indemnify Mortenson * * * from and against all such claims, damages, losses and expenses, including without limitation claims for which Mortenson or Owner may be or may be claimed to be liable, and legal fees and disbursements paid or incurred to defend any such claims or to enforce provisions of this Article."

[5] The contract provided, in part:

"16. INSURANCE

" * * * * *

"16.4 [Plaintiff] shall endorse its Comprehensive General Liability polic[y] to add Mortenson as an 'additional insured'* * *."

defend Northwestern under either policy. After proceeding to trial on Northwestern's other theories,[6] the trial court entered judgment for Wausau.[7]

Northwestern assigns error to the trial court's ruling that Wausau was not obligated to defend Mortenson in the **<142 Or App 228/229>** Sorenson lawsuit and was not required to defend Northwestern in the action by Mortenson under either the comprehensive general liability or workers' compensation insurance policies.

In determining whether an insurer has a duty to defend, we look only at the facts alleged in the complaint to determine whether they provide a basis for recovery that could be covered by the policy. *Ledford v. Gutoski*, 319 Or 397, 400, 877 P2d 80 (1994). A duty to defend an action against the insured arises when the claim stated in the complaint against the insured could, without amendment, impose liability for conduct covered by the policy. *Id.* at 399-400. In this light, an insurer should be able to determine from the face of the complaint whether to accept or reject the tender of the defense of the action. *Id.* at 400. Accordingly, our review is limited to two documents: the complaint and the insurance policy. *Id.* at 399.

Northwestern first argues that defendant had a duty to defend Mortenson in the Sorenson lawsuit even though Northwestern, the insured, was not a party to that action. It is Northwestern's contention that the Sorenson lawsuit was "effectively" against Northwestern because Northwestern agreed to indemnify Mortenson in the subcontract, and thus, Northwestern stood in the shoes of Mortenson.

First, we look at Northwestem's comprehensive general liability policy and Section I.A.1.a., which details the policy coverage. That section provides, in part:

> "[Wausau] will pay those sums *that the insured becomes legally obligated to pay* as damages because of 'bodily injury' or 'property damage' to which this insurance applies." (Emphasis supplied.)

Turning next to the policy exclusions, Section I.A.2.e. expressly excludes coverage for:

> " 'Bodily Injury' to:
>
> "(1) An employee of the insured arising out of and in the course of employment by the insured; * * *
>
> "* * * * *
>
> "This exclusion applies:
>
> **142 Or App 230>** " * * * * *
>
> "(2) To any obligation to share damages with or repay someone else who must pay damages because of the injury.
>
> "This exclusion does not apply to liability assumed by the insured under an 'insured contract.' "

An "insured contract" is defined under Section V.6.g as:

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[6] See footnote 3.

[7] The judgment included an award on Wausau's counterclaim to recover $25,000 that Wausau had contributed to the settlement in the Mortenson lawsuit. That award is not challenged here.

> "That part of any other contract or agreement pertaining to your business under which you assume the tort liability of another to pay damages because of 'bodily injury' or 'property damage' to a third person or organization, if the contract or agreement is made prior to the 'bodily injury' or 'property damage.' Tort liability means a liability that would be imposed by law in the absence of any contract or agreement."

Even accepting Northwestern's proposition that it stood in the shoes of Mortenson, Northwestern nonetheless fails to explain how it could be liable to Sorenson. We resolve that question by looking at ORS 656.018(l)(a), which provides:

> "The liability of every employer who satisfies the duty required by [the Workers' Compensation Law] *is exclusive* and in *place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of* and in *the course of employment* that are sustained by subject workers the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom, *specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such conditions,* except as specifically provided otherwise in this chapter." (Emphasis supplied.)

As a matter of law then, Northwestern could not be held directly or indirectly liable for Sorenson's work-related injuries, *i.e.*, by being named as a party in a lawsuit to recover for such damages or by virtue of a contractual indemnity provision, like that found in Section 17 of Northwestern's construction subcontract. It follows then, that Wausau had no duty under the terms of the comprehensive general liability policy to undertake Mortenson's defense in the Sorenson lawsuit on the theory that Northwestern was really the defendant. The trial court did not err.

142 Or App 231> We turn now to Northwestern's coverage under its workers' compensation insurance policy. There is no dispute that Northwestern complied with its statutory duties under the Workers' Compensation Law, and thus, Northwestern could not be held liable for Sorenson's job-related injuries. ORS 656.018(1)(a). Moreover, Part Two, Section C.1 of its workers' compensation policy, expressly excludes coverage for "liability assumed under a contract." Accordingly, the trial court did not err; Wausau had no duty under the terms of its workers' compensation policy to undertake Mortenson's defense in the Sorenson lawsuit on the theory that Northwestern was really the defendant.

Northwestern's second argument is that defendant had a duty to defend it in the Mortenson lawsuit based on Northwestem's failure to procure insurance for Mortenson. As we understand it, Northwestern's argument is that when Mortenson tendered the defense of the Sorenson lawsuit to Northwestem under the indemnity agreement in the subcontract, Wausau had a duty to defend. Plaintiff is incorrect. Mortenson brought suit against Northwestern claiming damages for breach of contract, contending that due to Northwestern's failure to procure insurance as it had agreed to do in the subcontract, Mortenson had to defend and pay claims that otherwise would have been insured. Wausau's policies only provided coverage for "bodily injury" and "property damage."[8] Thus, the trial court did not err, defendant had no duty to defend.

Affirmed.

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[8] We reject Northwestern's argument that its failure to name Mortenson as an additional insured in its comprehensive general liability policy constituted an "occurrence" or "accident" that resulted in "property damage" for which coverage is provided under the policy. Here, Northwestern's failure to procure insurance to protect Mortenson breached the agreement of the parties. It did not, however, constitute a breach of any duty imposed by law. *See Kisle v. St. Paul Fire & Marine Ins.*, 262 Or 1, 6-7, 495 P2d 1198 (1972). Therefore, the damages caused by Northwestern's failure to perform under the contract are not recoverable under its liability insurance policy. *Id.* at 7.

Cite as 142 Or App 351 (1996) July 31, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bill R. Offill, Claimant.
Bill R. OFFILL, *Petitioner,*
v.
GREENBERRY TANK AND IRON COMPANY and Liberty Northwest Insurance Corporation,
Respondents.
(WCB No. 94-01628; CA A88433)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 17, 1996.
Robert Wollheim argued the cause for petitioner. With him on the brief were Welch, Bruun, Green & Wollheim, James C. Egan and Emmons, Kropp, Kryger, et al.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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142 Or App 353> Claimant seeks review of an order of the Workers' Compensation Board that reduced his award of unscheduled permanent partial disability pursuant to OAR 436-35-007(3)(b). The rule provides, in part:

> "A worker is not entitled to be doubly compensated for a permanent loss of earning capacity in an unscheduled body part which would have resulted from the current injury but which had already been produced by a prior injury and had been compensated by a prior award. Only that portion of such lost earning capacity which was not present prior to the current injury shall be awarded. The following factors shall be considered when determining the extent of the current disability award:
>
> "(A) The worker's total loss of earning capacity for the current disability under the standards;
>
> "(B) The conditions or findings of impairment from the prior award which were still present just prior to the current claim;
>
> "(C) The worker's social-vocational factors which were still present just prior to the current claim; and
>
> "(D) The extent to which the current loss of earning capacity includes impairment and social-vocational factors which existed before the current injury."

Claimant suffered an injury to the back and neck in 1986, for which he received compensation for 25 percent unscheduled permanent disability. Following that injury, claimant was restricted from heavy labor. The Administrative Law Judge (ALJ) in this proceeding found that the restriction was the basis for the 25 percent award, and that determination is not challenged on review. In March 1993, claimant suffered the low back injury that gives rise to the presently disputed permanent disability award. The parties agree that claimant's permanent disability under present disability standards is 18 percent. Insurer contended that the award should be reduced pursuant to OAR 436-35-007(3)(b) in the light of the prior 25 percent award for the 1986 injury.

142 Or App 354> The ALJ found that claimant had made a full recovery from the 1986 injury and did not authorize an adjustment. The Board adopted all of the ALJ's findings; however, in the "Conclusions of Law and Opinion" portion of its order, it also said:

> "[T]he Referee concluded that claimant's 1986 low back injury was no longer disabling at the time of his 1993 injury (i.e., claimant made a full recovery from the impairment condition rated for disability in the 1986 claim). Thus, the Referee concluded that claimant's current extent of disability in his low back was completely attributable to the 1993 injury. We disagree.

> "Following the 1986 injury, Dr. Tiley restricted claimant from heavy work. There is no indication that the 'heavy labor' restriction was ever removed. However, at the time of the March 1993 injury, claimant was again performing heavy work. Subsequent to the 1993 injury, claimant's treating physician, Dr. Lax (neurological surgeon), permanently restricted claimant from heavy labor.
>
> "Despite being restricted from heavy work following the 1986 injury, claimant was again performing heavy work at the time of his 1993 injury. Inasmuch as there is no evidence that the earlier restriction against performing heavy labor had been removed, we find that claimant's current restriction from heavy work was previously considered and compensated by the 1986 permanent disability award."

Thus, despite its general adoption of the ALJ's findings, the Board expressly rejected the ALJ's determination that the disability caused by claimant's first injury had resolved before his second injury. The Board's finding is supported by substantial evidence.

The Board also considered and rejected claimant's contention that OAR 436-35-007(3)(b) is inconsistent with ORS 656.222, as we have interpreted that statute in *City of Portland v. Duckett*, 104 Or App 318, 801 P2d 847 (1990), *rev den* 311 Or 187 (1991), because it authorizes offsets in cases involving unscheduled disability. It held that the administrative rule authorized an offset for the previous unscheduled permanent disability award that claimant had received for his low back.

142 Or App 355> ORS 656.222 provides, in part:

> "Should a further accident occur to a worker who is receiving compensation for a temporary disability, or who has been paid or awarded compensation for a permanent disability, the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities."

The statute and the administrative rule are not facially inconsistent. The statute deals with all awards of compensation made to a worker who is receiving or who has received compensation for disability. With respect to a subsequent award, the statute requires consideration of the "combined effect" of the worker's injuries and the past receipt of money for those disabilities and does not restrict its application to scheduled injuries. The administrative rule expressly addresses unscheduled permanent disability only and requires that the second or subsequent award not compensate for disability that, although it could have been caused by the second injury, was in fact caused by the first injury and for which the worker has already received compensation.

Despite the absence of any facial inconsistency between the rule and the statute, claimant asserts that in *Duckett*, we limited the application of the statute to injuries involving scheduled disability, and that the rule therefore exceeds the scope of the statute. In *Duckett*, we affirmed a Board order holding that ORS 656.222 did not permit an adjustment of a second award for scheduled disability, because, before the second injury, the claimant had fully recovered from a first injury to a scheduled body part and there was no "combined effect" of the previous and the current injury, as required by the statute. Citing *American Bldg. Maint. v. McLees*, 296 Or 772, 679 P2d 1361 (1984); *Nesselrodt v. Compensation Department*, 248 Or 452, 435 P2d 315 (1967), and *Cain v. State Ind. Acc. Comm.*, 149 Or 29, 37 P2d 353 (1934), we noted in *dictum* that the statute applies only to cases involving scheduled disability.

Before *Duckett*, *in Thomason v. SAIF*, 73 Or App 319, 698 P2d 507 (1984), *rev den* 299 Or 443 (1985), we were faced squarely with the question of whether ORS 656.222 **<142 Or App 355/356>** applies to cases involving unscheduled disability. Referring to the same Supreme Court opinions that we later cited in *Duckett*, we held in Thomason that ORS 656.222 is applicable in the context of injuries causing *unscheduled* disability. Our *dictum* in *Duckett* is inconsistent with our earlier holding in *Thomason*. We are persuaded, after once again reviewing the pertinent Supreme Court opinions, that we were correct in *Thomason*, and that our *dictum* in *Duckett* was, thus, incorrect.

In *American Bldg. Maint.*, the question was whether ORS 656.222 required an adjustment of a workers' compensation award for a previous Veterans' Administration disability award. The court held that the statute applies only in the context of previous compensation paid to the worker under the workers' compensation system. The court noted that in Cain and *Green v. State Ind. Acc. Comm.*, 197 Or 160, 251 P2d 437, 252 P2d 545 (1953), both of which had involved unscheduled disability awards, it had held that the statute did not require a reduction. *American Bldg. Maint.*, 296 Or at 775. The court noted

further that in *Nesselrodt*, which had involved a scheduled injury, the statute had been applied and that *Cain* and *Green* had been distinguished on the ground that they had involved unscheduled awards.

In *Cain*, the worker had suffered two unscheduled injuries to the back. The court reasoned that the version of ORS 656.222 then in existence was inapplicable and did not require an adjustment to the claimant's second award, because the first award had been paid out in full and there would be no *doubling of payments* for the claimant to receive the full second award for disability *actually caused by the second injury*. The court construed the provision to apply only in the context of "injuries for which the workman is still receiving compensation, or for which lump sum payment has been made which, if divided into monthly installments, would still be in process of payment to him at the time of 'further injury.' " *Cain*, 149 Or at 41. The court understood the statute as a limitation on *double payments* but not a restriction on a worker's entitlement to the full award for disability caused by the second injury. *Id.* at 42. The court attached no special significance to the fact that the award in that case was for an **<142 Or App 356/357>** unscheduled disability. Implicitly, the court's holding would have applied as well in the context of a scheduled disability.

In *Green*, the two injuries the claimant had suffered involved unscheduled disability to the back. For his first injury, the worker had received the maximum award available for an injury of that type, the equivalent of 100 percent loss of use of the arm. The parties agreed that as a result of his second injury the worker had sustained an additional disability equal to 50 percent loss of function of the arm. The employer took the position, however, that under the then-existing version of the unscheduled permanent partial disability statute, OCLA Section 102-1760, and the then-existing version of ORS 656.222 the award of an injured worker suffering unscheduled disabilities from more than one injury to the same body part should not exceed the maximum recovery provided for unscheduled permanent partial disabilities in one accident. In other words, the worker should not be allowed to receive more than a total of 100 percent loss of use of the arm for his multiple back injuries. The Supreme Court rejected that view and adopted the opinion of the trial judge, holding that the claimant was entitled to be fully compensated for disability "actually suffered as a result of the second accident" without regard for the previous award. *Green*, 197 Or at 169.

As we understand the court's opinions in *Green* and *Cain*, they have interpreted the workers' compensation statutes so as to require a full recovery of benefits for disability actually caused by a subsequent injury but to avoid a double recovery of benefits for the same disability that was actually caused by earlier injuries. The rule applies with equal effect in the context of both scheduled and unscheduled disabilities. The fact that *Green* and *Cain* involved unscheduled disabilities is only coincidental to their holdings.

In *Nesselrodt*, the court applied ORS 656.222 to require an offset. *Nesselrodt* is distinguishable from *Green* and *Cain* because it involved a scheduled disability, but the distinction is of minimal significance. As we have noted, the bases for the holdings in *Green* and *Cain* related only coincidentally to the fact that the injuries caused unscheduled disabilities. In *Nesselrodt*, the factual discussion is brief, but it **<142 Or App 357/358>** must be assumed that the second award would have covered disability for which the worker had previously received benefits. As we read *Green* and *Cain*, both would have authorized an offset in that circumstance, even in the context of unscheduled disability.

In sum, *Cain*, *Green* and *Nesselrodt*, do not hold that ORS 656.222 is inapplicable to cases involving unscheduled disability, contrary to any suggestion in *American Bldg. Maint.* We decided *Thomason* in 1985. The Supreme Court then decided *Norby v. SAIF*, 303 Or 536, 738 P2d 974 (1987), which implicitly assumes that ORS 656.222 applies in the context of injuries involving unscheduled disability. We then decided *Duckett*, not citing *Thomason*.

We are satisfied, after reviewing the Supreme Court's opinions, that that court has never limited the application of ORS 656.222 to cases involving scheduled disabilities, and that their opinions cannot be read to require such a limitation. We were wrong in suggesting to the contrary in *Duckett*. Accordingly, we reject claimant's contention that ORS 656.222 is limited to scheduled injuries and that OAR 436-35-007(3), which expressly requires an offset in the context of unscheduled awards, is inconsistent with the statute. We hold that the Board did not err in applying the rule to this case, where the evidence supports the Board's finding that the unscheduled permanent disability for which claimant received his first award had not resolved at the time of the second injury.

Affirmed.

Cite as 142 Or App 383 (1996) July 31, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jay Nero, Claimant.
Jay NERO, *Petitioner,*
v.
CITY OF TUALATIN, *Respondent.*
(92-04986; CA A87555)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 15, 1995.
John Hogan argued the cause for petitioner. On the brief was Donald M. Hooton.
Brad J. Harper argued the cause for respondent. On the brief were Patric J. Doherty, Karli L. Olson and VavRosky, MacColl, Olson, Doherty & Miller, P.C.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DE MUNIZ, J.
Affirmed.

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142 Or App 385> Claimant seeks review of an order of the Workers' Compensation Board (Board) denying him attorney fees under ORS 656.382(1) and ORS 656.386(2). We affirm.

Claimant suffered a work-related injury in March 1991, and employer eventually accepted his claim for a herniated disc. The attending physician's final examination in October 1991 revealed no permanent impairment or disability, and, in November 1991, employer issued a Notice of Closure with no permanent disability. Claimant requested reconsideration by the Department of Insurance and Finance[1] (DIF) and sought a penalty pursuant to ORS 656.268(4)(g). DIF had an arbiter examine claimant. On reconsideration, the Director of DIF granted claimant an unscheduled award of 12 percent and a scheduled award of 11 percent, but did not award a penalty. Employer requested a hearing, and the referee eliminated claimant's scheduled award and reduced the unscheduled award to five percent. On review, the Board reinstated the Director's award but did not grant a penalty. We reversed the Board's holding as to the penalty. *Nero v. City of Tualatin,* 127 Or App 458, 873 P2d 390, *rev den* 319 Or 273 (1994), *overruled SAIF v. Cline,* 135 Or App 155, 897 P2d 1172, *rev den* 321 Or 560 (1995).

On remand, the Board awarded a penalty equal to 25 percent of the amount of compensation due under the Director's order, ORS 656.268(4)(g), but did not grant attorney fees incurred in obtaining that penalty. On reconsideration, the Board again denied attorney fees.

On judicial review, claimant first argues that he is entitled to attorney fees under ORS 656.382(l), which provides:

> "If an insurer or self-insured employer refuses to pay compensation due under an order of an Administrative Law Judge, board or court, or *otherwise unreasonably resists the payment of compensation,* except as provided in ORS 656.385, the employer or insurer shall pay to the claimant **<142 Or App 385/386>** or the attorney of the claimant a reasonable attorney fee[.]" (Emphasis supplied.)

Imposition of a penalty under ORS 656.268(4)(g), claimant argues, establishes as a matter of law that employer "unreasonably resisted payment of compensation."[2] We disagree.

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[1] The 1993 legislature changed the name of DIF to the Department of Consumer and Business Services. Or Laws 1993, ch 744, § 18.

[2] Employer responds that the Board previously rejected this argument in *Jesus R. Corona,* 45 Van Natta 886 (1993), which we affirmed without opinion. *Corona v. Pacific Resource Recycling,* 126 Or App 544, 871 P2d 133 (1994). Employer argues that there are no sound reasons for "overruling" *Corona.* Employer mistakes our disposition in *Corona* as an expression of agreement with the Board's reasoning in that case. A case affirmed without opinion has no precedential value.

ORS 656.268(4)(g), provides:

> "If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for either a scheduled or unscheduled permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."[3]

Imposition of a penalty under ORS 656.268(4)(g) means only that a claimant's compensation was increased on reconsideration by at least 25 percent, and the total award of permanent disability is at least 20 percent. *SAIF v. St. Clair*, 134 Or App 316, 320, 894 P2d 1264 (1995). The statute does not require "unreasonable conduct or wrongdoing by the insurer [or self-insured employer] before the penalty may be imposed." *Id.*[4] *See also SAIF v. Valencia*, 140 Or App 14, 16, **<142 Or App 386/387>** 914 P2d 32 (1996) (following *St. Clair); Cline*, 135 Or App at 157 n 1 (same).

Under *St. Clair,* imposition of a penalty pursuant to ORS 656 268(4)(g) does not necessarily mean that employer's conduct was "unreasonable" and, therefore, does not establish *as a matter of law* that employer "unreasonably resist[ed] the payment of compensation." Accordingly, we must consider as a factual matter whether employer's finding of no permanent disability constitutes unreasonable resistance when the director subsequently awarded partial permanent disability.

> "Whether a delay in paying compensation is unreasonable under ORS 656.382(1) * * * involves both legal and factual questions. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 763 P2d 408 (1988). The correct legal inquiry is whether the employer had a legitimate doubt as to its liability. 'Unreasonableness' and 'legitimate doubt' are to be considered in the light of all the evidence available to the employer. If the Board uses the correct legal standard, then we review its finding about reasonableness for substantial evidence. 93 Or App at 592[.]" *Tattoo v. Barrett Business Service,* 118 Or App 348, 353, 847 P2d 872 (1993).

Here, the Board concluded that employer did not unreasonably resist payment of compensation because, in finding no permanent disability, employer reasonably relied on "the attending physician's closing examination which found no permanent impairment or disability." We conclude that the Board used the correct legal standard because "[t]he proper focus * * * is on the evidence available to employer

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[3] A 1995 amendment to ORS 656.268(4)(g) added the following exception:

> "If the increase in compensation results from new information obtained through a medical arbiter examination or from the adoption of a temporary emergency rule, the penalty shall not be assessed."

However, that amendment applies only to claims that became medically stationary on or after June 7, 1996, the effective date of the amendment. 1995 Or Laws, ch 332, §§ 30, 66(4), 69. The claim here became medically stationary in November 1991, and the amendment has no effect on this case.

[4] In *St. Clair,* SAIF argued that a penalty under ORS 656.268(4)(g) should not imposed without some showing of wrongdoing by the insurer or employer. As support, it cited OAR 436-30-050(12), which provides, in part:

> "If an increase in compensation results from new information obtained through a medical arbiter examination or from the promulgation of a temporary emergency rule, penalties will not be assessed."

We noted, however, that the penalty statutes contained no similar exceptions, and concluded that no "unreasonable conduct or wrongdoing" is required. 134 Or App at 319-20.

Although the 1995 legislature amended ORS 656.268(4)(g) by adding an exception that is nearly identical to that of OAR 436-30-050(12), that amendment does not affect this case. *See* n 3.

at the time of the denial." *Tri-Met, Inc. v. Odighizuwa,* 112 Or App 159, 164, 828 P2d 468 (1992).[5] Furthermore, substantial **<142 Or App 387/388>** evidence supports the Board's findings as to the reasonableness of employer's reliance on that evidence. ORS 183.482(8)(c). The Board therefore correctly concluded that employer did not "unreasonably resist the payment of compensation," and claimant was not entitled to attorney fees under ORS 656.382(1).

Claimant next seeks attorney fees under ORS 656.386(2). ORS 656.386(1) directs the court to allow attorney fees in "all cases involving denied claims where a claimant finally prevails against the denial[.] " Attorney fees under ORS 656.386(1) are paid by the insurer or self-insured employer. ORS 656.386(2) provides:

> "In all other cases, attorney fees shall be paid from the increase in the claimant's compensation, if any, except as otherwise expressly provided in this chapter."

If employer is not responsible for paying claimant's attorney fees, claimant argues, then those fees should come out of the penalty itself under ORS 656.386(2). The Board rejected this argument, reasoning that a penalty is not "compensation." We agree.

In *Saxton v. SAIF,* 80 Or App 631, 723 P2d 355, *rev den* 302 Or 159 (1986), we held that a penalty is not "compensation" under ORS 656.382(2).[6] *Id.* at 633-34. Claimant argues that our holding in *Saxton* applies only to the statute construed there and should not be extended to ORS 656.386(2). He instead relies on the general definition of "compensation" in ORS 656.005(8), which provides:

> " '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 this chapter."

142 Or App 389> A penalty awarded pursuant to ORS 656.268(4)(g), claimant contends, is a "benefit" to the worker under ORS 656.005(8). However, in *Dotson v. Bohemia, Inc.,* 80 Or App 233, 720 P2d 1345, *rev den* 302 Or 35, (1986), we held that the term "benefits" under ORS 656.005(8) refers only to those benefits "set forth in *[former]* ORS 656.202 to ORS 656.258. These include payments for a worker's death, disability, medical services and vocational assistance." *Id.* at 236.[7] Because attorney fees are "provided for legal services, and not for a compensable injury, and are addressed in ORS 656.382 to ORS 656.388," we held that they were not part of "compensation" under ORS 656.382(2). *Id.*

The penalty imposed here is not among the "benefits" addressed in *Dotson.* Instead, like the attorney fees in that case, it is set out in a separate section of ORS chapter 656. Furthermore, a penalty under ORS 656.268(4)(g) is "provided" to penalize the employer, and not to compensate the claimant for his or her injury. Therefore, the penalty here is not "compensation" out of which attorney fees may be paid under ORS 656.386(2), and the Board correctly denied attorney fees on that basis.

Affirmed.

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[5] *See also Tattoo,* 118 Or App at 353 (although Board did not use the term "legitimate doubt," the context of its analysis indicates that it applied the proper legal standard).

[6] ORS 656.382(2) provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or crossappeal."

[7] *See also Buddenberg v. Southcoast Lumber,* 316 Or 180, 185, 850 P2d 360 (1993) ("compensation" includes benefits paid for death, ORS 656.204, permanent total disability, ORS 656.206, temporary total disability, ORS 656.210, temporary partial disability, ORS 656.212, and permanent partial disability, ORS 656.214, as well as medical services, ORS 656.245).

Cite as 142 Or App 404 (1996) July 31, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Perry A. Lang, Claimant.
REDMAN INDUSTRIES, INC., and AIG Claim Services, *Petitioners,*
v.
Perry A. LANG, *Respondent.*
(94-11757; CA A89422)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 17, 1996.
Jerald P. Keene argued the cause and filed the brief for petitioners.
David W. Hittle argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander, McCann & Smith.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DE MUNIZ, J.
Reversed and remanded.

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142 Or App 406> Employer seeks review of an order of the Workers' Compensation Board (Board) holding that claimant suffered a compensable injury when he was struck by a coworker who was angered by claimant's derogatory racial remarks. ORS 656.005(7)(a). We reverse.

We take the facts as found by the Administrative Law Judge (ALJ), which were adopted by the Board and are supported by substantial evidence. ORS 183.482(8)(c). Claimant, a Caucasian male, worked at employer's plant with Frazier, an African-American, male coworker. Claimant installed windows on manufactured homes, and Frazier installed doors. On August 3 or 4, 1994, claimant jokingly called Frazier a "watermelon," which angered Frazier. On August 4, referring to that or a similar remark, Frazier told claimant "don't be playing with me like that." The next morning, claimant referred to Frazier as "watermelon" and, less than an hour later, as "buckwheat," "Kentucky Fried Chicken," and "watermelon eatin' fool." Although Frazier knew claimant was trying to joke with him, Frazier became angry and called claimant "cracker" and another name, possibly "honkey."

Frazier remained very upset by claimant's remarks. Within a few minutes, another worker called Frazier a Spanish name that Frazier believed was a racial slur. Frazier struck that worker. Moments later Frazier saw claimant talking with an inspector. Assuming he would lose his job for striking the other employee, Frazier struck claimant at least twice. Frazier asked claimant, "Who's a Toby now?"

Claimant received emergency medical treatment and filed a workers' compensation claim, which employer denied. Claimant requested a hearing, and the ALJ ruled that claimant's injury "arose out of" his employment and was compensable. The Board adopted and affirmed the ALJ's order. The central issue on review is whether claimant's injury "arose out of" his employment.

Claimant has the burden of proving his injury is compensable. ORS 656.266.

> **142 Or App 407>** "A 'compensable injury' is an accidental injury * * * *arising out of and in the course of employment* requiring medical services or resulting in disability or death [.]" ORS 656.005(7)(a) (emphasis supplied).

In determining whether an injury is compensable under ORS 656.005(7)(a), the Oregon Supreme Court has adopted a "unitary approach," in which "arising out of" and "in the course of" are two elements of a single inquiry, i.e. "whether the relationship between the injury and the employment is sufficient that the injury should be compensable." *Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 366, 867 P2d 1373 (1994), *citing Rogers v. SAIF,* 289 Or 633, 616 P2d 485 (1980). However, both elements of ORS 656.005(7)(a) still must be satisfied to some degree. *Krushwitz v. McDonald's Restaurants,* 323 Or 520, 531, ___ P2d ___ (1996).

> " '[I]n the course of employment' concerns the time, place, and circumstances of the injury." *Norpac*, 318 Or at 366, *citing Clark v. U.S. Plywood*, 288 Or 255, 260, 605 P2d 265 (1980). Employer concedes that claimant's injury occurred "in the course of employment" because it happened on employer's premises, during work hours and on paid time. We accept that concession, and confine our analysis to whether the injury "arose out of" claimant's employment.

An injury "arises out of employment" when there is a causal connection between the injury and the employment. *Norpac*, 318 Or at 368.

> "An employer * * * is not liable for any and all injuries to its employes irrespective of their cause, and the fact that an employe is injured on the premises during working hours does not of itself establish a compensable injury. The employe must show a causal link between the occurrence of the injury and a *risk connected with his or her employment*." *Phil A. Livesly Co. v. Russ*, 296 Or 25, 29, 672 P2d 337 (1983). (Emphasis supplied.)

Under the risk factor, we must determine "whether the injury had its origin in a risk connected with the employment[.]" 296 Or at 32. The question here is whether the risk of being assaulted by a coworker for using racially derogatory remarks is sufficiently connected with claimant's employment. For the following reasons, we hold that it is not.

142 Or App 408> In *Barkley v. Corrections Div.*, 111 Or App 48, 825 P2d 291 (1992), the plaintiff employee,[1] a convenience store cashier working alone at night, was sexually assaulted by a prison inmate on leave. *Id.* at 50. We held that the plaintiff's injury arose out of her employment under ORS 656.005(7)(a) because there "was a sufficient relationship between the assault and a risk connected with plaintiff's employment[.]" *Id.* at 53.

> "Plaintiff's position as a cashier subjected her to unavoidable and indiscriminate contact with the general public. Behavior of store customers was a hazard of her employment. Her work environment increased her exposure to people who might commit violent crimes, and especially to those who have a history of attacking convenience store clerks." *Id.* at 52-53.

In *Carr v. U.S. West Direct Co.*, 98 Or App 30, 779 P2d 154, *rev den* 308 Or 608 (1989), we held that injuries suffered by an employee plaintiff[2] who was sexually harassed, assaulted and eventually raped by her supervisor did not arise out of her employment, because there was nothing about the nature of her job, or her job environment, that "created or enhanced" the risk of assault. Moreover, the attack was not provoked by anything related to her employment. *Id.* at 32, 35.

Here, as in *Carr*, and unlike *Barkley*, there was nothing about the nature of claimant's job as a window-installer that "created or enhanced" the risk of assault by a coworker. Furthermore, although an injury may arise out of employment when it stems from a work-related dispute, *Youngren v. Weyerhaeuser*, 41 Or App 333, 597 P2d 1302 (1979), the dispute here was not work-related.

142 Or App 409> In *Youngren*, the claimant's coworker boarded up a work exit, making the claimant's job more difficult, and seemed prepared to use physical violence if claimant tried to remove the barrier. 41 Or App at 336. In lieu of striking his coworker, the frustrated claimant struck a metal drum several times, breaking a bone in his hand. *Id.* at 335. In holding the injury compensable, we agreed with the Board, which stated:

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[1] Although *Barkley* was a civil action we were nonetheless required to determine whether the plaintiff's injury was compensable under the Workers' Compensation Act, ORS 656.005(7)(a), and therefore whether her action was barred by ORS 30.265(3)(a). 111 Or App at 51.

[2] As in *Barkley*, we were required in *Carr* to determine whether plaintiff's injury was compensable under ORS 656.005(7)(a), and therefore whether her civil action was barred by ORS 656.018. 98 Or App at 34.

> " '[T]he fact that claimant's employment required him to work with this co-employee and that such employment * * * [might give] rise to circumstances * * * result [ing] in a dispute between claimant and his co-employee *over a work-related matter* occurring on the employer's premises would satisfy the test that the injury 'arose out of' the claimant's employment.' " *Id.* at 336 (emphasis supplied).

See also SAIF v. Barajas, 107 Or App 73, 76-77, 81O P2d 1316 (1991) (implying that injury from coworker stabbing arose out of claimant's employment where dispute stemmed from assailant's distress over demotion and the fact that he was no longer claimant's supervisor).

Although day-to-day friction may provide the causal connection between a claimant's employment and a coworker's assault, disputes resulting from that friction must arise from a *work-related* matter.[3] In *Youngren*, the quarrel was based on the claimant's use of a work exit and in *Barajas* it centered on the assailant's recent demotion. Here, the dispute arose from claimant's use of racially derogatory remarks in an attempt to "joke" with a coworker. The resulting assault was therefore not "work-related" but pertained instead to claimant's personal relationship with that coworker. *See Robinson v. Felts*, 23 Or App 126, 133, 541 P2d 506 (1975) (on-the-job assault of employee stemming from her personal relationship with attacker was not connected with her **<142 Or App 409/410>** employment). Claimant's injuries therefore did not "arise out of" his employment.[4]

Reversed and remanded.

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[3] Claimant nonetheless urges us to hold an injury compensable where the injured worker and the assailant coworker are brought together solely through their employment, "even if the subject of the dispute is unrelated to the work." However, "[t]he fact that the employment placed plaintiff and [her assailant] together is not, in itself, enough" to establish a work connection. *Carr*, 98 Or App at 35.

[4] In holding otherwise, the Board erroneously relied on *McLeod v. Tecorp International, Ltd.*, 318 Or 208, 865 P2d 1283 (1993). The Supreme Court there construed the term "arising out of * * * employment" as used in an insurance policy. Responding to our conclusion that "the independent actions of an individual coworker * * * do not necessarily 'arise' out of employment," the Supreme Court stated "[t]hat may be true as concerns the individual coworker, but as to the victimized employee, the injury arises out of the employment." *Id.* at 217 n 6. However, the court specifically rejected the notion that that language had the same meaning as in ORS 656.005(7)(a). *McLeod* therefore does not apply.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Arthur D. Simon, Claimant.
Arthur D. SIMON, *Petitioner*,
v.
PIE NATIONWIDE, INC., and SAIF Corporation, *Respondents*.
(91-12398; CA A79303)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 8, 1995.
Richard A. Sly argued the cause and filed the brief for petitioner.
Michael O. 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 Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DE MUNIZ, J.
Reversed and remanded.

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142 Or App 413> Claimant seeks review of an order of the Workers' Compensation Board (Board) denying him an award for permanent partial disability. We reverse and remand.

Claimant filed a claim for a work-related hernia which SAIF accepted. After surgery, the attending physician Dr. Mollerus, found no permanent impairment, and SAIF issued a Determination Order awarding time loss only. However, an independent physician, Dr. Mayer, concluded claimant had "some permanent impairment" and "is going be very susceptible to injuries in the future and that should not return to heavy lifting[.]" On reconsideration, Department of Insurance and Finance[1] (DIF) ordered examination by a medical arbiter, Dr. Howell. Claimant not appear for his scheduled examination. Based on a review of the records, Howell found that claimant suffered from permanent impairment of up to five percent based removal of the "left inguinal nerve," a condition the arbiter considered unlikely to effect claimant's "ranges of motion." In its Order on Reconsideration, DIF affirmed SAIF's denial of permanent partial disability but did not conduct a substantive review.[2]

Claimant then sought a hearing. The Administrative Law Judge (ALJ) invalidated the temporary rules that set out standards for rating claims of permanent impainne and found that claimant was permanently partially disabled. The Board reversed, reasoning that the Hearings Division had no authority to invalidate DIF's rules. Applying the standard in those rules, the Board held that the arbiter's finding did not allow an award of partial permanent disability, and concluded that

> "claimant has failed to establish a chronic condition or any other permanent impairment on the basis of medical evidence supported by objective findings."

142 Or App 414> On review, claimant first contends that the Board's conclusion is inconsistent with its findings of fact. Specifically, claimant points out that the Board adopted the ALJ's findings, and the ALJ found, among other things, that claimant

> "has a permanent impairment due to his, compensable hernia and surgeries. * * * As a result of his compensable injuries, the claimant is susceptible to reinjury in the future and should avoid heavy lifting, pulling and pushing. * * * Claimant's compensable hemias have resulted in a chronic condition limiting his ability to repetitively lift, push and pull[.]"

The only basis for those findings is the independent examination by Mayer. The Board correctly noted, however, that only the attending physician or a medical arbiter may make impairment findings. ORS 656.245(3)(b)(B);[3] ORS 656.268(7);[4] *Tektronix, Inc. v. Watson*, 132 Or App 483, 48586, 888 P2d 1094 (1995). Mayer was neither. Furthermore, neither the findings of Mollerus, the attending physician, nor those of Howell, the medical arbiter, support that part of the ALJ's findings.[5] We conclude, therefore, that the Board implicitly rejected Mayer's medical opinion, and thus also rejected the ALJ's findings based on that opinion.

Claimant next assigns error to the Board's application of DIF's standards under the temporary rules, which claimant challenges as improperly adopted. In *Ferguson v. U.S. Epperson Underwriting*, 127 Or App 478, 873 P2d 393, *rev allowed* 320 Or 325 (1994), *rev dismissed* 321 Or 97 **<142 Or App 414/415>** (1995), we rejected a challenge to these same rules as moot because they were incorporated into permanent rules that were in effect on June 21, 1991, the date the Order on Reconsideration was issued. *Id.* at 480-81. Because the temporary rules were applied "only insofar as they had been incorporated by

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[1] The Department of Insurance and Finance is now called the Department Consumer and Business Services.

[2] DIF was unable to complete a substantive review within the time limits of the injunction issued in *Benzinger v. Oregon Dept. of Ins. and Finance*, 107 Or App 449, 812 P2d 36 (1991).

[3] ORS 656.245(3)(b)(B) provides, in part:

> "Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability."

A 1995 amendment renumbered subsection (3) as subsection (2), but made no substantive changes.

[4] ORS 656.268(7) allows referral of a claim to a medical arbiter when the parties disagree with the impairment used in the rating of the worker's disability.

[5] As the Board noted, the attending physician found no permanent impairment, and did not concur in Mayer's findings. Reports of independent medical examiners are inadmissible for the purpose of rating impairment unless the attending physician ratifies those findings. *Tektronix*, 125 Or App at 486; OAR 43635-007(8). Although the arbiter found permanent partial impairment, he believed that it would not likely affect claimant's "ranges of motion."

the permanent rules," which the claimant did not challenge, we held the claimant's challenge to the temporary rules moot. *Id.* at 482; *see also Jackson v. Tuality Community Hospital,* 132 Or App 182, 187, 888 P2d 35 (1994), *rev den* 321 Or 246 (1995) (following *Ferguson).* Here, DIF issued its Order on Reconsideration August 30, 1991, after it had adopted the permanent rules. Therefore, as in *Ferguson,* claimant's challenge to the temporary rules is moot.

Claimant next argues that, even under the temporary rules, the Board erred in holding that the medical arbiter's finding of permanent impairment did not allow an award of permanent partial disability. *Former* OAR 436-35320, the temporary standard on which the Board relied, provided, in part:

> "(5) A worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition."

Claimant contends that a preponderance of medical opinion established that "claimant had a permanent impairment due to his hernia and surgeries which made him susceptible to reinjury such that he should avoid heavy lifting, pulling or pushing[.]" However, as discussed above, the Board properly rejected that portion of the ALJ's findings as based on the independent medical examination by Mayer. Although the arbiter, Howell, found permanent partial impairment, he believed it would not likely affect claimant's "ranges of motion." The arbiter's finding therefore fails to demonstrate that claimant is "unable to repetitively use a body area due to a chronic and permanent medical condition," as required by *former* OAR 436-35-320(5). Accordingly, the Board correctly concluded that the temporary standards did not allow an award for permanent impairment based on the arbiter's finding.

142 Or App 416> Claimant next assigns error to the Board's conclusion that it had no authority to remand to DIF for adoption of a temporary rule amending the standards to accommodate claimant's impairment. SAIF concedes error under *Gallino v. Courtesy Pontiac-Buick-GMC,* 124 Or App 538, 863 P2d 530 (1993) (holding that Board can, and must, remand to department for adoption of temporary rules accommodating worker's impairment when disability not addressed by existing standards). We accept that concession.

SAIF contends, however, that the error is harmless, because the arbiter's finding of physical impairment is unsupported by proper medical evidence. A compensable injury must be "established by medical evidence supported by objective findings." ORS 656.005(7)(a). ORS 656.005(19) provides:

> " 'Objective findings'in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

According to SAIF, that language "contemplates that a predicate to the existence of objective findings is a physical examination." The only medical evidence in the record indicating a permanent impairment, SAIF points out, is from the arbiter. However, claimant did not appear for his physical examination with the arbiter, who based his finding of permanent impairment on an examination of the medical records. The arbiter's conclusion, SAIF contends, therefore does not qualify as "medical evidence supported by objective findings."

ORS 656.005(19) was amended by Oregon Laws 1995, chapter 332. Because the amended version of the statute is applicable,[6] it is for the Board in the first instance to **<142 Or App 416/417>** address that argument. We reverse and remand for reconsideration in the light of the new law. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

Reversed and remanded.

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[6] The amendment to ORS 656.005(19) applies to all claims existing or arising on or after June 7, 1995, the amendment's effective date. Or Laws 1995, ch 332, §§ 1, 66(1), 69. Because the claim here existed on that date, the amendment applies.

Cite as 142 Or App 433 (1996) July 31, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Darlene L. Bartz, Claimant.
JELD-WEN, INC., *Petitioner,*
v.
Darlene L. BARTZ, *Respondent.*
(94-08692; CA A88944)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 18, 1995.
Jaurene R. Judy argued the cause and filed the brief for appellant.
Philip H. Garrow argued the cause for respondent. With him on the brief was Janet H. Breyer.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed.

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142 Or App 435> Employer seeks judicial review of an order of the Workers' Compensation Board requiring it to pay temporary total disability benefits in accordance with an earlier order requiring it to do the same. We affirm.

In 1991, claimant filed a claim for bilateral carpal tunnel syndrome (CTS) and bilateral osteoarthritis of the thumbs. Employer denied both claims. On January 13, 1993, the Board upheld the denial as to the osteoarthritis claim, but overturned it as to the CTS claim and remanded the claim to employer for "processing according to law." Employer sought our review with respect to the CTS claim. In the meantime, however, it did not process the CTS claim. We affirmed the Board. *Jeld-Wen, Inc. v. Bartz,* 123 Or App 359, 859 P2d 1208 (1993).

Claimant requested a hearing on her entitlement to benefits during the pendency of judicial review. On October 18, 1993, the administrative law judge (ALJ) ordered employer to pay temporary total disability benefits from January 14, 1993, the date following the Board's order requiring processing of the claim, and continuing until either the claim is lawfully closed or the Board's order is reversed, as required in ORS 656.313(1).[1]

On October 30, 1993, employer issued a notice of closure declaring claimant medically stationary as of September 9, 1992, and paid claimant temporary total disability benefits through that date. Employer did not, however, pay the benefits from January 14, 1993, through October 30, 1993, the date of closure. Claimant requested a hearing on the notice of closure; the disposition of that proceeding is not before us.

142 Or App 436> On May 17, 1994, the Board affirmed the ALJ's October 18, 1993, order requiring employer to pay temporary total disability benefits pursuant to ORS 656.313(1). Employer did not petition for judicial review of the Board's order. Still, employer did not pay claimant temporary total disability benefits as ordered. Claimant then initiated this action to enforce the Board's May 17, 1994, order.

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[1] At the time, ORS 656.313(1)(a) provided:

"Filing by an employer or the insurer of a request for hearing on a reconsideration order or a request for board review or court appeal stays payment of the compensation appealed, except for:

"(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs[.]"

In 1995, the legislature amended that statute in a manner not relevant to the disposition of this case.

Employer does not dispute that the Board's findings of fact are supported by substantial evidence but argues that the Board applied the incorrect legal standard to those facts. It contends that the Board erred in holding that "good cause" could be established by a showing that the request was not timely filed because of the omission or negligence of someone other than the person specifically responsible for "filing" the request for hearing. Employer contends that, under *Brown v. EBI Companies,* 289 Or 455, 460, 616 P2d 457 (1980), the correct standard does not depend on responsibility for filing but, rather responsibility for "recognizing and correctly handling" the denial. Claimant responds that the Board's order should be affirmed because "good cause" is a delegative term under *Springfield Education Assn. v. School Dist.*, 290 Or 217, 621 P2d 547 (1980), and the Board's determination here of what constitutes "good cause" is within the range of its delegated authority.[3]

In *SAIF v. Curtis,* 107 Or App 625, 813 P2d 1112 (1991), we discussed our standard of review of the Board's determination of "good cause" under ORS 656.319. In particular, we concluded that, notwithstanding a history of reviewing such determinations de novo, our review was properly governed by standards prescribed in the Administrative Procedures Act. ORS 183.482. We explained that we would reverse the Board's determination of good cause "only if the [Board's] findings are not supported by substantial evidence or if it has erroneously interpreted a provision of law. ORS 138.482(8)(a)." *Id.* at 630.[4]

142 Or App 473> For the reasons that follow, we conclude that *Curtis,* perhaps inadvertently, may have signaled a misleading standard of review. Because, as we explain below, the ultimate determination of whether particular circumstances constitute "good cause" for filing an untimely request for a hearing under ORS 656.319(1)(b) is a matter within the Board's delegative discretion, that ultimate determination is more precisely and pertinently reviewed under ORS 183.482(8)(b),[5] not ORS 183.482(8)(a).

"Good cause" is a "delegative term" within *Springfield's* rubric. In *McPherson v. Employment Division,* 285 Or 541, 591 P2d 1381 (1979), the court addressed the proper standard for reviewing the Employment Division's determination of whether an employee had "good cause" to leave her employment. The court concluded that "good cause" within the meaning of ORS 657.176(2)(c)

> "calls for completing a value judgment that the legislature itself has only indicated: evaluating what are 'good' reasons for giving up one's employment and what are not. Judicial review of such evaluations, though a 'question of law,' requires a court to determine how much the legislature has itself decided and how much it has left to be resolved by the agency. For an agency decision is not 'unlawful in substance,' ORS 183.482(8), *supra,* if the agency's elaboration of a standard like 'good cause' is within the range of its responsibility for effectuating a broadly stated statutory policy." *Id.* at 550.

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[3] Claimant challenges employer's petition for review as deficient for noncompliance with ORS 656.298. We reject that challenge without further discussion.

[4] ORS 183.482(8)(a) provides:

"The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

"(A) Set aside or modify the order; or

"(B) Remand the case to the agency for further action under a correct interpretation of the provision of law."

[5] ORS 183.482(8)(b) provides:

"The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

"(A) Outside the range of discretion delegated to the agency by law;

"(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

"(C) Otherwise in violation of a constitutional or statutory provision."

Brown v. EBI involved a materially different sort of "good cause" that is, "good cause" for an untimely request for a hearing under ORS 656.319(1). In remanding the Board's determination that a pre-*McPherson* decision, *Sekerinestrovich v. SAIF*, 280 Or 723, 573 P2d 275 (1977), foreclosed any finding of good cause, the court observed:

> **142 Or App 474>** " '[G]ood cause' under ORS 656.319(1)(b) is not a matter of 'discretion' but of agency judgment in the sense stated in *McPherson[.]*" *Brown*, 289 Or at 460 n 3.

In *Springfield*, the court refined and amplified the proper review of agency determinations of good cause:

> "The legislature may use general delegative terms because it cannot foresee all the situations to which the legislation is to be applied and deems it operationally preferable to give an agency the authority, responsibility and discretion for refining and executing generally expressed legislative policy. This pattern of general legislation and specific application arises in several contexts. In *McPherson*, we dealt with a statutory term, 'good cause' which 'calls for completing a value judgment that the legislature itself has only indicated.'*
>
> "* * * * *
>
> "When an agency determines whether certain facts constitute good cause, for example, a decision either way reflects a choice of policy which is essentially legislative in that it refines a general legislative policy. * * * The delegation of responsibility for policy refinement under such a statute is to the agency, not to the court. The discretionary function of the agency is to make the choice and the review function of the court is to see that the agency's decision is within the range of discretion allowed by the more general policy of the statute. *This decisional relationship of agency and courts in contested cases is provided for in ORS 183.482(8)(b)[.]*" 290 Or at 228-29 (emphasis supplied).

Thereafter, in *Sayers v. Employment Division*, 59 Or App 270, 650 P2d 1024 (1982), we reviewed the Employment Division's determination that the petitioner had not demonstrated "good cause" for an untimely request for hearing under ORS 657.875.[6] Referring to *McPherson* and *Springfield* and to *Brown*, which involved the directly analogous workers' compensation "untimely request for hearing"/"good cause" statute, we concluded that the Employment Division's **<142 Or App 474/475>** determination of "good cause," and particularly its application of its own rule defining "good cause" for an untimely filing, was "a matter of agency policy" subject to review under ORS 183.482(8)(b). *Sayers*, 59 Or App at 281.

Notwithstanding our analysis in *Sayers*, between the enunciation of the *McPherson/Springfield* analysis in the early 1980's and the abrogation of this court's *de novo* review in workers' compensation cases in 1987, Oregon Laws 1987, chapter 884, section 12a, we continued to engage in *de novo* review determinations of good cause under ORS 656.319(1). *See Curtis*, 107 Or App at 629 (describing history). In doing so, we questioned the correctness of the Supreme Court's suggestion in *Brown* that determinations of "good cause" under the workers' compensation laws were subject to APA review:

> "[I]t is difficult to believe that the Supreme Court in *Brown* intended to say that, although our review under the Workers' Compensation Act is *de novo*, judicial review of whether good cause exists or not under ORS 656.319 is limited by the Administrative Procedures Act as interpreted in *McPherson v. Employment Division* * * *. If that is what the court meant, there may be other questions arising under the Workers' Compensation Act that are subject to that kind of limited review." *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517-18, 717 P2d 635, *rev den* 301 Or 666 (1986), *following remand* 93 Or App 516, 763 P2d 398 (1988) (footnote omitted).

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[6] ORS 657.875 provides:

"The period within which an interested party may request a hearing or file with the Employment Appeals Board an application for review * * * may be extended, upon a showing of good cause therefor, a reasonable time under the circumstances of each particular case."

But see id. at 518-19 (Warren, J., dissenting) ("The term 'good cause' is a delegative one, and we should not disturb the Board's decision unless it is 'unlawful in substance.' " (citing *McPherson*)).

In 1987, the legislature eliminated our *de novo* review in workers' compensation cases, replacing it with APA-type review. ORS 656.298(6) ("The review by the Court of Appeals shall be on the entire record forwarded by the board. Review shall be as provided in ORS 183.482(7) and (8)."). Nevertheless, vestiges of our adherence to *de novo* review of "good cause" determinations persisted until *Curtis* in 1991. *See* 107 Or App at 629-30. After reviewing that history in *Curtis*, we concluded that our review of the Board's **<142 Or App 475/476>** determination of "good cause" was governed by the APA, ORS 183.482, and that, in particular:

> "We may reverse the Board only if its findings are not supported by substantial evidence or if it has erroneously interpreted a provision of law. ORS 183.482(8)(a)." *Id.* at 630.

Curtis's reference to ORS 183.482(8)(a) could be read as implying that the Board's ultimate conclusion that particular facts constitute "good cause" is not subject to review, as a matter of agency judgment, under ORS 183.482(8)(b). Such an implication cannot, however, be squared with *McPherson, Brown,* and *Springfield.* Nor can it be reconciled with our analysis in *Sayers* of the closely analogous "good cause" standard in chapter 657. Accordingly, we clarify[7] that our review of determinations of "good cause" under ORS 656.319(1) is pursuant to ORS 183.482(8)(b).

Our review here, thus, is to see whether the agency's determination of "good cause" is,within "the range of discretion delegated to" the Board by ORS 656.319(1). ORS 183.482(8)(b). The Supreme Court considered the contours of that policy in *Sekermestrovich,* 280 Or 723. It construed "good cause" as meaning "mistake, inadvertence, surprise or excusable neglect," as found informer ORS 18.160,[8] 280 Or at 726-27, and held that negligence of an attorney is not good cause unless the attorney's reason for failing to file would be good cause if attributed to the claimant. *Id.* at 727.

It is employer's position here, however, that the legal standard against which "good cause" must be measured is more exactly or precisely defined than merely whether the facts demonstrate "mistake, inadvertence, surprise or excusable neglect." In particular, employer argues that, although error by a member of the attorney's legal staff with only "indirect" responsibility may be excused, under Brown, error by someone who directly participates and is responsible for "recognizing and handling" the denial cannot be excused, as a matter of law.

142 Or 477> We do not agree with employer's understanding that Brown purports to circumscribe the content of "good cause" under ORS 656.319(1) as a matter of law. In *Brown,* the court reviewed the Board's determination that mishandling of a written notice of denial by someone in the claimant's attorney's office, other than the attorney himself, did not constitute "good cause" for a late filing under ORS 656.319(1). In so holding, the Board had construed the opinion in *Sekermestrovich* as compelling such a result as a matter of law.

On judicial review, the court characterized the question before it as

> "whether the claimant is disqualified as a matter of law when neither she nor her attorney has carelessly neglected to make a timely request for hearing but the failure to do so is attributable to someone in the attorney's office.
>
> "* * * * *
>
> "Thus, the question, as already stated, is *whether negligence in the chain of communication as a matter of law is beyond excuse[.]* " 289 at 458-59 (emphasis supplied).

In reversing the Board, the Supreme Court explained that the Board had misinterpreted its role in applying facts to a delegative term:

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[7] We have not subsequently relied on *Curtis's* specific reference to ORS 183.482(8)(a). In *Mendoza,* for example, we simply stated that "we review for errors of law, ORS 183.482(8)." 123 Or App at 351.

[8] Those excuses are now incorporated into ORCP 71 B.

> "[O]nce 'good cause' under ORS 656.319(1)(b) is equated with the excuses stated in ORS 18.160, it is at least within the range of discretion to relieve a claimant from a default caused by the mistake or neglect of an employee who is not charged with responsibility for recognizing and correctly handling the message that constitutes the legally crucial notice from which the time to respond is measured. The reasons why a party who chooses an attorney to represent her is bound by that attorney's action or neglect to act do not extend so far that she is indirectly bound as a matter of law by every negligent mistake of anyone employed by her attorney." 289 Or at 460.

Thus, the court concluded that the Board was not foreclosed, as a matter of law, from determining that mistake or neglect by a person not responsible for recognizing and handling a denial constituted "good cause." Conversely--and contrary to employer's position here--neither *Brown* nor any subsequent case has held that, as a matter of law hedging the **<142 Or App 477/478>** Board's discretion, neglect by a staff member who is charged with recognizing or handling claim denials can *never* be "good cause" for purposes of ORS 656.319(1)(b). Consequently, even if we assumed, as the employer asserts here, that the record shows that claimant's attorney's secretary had such responsibility, that fact would not, as a matter of law, preclude the Board's determination of "good cause."

We note, finally, that the Board's determination of "good cause" here accords with *Mendoza*. There, the claimant's attorney instructed his legal assistant to request a hearing and she forgot to do so. The Board concluded that those facts did not demonstrate "good cause," and we affirmed:

> "In this case, the attomey and the legal assistant were responsible for filing the request for hearing. *The Board correctly concluded: '[B]ecause failure to request a hearing by someone charged with that responsibility is not excusable neglect,* we hold that claimant has failed to establish good cause for his untimely request * * *.' We find no error." 123 Or App at 352 (emphasis supplied).

Here, in contrast, there is no evidence that claimant's attorney's secretary had any responsibility for filing hearing requests; rather, at most, she was responsible for recognizing and handling notices of denial. Thus, the determination of "good cause" here was not inconsistent with prior Board position or practice, as expressed in *Mendoza.*

Affirmed.

Cite as 143 Or App 159 (1996) August 28, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kathleen A. Robinson, Claimant.
Kathleen A. ROBINSON, *Petitioner,*
v.
NABISCO, INC., *Respondent.*
(WCB No. 93-02515; CA A85643)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 22, 1995.
Robert Wollheim argued the cause for petitioner. With him on the brief was Welch, Bruun, Green & Wollheim.
Patric J. Doherty argued the cause for respondent. With him on the brief were Karli L. Olson and VavRosky, MacColl, Olson, Doherty & Miller, P.C.
Before Deits, Presiding Judge, and De Muniz and Landau,Judges.
DEITS, P. J.
Affirmed.

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143 Or App 61> Claimant seeks review of a Workers' Compensation Board order holding that a herniated disc injury that she sustained during an independent medical exam (IME) was not compensable as a consequence of the compensable low back injury that necessitated the IME. We affirm.

On December 1, 1994, the ALJ ordered employer to pay temporary total disability benefits from January 14, 1993, through October 30, 1993. The ALJ also assessed a penalty and awarded attorney fees. The Board affirmed, and it is that decision employer now asks us to reverse.

Employer argues that the Board erred, because, following the Board's decision, the legislature amended the workers' compensation statutes to eliminate the requirement that employers pay benefits pending an appeal. Claimant argues that any amendments to the statutes are immaterial to the disposition of this case, because the Board's unchallenged May 17, 1994, order requiring the payment of such benefits became final and is not subject to collateral challenge. In the alternative, claimant argues that the 1995 amendments to the workers'compensation statutes do not alter in any way the extent to which employers must pay benefits while judicial review is pending.

We need not address the asserted effect of the 1995 statutory amendments, because we agree with claimant that they are beside the point. On May 17, 1994, the Board ordered employer to pay temporary total disability benefits commencing January 14, 1993. Employer did not seek judicial review of that order. In a separate proceeding, claimant obtained an order requiring employer to comply with the May 17, 1994, final order. Employer's only argument in opposition is that the final order was invalid. It is too late to make such an argument. Collateral attacks on final orders of the Board are not permitted. *King v. Building Supply Discount,* 133 Or App 179, 182-83, 889 P2d 1310 (1995); *Vanslyke v. Fred Meyer, Inc.,* 108 Or App 493, 494, 816 P2d 664, *rev den* 312 Or 528 (1991).

The 1995 amendments to the workers'compensation statutes do not have the effect of retroactively invalidating **<142 Or App 436/437>** the 1994 order, even assuming the amendments read as employer suggests. Section 66(5)(a) of the 1995 Act provides:

> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which an order or decision has become final on or before the effective date of this Act."

Or Laws 1995, ch 332, § 66. In *Volk v. America West Airlines,* 135 Or App 565, 569, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996), we held that the foregoing provision means that

> "the legislature intended the changes in the law to apply to Board orders for which the time to appeal had not yet expired on the effective date of the Act or, if the case had been appealed, to any case that was still pending before the court on the effective date of the legislation."

The bill containing the amendments to the workers' compensation statutes contained an emergency clause and became effective on June 7, 1995. By that time, the Board's unappealed May 17, 1994 order had become final. Thus, the 1995 amendments-whatever they may say about payment of benefits pending appeal do not affect the validity of the Board's 1994 order.

Affirmed.

Cite as 142 Or App 471 (1996) July 31, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Debra L. Lay, Claimant.
OGDEN AVIATION and AIG Claim Services (AIGCS), *Petitioners*,
v.
Debra L. LAY, *Respondent*.
(94-04856; CA A89107)

Judicial Review from Workers' Compensation Board.
Argued and submitted Apzil 18, 1996.
Jerald P. Keene argued the cause and filed the brief for petitioners.
Glen H. Downs argued the cause for respondent. With him on the brief were Gerald C. Doblie and Doblie & Associates.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Affirmed.

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142 Or App 471> Employer seeks review of an order of the Workers' Compensation Board[1] finding that claimant established good cause for filing a request for hearing beyond 60 days but within 180 days following the denial of her compensability claim. ORS 656.319(1)(b).[2] We affirm.

Claimant mailed the notice of denial to her attorney's office. The attorney's legal secretary did not put the denial on the attorney's desk. The Board found:

> "There is no dispute that [here] the denial was received by [the attorneys] office in January, 1994. The normal procedure was for [the attorney's] legal secretary to process that incoming mail and place the denial on [the attorney's] desk. That was not done through no fault of [the attorney] or anyone else responsible for filing claimant's request for hearing. The fault is attributable to a support person, not claimant's attorney and not someone responsible for filing claimant's request for hearing."

Relying, *inter alia*, on *Mendoza v. SAIF*, 123 Or App 349, 859 P2d 582 (1993), *rev den* 318 Or 326 (1994), the Board found that claimant had shown good cause for the late filing under

> "the legal standard [which is], if the failure to file claimant's request for hearing is the fault of claimant's attorney and/or anyone in claimant's attorney's office who is responsible for filing requests for hearing, then that fault is attributable to claimant and good cause is not established. On the other hand, if the fault is attributable to a support person not responsible for filing requests for hearings, then that fault **<142 Or App 471/472>** is not attributable to claimant and assuming no other relevant factors, good cause for late filing is established."

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[1] Without opinion, the Board adopted the opinion and order of the administrative law judge.

[2] RS 656.319(1) provides:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the mailing of the denial to the claimant; or

"(b) The request is filed not later than the 180th day after mailing of the denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after mailing of the denial."

Claimant suffered a compensable injury on April 15, 1981, while working on an assembly line for employer. She was diagnosed with low back strain and leg radiculopathy, both on the right side. She was hospitalized and eventually returned to work. On February 9, 1982, she was declared medically stationary, her claim was closed and she was awarded time loss benefits. Claimant continued to experience pain on the right side and, on March 14, 1984, her claim was again closed and she was awarded 15 percent permanent partial disability.

The claim was subsequently reopened due to an aggravation of claimant's condition and was reclosed by a third determination order of May 15, 1986, which awarded only additional time loss benefits. On February 18, 1987, claimant and employer stipulated to an increase in claimant's permanent partial disability for a total award of 25 percent. In January of 1988, she began receiving treatment from Dr. Kemple, who has followed her progress to date. Claimant has not worked since April of 1988. On April 15, 1988, her claim was again reopened and benefits continued until the Board, on its own motion, issued a notice of closure on May 30, 1990. In April of 1991, claimant received a lump sum payment pursuant to a Disputed Claim Settlement, in which employer denied claimant's upper back injury as a new injury/occupational disease claim, but continued acceptance of her conditions as an aggravation of the original 1981 claim.

On June 23, 1992, claimant was sent to two independent medical examinations (IME). The first was with Dr. Watson, a neurologist, and Dr. Dinneen, an orthopedist. During that examination, which was performed by Watson, claimant told the doctor of significant back problems. Watson had her perform straight leg raising tests while lying on her back. She told him that she could not raise her right leg. He **<143 Or App 61/62>** asked her to raise her left leg and, when she did so, Watson moved it past where she had, causing her immediate pain in the left low back and hip area. She told Watson that he had hurt her and reported the same to her daughter that evening. On July 1, 1992, claimant returned to Kemple for care. Claimant also saw Dr. Gandler, who ordered a lumbar CT scan. On January 6, 1993, Dr. Stoney performed a CT scan which revealed for the first time, significant bulging and leftsided herniation of the L5-Sl disc. Claimant attended a neurosurgical evaluation by Dr. Morris and surgery was recommended.

On February 17, 1993, employer issued a partial denial for claimant's left L5-S1 herniated disc injury and surgery. Claimant subsequently had surgery with Dr. Morris in March of 1993. She requested a hearing on employer's partial denial. A hearing was held in May of 1993. The ALJ upheld employer's partial denial of claimant's surgery and treatment for her herniated disc, concluding that although claimant's testimony was credible, the evidence presented did not prove that her original compensable injury was the major contributing cause of her new consequential injury.[1] On review, the Board adopted and affirmed the ALJ's order.

The Board subsequently issued an order on reconsideration.[2] In that order, it held that

> "if a claimant sustains an injury while attending a carrierrequested medical examination, to be compensable under ORS 656.005(7)(a)(A), the claimant must establish that the compensable injury that necessitated the examination was the major contributing cause of the consequential condition. That a claimant is injured during a carrier-requested medical examination establishes that claimant has sustained a consequential condition cognizable under ORS 656.005(7)(a)(A). What remains to be determined, on a **<143 Or App 62/63>** case-by-case basis, is whether the claimant has established by persuasive medical evidence that her original injury is the major contributing cause of her consequential condition. For the reasons set forth above, we conclude that, in this case, claimant has not met her burden of proof under that standard."

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[1] The ALJ found that there was "no medical evidence that the major contributing cause of claimant's surgery for the herniated disc at L5-S1 was the initial industrial injury. The major cause of the need for surgery was a new injury that claimant sustained during the independent medical exam or the combination of that injury with some degree of preexisting degenerative disc disease in the spine." (ALJ's Opinion at 2.)

[2] We note that the Board was without the benefit of our decision in *Barrett Business Services v. Hames*, 130 Or App 190, 193, 881 P2d 816, *rev den* 320 Or 492 (1994), when it issued its order on reconsideration in this case.

The Board concluded:

> "Here the evidence establishes that the major contributing cause of claimant's need for surgery was the new injury that she sustained during the medical examination. Her treating physician concluded that there was only a remote possibility that her current need for surgery was predominately related to her original compensable injury * * * whereas her treating surgeon was unable to render an opinion regarding whether her original injury was causally related to her current low back condition."

Claimant argues that the Board erred as a matter of law in concluding that her compensable injury was not the major contributing cause of the consequential injury that she sustained during the IME. Claimant contends that no meaningful distinction can be drawn between an injury incurred during treatment and one suffered during an IME. Claimant reasons, therefore, that because a consequential injury which results from treatment is compensable, *Barrett Business Services v. Hames*, 130 Or App 190, 193, 881 P2d 816, *rev den* 320 Or 492 (1994), a consequential injury sustained during an IME also should be compensable.

The governing statute is ORS 656.005(7), which provides in pertinent part:

> "(a) A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

143 Or App 64> We have previously considered the language of this statute. Specifically, we have addressed its meaning after an amendment by the 1990 legislature. In *Hicks v. Spectra Physics*, 117 Or App 293, 296, 843 P2d 1009 (1992), we discussed whether the language, "consequence of a compensable injury," included injuries that did not directly result from the compensable injury, but were the result of activities that would not have been undertaken "but for" the compensable injury. After reviewing the legislative history of the 1990 amendments, we concluded that the legislature intended to restrict the compensability of such injuries. We said:

> "Under ORS 656.005(7)(a)(A), any injury or condition that is not *directly* related to the industrial accident is compensable *only if* the major contributing cause is the compensable injury." *Id.* at 297. (Emphasis in original.)

Accordingly, in *Hicks*, we held that where a claimant suffered injuries in an auto accident while returning from treatment of a compensable injury, those accident-related injuries were not compensable under ORS 656.005(7)(a)(A), because the compensable injury was not the major contributing cause of the accident-related injuries.

Applying this same rationale in *Kephart v. Green River Lumber*, 118 Or App 76, 79, 846 P2d 428, *rev den* 317 Or 272 (1993), we concluded that the injury that the claimant incurred during vocational rehabilitation was not directly related to the compensable injury, but rather, was a consequence of that injury. Accordingly, we held that the Board correctly applied the major contributing cause standard of ORS 656.005(7)(a)(A) and concluded that the injury that claimant incurred while participating in vocational rehabilitation was not the major contributing cause of the new injury and, therefore, was not compensable. We specifically noted in *Kephart* that it made no difference that the claimant was injured while actually involved in vocational training, as opposed to being en route to training.

As noted above, claimant relies, in particular, on our decision in *Hames*. In that case, the claimant sustained a compensable dislocation of his right shoulder. As part of claimant's therapy for that injury, the treating orthopedic surgeon prescribed "extremely aggressive" physical therapy **<143 Or App 64/65>** involving rigorous range of motion exercises of the claimant's arm and shoulder. During that therapy, the claimant's right ulnar nerve was injured.

We held that the injury that occurred during physical therapy was compensable. In explaining our conclusion, we recognized the holdings in *Hicks* and *Kephart*, but found them to be distinguishable. We noted that the causal connection in Hames between the original compensable injury and the later injury was far more direct than in those earlier decisions. We pointed out that *Hames* did not involve a "but for" causation link as did *Hicks* and *Kephart*. We explained that the new injury in *Hames* "flowed directly and inexorably from the shoulder injury."

We also based our conclusion in Hames on our understanding of the legislative intent in adopting the 1990 amendments. Specifically, we considered whether the legislature intended to effect changes with respect to the compensability of medical treatment injuries, because prior to 1990, Oregon courts had routinely held that new injuries incurred during medical treatment of compensable injuries were themselves compensable. *Id.; see Williams v. Gates, McDonald & Co.*, 300 Or 278, 709 P2d 712 (1985). *See also* Larson 1, *Workmen's Compensation Law*, § 13.21 (1995). We concluded that the legislature did not intend to change the law relating to the compensability of medical treatment injuries. In particular, we relied on statements made during the legislative discussion that indicated that the change was intended to make "natural consequences" cases compensable. An example used in the legislature's discussion of a "natural consequence" involved circumstances where a person trips over crutches that are being used as a result of a compensable injury. Based on the apparent legislative intent, we concluded that the legislature intended to include medical treatment cases within the category of "natural consequences" cases.

In addition, we concluded that drawing a distinction between a compensable injury and the treatment of such an injury would be artificial. Accordingly, we held where a claimant suffers an injury as the direct result of reasonable **<143 Or App 65/66>** and necessary treatment of a compensable injury, the compensable injury is properly deemed the major contributing cause of the new condition for purposes of ORS 656.005(7)(a)(A). *Id.* at 196-97.

In this case, the Board held, and claimant does not dispute, that the major contributing cause of claimant's need for surgery was the new injury that she sustained during the IME. Claimant essentially is urging us to extend our holding in *Hames* to hold that the compensable injury is properly deemed the major contributing cause of injuries incurred during an IME that has been ordered relating to a compensable injury.

In its decision in this case, the Board first explained that it continued to adhere to its view that in circumstances where medical treatment for a compensable injury is the major contributing cause of a new injury, the compensable injury is deemed to be the major contributing cause of the consequential condition. The Board refused, however, to extend that rationale to an injury that occurs during an IME. The Board reasoned that such an injury is different from an injury that occurs during treatment. It explained that an injury that occurs during an IME comes within the category of activities "that would not have been undertaken *but for* a compensable injury." Because of that, the Board concluded that this court's decisions in *Hicks* and *Kephart* control and, accordingly, an injury incurred during an IME will not be found compensable unless the evidence shows that the compensable injury is actually the major contributing cause of the consequential condition.

We agree with the Board's reasoning and its conclusion. Admittedly, an injury that occurs during an IME is similar in some respects to an injury arising out of medical treatment. It does flow from the compensable injury. The difference, however, is a matter of degree. It simply does not flow as "directly and inexorably" from the compensable injury as does an injury arising out of medical treatment for the compensable injury. The break in the causal connection between the original injury, and the injury incurred during the IME in this case, is not as distinct as the accident in *Hicks*. The events here come closer to the facts of *Kephart*, **<143 Or App 66/67>** where the injury occurred during vocational rehabilitation. In view of our decisions in *Hicks* and *Kephart*, as well as the apparent legislative intent to limit what is included as part of the "natural consequences" of an injury, we conclude that in order for an injury incurred during an IME to be compensable as a consequence of a compensable injury, it must be established that the original injury was the major contributing cause of the consequential condition. As the Board found, the major contributing cause of the new condition here was the activities that occurred during the IME, not the original injury. Accordingly, the Board did not err in upholding employer's partial denial.

Affirmed.

Cite as 143 Or App 73 (1996) August 28, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Daniel L. Bourgo, Claimant.
TINH XUAN PHAM AUTO and Mid-Century Insurance Company, *Petitioners,*
v.
Daniel L. BOURGO, *Respondent.*
(WCB No. 93-10892; CA A87116)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 8, 1995.
Vera Langer argued the cause for petitioners. With her on the brief was Scheminske, Lyons & Bussman.
Robert Wollheim argued the cause for respondent. With him on the brief were Patrick K. Cougill and Welch, Brunn, Green & Wollheim.
Before Deits, Presiding Judge, and De Muniz and Armstrong, Judges.
DEITS, P. J.
Affirmed.

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143 Or App 75> Employer seeks review of an order of the Workers' Compensation Board that determined the extent of claimant's impairment. Employer argues that the Board erred in refusing to admit Exhibit 46, a "supplemental" medical arbiter's report prepared at the request of employer, and Exhibit 47, a document entitled *Guide to the Evaluation of Permanent Impairment.* We affirm.

Claimant suffered a compensable low back strain in 1992. Employer initially accepted the claim as a nondisabling low back strain. In September 1992, employer reclassified the claim as disabling and accepted the central and left-side L5/S1 disc herniation. Claimant had surgery in September 1992. In January 1993, employer issued a notice of closure in which it granted claimant an award of compensation of 28.80 degrees for 9 percent unscheduled low back permanent partial disability (PPD). Claimant sought reconsideration of this award and, pursuant to ORS 656.268(7)(b), employer requested a three-member medical arbiters panel. The panel issued a report in August 1993, and, based on the findings of the panel, the Department of Consumer and Business Services issued an order on reconsideration granting claimant an award of 89.60 degrees for 28 percent unscheduled low back PPD.

In September 1993, employer requested a hearing on the order on reconsideration. On October 7, 1993, after employer's request for hearing was filed, Dr. Dinneen, one of the three medical arbiters, signed off on a letter from employer's attorney that purportedly clarified the initial medical arbiters' report. At the hearing before the ALJ, employer sought to introduce the letter as Exhibit 46. In addition, employer offered as evidence a publication by the American Medical Association, entitled *Guide to the Evaluation of Permanent Disability.*[1] The ALJ denied the admission of Exhibit 46 on the ground that it was subsequent medical evidence **<143 Or App 75/76>** and was not admissible pursuant to ORS 656.268(7). The ALJ also denied the admission of Exhibit 47 on the ground that there was no evidence identifying where the *Guide* came from and no evidence demonstrating that it was any different from the information that the Department had given to the panel of arbiters to determine impairment. The Board agreed with the ALJ as to Exhibit 46, concluding that the statutes do not allow a "supplemental" or "clarifying" medical arbiter report, generated after the initial arbiter's report and the order on reconsideration. The Board also concluded that the ALJ did not abuse his discretion in denying the admission of Exhibit 47.

Employer assigns error to the Board's refusal to admit these two exhibits. The pertinent statutes are ORS 656.268(6)(e) and ORS 656.268(7)(g). ORS 656.268(6)(e)[2] provides:

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[1] Employer seeks to introduce this publication to show that the panel's impairment evaluation was invalid. Apparently, employer was advised by Dr. Dinneen that during the medical examination of claimant, it was necessary to repeat the range of motion testing six times. Employer relies on the *Guide* to demonstrate that this fact invalidates the test results.

[2] After the ALJ's order, the legislature renumbered ORS 656.268(6)(a) to 656.268(6)(e) Or Laws 1995, ch 332, § 30. The pertinent language of the subsection was not changed.

> "Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding."

ORS 656.268(7)(g) states:

> "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."[3]

Employer relies on what it characterizes as the plain language of ORS 656.268(6)(e) to support its argument that **<143 Or App 76/77>** Exhibit 46 is admissible. It contends that the reference to "any medical arbiter report" contemplates that there may be more than one report and that a later supplementation or clarification of the initial report clearly would come within those terms. In considering this argument, the Board concluded that it was unclear from the language of the statutes whether a "clarifying" or "supplemental" report from a medical arbiter or panel of arbiters, prepared after the initial report or after the order on reconsideration would be admissible. The Board then took into consideration the legislative history. After reviewing that history, the Board concluded that the legislature did not intend that such reports would be admissible.

We also conclude that the terms of the statute a ambiguous and that it is necessary to examine the legislativ history of the statutes. *See PGE v. Bureau of Labor an Industries*, 317 Or 606, 859 P2d 1143 (1993). As explained in the Board's opinion, the terms "any medical arbiter report" were added to the statute in 1991. The purpose of these changes, as evident from the legislative history, was to ensure that a medical arbiter's report that was not prepared in time to be used in the reconsideration process could be considered in later proceedings reviewing the reconsideration order.[4] The Board explained:

> "[W]hen viewed in light of the purpose behind the amendment, it is apparent that the provision was added to permit admission of an initial medical arbiter report that was requested, yet not completed, before the statutory item
>
> "The phrase 'was not prepared in time for use at the reconsideration proceeding' is consistent with such interpretation. The statutory amendment further confirms that the provision is intended to permit admission of evidence at hearing of a medical arbiter report that is designed for use by the Appellate Unit during the reconsideration process, but was not prepared in time for consideration **<143 Or App 77/78>** prior to the issuance of the reconsideration order (whether actually or'deemed'issued).
>
> "Such an interpretation is likewise consistent with the intentions expressed regarding the medical arbiter and reconsideration process. In other words, while the parties can no longer request opinions from their respective medical experts, permitting them to solicit supplemental opinions from the medical arbiter would tend to further the very same 'dueling doctors' and litigious system the legislature was attempting to avoid. Moreover, allowance of such a practice would undermine the objectivity of the arbiter and raise a question with regard to whether the arbiter had become a witness for one party or the other.

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[3] The 1995 legislature also amended ORS 656.268(7). Or Laws 1995, ch 332, § 30. The subsections of ORS 656.268(7) were renumbered and the language of a number of the subsections was amended. The only alteration that has any relevance here is that the language under the former statute that is now subsection (7)(g) provided that no medical evidence *subsequent to the medical arbiter's report* was admissible. ORS 656.268(7)(g) now provides that no medical evidence *after reconsideration* is admissible. The evidence here was generated after reconsideration and, therefore, the change has no effect on this case. The Board so concluded in its decisions in *Robert K Warren*, 47 Van Natta 1471 (1995), and *Joyce A. Crump*, 47 Van Natta, 1516 (1995). In these cases, the Board considered this specific change in the same context as here and concluded that the change made no difference in its analysis.

[4] In our decision in *Pacheco-Gonzalez v. SAIF*, 123 Or App 312, 860 P2d (1993), we held that the statutes do not prohibit the admission of a medical arbiter's report in a later proceeding if it was not completed in time for the reconsideration process.

"Finally, to interpret ORS 656.268(6)(a) as allowing the admission of supplemental or clarifying medical arbiter reports would ignore the context in which the statute was amended. When both provisions are considered in light of the legislative history, we conclude neither provision allows the admission of a 'supplemental' or 'clarifying' medical arbiter's report which was prepared at the request of either party. Therefore, we agree with the Referee that Exhibit 46 is not admissible."[5] (Footnotes omitted.)

We agree with the Board's reasoning and conclusions and, accordingly, hold that the Board did not err in upholding the denial of the admission of Exhibit 46.[6] We also conclude that the Board did not err in denying the admission of Exhibit 47.

Affirmed.

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[5] The Board has held that there are some circumstances where a supplemental or clarifying medical arbiters' report would be admissible, for example, if the initial report itself indicates that it is not complete or when the Department requests the clarification. *See Jason O. Olson,* 47 Van Natta 2192 (1995). That question is not before us because here the report does not indicate that it was incomplete, and the request for clarification was made by the employer.

[6] On judicial review, claimant also argues that Exhibit 46 was not admissible because, as the opinion of only one of the three members of the medical arbiters panel, it cannot be a medical arbiter report. We do not address that issue because it is unnecessary to do so in view of our holding and because claimant did not argue that issue below.

Cite as 143 Or App 138 (1996) August 28, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

NORTHWEST REFORESTATION CONTRACTORS ASSOCIATION, INC.; C & H Reforesters, Inc.; Grayback Forestry, Inc.; Hugo Reforestation, Inc.; Miller Timber Services, Inc.; Rincon Reforestation, Inc.; Second Growth, Inc.; Shiloh Forestry, Inc.; Skookum Reforestation, Inc.; Timber West, Inc.; and Strata Industries, Inc., *Appellants,*

v.

SUMMITT FORESTS, INC., *Respondent.*

(16-93-09532; CA A86294)

In Banc*

Appeal from Circuit Court, Lane County.

David V. Brewer, Judge.

Argued and submitted September 20, 1995; resubmitted in banc June 12, 1996.

George W. Kelly argued the cause and filed the briefs for appellants.

Judith Giers argued the cause for respondent. With her on the brief were William F. Gary and Harrang Long Gary Rudnick P.C.

D. Michael Dale filed a brief *amicus curiae* for Oregon Legal Services Corporation.

Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and Janie M. Burcart, Assistant Attorney General, filed a brief *amicus curiae* for Bureau of Labor & Industries.

* De Muniz, J., not participating.

EDMONDS, J.

Reversed and remanded as to claims under ORS 658.417(3) and ORS 654.440(3)(d); otherwise affirmed.

Warren, J., concurring in part and dissenting in part.

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143 Or App 141> Plaintiffs seek an injunction and damages under ORS 658.475, which provides remedies against farm labor contractors who violate certain statutes and administrative rules. The trial court granted summary judgment to defendant, ORCP 47, and plaintiffs appeal. We reverse in part.

Defendant is a large reforestation contractor working on federal lands in Oregon. In each of the last several years, defendant or Summitt Enterprises, Inc.,[1] its predecessor, received federal reforestation contracts. As a reforestation contractor, defendant is subject to ORS 658.475, which provides:

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[1] Summitt Enterprises and defendant are both owned by Scott R. Nelson and his wife. Summitt Enterprises apparently ceased doing any significant reforestation business at the same time that defendant became active.

"The Commissioner of the Bureau of Labor and Industries, or any other person, may bring suit in any court of competent jurisdiction to enjoin any person from using the services of an unlicensed farm labor contractor or to enjoin any person acting as a farm labor contractor in violation of ORS 658.405 to 658.503 and 658.830, or rules promulgated pursuant thereto, from committing future violations. The court may award to the prevailing party costs and disbursements and a reasonable attorney fee. *In addition, the amount of damages recoverable from a person acting as a farm labor contractor with regard to the forestation or reforestation of lands who violates ORS 658.410, 658.417(3) or (4) or 658.440(3)(e) is actual damages or $500, whichever amount is greater."* (Emphasis supplied.)

Plaintiffs are also reforestation contractors subject to ORS 658.475. In November 1993, they filed a complaint against defendant, which was eventually replaced with a third amended complaint that frames the issues for purposes of summary judgment. The third amended complaint provides, in part:

"5.

"Defendant is a foreign corporation doing business and acting as a farm labor contractor as defined in ORS 658.405 **<143 Or App 141/142>** in the State of Oregon, including Lane County. Defendant is one of the largest reforestation contractors to perform work in Oregon. Defendant was awarded 24 federal contracts worth a gross value of $1.14 million on public lands in Oregon in 1993 and Defendant did not have an Oregon workers' compensation policy to cover its Oregon workers.

"6.

"Defendant has violated the requirements of ORS 658.417(4) by failing to provide workers' compensation insurance for at least 99 individuals who perform forestation or reforestation activities in the State of Oregon.

"7.

"Defendant has violated the requirements of ORS 658.417(3) by failing to provide to the Commissioner of the Bureau of Labor and Industries a certified copy of all payroll records for work labor done as a farm labor contractor at the time prescribed by the Commissioner.

"8.

"The actions of Defendant have aggrieved [plaintiffs] by providing to Defendant an unfair competitive advantage, including a bidding advantage because Defendant does not properly report and pay as much workers' compensation premiums as do contractors who provide Oregon workers compensation coverage. * * * Several of the Plaintiffs lost contracts to Defendant because of Defendant's illegal activities.

"9.

"Pursuant to ORS 658.475 Defendant is liable for $500 statutory damages for each of Defendant's violations, for a total of $50,000.00, and for Plaintiffs' attorney fees and costs.

"10.

"Pursuant to ORS 658.475 Defendant should be enjoined from acting as a Farm Labor Contractor in violation of ORS 658.405 to 658.503. An injunction is necessary **<143 Or App 142/143>** to prevent future violations in view of the foregoing and following allegations of fact * * *:

" * * * * *

"(e) Defendant utilizes illegal aliens as workers."

In August 1994, defendant moved for summary judgment. In support of its motion for summary judgment, defendant offered uncontroverted evidence that it has had Oregon workers' compensation insurance in effect since October 1993, and that that coverage had continued since that time. It also offered evidence that it was in compliance with ORS 658.417(3),[2] ORS 658.417(4)[3] and ORS 658.440(3)(e).[4] Plaintiffs offered evidence in contravention of defendant's motion. That evidence demonstrated that defendant was often late in filing required payroll reports in 1993 and 1994 and that, during that time, the Border Patrol made several raids on defendant's work sites. As a result of those raids, the Immigration Service took a number of defendant's workers and those of its subcontractors into custody as illegal aliens. In each instance, there is evidence from which a trier of fact could reasonably infer that violations were continuing to occur in November 1993, the date plaintiffs filed their complaint, and thereafter. As a result, we conclude that the trial court erred in granting summary judgment to defendant on those claims that seek injunctive relief based on violations of ORS 658.417(3) and ORS 658.440(3)(d). *Jones v. General Motors*, 139 Or App 244, 911 P2d 1243, *rev allowed* 323 Or 483 (1996).

The remaining claim focuses on the allegation that defendant was entitled to injunctive relief and damages **<143 Or App 143/144>** under ORS 658.475 because it failed to provide workers' compensation insurance for individuals who performed forestation or reforestation activities in the State of Oregon as required by ORS 658.417(4). As mentioned previously, the uncontroverted evidence establishes that, at the time that plaintiffs filed their complaint, defendant was in compliance with the requirements of ORS 658.417(4) and had been for over a month. Although plaintiffs concede that defendant was in compliance with the statute as of November 1993, and defendant continued to be in compliance at the time of the summary judgment hearing, they argue that the considerable evidence that defendant was violating ORS 658.417(4) before October 1993, entitles them to injunctive and damage remedies under ORS 658.475 and precludes summary judgment for defendant.

Plaintiffs' argument frames an issue of statutory interpretation: Does ORS 658.475 afford a remedy for past violations? In interpreting a statute, our goal is to discern the intent of the legislature. If the meaning of a statute is clear on its face, our inquiry goes no further. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 611, 859 P2d 1143 (1993). In order for a party to be entitled to the additional remedy of damages under ORS 658.475, the person against whom the remedy is sought must be "acting * * * *in violation*" of the act or the administrative rules promulgated pursuant to the statute. (Emphasis supplied.) The statute is clear on its face as to the time frame to which it applies. The requirement that the contractor be "acting in violation" of the enumerated statutes or rules is in the present tense. It does not authorize an injunction or damages against a person who has violated the statutes or rules in the past. There is nothing in the record to suggest that defendant did not have coverage or was threatening to drop the Oregon coverage it had procured at the time the complaint was filed or thereafter.[5] As a result, **<143 Or App 144/145>** there is no genuine issue of material fact as to whether defendant was acting in violation of ORS 658.417(4) by not having workers' compensation insurance for its employees in November 1993, and consequently, defendant is entitled to summary judgment on that claim.

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[2] ORS 658.417(3) requires that reforestation contractors provide payroll records to the Commissioner of the Bureau of Labor and Industries (Commissioner) when a contractor pays employees directly at such times and in such form as the Commissioner may prescribe.

[3] ORS 658.417(4) requires a reforestation contractor to provide workers' compensation insurance for those individuals who perform manual labor and forestation or reforestation activities.

[4] ORS 658.440(3)(d) provides that no person acting as a farm laborer contractor shall knowingly employ an alien not legally present or legally employable in the United States.

[5] The dissent argues that we misconstrue the meaning of the word "acting" in the statute because we fail to characterize defendant's conduct as part of an ongoing series of violations from which it could be inferred that there will be future violations. However, the dissent fails to point to any evidence from which it could be inferred that defendant intended at the time of the complaint to violate the statute in the future, having been in compliance with Oregon law *before the complaint was filed*. Moreover, assuming that general principles of equity apply to the statutory remedies in ORS 658.475, plaintiffs must show existing violations or an intent on the part of defendant to commit future violations at the time of the complaint.

Nonetheless, the dissent asserts that under the language of the statute, plaintiff may bring a claim for damages for past violations of ORS 658.417(4), and it relies on an analysis that equates the statute to general equitable principles. The reliance on equitable principles is misplaced. ORS 658.475 is solely a creation of the legislature. There is nothing on the face of the statute that supports the dissent's analysis. Even if an argument can be made that the statute is unclear on its face, there is nothing in the legislative history that suggests that the legislature intended to adopt general equitable principles or create a private statutory cause of action for damages for past violations when it enacted the statute.

Finally, even if the statutory claim is treated as an equitable claim, the case law does not support the dissent's reasoning. At common law, the availability of an award of damages in a case in equity depended on whether plaintiff was entitled to relief at the time of the filing of the suit. In *Oregon Growers' Co-op. Assn. v. Riddle,* 116 Or 562, 569, 241 P 1011 (1926), the court explained:

> "When a court of equity has acquired jurisdiction over some portion of a controversy, it will proceed to decide the whole issue and award complete relief, though the rights of the parties are strictly legal and the final remedy is of a kind that may be granted by a court at law. There are circumstances under which a court of equity will grant compensation in money, ordinarily obtainable at law. One of these cases is where the plaintiff established his equity, but equitable relief is found impracticable * * *.
>
> " 'The test of the jurisdiction of a court of equity is *whether facts exist at the time of the commencement of the action* sufficient to confer jurisdiction on the court. *If plaintiff is then entitled to the aid of equity* the jurisdiction will not be defeated by subsequent events which render equitable relief unnecessary or improper." ' (Emphasis supplied; citations omitted; quoting 21 CJS, *Equity,* § 123.)

143 Or App 146> In this case, defendant was not acting in violation of ORS 658.417(4) at the time the complaint was filed. Even if the statute is viewed as a statutory expression of equitable principles, it does not afford relief under the facts of this case.

In sum, the dissent's interpretation of ORS 658.475 would create a statutory claim for damages out of whole cloth, even when there was no evidence to support entitlement to injunctive relief. That interpretation is inconsistent with the text and context of the statute. Because defendant had Oregon workers' compensation insurance in effect at the time plaintiffs filed their complaint and because they have offered no evidence on summary judgment that would entitle them to injunctive relief on that claim, there is no legal basis for their claim for the "additional" remedy of damages. On remand, plaintiffs' claims under ORS 658.417(3) and ORS 658.440(3)(d) should be litigated as separate claims for injunctive relief. In the event that plaintiffs are successful in proving that defendant was acting in violation of those statutes at the time plaintiffs filed their complaint, then the court may consider whether plaintiffs are entitled to damages on those claims as additional relief.

Reversed and remanded as to claims under ORS 658.417(3) and ORS 658.440(3)(d); otherwise affirmed.

WARREN, J., concurring in part and dissenting in part.

Although I concur in much of the majority's opinion, I cannot join in its misreading of ORS 658.475 to deny plaintiffs a claim for damages. The majority effectively guts the statute by giving reforestation contractors a foolproof method for avoiding private actions for their violations of the Farm Labor Contractors Act. All a contractor now has to do is to suspend its violations before a private party actually files a lawsuit. The contractor will then be feee, once the trial court dismisses the private action, to resume its violations until the next lawsuit threatens. It will never risk an injunction, and it will never have to pay damages for the harm that its violations have caused. That is not the protection that the legislature intended to give those who work for or otherwise deal with reforestation contractors.

143 Or App 147> ORS 658.417(4) requires defendant to provide workers compensation coverage for each individual who performs manual labor on its forestation or reforestation activities, without regard to defendant's business form or to its contractual relationship to the workers. ORS 658.475 provides a private action to enforce that obligation by an injunction and an award of damages. The

record is replete with evidence that both defendant and Summitt Enterprises, Inc., its predecessor,[1] have conducted extensive reforestation work in Oregon while violating that requirement.[2] Despite that evidence, which I summarize below, the majority holds that the fact that defendant was complying with the law at the moment that plaintiffs filed this case defeats their claim.

SAIF, the compensation carrier for Summitt Enterprises, audited its books for 1989 and 1990, assessed Summitt Enterpiises $275,000 for unpaid premiums and canceled its coverage. Summitt Enterprises paid the assessment. Its owners thereafter conducted their business through defendant, receiving workers' compensation coverage from WAUSAU through the assigned risk pool. In 1992, WAUSAU determined that defendant's books were not independently verifiable and auditable, assessed it $443,000 in unpaid premiums and canceled its coverage. Defendant disputed the assessment; the dispute was unresolved at the time of the trial court proceedings in this case.

After losing its WAUSAU coverage, defendant moved its headquarters to Hornbrook, California, just across the Oregon border from its previous location, and obtained California workers' compensation coverage at a much lower rate than Oregon contractors paid. Although it continued to bid on and receive reforestation contracts in Oregon, it purported to perform them either through subcontractors who were licensed in Oregon or by using California workers at **<143 Or App 147/148>** temporary workplaces in Oregon; such workers would not require Oregon coverage. ORS 656.126(2), (6).

In early 1993, the Workers' Compensation Division investigated whether defendant was complying with the Oregon Workers' Compensation Law. As part of its investigation, it interviewed the workers on one of defendant's crews in Oregon and determined that they were Oregon subject workers. At the conclusion of the investigation, the Division issued an order finding defendant not to be in compliance from September 7, 1992, through May 24, 1993, and assessing the maximum $1,000 penalty. Although defendant initially disputed the assessment, it obtained Oregon coverage on October 17, 1993. At the same time, it entered into a stipulation with the Division, under which (1) the Division amended the order to find that defendant was not in compliance during the entire period that defendant was without Oregon coverage; (2) defendant permitted the order to be become final without seeking review; (3) defendant paid the $ 1,000 penalty; but (4) defendant formally denied that it was not in compliance.[3]

In short, the trier of fact could find that over the course of a few years defendant and its predecessor twice failed to pay large amounts of workers' compensation premiums, that in order to avoid complying with the Oregon Workers' Compensation Law defendant moved to another state while continuing to conduct business as usual in Oregon, that it attempted to hide its use of Oregon subject workers from the regulatory authorities and that it complied with the law only when those authorities forced it to do so. That evidence could lead the trier of fact to conclude that defendant had engaged in a pattern of violations and that there was a threat that its compliance at the time that this case was filed would cease once the pressure to comply diminished.

143 Or App 149> Despite these facts, the majority denies plaintiffs' claim under ORS 658.475 for the workers' compensation violations on the ground that, at the time of the original complaint, defendant was not "acting as a farm labor contractor in violation" of ORS 658.417(4). It treats the issue as whether ORS 658.475 "afford[s] a remedy for past violations," 143 Or App 144, stating that [t] here is nothing in the record to suggest that defendant * * was threatening to drop the Oregon coverage it had procured at the time the complaint was filed or thereafter." 143 Or App at 144. The majority fails to recognize that the evidence would permit the trier of fact to find that defendant was acting in violation at the time of the original complaint, even if at the moment it was temporarily in compliance.

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[1] Defendant and Summitt Enterprises are owned by the same people; Summitt Enterprises became inactive in the reforestation business at the same time that defendant became active.

[2] Because workers' compensation coverage is one of the largest expenses for reforestation contractors, defendant's failure to comply forced those contractors who did obtain Oregon coverage to carry an extra burden from which defendant was free.

[3] There is also evidence that defendant listed Oregon residents under California addresses in order to avoid paying Oregon compensation premiums for them. A worker's residence is one of the factors used to determine whether the worker is an Oregon subject worker. *Northwest Greentree, Inc. v. Cervantes-Ochoa*, 113 Or App 186, 189-90, 830 P2d 627 (1992).

In holding that defendant was not acting in violation of ORS 658.417(4), because it had come into compliance with the law less than a month before the plaintiff association filed the lawsuit, the majority ignores the normal meaning of the term "acting." The term refers to a continuing process, not to a static moment in time. Thus, when we say that a person is "acting" in a play, we refer to a process that extends from the opening to the final curtains, including intermissions and scenes when the person's character is not on stage. When we say that a person is "acting" in an office, we include the period when the person is sleeping or otherwise engaged in nonofficial activities. Similarly, when we say that a person is "playing" a game, we refer to a process that extends from the time that the game begins until it is over, including times out and other breaks in the action. Thus, "acting" in violation of the Act is a course of conduct that may continue despite a temporary respite. The very nature of an injunction recognizes that fact.

The essential purpose of an injunction is to prevent a threatened injury, "to stay the lawless hand before it strikes the blow." *Wiegand v. West*, 73 Or 249, 254, 144 P 481 (1914). A court cannot enjoin conduct already committed, *Garratt-Callahan Co. v. Yost*, 242 Or 401, 402, 409 P2d 907 (1966), but must be able to act when the harm is only threatened. The provision in ORS 658.475 for an injunction makes sense, thus, only if "acting * * * in violation" describes a process, **<143 Or App 149/150>** thereby allowing a court to enjoin a person who is temporarily complying with the law, if there is a threat of future violations. Although the statute appears to make proof of past violations an essential part of proving threatened harm, it does not condition an injunction on proof of violations at the precise time that the court enters the injunction.[4] The majority's holding that there was no equitable jurisdiction because defendant was in compliance at the time of the original complaint thus ignores both that "acting" is a process and that the purpose of an injunction is to prevent future harm.

The majority also argues that ORS 658.475 is solely a creature of the legislature and that any reliance on general equitable principles in construing the statute is misplaced. 143 Or App at 145. It ignores the fact that an "injunction" is not a new concept that the legislature created out of thin air for the purposes of this statute; rather, it is a well-known equitable remedy with centuries of learning behind it.[5] Under the relevant Supreme Court precedent, the legislature, in authorizing an injunction, both invoked the jurisdiction of a court of equity and adopted the normal criteria for that remedy, except to the extent that the statute clearly modified them. To the extent that it did not modify the normal criteria, they apply to actions under ORS 658.475.[6]

In *State (PUC) v. O.K Transfer Co.*, 215 Or 8, 330 P2d 510 (1958), the issue was whether the Public Utilities Commissioner was entitled to an injunction under *former* ORS 767.465(l), *repealed by* Or Laws 1971, ch 655, § 250, which authorized the Commissioner to seek an injunction **<143 Or App 150/151>** against a person who "is engaged or about to engage" in acts that would violate certain statutes. 215 Or at 13-14. The defendant argued that the Commissioner was not entitled to an injunction because he had failed to show irreparable harm or the absence of an adequate remedy at law. Those are normal criteria for an injunction. The court disagreed, because the statute expressly authorized injunctive relief based on the showing that the Commissioner did make. 215 Or at 14-15. In its discussion, the court assumed that the normal equitable limits on issuing an injunction would apply in the absence of the statutory modifications. 215 Or at 15-18.[7]

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[4] In this respect the statute sets forth criteria that are similar to those for enjoining a continuing trespass. Those criteria require both a previous trespass and the threat of repeated trespasses but do not require that the defendant be trespassing at any specific moment. *See Seufert Bros. v. Hoptowit et* al., 193 Or 317, 328, 237 P2d 949 (1951), *cert den* 343 US 926 (1952); *Micelli v. Andrus*, 61 Or 78, 89-90, 120 P 737 (1912).

[5] Indeed, the statute appears to adopt the equitable principles that directly apply to this case.

[6] Treating statutory injunctions as equitable proceedings, modified by the statutory requirements, is consistent with the rule that a court construes a statute in light of the existing law. *See, e.g., Swarens v. Dept. of Rev.*, 320 Or 326, 333, 883 P2d 853 (1994) (legislature presumed to know of prior enactments); *Simpson v. First Nat. Bank*, 94 Or 147, 157-58, 165, 185 P 913 (1919) (construing Negotiable Instruments Act in light of the law merchant).

[7] The requirement in ORS 658.475 that the defendant be "acting * * * in violation" has essentially the same meaning as the requirement in *O.K Transfer* that the defendant be "engaged or about to engage" in the prohibited practice. "Acting," that is, includes both being "engaged" in an activity (actually doing it) and being "about to engage" in the activity (on the threshold of doing it).

The majority is thus wrong in holding that the complaint was insufficient to invoke the court's equitable jurisdiction to issue an injunction under ORS 658.475. I agree, however, that by the time the court granted defendant's motion for summary judgment there was no longer any basis for finding that defendants were acting in violation of the Act. By then defendant had complied with the Oregon workers' compensation law for the major portion of a year, and there was no evidence that it was still threatening to drop that coverage.[8]

The loss of a basis for an injunction does not mean, however, that plaintiffs had also lost their claim for damages. The statute provides that

> "[i]n addition, the amount of damages recoverable from a person acting as a farm labor contractor with regard to the forestation or reforestation of lands who violates * * * ORS **<143 Or App 151/152>** 658.417 * * * (4) * * * is actual damages or $500, whichever amount is greater."

That provision does not create a right to damages. Rather, it assumes the existence of the right and states the amount of damages that the plaintiff may recover. It thus recognizes an equity court's authority, once it has acquired jurisdiction, to award damages, even if equitable relief turns out not to be appropriate.

Courts of equity have long had the power to award damages when a plaintiff is unable to obtain an injunction. Once equity obtains jurisdiction, it will retain it to grant full relief, including relief that would otherwise be obtainable in a court of law. *Rexnord Inc. v. Ferris*, 55 Or App 127, 134, 637 P2d 619 (1981), *revd on other grounds* 294 Or 392, 657 P2d 673 (1983); *Papadopoulos v. Bd. of Higher Ed.*, 14 Or App 130, 178 n 12, 511 P2d 854, *rev den* (1973), *cert den* 417 US 919 (1974). Thus an equity court may award damages for interference with an exclusive franchise even after the legislature repeals the statute making the franchise exclusive and thereby removes the basis for an injunction. *Fisk v. Leith*, 137 Or 459, 464, 467, 299 P 1013, 3 P2d 535 (1931). In the same way, an equity court may award damages for a public nuisance even after the defendant removes the nuisance, thus making an injunction inappropriate. *Bernard v. Willamette Box & Lumber Co.*, 64 Or 223, 233, 129 P 1039 (1913). The cases seem to require no more than a possible basis for an injunction at the time that the plaintiff filed the suit.

After authorizing an injunction in its first part, ORS 658.475 provides, *in addition*, that "the amount of damages recoverable from a person acting as a [reforestation contractor] is actual damages or $500, whichever amount is greater." That provision does not purport to create a right to damages; rather, it declares what those damages shall be. It thus treats damages as an incident of equitable relief, which includes the potential for damages even when the plaintiff fails to obtain the equitable relief that it originally sought. The text of the statute, thus, is inconsistent with treating damages as contingent on actually receiving that relief.[9]

143 Or App 153> Because the facts could have justified the issuance of an injunction when the complaint was filed, the complaint invoked the court's equitable jurisdiction. Because ORS 658.475 expressly contemplates that plaintiffs may recover damages in the same circumstances that they could do so in any other proceeding for an injunction, plaintiffs are entitled to proceed with their claim for damages. The majority errs in affirming the dismissal of this part of plaintiffs claim.

Riggs, Leeson and Armstrong, JJ., join in this dissent.

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[8] Plaintiffs argue that defendant under reported the number of its workers and thus paid lower premiums than it should have paid. Whether or not plaintiffs are correct is irrelevant. Defendant's compensation coverage, as a matter of law, ensures payment of all claims that its workers may have without regard to whether defendant properly reported them to its insurer or to the Bureau of Labor and Industries and without regard to whether defendant paid the correct premium. *See* ORS 656.419(l) (insurer's guaranty contract is assumption of liability, without monetary limit, for all compensation that may become due to employer's subject workers and their beneficiaries). Any failure to pay premiums for the correct number of workers is a matter between defendant and its carrier; it is not a violation of the obligation in ORS 658.417(4) to provide compensation coverage to all workers.

[9] ORS 658.475 recognizes a basis for damages that is distinct from both ORS 658.453(4), which gives a *worker* a direct claim against the farm labor contractor for damages that are the result of the violation of certain statutes, if the worker first files with the Bureau of Labor and Industries, and from ORS 658.415(8) through (12), which establish the procedures for making a claim against a farm labor contractor's bond.

Cite as 143 Or App 321 (1996) September 4, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Wilma K. PERRY, *Appellant,*
v.
EXPRESS SERVICES, INC., a Colorado corporation, and Ruth Boarts, *Respondents.*

EXPRESS SERVICES, INC., a Colorado corporation, *Third-Party Plaintiff,*
v.
ALAMO RENT-A-CAR, a Florida corporation, *Third-Party Defendant.*
(940302210; CA A89109)

Appeal from Circuit Court, Multnomah County.
Donald J. Londer, Judge.
Argued and submitted February 12, 1996.
Brien F. Hildebrand argued the cause for appellant. On the brief were Robert J. Miller, Lilian Bier and Moomaw, Miller & Hildebrand.
Dian R. Rogers argued the cause for respondent Express Services, Inc. With her on the brief were Thomas W. Sondag and Lane Powell Spears Lubersky.
Rick A. Lee argued the cause for respondent Ruth Boarts. On the brief were Peter R. Chamberlain and Bodyfelt Mount Stroup & Chamberlain.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Reversed and remanded as to defendant Express Services, Inc.; otherwise affirmed.

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143 Or App 323> Plaintiff was injured in an automobile accident while she was working on temporary assignment at an automobile rental company. The car she was driving collided with another driven by defendant Boarts, who also was a temporary employee on assignment at the same automobile rental company. Plaintiff sued Boarts and Boarts's temporary employment service, Express Services, Inc. (Express), which had assigned Boarts to the rental company. Boarts moved for summary judgment on the ground that plaintiff's exclusive remedy for work-related personal injuries caused by a coworker lay in workers' compensation. Express likewise moved for summary judgment on the basis of the exclusive remedy statute. In the alternative, Express argued that it could not be held vicariously liable as a matter of law, because it exercised no control over Boarts's work at the automobile rental company. The trial court granted the motions and entered judgment dismissing all claims against both defendants. We affirm the entry of summary judgment as to Boarts, but reverse as to Express.

In reviewing the trial court's summary judgment rulings, we determine whether there are genuine issues of material fact and whether defendants are entitled to judgment as a matter of law. ORCP 47C. A genuine issue of material fact exists when, based on the record as a whole and viewing the evidence in a manner most favorable to the adverse party, an objectively reasonable juror could return a verdict for the adverse party on the matter that is the subject of the summary judgment motion. *Id.*

The relevant facts are undisputed. Plaintiff worked for a temporary employment service, Interim Personnel (Interim). Interim provides temporary workers to its clients, other businesses. Interim entered into an agreement with Alamo Rent-a-Car (Alamo) and, pursuant to that agreement, assigned plaintiff to work at Alamo. Alamo paid Interim an hourly rate for plaintiff's work. That hourly rate included an amount sufficient to pay workers' compensation benefits for plaintiff. Interim did in fact pay premiums for plaintiff's workers' compensation coverage. While assigned to work at **<143 Or App 323/324>** Alamo, Alamo directed plaintiff when to come to work, when to leave, where to work and what to do while at work.

Boarts worked for Express, another temporary employment service that provides temporary workers to its client businesses. Express also had an agreement with Alamo to provide temporary workers to the rental car company. Pursuant to that agreement, Express assigned Boarts to work at Alamo. Part of the fee that Express charged Alamo included an amount for workers' compensation coverage for Boarts. While assigned to work at Alamo, Alamo directed Boarts when to come to work,

when to leave, where to work and what to do while at work. Before assigning Boarts to work at Alamo, Express checked Boarts's personnel records to ensure that Boarts was properly qualified to perform the assignment; it also checked to ensure that Boarts had a valid Oregon driver's license and that she had not been in an automobile accident or received any traffic citations during the last three years.

Plaintiff was injured as she shuttled cars while on assignment at Alamo. She was hit from behind by a vehicle driven by Boarts, who was also shuttling cars while on assignment at Alamo. The accident occurred on a public highway, off Alamo's premises. Plaintiff sued both Boarts and Express. Plaintiff's theory of liability was that Boarts was negligent and that Express, as Boart's employer, is strictly liable for that negligence. As we have noted, the trial court entered summary judgment in favor of both defendants.

On appeal, plaintiff first argues that the trial court erred in granting Boarts's summary judgment motions. According to plaintiff, Boarts is not subject to the exclusive remedy provision of the workers' compensation statutes, because that statute accords immunity from tort liability only to employers of a subject worker and to his or her coworkers, and, she argues, Boarts was neither. Boarts argues that she was, in fact, a coworker, because at the time of the accident both she and plaintiff were working for the same employer, Alamo.

The issue presented requires that we determine the scope of the exclusive remedy provisions of the workers' compensation statutes. We do that by ascertaining the intended **<143 Or App 324/325>** meaning of the applicable statutes, considering the text in context and, if necessary, legislative history and other aids to construction. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). Also relevant are prior judicial decisions concerning the intended meaning of the relevant statutes. *State v. Sullens*, 314 Or 436, 443, 839 P2d 708 (1992).

ORS 656.017(l) provides that every employer who employs workers subject to the workers' compensation statutes must ensure that the workers will receive workers'compensation coverage for compensable on-the-job injuries. ORS 656.018 then provides, in relevant part:

> "(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017 (1) is exclusive and in place of all other liability arising out of injuries * * * that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom * * *.
>
> " * * * * *
>
> "(2) The rights given to a subject worker and the beneficiaries of the subject worker under this chapter * * * are in lieu of any remedies they might otherwise have * * * against the worker's employer * * *.
>
> "(3) The exemption from liability given an employer under this section is also extended to the employer's insurer, the self-insured employer's claims administrator, the department, and the contracted agents, employees, officers and directors of the employer * * *."

Thus, a worker compensably injured may not sue in tort the worker's employer or the worker's coworker. The injured worker may, however, sue a "third person not in the same employ" as the worker. ORS 656.154. For the purposes of ORS 656.017(l) and ORS 656.018, a temporary worker is considered to be an employee both of the temporary employment agency and the employment agency's client. *Blacknall v. Westwood Corporation*, 89 Or App 145-47, 148, 747 P2d 412 (1987), *affd* 307 Or 113, 764 P2d 544 (1988); *Robinson v. Omark Industries*, 46 Or App 263, 265-66, 611 P2d 665 (1980), *rev dismissed* 291 Or 5 (1981).

143 Or App 326> In the light of the foregoing principles, it is clear that Interim and Alamo were plaintiff's "dual employers," and, by virtue of the exclusive remedy provision of ORS 656.018, plaintiff has not sued either of them. It is also clear that Express and Alamo were Boarts's dual employers. As to both Boarts and plaintiff, Alamo was an employer for workers' compensation purposes. That means that, for workers' compensation purposes, Boarts and plaintiff were "in the same employ"; they both worked for the same employer, Alamo, at the same time. It follows that Boarts is a coworker who is entitled to claim the exclusive remedy provision of ORS 656.018. We conclude that the trial court correctly granted Boarts's summary judgment motion.

Plaintiff next argues that the trial court erred in granting Express's motion for summary judgment. Plaintiff contends that, because Express is neither her employer nor her coworker, the exclusive remedy provisions of the workers' compensation statutes do not apply. Express argues that plaintiff cannot maintain a claim against it under ORS 656.154, because that statute permits an action that is based on the negligence of a "third person not in the same employ." In this case, Express argues, plaintiffs claim against it is based solely on the conduct of Boarts, who *was* in the same employ as plaintiff. Express argues in the alternative that, even if it is not subject to the exclusive remedy provisions of the workers' compensation statutes, plaintiff's suit fails because there is no factual predicate for extending vicarious liability. According to Express, vicarious liability can only be extended when an employer has the right to control the work of the employee, and in this case, only Alamo had the right to control Boarts's work.

The applicability of the exclusive remedy provisions of the workers' compensation statutes also is disposed of on the basis of our construction of the foregoing statutes. ORS 656.018(1)(a) exempts from liability an injured worker's employer. Express was not plaintiff's employer, and therefore cannot claim exemption on that basis. As noted above, ORS 656.018(3) extends, subject to exceptions that are not pertinent to this case, the same exemption from liability to

> **143 Or App 327>** "the employer's insurer, the self-insured employer's claims administrator, the department, and the contracted agents, employees, officers and directors of the employer, the employer's insurer, the self-insured employer's claims administrator and the department * * *."

Express was not plaintiff's employer's insurer, nor was it the self-insured employer's claims administrator, nor the agent, employee, officer or director of any of the foregoing. In short, the statute extends the exemption from liability to a limited universe of persons, which does not include Express.

Express insists that it is exempt from liability on the ground that it is not subject to the third-party suit provisions of ORS 656.154, which apply only to suits for injuries "due to the negligence or wrong of a third person not in the same employ" as the injured worker. We agree with Express that ORS 656.154 does not apply, because plaintiff's suit is for injuries due to the asserted negligence of Boarts, who was in the same employ. It does not follow, however, that because a person may not be sued under ORS 656.154, that person is subject to the exclusive remedy provisions of ORS 656.018. Indeed, to adopt Express's reading of the statutes would require us effectively to revise the wording of ORS 656.018(3) to include in the list of persons exempt from liability "any person who is not a 'third person' within the meaning of ORS 656.154." We lack the authority to do that. ORS 174.010; *Fernandez v. Board of Parole,* 137 Or App 247, 252, 904 P2d 1071 (1995). We conclude, therefore, that Express is not subject to the exemption from liability contained in ORS 656.018.

Express argues that, even if it is not statutorily exempt from liability, it still is not vicariously liable for Boarts's negligence, as a matter of law, because the undisputed evidence is that only Alamo controlled, and had the right to control, her day-to-day work. Express, however, misapprehends the test for vicarious liability. The Supreme Court has explained the test for determining whether an employer may be held vicariously liable as follows:

> "Under the doctrine of *respondeat superior,* an employer is liable for an employee's torts when the employee acts within the scope of employment. * * *
>
> **143 Or App 328>** "Three requirements must be met to conclude that an employee was acting within the scope of employment. These requirements traditionally have been stated as: (1) whether the act occurred substantially within the time and space limits authorized by the employment; (2) whether the employee was motivated, at least partially, by a purpose to serve the employer; and (3) whether the act is of a kind which the employee was hired to perform.

Chesterman v. Barmon, 305 Or 439, 442, 753 P2d 404 (1988) (citations omitted). *See also G.L. v. Kaiser Foundation Hospitals,* Inc., 306 Or 54, 60-61, 757 P2d 1347 (1988). The issue of right to control more properly relates to a determination of whether an employment relation exists in the first place. *Jenkins v. AAA Heating,* 245 Or 382, 386-87, 421 P2d 971 (1966). As the court explained in *Stanfield v. Laccoarce,* 284 Or 651, 656, 588 P2d 1271 (1978) (citation omitted):

> "We have recognized, particularly in automobile cases, that the 'right to control' is often of no assistance in deciding whether an employee is acting within the scope of his employment. No employer can 'control' the manner in which an employee drives or other details of his trip. In reality, the question of whether the employer had a 'right to control' the employee is merely another way of asking whether the activity in question occurred within the authorized limits of time and space, so that it is fair to make the employer vicariously liable for the conduct of the employee."

In this case, Express does not contest that it was Boarts's employer at the time of the accident. The determinative questions are, therefore, not whether Express had the right to control Boarts, but whether the accident occurred substantially within the time and space limits authorized by the employment, whether Boarts was motivated, at least in part, by a purpose to serve Express, and whether her act of driving was of the kind that she was hired to perform. The summary judgment record shows that it is undisputed that Express assigned Boarts to work at Alamo as a temporary worker, that the accident with plaintiff occurred while Boarts attempted to perform the duties of that assignment and that the accident occurred as a result of her driving vehicles for Alamo, which was precisely the sort of work that Express sent Boarts to Alamo to perform. Express, in fact, makes no **<143 Or App 328/329>** argument to the contrary; its only defense is that Alamo was solely responsible for determining the details of Boarts's driving. That, as the Supreme Court's decisions make clear, is beside the point.

Finally, at oral argument, Express argued that, even if it is not subject to the exemption from liability expressed in ORS 656.018, it still cannot be held liable as a matter of law, because Boarts is subject to the exclusion, and Express's liability, if any, derives exclusively from Boarts's conduct. The fact that an employee may be immune from liability, however, does not mean that the employer may not be vicariously liable for the employee's tortious conduct. The Supreme Court directly addressed that question in *Kowaleski v. Kowaleski*, 227 Or 45, 361 P2d 64 (1961). In that case, the plaintiff was injured in an automobile accident when rear-ended by her husband, who was driving his employer's car at the time. The plaintiff sued the husband's employer on a theory of vicarious liability for the tortious conduct of its employee. The defendant employer argued that, because the husband was immune from suit--under then prevailing doctrines of spousal immunity--it could not be held liable, because its liability was exclusively derivative of the husband's. The court rejected that argument, holding:

> "The proposition that unless the servant is liable the master can not be liable is an over generalization and inaccurate statement of the law * * *. It means merely that if the principal is sought to be held liable on the theory of respondeat superior he is not answerable in damages unless the agent was negligent; *the statement does not cover the situation when the agent is granted an immunity.*"

Id. at 50 (emphasis supplied; citation omitted). The court noted that courts around the country had split on the question, but, citing the *Restatement Agency (Second)* § 217,[1] it **<143 Or App 329/330>** concluded that the law in most states was that an employer has no defense on the basis of an employee's immunity that such cases were better reasoned. *Id.* at 50-54. We conclude that the trial court erred in allowing Express's motion for summary judgment.

Reversed and remanded as to defendant Express Services Inc.; otherwise affirmed.

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[1] The Restatement states that

"In an action against a principal based on the conduct of a servant in the course of employment:

"(b) The principal has no defense because of the fact that:

"(i) he had a non-delegable privilege to do the act, or

"(ii) the agent had an immunity from civil liability as to the act."

Restatement Agency (Second) § 217.

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OREGON RULES OF CIVIL PROCEDURE CITATIONS

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