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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.

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CITE AS

48 Van Natta ____ (1996)

In the Matter of the Compensation of
JAMES C. ENGLISH, Claimant
WCB Case No. 95-13067
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall, Christian and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) upheld the SAIF Corporation's partial denial of claimant's injury claim for somatic dysfunction of the cervical, dorsal/thoracic and lumbar areas of the spine; and (2) declined to assess penalties for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant was injured in a compensable motor vehicle accident on July 9, 1993. SAIF accepted thoracic and lumbosacral strains, left elbow and shoulder abrasions, herniated disc at L4-5 and cervical strain. (Exs. 10, 40, 42).

Claimant's November 28, 1995 request for hearing raised issues regarding "de facto" denials of "cervical, cervicodorsal, lumbar strains, and somatic dysfunction." On January 18, 1996, SAIF denied compensability of claimant's "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas" on the grounds that the July 9, 1993 injury was not the major contributing cause of the condition and there were insufficient objective findings which supported medical evidence of a diagnosable condition. (Exs. 41, 42).

The ALJ found that the evidence did not establish that "somatic dysfunction" meant something different than a strain. The ALJ upheld SAIF's January 18, 1996 partial denial as to "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas" to the extent that that terminology meant something other than the cervical, dorsal/thoracic and lumbar strains which had already been accepted.

Claimant contends that SAIF should have accepted the "somatic dysfunction" of the cervical, dorsal/thoracic, and lumbar areas of the spine. On the other hand, SAIF asserts that its acceptance of claimant's neck and back strains comprised everything that Dr. Winans sought to include in his less specific diagnoses of "somatic dysfunction."

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449, 454 (1992). We find that claimant's "somatic dysfunction" of the cervical, dorsal/thoracic, and lumbar areas of the spine are the same conditions accepted by SAIF, even though different diagnoses have been used to describe claimant's conditions. See Leslie C. Muto, 46 Van Natta 1685 (1994) (despite differing diagnoses, there was no medical evidence that the claimant sought treatment for a new or different condition), aff'd mem 133 Or App 770 (1995) . We base this conclusion on the following reasoning.

After the July 9, 1993 motor vehicle accident, claimant was initially treated in a hospital emergency room for upper, middle and lower back pain. Claimant was diagnosed with a back strain and multiple contusions. (Ex. 3). On July 15, 1993, claimant began treatment with Dr. Winans. Claimant was having pain in the neck, middle and low back and shoulders. (Ex. 6). Dr. Winans noted limited range of motion and spasm of the paravertebral musculature in the cervical, dorsal and lumbar areas. Dr. Winans diagnosed acute somatic dysfunction, post-traumatic, cervicodorsolumbar. (Id.) Claimant was treated with osteopathic manipulation and medication.

Dr. Winans' subsequent reports in July 1993 provided the same diagnosis. (Exs. 8, 9, 11). On August 9, 1993, Dr. Winans' diagnosis changed slightly to acute somatic dysfunction, post-traumatic, dorsolumbar. (Ex. 12). Thereafter, Dr. Winans continued to diagnose acute somatic dysfunction, post-traumatic, dorsolumbar (Exs. 18, 19, 20, 22, 25, 26, 27, 30), or somatic dysfunction, post-traumatic, cervicodorsolumbar. (Ex. 20).

On September 3, 1993, Dr. Struckman examined claimant and concluded that his symptoms were due to muscle strain, rather than to a disc herniation or spondylosis. (Ex. 17). On May 6, 1994, Dr. Struckman reported that claimant had suffered a low back strain as a result of the motor vehicle accident. (Ex. 32). Dr. Winans concurred with Dr. Struckman. (Ex. 33).

On April 6,1994, claimant was referred for a work-hardening evaluation. The physicians concluded that claimant had a "chronic lumbar strain by history, resolved," chronic mid-back pain without evidence of root problems, and some somatic overfocus. (Exs. 28, 29). Dr. Winans concurred with the April 6, 1994 work hardening evaluation. (Ex. 31).

In August 1994, Dr. Winans diagnosed somatic dysfunction, post-traumatic, cervicodorsolumbar SIJ, bilateral. (Ex. 36). On October 25, 1994, Dr. Winans performed a "closing exam," diagnosing acute somatic dysfunction, post-traumatic, dorsolumbar, resolving. (Ex. 37).

Based on our review of the medical evidence, we conclude that, although different diagnoses have been used to describe his conditions, claimant's "somatic dysfunction" of the cervical, dorsal/thoracic, and lumbar areas of the spine are the same conditions that were accepted by SAIF. See Leslie C. Muto, supra. Consequently, we set aside SAIF's partial denial of claimant's "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas."[1]

Penalties

Claimant requests penalties for SAIF's allegedly unreasonable denial. Claimant contends that there appears to be a clear distinction between two separate conditions which SAIF failed to process. We disagree.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the 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).

On January 18, 1996, SAIF issued its partial denial of claimant's somatic dysfunction of cervical, dorsal/thoracic and lumbar areas, in part because there were insufficient objective findings which supported medical evidence of a diagnosable condition. (Ex. 41). At the time it issued the denial, SAIF had a report from Dr. Winans concurring with a report from Dr. Struckman, who had diagnosed claimant with a low back strain as a result of the motor vehicle accident. (Exs. 32, 33). SAIF also had a report from Dr. Winans that concurred with a work hardening evaluation dated April 6, 1994, which had diagnosed claimant's condition as "chronic lumbar strain by history, resolved" and "[c]hronic mid-back pain without evidence of root problems."[2] (Exs. 28, 29, 31).

In light of Dr. Winans' concurrence with reports that diagnosed claimant's condition as a low back strain, chronic lumbar strain and chronic mid-back pain, we conclude that SAIF had a legitimate doubt as to whether claimant's "somatic dysfunction" of the cervical, dorsal/thoracic and lumbar areas was a separate condition from the "strain" diagnoses. Therefore, we do not assess a penalty against SAIF for an unreasonable denial.

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[1] Although the dissent focuses on "de facto" denial cases, this is not a "de facto" denial. Rather, we are reversing SAIF's express denial of claimant's "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas." Based on our finding that claimant's somatic dysfunction of cervical, dorsal/thoracic and lumbar areas are the same conditions accepted by SAIF, SAIF's express denial must be reversed. Indeed, the ALJ recognized this by upholding SAIF's denial of "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas," but only to the "extent that terminology means something other than cervical, dorsal/thoracic and lumbar strains, which conditions have already been accepted." (Opinion & Order at 6).

[2] The April 6, 1994 work hardening evaluation also noted that claimant had some "somatic overfocus." (Exs. 28-6, 29). The report indicated that claimant's MMPI-2 responses were consistent with those who may be mildly overfocused on physical symptoms and may have some tendencies to experience exacerbation of symptoms when under stress or tension. (Ex. 28-5,-6). There is no indication from the report that claimant had a "somatic dysfunction" of the cervical, dorsal/thoracic and lumbar areas.

Attorney Fee

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 SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Claimant's attorney is not entitled to an attorney fee for services 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 March 22, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld SAIF's partial denial of claimant's somatic dysfunction of the cervical, dorsal/thoracic and lumbar areas of the spine is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's attorney is awarded $3,000, payable by the SAIF Corporation.

Board Member Haynes dissenting.

The majority concludes that claimant's "somatic dysfunction" of the cervical, dorsal/thoracic, and lumbar areas of the spine are the same conditions accepted by SAIF. In reaching that conclusion, the majority completely ignores claimant's arguments and, in fact, rejects those arguments.

Claimant argues that the ALJ erred when he opined that SAIF's acceptance of a "strain" also encompassed "somatic dysfunction." (Appellant's brief at 2). Claimant contends that "somatic dysfunction" is a much broader term than "strain" and constitutes a separate and different condition. (Id. at 2, 6). According to claimant, SAIF should have been required to process the "somatic dysfunctions" as separate conditions.

Although the majority implicitly rejects claimant's arguments, finding that the "somatic dysfunction" conditions of the spine are the same conditions accepted by SAIF, claimant somehow "wins" and is even entitled to an attorney fee. In doing so, the majority misses the entire point of claimant's arguments.

Claimant's November 28, 1995 request for hearing raised issues regarding "de facto" denials of "cervical, cervicodorsal, lumbar strains, and somatic dysfunction." On January 18, 1996, SAIF expressly denied compensability of claimant's "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas" on the grounds that the July 9, 1993 injury was not the major contributing cause of the condition and there were insufficient objective findings which supported medical evidence of a diagnosable condition. (Ex. 41).

At hearing, the ALJ reviewed the record in detail and concluded that there was no evidence that "somatic dysfunction" meant something different from a "strain." The ALJ also commented that it was nearly impossible to determine from this record what "somatic dysfunction" actually meant.

If this case had been litigated as a "de facto" denial of claimant's "somatic dysfunction" (as claimant framed the request for hearing), claimant would lose. Based on the majority's reasoning, the majority would have to conclude that there was no "de facto" denial because claimant's "somatic dysfunction" condition is the same as that accepted by SAIF, even though different medical terminology was used to describe the condition. See, e.g., Debra S. Harrison, 48 Van Natta 920 (1996); Leslie C. Muto, 46 Van Natta 1685 (1994), aff'd mem 133 Or App 770 (1995). In this case, it makes no sense to change the result simply because SAIF issued a written denial, particularly when SAIF's denial is still valid.

Here, without an adequate explanation, the majority reverses the ALJ, even though it actually agrees with the ALJ's determination that "somatic dysfunction" did not mean something different than a strain. The majority does not address the fact that SAIF denied the claim, in part, because there were insufficient objective findings which supported medical evidence of a diagnosable condition of "somatic dysfunction." (Ex. 41).

Claimant has the burden of proving that an injury is compensable. ORS 656.266. In arguing that "somatic dysfunction" constitutes a separate and different condition from the "strain" conditions accepted by SAIF, claimant relies on the medical dictionary definitions of "somatic dysfunction" and "strain." However, in order to prevail on his argument that "somatic dysfunction" should be processed as a separate condition, claimant should have presented some medical evidence from Dr. Wynans to demonstrate that "somatic dysfunction" meant something different than a strain. Because claimant failed to do so, he did not carry his burden of proving that the somatic dysfunction of cervical, dorsal/thoracic and lumbar areas are separately compensable conditions. The ALJ correctly concluded that the medical evidence does not establish that the "somatic dysfunction" means something different than "strain."

The majority incorrectly sets aside SAIF's partial denial without any analysis whatsoever of claimants arguments or of the grounds for SAIF's denial. Because I would affirm the ALJ order rejecting claimant's argument that his "somatic dysfunction" should be accepted as a separate condition, I repectfully dissent.

October 1, 1996 Cite as 48 Van Natta 2080 (1996)

In the Matter of the Compensation of
BEVERLY J. HOTCH, Claimant
WCB Case No. 95-07094
ORDER ON REVIEW
Ginsburg, et al, Claimant Attorneys
Ronald Atwood & Associates, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order which: (1) set aside its denial of claimant's current cervical disc condition; and (2) determined that claimant's aggravation claim for her cervical disc condition was "moot." On review, the issues are compensability and aggravation. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. Claimant's compensable August 1993 cervical disc and right shoulder claim was closed by Notice of Closure of November 16, 1994, with an award of 11 percent unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial of claimant's current cervical disc condition, reasoning that the opinion of claimant's current attending physician and surgeon, Dr. Brett, established that claimant's compensable August 12, 1993 injury was the major contributing cause of a pathological worsening of claimant's cervical disc disease at C5-6 and C6-7. Concluding that the compensable worsening of claimant's degenerative cervical condition occurred when she sustained her compensable injury, the ALJ determined that claimant's aggravation claim was "moot" because the fact that claimant's cervical condition did not pathologically worsen after the compensable injury did not affect her entitlement to benefits.

On review, the insurer contends that the ALJ should have addressed the merits of claimant's aggravation claim and determined that it was not compensable based on his finding that claimant's cervical condition did not worsen after the compensable August 1993 injury. Moreover, the insurer asserts that the ALJ incorrectly relied on Dr. Brett's opinion in finding that claimant's current cervical disc condition is compensable.

To establish a compensable aggravation, claimant must show an actual worsening resulting from

the original injury. ORS 656.273(1)[1]; Gloria T. Olson, 47 Van Natta 2348 (1995). An aggravation has two components: (1) "actual worsening"; and (2) a compensable condition. 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. ORS 656.273(8). 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."

Claimant compensably injured her neck and right shoulder on August 12, 1993. The insurer accepted the claim for cervical and right shoulder sprains. According to Dr. Brett, claimant's current treating physician, claimant's worsened condition concerns degenerative changes at both C5/6 and C6/7. (Exs. 175, 191). The degenerative changes are not accepted conditions. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the degenerative changes are compensable conditions. Gloria Olson, supra.

For the reasons cited by the ALJ, we agree that claimant's August 12, 1993 injury is the major contributing cause of her disability and need for medical treatment for her "combined" condition; i.e. her work injury and her preexisting degenerative disc disease at C5/6 and C6/7. See ORS 656.005(7)(a)(B). Thus, we find that claimant's current cervical condition is a compensable condition. We now turn to the issue of whether claimant's cervical condition "actually worsened."

The ALJ declined to address the issue of whether claimant's cervical condition had actually worsened as a result of claimant's compensable condition, concluding that the aggravation issue was "moot." We agree with the insurer that the ALJ should have analyzed the issue of whether claimant's cervical condition had "actually worsened." Although the insurer's denial did not expressly deny aggravation, the parties agreed to litigate the issue at hearing. (Trs. 12, 13). Thus, the issue of aggravation was properly raised. See Larry R. Burnside, 47 Van Natta 2040 (1995) (parties to a workers' compensation proceeding may, by agreement, try an issue that falls outside the express terms of a denial). In addition, the fact that claimant's current cervical condition and need for treatment are compensable does not entitle claimant to claim reopening and potential temporary and permanent disability benefits unless claimant establishes a compensable worsening. Therefore, we disagree with the ALJ's conclusion that the aggravation issue was "moot."

As previously noted, 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. Moreover, the "actual worsening" must occur since the last award or arrangement of compensation. ORS 656.273(1); See Julianne Cartwright, 48 Van Natta 918, 921 (1996).

Here, the accepted August 1993 right shoulder and cervical claim was closed on November 16, 1994 with an award of 11 percent unscheduled permanent disability for injury to claimant's neck and right shoulder. (Ex. 165). To establish entitlement to claim reopening, claimant must prove either a pathological worsening of her underlying cervical disc condition since the last award or arrangement of compensation on November 16, 1994, or a symptomatic worsening greater than anticipated by the prior award of permanent disability.

Although finding that the August 12, 1993 compensable injury caused a pathological worsening of claimant's degenerative cervical disc condition, the ALJ also determined that the pathological worsening of claimant's cervical disc condition occurred on the date of injury and that the cervical condition did not further worsen after that time. In light of claimant's 1995 surgery (during which Dr. Brett discovered spondylitic changes with nerve root impingement), we find that claimant's compensable condition pathologically worsened. In this regard, we further note that a cervical MRI scan performed prior to the November 1994 claim closure showed no nerve root compromise. (Exs. 158, 159).

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[1] ORS 656.273(1) provides, in pertinent part:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." (Emphasis added).

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

Claimant's attorney is also entitled to an assessed fee for services at hearing and on review regarding the compensability of her aggravation claim. 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 aggravation claim is $2,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 20, 1996 is reversed in part and affirmed in part. That portion which determined that claimant's aggravation claim was moot is reversed. The insurer's aggravation denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services on review and at hearing regarding the aggravation issue, claimant is awarded a $2,000 assessed fee, payable by the insurer. For services on review regarding the compensability issue, claimant's attorney is awarded $1,500 to be paid by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
CLEMENTE MALDONADO, Claimant
WCB Case No. 95-11738
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Neal's order that set aside its denial of claimant's injury claim for low back strain, iliopsoas strain and psoas abscess. On review, the issue is compensability.

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

SAIF argues that the medical opinions of Drs. Antolik and Crislip are unpersuasive because they do not weigh the relative contributions of each cause to determine the major contributing cause. See Dietz v. Ramuda, 130 Or App 397 (1994). We disagree. The medical evidence persuasively establishes that claimant's work-related strain was the major contributing cause of his staphylococcal iliopsis abscess. In this regard, Dr. Crislip, a specialist in infectious diseases, explained that trauma to the iliopsoas muscle allows a transient staph bacteremia to infect the damaged area. Dr. Crislip believed that the trauma at work caused claimant to develop the ilioposoas abscess. (Ex. 12-1). We find Dr. Crislip's opinion sufficient to establish that the low back and iliopsis strain injury which occurred at work was the major contributing cause of the abscess in claimant's iliopsis muscle. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991) (medical evidence is not required to consist of a specific incantation or mimic statutory language).

Moreover, based on Dr. Crislip's opinion and that of Dr. Antolik, we are persuaded that the strain injury at work was the major contributing cause of the abscess and was not merely the precipitating cause. Dr. Antolik opined that the work incident and the lumbar strain caused by the work incident were the major contributing cause of the psoas abscess. We find the opinions of Drs. Antolik and Crislip to be persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986) (when there is a dispute between medical experts, we rely on those medical opinions which are both well reasoned and based on complete information). Accordingly, we conclude that claimant's strain injuries and his abscess are compensable. See ORS 656.005(7)(a)(A).

We further find that Dr. Goodall's opinion lends some support to the conclusions of Drs. Crislip and Antolik. Dr. Goodall is an infectious disease specialist who reviewed claimant's medical records on behalf of SAIF. Although he could not firmly relate claimant's condition to a work-related event, Dr. Goodall indicated that the most likely initiating event of claimant's infection was an iliopsis muscle strain.

We are not persuaded by the opinion of Dr. Kaesche, orthopedic surgeon. Dr. Kaesche believed it unlikely that claimant's iliopsoas abscess was caused by any physical activity at work. We find Dr. Kaesche's opinion to be conclusory and we accord greater weight to the opinion of Dr. Crislip who is a specialist in infectious diseases. Moreover, we note that Dr. Kaesche's previous opinion related claimant's problem to a ruptured appendix, a condition claimant did not have.

For the foregoing reasons, we find that claimant has established compensability of his lumbar and iliopsis strains, as well as his iliopsis abscess.

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 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 25, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by SAIF.

October 1, 1996 Cite as 48 Van Natta 2083 (1996)

In the Matter of the Compensation of
CARL H. MELUGIN, Claimant
WCB Case No. 95-03506
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that declined to assess an attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees.

We adopt and affirm the ALJ's order with the following change and supplementation. In the second paragraph of the findings of fact, we change the date of the supplemental hearing request to "May 4, 1995."

In our previous order, Carl H. Melugin, 48 Van Natta 383 (1996), we referred to the ALJ's finding that "[o]n the scheduled date of hearing, the employer conceded compensability of the right tibialis posterior partial tendon rupture." On review, the parties disagreed with the ALJ's characterization of the employer's concession. Since the concession was not part of the written record and there were no recorded proceedings, we were unable to determine whether claimant's tendon rupture condition was a "denied claim" pursuant to ORS 656.386(1). Consequently, we remanded to allow the parties the opportunity to present evidence regarding claimant's entitlement to an attorney fee under ORS 656.386(1), including the issue of whether claimant's ruptured tendon condition constitutes a "denied claim".

On remand, the ALJ found no evidence in the record to support claimant's contention that the employer conceded that the ruptured tendon condition had been improperly omitted from its acceptance. Moreover, the ALJ found there was no evidence that the employer had ever questioned the causal relationship between the ruptured tendon and the compensable injury. In addition, relying on Guillermo Rivera, 47 Van Natta 1723 (1995), the ALJ found that claimant's May 4, 1995 hearing request satisfied the "communication in writing" requirement of amended ORS 656.262(6)(d).

After the ALJ's order, we issued Shannon E. Jenkins, 48 Van Natta 1482 (1996) (Chair Hall, dissenting), in which we held that the worker's "communication in writing" under amended ORS 656.262(6)(d) must precede the worker's request for hearing. We disavowed our holding in Guillermo Rivera, supra, that a worker's request for hearing could constitute "communication in writing" under amended ORS 656.262(6)(d). In Shannon E. Jenkins, supra, we found that, since the claimant had only filed a request for hearing alleging a "de facto" denial, she did not satisfy amended ORS 656.262(6)(d) and was precluded from alleging at hearing that the employer "de facto" denied a left knee condition.

Here, claimant filed a supplemental hearing request on May 4, 1995 that raised the additional issue of "de facto" denial of right tibialis posterior partial tendon rupture. The employer did not respond to claimant's hearing request within the 30 day period provided under amended ORS 656.262(6)(d). The parties do not dispute that, on June 14, 1995 (the previous scheduled hearing date), the employer conceded that the tendon condition was compensable. In this proceeding, claimant argues that he is entitled to an attorney fee for the tendon condition.

As in Shannon E. Jenkins, claimant here filed only a supplemental request for hearing alleging a "de facto" denial of her right tibialis posterior partial tendon rupture and, therefore, did not satisfy amended ORS 656.262(6)(d). Notwithstanding that claimant did not satisfy amended ORS 656.262(6)(d), since the employer has conceded that the tendon condition is compensable and in light of the procedural posture of this case, we proceed to address the merits of the attorney fee issue. See James W. Vullo, 48 Van Natta 1061 n.2 (1996) (declining to address the employer's argument that the claimant failed to satisfy amended ORS 656.262(6)(d) because there was no "denied claim" upon which to award an attorney fee under 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 in 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 any compensation." (Emphasis added). In Michael J. Galbraith, 48 Van Natta 351 (1996), we held 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 condition was not compensable.

In this case, as in Michael J. Galbraith, supra, we agree with the ALJ that there is no evidence that the employer refused to pay compensation on the express ground that the injury was not compensable or did not give rise to an entitlement to compensation. The employer did not respond to claimant's hearing request until the scheduled hearing date of June 14, 1995, when it conceded that the tendon condition was compensable. Compare Emily M. Bowman, 48 Van Natta 1199 (1996) (carrier's response to a request for hearing denying that the claimant sustained a work-related injury or occupational disease was a refusal to pay compensation on the express ground that the condition was not compensable). Therefore, no "denied claim" has been established and claimant is not entitled to an attorney fee under ORS 656.386(1).

Claimant previously requested an attorney fee pursuant to ORS 656.382(1) as well as ORS 656.386(1). On September 21, 1995, as amended on October 11, 1995, the ALJ found that, because the employer timely paid for all benefits associated with the tendon rupture, there had been no unreasonable resistance to the payment of compensation justifying an assessed attorney fee pursuant to ORS 656.382(1). On review, we adopted the ALJ's reasoning and conclusion regarding this issue. Carl H. Melugin, supra. We remanded only for a determination on the ORS 656.386(1) issue. Id.

Although the issue concerning ORS 656.382(1) was not before the ALJ on remand, claimant contends on review that the employer unreasonably refused to comply with the law by failing to issue a written acceptance which should entitle claimant to penalties and fees pursuant to ORS 656.382(1). We are not inclined to address this issue because it was not before the ALJ. In any event, we disagree with claimant. There is no evidence that any compensation for the tendon condition was unpaid. Therefore, there was no unreasonable resistance to the payment of compensation that would allow for the assessment of an attorney fee under ORS 656.382(1). See SAIF v. Condon, 119 Or App 194, rev den 317 Or 163 (1993); Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991). We adhere to our earlier conclusion that the ALJ correctly concluded that claimant is not entitled to a penalty-related fee under ORS 656.382(1).

Finally, claimant challenges the statutory scheme that allows an attorney to go uncompensated for obtaining acceptance of a worker's previously unaccepted condition. We acknowledge that obtaining an employer's concession that an additional condition is part of the accepted claim can be of major significance to claimant for purposes of receiving future benefits. Notwithstanding such potential benefits, the legislature has chosen to set forth specific criteria for receiving an attorney fee for an injured worker's counsel's services, i.e., a "denied claim" under ORS 656.386(1). For the reasons discussed above, the circumstances in this case do not satisfy the statutory prerequisite for the award of a carrier-paid attorney fee under ORS 656.386(1).

ORDER

The ALJ's order dated May 29, 1996 is affirmed.

October 1, 1996 Cite as 48 Van Natta 2085 (1996)

In the Matter of the Compensation of
CHARLES E. MOODY, Claimant
WCB Case Nos. 94-09278, 94-05349 & 94-02483
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney
Steven T. Maher, Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation, on behalf of Fred Shearer & Sons (Shearer), requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) set aside its denials of compensability and responsibility for claimant's occupational disease claim for right shoulder and bilateral upper extremity conditions; (2) upheld Liberty Northwest's denials, on behalf of Ceiling Systems, Inc. (CSI), for the same conditions; and (3) upheld Liberty Northwest's denials, on behalf of Northwest Construction Specialties (NW), for the same conditions. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin by summarizing the relevant facts. Claimant, age 44 at hearing, worked as a lather for a series of different employers for about 25 years. Claimant's work duties included repetitive use of his arms and wrists in bending, tying and cutting heavy wire, and carrying and installing heavy sheetrock panels. In 1989, claimant was treated by Dr. Silver for right hand throbbing, numbness and swelling and forearm aching. Dr. Silver diagnosed right carpal tunnel syndrome (CTS). (Exs.1, 62-2). NW, his employer at the time, denied claimant's right wrist claim. That denial has become final. Claimant continued to work for NW through March 1, 1990.

When claimant saw Dr. Silver in 1989, he noted that claimant had been working 75 hours a week for three or four months, had gained weight, and had not been working out for some time. (Ex. 1-2). In late 1991, claimant began lifting free weights and, in early 1993, competed in body building competitions. (Tr. 74, 116, 121, 149). His workout schedule decreased in intensity and frequency in mid-March 1993. (Tr. 149).

In early February 1993, claimant went to work for Shearer and worked there until July 26, 1993, when he quit because of the severity of his wrist and hand symptoms. After he quit working, claimant's symptoms improved. Claimant stopped weight-lifting in about August or September 1993. (Ex. 23).

On October 5, 1993, claimant began working for CSI. Claimant's bilateral arm symptoms returned to the same level he had experienced when he quit working in July 1993. In October 1993, claimant felt a "pop" in his forearm and filed an injury claim with CSI. Dr. Kaesche diagnosed claimant's bilateral ulnar pain and tenderness as synovitis/tendinitis. (Ex. 30). Claimant stopped working for CSI on November 5, 1993. On December 14, 1993, Dr. Kaesche examined claimant for CSI. Dr. Kaesche diagnosed two different bilateral wrist conditions: bilateral carpal tunnel syndrome of at least 15 years' duration and bilateral synovitis/tendinitis involving the ulnar collateral ligament region. (Ex. 33). CSI denied compensability and responsibility for a bilateral wrist condition. (Ex. 36).

On December 6, 1993, claimant returned to work at Shearer. On December 28, 1993, Dr. Kaesche opined that claimant's tendinitis condition had resolved. However, claimant's symptoms increased over the next month and he quit work on February 2, 1994. On February 23, 1994, claimant sought treatment from Dr. Kaesche for CTS symptoms and other complaints of pain in the right shoulder and both elbows. On March 4, 1994, Dr. Kaesche diagnosed claimant's condition as right shoulder myositis, extensor tendinitis both elbows and bilateral carpal tunnel syndrome. (Ex. 34-2). On April 4, 1994, Dr. Kasche performed bilateral carpal tunnel releases.

Shearer denied compensability and responsibility for claimant's right shoulder and bilateral upper extremities condition. (Exs. 51, 52, 59A). NW denied compensability and responsibility for claimant's current right wrist condition. (Ex. 59).

Claimant was subsequently examined by Dr. Nathan for Shearer, by Dr. Button for CSI, and by Dr. Long.

The ALJ concluded, first, that the various diagnoses of claimant's right shoulder and upper extremity conditions should be analyzed as a single occupational disease. The ALJ then applied ORS 656.802(2), and concluded that claimant had proven by a preponderance of the evidence that his work activities as a lather were the major contributing cause of his bilateral upper extremity conditions. Reasoning that ORS 656.308(1) was inapplicable because there was no accepted claim for claimant's bilateral upper extremity conditions, the ALJ applied the last injurious exposure rule to assign initial responsibility for claimant's bilateral upper extremity claim to NW, claimant's last employer prior to his seeking treatment for his bilateral upper extremity conditions in 1989. Finally, after finding that the employment conditions at Shearer actually contributed to a worsening of claimant's conditions, the ALJ assigned responsibility to Shearer. On review, Shearer continues to dispute both compensability and responsibility.

Compensability

Shearer argues that the medical evidence fails to establish that claimant's work is the major contributing cause of his conditions. We disagree, and affirm the ALJ's opinion on the compensability issue, with the following supplementation.

Because of claimant's multiple work exposures, the causation issue presents a complex medical question requiring expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Where, as here, resolution of a matter involves expert analysis rather than expert external observation, we do not give special deference to a treating physician's opinion. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini Corp., 43 Or App 299 (1979). Rather, where there is a dispute between medical experts, the greater weight will be given to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986).

Opinions regarding the cause of claimant's conditions were provided by Dr. Long, Dr. Nathan, Dr. Button and Dr. Kaesche, who performed claimant's carpal tunnel surgery.

Although Dr. Long did not examine claimant until January 6, 1995, he had the most complete and detailed history of claimant's bilateral arm complaints and diagnoses, claimant's work exposures for various employers, and claimant's weight-lifting and body-building activities. (Ex. 62). Based on this information, Dr. Long evaluated the relative contributions of claimant's work activities and avocational activities to claimant's arm conditions. After weighing these factors, Dr. Long concluded that claimant's many years of work as a lather was the major contributing cause of his right shoulder and bilateral arm conditions. We find Dr. Long's complete and well-reasoned analysis of the development and cause of claimant's conditions to be more persuasive than the opinions of the other examining and treating physicians. Somers v. SAIF, supra.

Dr. Nathan, who examined claimant for Shearer, concluded that claimant was statistically three times more likely than the average person in a population of 471 industrial workers to develop carpal tunnel syndrome, given his age, body mass index, wrist ratio and hand dominance. (Exs. 55, 57). Based on the severity of claimant's nerve conduction studies, Dr. Nathan opined that both claimant's occupational and avocational pursuits ("extrinsic factors") contributed to the acceleration of the underlying neuropathies, stating, "Given the fact that [claimant] spends more time at work than in the gym, it could be argued that at least on a temporal basis the work activities would be the major contributing extrinsic factor." Nevertheless, Dr. Nathan also opined that, based on the severity of claimant's median nerve slowing, the major contributing cause of claimant's carpal tunnel condition was claimant's "intrinsic" factors (i.e., age, etc.). We do not give Dr. Nathan's opinion great weight, as he failed to explain why he believed that claimant's age, body mass index, wrist ratio and hand dominance were more significant than claimant's 25 years of exposure to repetitive and heavy work with both arms and hands.[1] Moreover, because Dr. Nathan relied on a study regarding carpal tunnel syndrome that did not involve claimant, we find his opinion concerning claimant insufficiently explained. For these reasons, we find Dr. Nathan's opinion unpersuasive. Somers v. SAIF, supra; Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Claimant was examined for CSI by Dr. Button. (Ex. 51A). When asked to address the relative contribution of claimant's work activities and avocational activities to his conditions, Dr. Button declined to offer an opinion, stating that claimant's weight lifting activities were an important factor in the development of his carpal tunnel syndrome, based on his own personal experience with weight lifting. Because Dr. Button's opinion, like that of Dr. Nathan, was based on a generalization which did not involve claimant, we conclude that Dr. Button's opinion is not persuasive and give it little weight. Somers v. SAIF, supra.

Dr. Kaesche, who began treating claimant's wrists in 1993, had a history that claimant's wrist symptoms did not develop until the summer of 1993. He opined that claimant's synovitis/tendinitis resulted from his heavy physical labor and that claimant's carpal tunnel symptoms were the result both of weight training and heavy physical labor. Subsequently, in response to Shearer's attorney's query directed to claimant's carpal tunnel condition, Dr. Kaesche stated that he was unable to formulate an opinion regarding whether claimant's work activities or off-the-job athletic activities were the major contributing cause of his conditions, in that either may cause carpal tunnel symptoms to develop. (Ex. 58). Inasmuch as Dr. Kaesche's opinion was based on an incorrect history and is conclusory and without explanation, we do not find it persuasive. Somers v. SAIF, supra.

In sum, we are more persuaded by Dr. Long's detailed analysis of the cause of claimant's right shoulder and bilateral upper extremity conditions. Consequently, we find that claimant has established the compensability of his occupational disease claim.[2]

Responsibility

Shearer contends that, because claimant first sought treatment for his current condition in October 1993, while working for CSI, that initial responsibility should be assigned to CSI. Shearer further argues that responsibility remains with CSI because claimant's work activities in late 1993 worsened claimant's condition. We disagree.

No one has accepted claimant's right shoulder and bilateral arm condition claim. Accordingly, we analyze this matter under the last injurious exposure rule (LIER). SAIF v. Yokum, 132 Or App 18, 24 (1994); Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71, 75 n. 1 (1994).

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[1] We need not decide whether the "intrinsic factors" identified by Dr. Nathan are "preexisting conditions" under ORS 656.005(19), as the analysis and result would be the same.

[2] We note that, for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws. Silveira v. Larch Enterprises, 133 Or App 297 (1995). Likewise, should claimant rely on "non-Oregon Worker's Compensation system" employments, Oregon carriers may resort to the defensive use of LIER. See United Parcel Service v. Likos, 143 Or App 486 (1996).

LIER provides that where, as here, a worker proves than 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 worker receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, even if we agreed with Shearer that claimant first sought treatment for his current condition in October 1993, and thus assigned initial responsibility to claimant's then-employer, CSI, we would nevertheless conclude that responsibility shifted forward to Shearer, his employer in December 1993 and January 1994. We base our conclusion on the following reasoning.

In order to shift responsibility forward to a subsequent employer, the presumptively responsible employer must prove that employment conditions at a subsequent employer contributed to the cause of, aggravated or exacerbated the underlying disease. Bracke v. Baza'r, supra 293 Or at 250 ("A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer"); Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (Later employment conditions must actually contribute to a worsening of the condition). A claimant must experience more than a mere increase in symptoms. Timm v. Maley, supra, 134 Or App at 249.

In October 1993, when employed by CSI, claimant was treated for bilateral wrist pain over the ulnar aspect of both wrists. Dr. Kaesche diagnosed claimant's condition as tendinitis/synovitis. In December 1993, Dr. Kaesche also diagnosed chronic intermittent bilateral carpal tunnel symptoms of 15 years' duration. He concluded that claimant's chronic CTS had not worsened at that time. (Ex. 33).

When claimant returned to Dr. Kaesche in February 1994 with increased symptoms in his arms and right shoulder, Dr. Kaesche found a positive Phalen's test and diminished nerve conduction velocities in both wrists. (Ex. 34). Dr. Kaesche diagnosed claimant with bilateral CTS, complicated by myositis of the right shoulder and extensor tendonitis at the elbows. In April 1994, Dr. Kaesche performed bilateral carpal tunnel releases.

Two doctors offered opinions on whether claimant's underlying condition had worsened: Dr. Button and Dr. Long. Dr. Button opined that claimant's underlying condition had pathologically worsened since 1989. However, he declined to indicate when that worsening occurred. (Ex. 51A-4, -5). Dr. Long, on the other hand, reviewed his office notes and the available medical records regarding the issue. Dr. Long noted that claimant had presented to Dr. Kaesche in late February 1994 with a considerable increase in forearm and hand symptoms, complicated by right shoulder and bilateral elbow conditions. Dr. Long stated that it was clear that claimant had symptoms of CTS prior to 1993, but it was also clear that claimant's symptoms were considerably more severe and troublesome in January and February 1994 than in the prior two months. He opined that that increase in symptoms necessarily reflected a worsening of the underlying condition. He further opined that the worsening was principally a result of claimant's work activities as a lather during 1994, when claimant was employed by Shearer. (Ex. 65).

Based on Dr. Long's opinion that claimant's underlying condition had worsened, which is confirmed by Dr. Button and the medical record, and Dr. Long's opinion that the worsened condition occurred as a result of claimant's January 1994 employment, which is confirmed by Dr. Kaesche's chart notes, we conclude that claimant's work activities subsequent to December 1993 actually contributed to a worsening of his right shoulder and bilateral upper extremity conditions. Consequently, responsibility for claimant's condition shifted forward to Shearer. Accordingly, we affirm the ALJ's conclusion that Shearer is the responsible employer.

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 Shearer. 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 20, 1996 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by Shearer.

October 1, 1996 Cite as 48 Van Natta 2089 (1996)

In the Matter of the Compensation of
MELODY L. RIVERS, Claimant
WCB Case Nos. 95-04261 & 95-01094
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
VavRosky, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Christian and Haynes.

The SAIF Corporation, on behalf of Holiday Inn (SAIF/Holiday), requests review of those portions of Administrative Law Judge (ALJ) Johnstone's order that: (1) set aside its denials of compensability and responsibility for claimant's "new injury" claim for a neck condition; (2) upheld the self-insured employer's denials of claimant's aggravation claim for the same condition; and (3) awarded a $7,300 attorney fee for claimant's counsel's services at hearing. In her brief, claimant contends that a penalty should be awarded for SAIF's untimely denial. On review, the issues are compensability/aggravation, responsibility, penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

We adopt and affirm the ALJ's opinion and conclusions regarding these issues.

Penalty and Attorney Fees for Untimely Denial

After finding that this case presented a complex medical question with opposing medical opinions, the ALJ concluded that SAIF's denial was not unreasonable and denied claimant's penalty request. On review, claimant requests a penalty for SAIF's failure to timely accept or deny claimant's claim.[1] We affirm the ALJ, but for different reasons.

Claimant filed her claim on October 19, 1994. (Ex. 22). SAIF denied compensability and responsibility on March 13, 1995. (Ex. 41A). Because SAIF did not accept or deny claimant's claim within 90 days, and the lateness is unexplained, we conclude that the insurer's nonaction constituted an unreasonable delay in acceptance or denial of the claim. A penalty may be assessed under ORS 656.262(11)(a) if there were amounts then due between the date when the acceptance or denial should have issued and the date of the denial. Jeffrey D. Dennis, 43 Van Natta 857 (1991). In this case, the record does not support a finding that there were amounts due at the time of the unreasonable delay; therefore, there is no basis for a penalty. See Wacker Siltronic v. Satcher, 103 Or App 513 (1990). Moreover, claimant is not entitled to an assessed attorney fee under ORS 656.382(1) because the insurer did not unreasonably resist the payment of compensation. SAIF v. Condon, 119 Or App 194 (1993).

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[1] At hearing, claimant specified only two bases for penalties: (1) SAIF's allegedly late denial; and (2) SAIF's failure to timely provide discovery. See Tr. 12. On review, claimant's sole basis for requesting a penalty is SAIF's allegedly late denial. See Claimant's Respondent's Brief at 1, 16.

Attorney Fees - ORS 656.386(1)

The ALJ awarded claimant a $7,300 attorney fee for his counsel's services at hearing. SAIF asserts that the ALJ's attorney fee award was excessive and should be reduced to $2,500. We modify the ALJ's attorney fee award.

Under ORS 656.386(1), a claimant is entitled to an attorney fee in cases involving denied claims where a claimant prevails finally in a hearing. Under ORS 656.308(2)(d), a claimant may also be entitled to an attorney fee for prevailing against a responsibility denial, that is separate from and in addition to the attorney fee awarded for finally prevailing over a compensability denial under ORS 656.386(1); or pursuant to ORS 656.382(2) when a carrier unsuccessfully appeals an order that addressed the compensability issue. Paul R. Huddleston, 48 Van Natta 4, on recon 48 Van Natta 203 (1996).

Here, at the hearings level, claimant prevailed against SAIF's denial of compensability of her neck condition. Thus, she is entitled to a carrier-paid attorney fee award under ORS 656.386(1) for her counsel's services provided at the hearings level. In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. Claimant's counsel prepared for two hearings, the first in July 1995, which was postponed in order to address issues raised by passage of Senate Bill 369, and the second on January 16, 1996. Hearing preparation was time-consuming in large part because claimant needed extensive preparation to understand the issues and to testify effectively. Additional time was required to address issues raised by passage of Senate Bill 369, which extensively changed the Workers' Compensation Law.

The January 1996 hearing record consists of 62 exhibits, 13 of which were generated by claimant's counsel. The transcript consists of 70 pages. Two witnesses, including claimant, testified on claimant's behalf. No witnesses testified for the defense. The hearing lasted three hours and ten minutes, with closing arguments presented orally. Claimant submitted a 12-page hearing memorandum regarding the standard of proof to be applied in this case and a two-page reply to SAIF's response to the hearing memorandum.

The value of the compensability issue is high, as claimant stands to gain substantial benefits, including substantial medical expenses, extensive time loss from work, and a probable award of permanent disability compensation. The issue in dispute involved factual and legal matters that were more complex than those compensability disputes that are generally presented at hearing and for Board resolution. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner, identifying the relevant factual and legal issues for our resolution. Based on counsel's statement of services, approximately 48 hours were devoted to the case at the hearing level.[2] Finally, there was a decided risk that claimant's counsel's efforts might have gone uncompensated.

After considering these factors, we agree that an above-average attorney fee award is appropriate for services rendered at the hearings level regarding the compensability issue. Specifically, we conclude that $6,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing.

Attorney Fees - ORS 656.308(2)(d)

Claimant is also entitled to a carrier-paid attorney fee award under ORS 656.308(2)(d) for his attorney's active and meaningful participation in the responsibility dispute at hearing and on Board review. Claimant filed a hearing request contesting SAIF's responsibility denial and has successfully prevailed over that denial.

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[2] The statement does not differentiate between services devoted to the compensability issue from those directed at the penalty and related attorney fee issues (late denial and failure to timely provide discovery, see Tr. 12-15, 69). Since claimant did not prevail on the penalty and related attorney fee issues, services devoted to those issues are not considered in determining a reasonable fee for services on the compensability issue at the hearings level.

Under ORS 656.308(2)(d), an attorney fee shall not exceed $1,000 at hearing and on review, absent a showing of extraordinary circumstances. ORS 656.308(2)(d); Paul R. Huddleston, supra; Tammy Locke, 48 Van Natta 250 (1996).

Although claimant's attorney's arguments regarding the responsibility issue were successful and, as noted above, the value of the claim was above average proportions, the complexity of the issue or value of the benefits do not differ appreciably from those in most cases litigated before this forum. Consequently, claimant has not demonstrated extraordinary circumstances to justify an attorney fee greater than the $1,000 cap. Accordingly, after considering the factors set forth in OAR 438-015-0010(4), we award $1,000 for claimant's attorney's services at hearing and on Board review, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the responsibility issue (as represented by the hearing record and claimant's respondent's brief), the nature of the proceeding, and the value of the interest involved.

Attorney Fee - ORS 656.382(2)

Claimant's attorney is also entitled to an assessed fee for services on review under ORS 656.382(2) regarding the compensability issue. See Paul R. Huddleston, supra. After applying the same factors on review, we find that a reasonable fee for claimant's counsel's services concerning the compensability issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and claimant's attorney's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee for services on review regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 1, 1996 is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award, claimant is awarded $6,000 under ORS 656.386(1), payable by the SAIF Corporation, for services at hearing regarding the compensability issue. For services at hearing and on review regarding the responsibility issue, claimant's attorney is awarded $1,000 under ORS 656.308(2)(d), to be paid by SAIF. The remainder of the order is affirmed. For services on Board review regarding the compensability issue, claimant is awarded $1,000 under ORS 656.382(2), payable by SAIF.

October 1, 1996 Cite as 48 Van Natta 2091 (1996)

In the Matter of the Compensation of
JOHN R. SYRON, Claimant
WCB Case No. 95-09617
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that declined to award an attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back in 1988. SAIF accepted the claim as a nondisabling "acute low back strain." In 1992, claimant sought further treatment for his back and an L5-S1 disc herniation was discovered. In 1993, claimant underwent surgery for his low back condition. The claim was reopened by SAIF as an aggravation of the 1988 injury.

In a letter dated July 20, 1995, claimant's attorney requested that SAIF amend its Notice of Acceptance of claimant's 1988 injury to include the L5-S1 disc herniation. On August 23, 1995, claimant requested a hearing raising the issue of "de facto" denial and attorney fees. SAIF's September 5, 1995 response to the request for hearing stated that "There is no known basis for an award of penalties/attorney fees."

On October 4, 1995, SAIF wrote to claimant's attorney and offered to amend its Notice of Acceptance and pay a $100 attorney fee. SAIF did not amend its Notice of Acceptance prior to the November 28, 1995 hearing.

Reasoning that SAIF had not refused to pay any compensation for claimant's L5-S1 herniated disc and had not expressly indicated that the condition was not compensable, the ALJ declined to award an attorney fee under ORS 656.386(1).

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).

At the hearing, SAIF contended that its January 25, 1989 Notice of Acceptance included claimant's L5-S1 disc herniation. Alternatively, SAIF argued that claimant was barred by claim preclusion from seeking modification of the notice of acceptance. The ALJ found that the 1989 acceptance did not include the L5-S1 disc condition and that claimant was not barred by claim preclusion from arguing that the acceptance notice should be modified.

Claimant asserts that SAIF's claim preclusion argument at hearing amounted to a refusal 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 agree.

We conclude that SAIF's argument that claim preclusion barred modification of the Notice of Acceptance constitutes an express assertion that the L5-S1 disc condition is not compensable or <u>otherwise does not give rise to an entitlement to compensation</u>. Under such circumstances, we find that the requirements for an attorney fee under ORS 656.386(1) have been met.

We find this case to be similar to <u>Elizabeth A. O'Brien</u>, 47 Van Natta 2152 (1995). There, a prior ALJ's order had set aside an aggravation denial which included the claimant's cervical disc herniations. The claimant requested in writing that the insurer amend its acceptance to include the cervical disc herniations. The insurer declined to do so. The claimant requested a hearing regarding the insurer's refusal to modify its acceptance. At the hearing, the insurer challenged the claimant's contentions that the disc herniations were compensable, arguing that the prior ALJ's order had not pertained to the herniations.

In <u>O'Brien</u>, we found that the insurer refused to pay compensation for the claimant's disc herniations on the express ground that the herniations were not compensable or otherwise did not give rise to an entitlement to any compensation. Consequently, we held that there was a "denied claim" and awarded an attorney fee under ORS 656.386(1).

Here, as in <u>O'Brien</u>, claimant challenged the carrier's acceptance notice and requested that his disc herniation be included in the acceptance. The carrier did not amend its acceptance and claimant requested a hearing. At the hearing, the carrier unsuccessfully contended that its prior acceptance encompassed the disc herniation. Alternatively, the carrier asserted that claim preclusion barred claimant from seeking modification of its acceptance notice. Since the carrier's contention that the disc herniation was encompassed within the notice of acceptance was rejected, the carrier's "claim preclusion" defense became relevant. If successful, such a defense would have prevented claimant from receiving compensation for his disc herniation. Under such circumstances, we conclude that the carrier refused to pay on the express ground that the herniation was not compensable or otherwise did not give rise to an entitlement to any compensation. Inasmuch as claimant has prevailed over SAIF's "claim preclusion" argument, we hold that claimant's attorney is entitled to a 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 hearing is $1,500, 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 value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 12, 1995 is reversed in part. For services rendered at the hearings level regarding the disc herniation, claimant's attorney is awarded $1,500, payable by SAIF. The remainder of the order is affirmed.

October 1, 1996 Cite as 48 Van Natta 2093 (1996)

In the Matter of the Compensation of
DOUGLAS P. THEISEN, Claimant
WCB Case No. 95-10875
ORDER ON REVIEW
Welch, Bruun, 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) Davis' order that: (1) upheld the SAIF Corporation's denial of claimant's injury/occupational disease claim for a low back condition; and (2) declined to find portions of SB 369 unconstitutional or violative of the Americans with Disabilities Act (ADA). On review, the issues are constitutionality and compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's ADA and constitutional arguments.

Claimant argues that the ADA preempts ORS 656.005(24). We have previously held that the Board is not the proper forum for an ADA challenge. See Gary W. Benson, 48 Van Natta 1161 (1996); Rex Brink, 48 Van Natta 916 (1996). Moreover, even if we had jurisdiction to consider claimant's ADA arguments, we would find that the record lacks sufficient evidence to establish even the first element of a prima facie case of discrimination under the ADA, i.e., that claimant is an "individual with a disability" under the terms of the Act. See Gary W. Benson, supra.[1]

Claimant asserts that his low back condition is compensable as either an industrial injury or an occupational disease. He further contends that retroactive application of ORS 656.005(24) to his claim is prohibited by the Due Process Clause of the U.S. Constitution. Because we conclude that claimant's claim would not be compensable under the law in effect prior to the 1995 amendments, we find it unnecessary to address claimant's arguments that retroactive application of ORS 656.005(24) is unconstitutional.

Even if ORS 656.005(24) was not retroactively applicable to claimant's claim, claimant's claim would fail under former ORS 656.005(7)(a)(B) and ORS 656.802. Under former ORS 656.802(2), claimant would have had to establish that his work activities were the major contributing cause of his low back condition or its worsening. Based on Dr. Fuller's persuasive medical opinion, we find that claimant's work activities were not the major contributing cause of claimant's low back condition or its worsening.

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[1] Although claimant contends that he has satisfied the ADA's definition of disability, there is no medical evidence establishing that claimant's low back condition is a physical impairment that substantially limits a major life activity such as working. See 42 U.S.C. § 12102(2). In Gary W. Benson, supra at 1163 n. 2, we noted that in order to show that he is substantially limited in the major life activity of working, he must prove that he is "significantly restricted in ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person with comparable training, skills and abilities. The inability to perform a single, particular job does not constitute a substantial limitation in the major life activity of work." 29 C.F.R. § 1630.2(j)(3)(i). Here, there is insufficient evidence to establish that claimant is substantially limited in the major life activity of working or in any other major life activities.

Similarly, assuming that the current versions of ORS 656.005(7)(a)(B) and 656.005(24) were not retroactively applicable, we would conclude that claimant's condition was not compensable under former ORS 656.005(7)(a)(B).

Based on the persuasive medical evidence from Dr. Fuller, we conclude that claimant's preexisting degenerative disc disease combined with the April 10, 1995 incident to cause or prolong disability or a need for treatment. The persuasive medical evidence fails to establish that claimant's work activities were the major contributing cause of claimant's low back disability or need for treatment. Because claimant's claim would fail even if ORS 656.005(24) was not retroactively applied, we conclude that claimant's constitutional arguments are without merit.

ORDER

The ALJ's order dated April 11, 1996 is affirmed.

October 2, 1996 Cite as 48 Van Natta 2094 (1996)

In the Matter of the Compensation of
HENRY F. DOWNS, Claimant
WCB Case No. 95-13394
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
John Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's occupational disease claim for a bilateral hearing loss condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. At the time claimant first started working for the employer, claimant had some hearing loss. (Ex. 7-10).

Claimant was examined on behalf of the employer by Dr. Ediger, Ph.D., audiologist, and Dr. Hodgson, M.D., otolaryngologist, on September 13, 1995, and January 15, 1996, respectively. (Exs. 3, 6).

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that this matter was submitted on the written record, with written closing arguments. No hearing was convened. In his order, the ALJ stated that the record consisted of six exhibits. However, both the ALJ and the parties also cited to Exhibit 7, an exhibit included in the Hearings file. Exhibit 7 is the February 20, 1996 deposition of Dr. Ediger, clinical audiologist, who examined claimant on behalf of the employer. Under these circumstances, we find that the ALJ mistakenly stated that the written record consisted of only six exhibits. Accordingly, we conclude that Exhibit 7 was part of the written record submitted by the parties and consider that exhibit in our "de novo" review.

In addition, subsequent to the filing of Board briefs in this case, the employer submitted a document captioned "Appellant's Memorandum of Supplemental Authorities" in which it cited and summarized the following cases: Mary F. Krieger, 48 Van Natta 948 (1996), and Anselmo Perez, 48 Van Natta 71 (1996). In response, claimant submitted additional argument contending that these cases were not relevant. Any party may provide supplemental authorities to assist the Board in its review of a case, but only if the case was not in existence until after the time of briefing. Here, the cases to which the employer cites were in existence at the time of briefing. Moreover, unless otherwise authorized by the Board, further argument will not be considered. OAR 438-11-020(2); Betty L. Juneau, 38 Van Natta 553 (1986). Accordingly, we do not consider the employer's submission or claimant's response in our review.

We begin with a summary of the relevant facts. Claimant was employed in the employer's box factory essentially 33 years before he retired in January 1984. During this employment, claimant was exposed to loud noises regularly exceeding 90 decibels. (Ex. 3-1, -2). He did not use hearing protection during the first 20 years of employment, and used it occasionally thereafter. Id.

Before his retirement in January 1984, claimant's hearing was last tested in 1982, when he was 60 years old. At that time, his binaural hearing loss adjusted for presbycusis (100 at age 60) was 7.5 percent. Claimant first filed a hearing loss claim on August 28, 1995. (Exs. 1, 2). On September 13, 1995, claimant had a binaural hearing loss of 41.4 percent, under the Oregon rating standards when his hearing was tested by Dr. Ediger. (Ex. 3-7). Under those same standards, claimant had a binaural hearing loss of 44.38 percent on January 15, 1996, when his hearing was tested by Dr. Hodgson, otolaryngologist, on behalf of the employer. (Ex. 6-6).

At hearing, relying on Bohemia, Inc. v. McKillop, 112 Or App 261 (1992), the ALJ rejected the employer's argument that claimant's occupational disease claim should be found time-barred. On review, the employer again argues that claimant's claim is time-barred. We agree with the ALJ.

An occupational disease claim is considered "void" unless filed within one year from the later date of the following: (1) the date the worker first discovers the disease; (2) the date the worker becomes disabled from the disease; or (3) the date the worker is informed by a physician that he or she is suffering from an occupational disease. ORS 656.807(1); Bohemia, Inc. v. McKillop, supra; Ralph T. Masuzumi, 45 Van Natta 361 (1993). Here, the parties stipulated that claimant was first informed his hearing loss was work related when he was examined by Dr. Ediger in 1995. Since claimant filed his occupational disease claim in 1995, we conclude the claim is timely.

At hearing and on review, claimant argues that his 7.5 percent binaural hearing loss at retirement, after adjusting for presbycusis, is due to noise exposure during his 33 years of work for the employer. In addition, claimant argues, because he is seeking benefits only for this 7.5 percent binaural hearing loss, his hearing loss due to presbycusis is irrelevant. Therefore, claimant argues, he has established a compensable occupational disease claim under ORS 656.802. We disagree.

In order to establish his hearing loss as an occupational disease, claimant must prove that employment conditions were the major contributing cause of the occupational disease. ORS 656.802(2)(a). In addition, ORS 656.802(2)(c) provides that occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7). One of those limitations is set forth in ORS 656.005(7)(a)(B), which provides:

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

Due to the passage of time since claimant's retirement, we find the causation issue in this case is a complex medical question which requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Drs. Hodgson and Ediger provide the only medical opinions regarding causation.

Dr. Hodgson examined claimant on January 15, 1996, and performed audiology tests. (Ex. 6). Dr. Hodgson had a complete history of claimant's work-related noise exposure. He opined that claimant's pattern of hearing loss, as evidenced by the audiogram, was not typical of hearing loss due to noise exposure but was much more typical of presbycusis and "would be considered to be a greater amount than the median for [claimant's] age and would probably be closer to the 75th percentile." (Ex. 6-3). He reviewed claimant's previous hearing tests and concluded that claimant had a significant progression of his hearing loss since his retirement in 1984. He noted that this additional hearing loss was caused by claimant's advancing age, not work-related noise exposure. He opined that the primary cause of claimant's hearing loss was presbycusis. In addition, Dr. Hodgson calculated that 16.96 percent of claimant's binaural hearing loss (or 7.53 percent) was due to work-related noise exposure, while 83.04 percent was due to claimant's age. (Ex. 6-3). He concluded that work-related noise exposure was a minor factor in claimant's hearing loss and age was the major factor, both currently and at the time claimant retired in 1984. (Ex. 6-4).

Dr. Ediger examined claimant on September 13, 1995, and performed audiology tests. (Ex. 3). Dr. Ediger also had a complete history of claimant's work-related noise exposure. He opined that claimant's hearing loss was sensorineural and the hearing loss pattern resembled that caused by presbycusis. (Ex. 3-4, -5). He also noted that, claimant's hearing loss pattern at age 49 also resembled hearing loss caused by presbycusis, rather than a noise-induced hearing loss. (Ex. 3-5). He opined that claimant had a 7.5 percent binaural hearing loss due to work-related noise exposure. Id. He noted that claimant's increased hearing loss since his retirement was unrelated to the noise exposure during his years of work for the employer. During his deposition, Dr. Ediger opined that claimant had some preexisting hearing loss when he started working for the employer in 1961 and claimant's work exposure combined with that hearing loss. (Ex. 7-10).

Claimant contends that this medical record does not establish that ORS 656.005(7)(a)(B) applies to his claim. First, claimant contends, Dr. Ediger's statement in his deposition that presbycusis or other hearing loss causes are "'additive,' that causes add up" does not support a finding that claimant's hearing loss condition is a "combined condition." (Ex. 7-33). Second, claimant contends, based on Dr. Ediger's deposition responses, presbycusis does not fit within the statutory definition of a "preexisting condition" under ORS 656.005(24). Assuming arguendo that claimant's contentions are correct, and ORS 656.005(7)(a)(B) does not apply to his claim, we nevertheless find that the medical evidence does not establish a compensable occupational disease claim under ORS 656.802.

ORS 656.802(2)(a) requires that, in order to establish a compensable occupational disease claim, the "worker must prove that employment conditions were the major contributing cause of the disease." Here, claimant's "disease" is a bilateral hearing loss. The medical evidence establishes that the factors contributing to this bilateral hearing loss are work-related noise exposure and presbycusis.[1] In light of Dr. Hodgson's specialized expertise as an otolaryngologist, we defer to his opinion that, both at the present time and at the time of retirement, the major contributing cause of claimant's bilateral hearing loss condition was presbycusis, not work-related noise exposure. See Abbott v. SAIF, 45 Or App 657, 661 (1980). Claimant is not permitted to extract a portion of the disease (hearing loss) and claim that only that portion is caused in major part by work exposure. Pursuant to ORS 656.802(2)(a), claimant must prove that the major contributing cause of his overall hearing loss was work-related noise exposure. On this record, we conclude that claimant has failed to meet his burden of proving a compensable occupational disease claim.

ORDER

The ALJ's order dated April 15, 1996 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's assessed attorney fee award is reversed.

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[1] Dr. Ediger opined that claimant had some presbycusis related hearing loss when he began working for the employer. However, even if there was no "preexisting" hearing loss, for the reasons that follow, we find that claimant has not established a compensable occupational disease claim under ORS 656.802.

In the Matter of the Compensation of
JOHNNY GUYTON, Claimant
WCB Case No. 95-12949
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) McKean's order that: (1) declined to order a medical arbiter examination in connection with claimant's appeal of the SAIF Corporation's Order on Reconsideration of Final Determination issued on behalf of the Inmate Injury Fund under ORS Chapter 655; and (2) affirmed the Order on Reconsideration awarding 2 percent (3 degrees) scheduled permanent disability for loss of use or function of the left leg (knee). On review, the issues are whether claimant is entitled to a medical arbiter examination and extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following corrections and supplementation with regard to claimant's entitlement to a medical arbiter examination.

Applying the provisions of ORS Chapter 655 as amended by the 1995 Oregon Legislature,[1] the ALJ determined that claimant was not entitled to a medical arbiter's examination, and that neither the ALJ nor SAIF had the authority to appoint an arbiter. The ALJ further declined to remand the claim to the Director of the Department of Consumer and Business Services with directions to appoint an arbiter under ORS 656.268.

As both parties argue on review, the amendments to ORS Chapter 655 do not apply in this case because claimant's injury occurred prior to the Act's June 30, 1995 effective date. See Terry Hickman, 48 Van Natta 1073, 1074 n 1 (1996); Freddy Vasquez, 47 Van Natta 2182, 2183 n.4 (1995). We therefore analyze this case under the former law.

In Freddy Vasquez, 47 Van Natta 2159 (1995), we held that only the Director may appoint a medical arbiter under ORS 656.268, and that neither the Board, its Hearings Division, nor SAIF had the authority to appoint such an arbiter. We explained that, pursuant to former ORS 655.515, injured inmates are entitled to the same benefits as other injured workers, but not necessarily the same procedures for payment of those benefits. We concluded that review of determination action pursuant to former ORS 655.525[2] did not involve the Director's reconsideration process under ORS under 656.268, and therefore the claimant was not entitled to a medical arbiter examination. Id.; accord Ervei F. Salazar, 48 Van Natta 394 (1996).

Consequently, although we disagree with the ALJ's application of the new law, we find that the ALJ properly declined to order a medial arbiter examination in connection with the rating of claimant's permanent disability.[3] Freddy Vasquez, supra; Ervei F. Salazar, supra.

ORDER

The ALJ's order dated March 14, 1996 is affirmed.

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[1] See Or Laws 1995, ch. 384, § 18 (HB 2903, § 18).

[2] Former ORS 655.525 provided: "An inmate * * * may obtain review of action taken on the claim as provided in ORS 656.283 to 656.304."

[3] On review, claimant requests that we take official notice of the Department's orders concerning his entitlement to reconsideration under ORS 656.268. We have the authority to do so. See Rodney J. Thurman, 44 Van Natta 1572, 1573 (1992). We note, however, that to the extent the Department's Final Order suggests that the Board and Hearings Division have the authority to order a medical arbiter examination in an inmate injury case pursuant to OAR 438-007-0005(5), this statement is dicta and not controlling on the Board. It is also contrary to our ruling in Freddy Vasquez, supra.

Chair Hall specially concurring.

Although I am bound by principles of stare decisis to follow the Board's holdings in Freddy Vasquez, 47 Van Natta 2159 (1995), and Ervei F. Salazar, 48 Van Natta 394 (1996), I write separately to note that, if I was deciding this case on a clean slate, I would conclude that claimant is entitled to an examination by a medical arbiter. In fact, I agree with Member Gunn's dissent in Vasquez, supra. I believe that denying an injured inmate access to a medical arbiter examination is tantamount to denying the inmate payment of benefits in the same manner as provided for injured workers under ORS 656, which is contrary to the language and spirit of former ORS 655.515.

In the Matter of the Compensation of
GREGORY J. BACKER, Claimant
WCB Case Nos. 95-13418 & 95-05744
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that awarded 10 percent (32 degrees) unscheduled permanent disability for claimant's low back condition, whereas an Order on Reconsideration awarded 23 percent (73.6 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

On review, claimant argues that a Department rule, OAR 436-035-0007(27), which was applied by the ALJ, is unconstitutional on equal protection grounds.[1] SAIF argues that claimant should not be permitted to raise the constitutional challenge for the first time on review.[2]

We have previously held that a constitutional challenge must be raised at the hearings level before it can be argued on review. Eugenio Gonzalez, 45 Van Natta 921 (1993). Additionally, constitutional arguments must be adequately developed for our review. Preston E. Jones, 45 Van Natta 853 (1993).

Here, claimant argues that he could not have raised the constitutional argument at hearing because he did not know at the time that the ALJ was going to apply the Department's rule. However, at hearing, SAIF argued that the Department's bulletin precluded an award when claimant's range of motion findings did not meet the validity test. Resp. brief at 4. Consequently, claimant did have the opportunity to raise a constitutional challenge to this standard, but did not do so at the time of hearing. Under the circumstances, are not inclined to consider the argument for the first time on review.

In any event, even if we had considered such an argument, it would not have altered our decision. Claimant asserts that OAR 436-035-0007(27) violates equal protection because it favors those injured workers whose lumbar range of motion testing is validated by AMA Guides validity criterion over those workers whose testing is not so validated. While equal protection principles prohibit the granting of privileges to any "class" of citizens, the class must exist "by virtue of characteristics * * * apart from the law in question." Sealy v. Hicks, 309 Or 387, 397 (1990). A class that is defined only by the challenged law is not cognizable under Article I, section 20 of the Oregon Constitution because "every law itself can be said to 'classify' what it covers from what it excludes." See State ex rel Borisoff v. Workers' Comp. Board, 104 Or App 603 (1990).[3]

Here, as in Borisoff, the favored class, i.e., those workers whose range of motion findings meet the AMA Guide validity criterion, exists only by reference to the challenged law itself. Because all

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[1] Claimant cites to Article 1, section 20 of the Oregon Constitution and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

[2] SAIF also argues that the rule is not applicable in this case because claimant's claim was closed prior to the effective date of the rule. Rather, SAIF argues, Bulletin 242 applies to this case. In any event, as SAIF points out, the language contained in the Bulletin is the same as that of the Department rule which was applied by the ALJ.

[3] In Borisoff, the court held that the 1987 amendments to ORS 656.278(1)(a) (which eliminated the Board's own motion jurisdiction over permanent disability benefits) did not violate Article I, section 20 of the Oregon Constitution or the Equal Protection Clause of the Fourteenth Amendment because the statute treated all injured workers the same.

injured workers (the potential beneficiaries of the workers' compensation system) are subject to the same criteria (the Director's disability standards), we conclude that the rule in question does not violate equal protection principles.[4]

ORDER

The ALJ's order dated March 28, 1996 is affirmed.

[4] Moreover, because claimant had the opportunity to present evidence and arguments at hearing challenging the Department's Bulletin and/or the rule in question, there has been no due process violation.

In the Matter of the Compensation of
DANA W. WOOD, Claimant
WCB Case No. 95-13608
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's occupational disease claim for an L4-5 disc condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the first paragraph on page 2, we add the word "pain" at the end of the second sentence. In the second paragraph on page 2, we change the citation to "Dana W. Wood, 44 Van Natta 2241 (1992)."

Claimant compensably injured his low back in 1989. SAIF accepted a claim for acute lumbar sprain. (Ex. 2). An October 3, 1990 MRI showed "very mild central bulging at L4-5" and moderate disc desiccation at L4-5.[1] (Ex. 9). Claimant was awarded 19 percent unscheduled permanent disability for his low back condition. Dana W. Wood, 44 Van Natta 2241 (1992).

Claimant sought additional medical treatment in November 1995. A November 3, 1995 MRI showed "[m]ild peripheral disc bulging at L4-5 without significant impingement on neural structures and no associated spinal stenosis." (Ex. 27). On December 28, 1995, Dr. Bert performed a laminectomy and diskectomy at L4-5. (Ex. 33).

Claimant asserts that he developed a new occupational disease involving the L4-5 disc as a result of his employment activities in the fall of 1995. The ALJ concluded that, based on Dr. Bert's opinion, the L4-5 disc was compensable.

SAIF argues that the ALJ erred by concluding that Dr. Bert's opinion satisfied claimant's burden of proving the compensability of his L4-5 disc herniation under ORS 656.802(2)(b). We disagree.

Under ORS 656.802(2), when an occupational disease claim is based on the worsening of a preexisting disease, the claimant must prove not only that employment conditions were the major contributing cause of the pathological worsening of the disease, but also that employment conditions were the major contributing cause of the "combined condition" itself. ORS 656.802(2)(b); Dan D. Cone, 47 Van Natta 2220, on recon 47 Van Natta 2343 (1995).

[1] The October 3, 1990 MRI also showed a "[c]entral disc L5-S1" which progressed to a "[m]oderate to large posterior disc herniation at L5-S1" in 1995. (Exs. 9, 27). The L5-S1 disc is not at issue on review.

Claimant has a preexisting disc bulge at L4-5. An October 3, 1990 MRI showed "very mild central bulging at L4-5." (Ex. 9). Dr. Bert testified that, by the time he performed surgery, the mild bulge at L4-5 had progressed to a frank herniation. (Ex. 34-18). Thus, the "combined condition" in this case is the herniation at L4-5, which resulted from the combination of the preexisting L4-5 disc bulge and claimant's subsequent work activities.

Dr. Bert testified that claimant's work activities between 1990 and 1995, including lifting, bending and stooping, caused increased amounts of loads on claimant's spinal cord, which contributed to the wear and tear on the already damaged tissues around L4-5. (Exs. 34-18, -19, -20). Dr. Bert agreed that claimant's increased problems with his lower back, including increased numbness and pain with his leg, indicated a change in the disc pathology. (Ex. 34-20). Dr. Bert agreed that claimant's work activities were the major cause of the worsening of the disc pathology at L4-5, assuming that claimant had no significant off-work exposure. (Id.) The ALJ found, and we agree, that claimant's off-work activities were not significant.

On April 24, 1996, Dr. Dickerson performed a file review on behalf of SAIF. Dr. Dickerson commented that claimant never had clinical symptoms referable to disc pathology at the L4-5 level. (Ex. 35).

Dr. Bert testified that, other than back and leg pain, there was no specific neurologic deficit at L4-5. However, he testified that it would have been "very difficult clinically to separate back pain at L4-5 and S-1 without some nerve deficit caused by the L4-5 level." (Ex. 34-12). When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810 (1983). In light of Dr. Bert's opinion that it would have been difficult to separate the back pain at L4-5 and S-1, we are not persuaded by Dr. Dickerson's conclusion that claimant never had clinical symptoms at the L4-5 level.

Based on Dr. Bert's opinion, we conclude that claimant's employment conditions were the major contributing cause of the pathological worsening of the L4-5 disc bulge, and also that employment conditions were the major contributing cause of the "combined condition" itself.[2] See ORS 656.802(2)(b).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, 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 May 6, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the SAIF Corporation.

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[2] According to SAIF, the evidence suggests that Dr. Bert operated on the L4-5 disc by mistake and that inference undermines the probative value of his causation opinion. We find the issues of causation and the reasonableness and necessity of surgery to be separate issues. In any event, as the ALJ pointed out, we do not have jurisdiction to determine whether Dr. Bert's surgery at the L4-5 level was reasonable and necessary.

In the Matter of the Compensation of
EARL L. WRIGHT, Claimant
WCB Case No. 95-07829
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Christian and Hall.

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

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

On review, the employer contends that Dr. Brett's opinion was inconsistent, in that he attributed claimant's radicular pain in the right leg to a herniated disc at L4-5 (Ex. 8-2), a herniated disc at L3-4 (Ex. 12), and a disc protrusion at L3-4 (Ex. 15-1). The employer cites Barbara Cooper-Townsend, 47 Van Natta 2379 (1995), for the proposition that a physician's opinion which inconsistently diagnoses a claimant's condition is unpersuasive.

In Cooper-Townsend, the issue was extent of permanent disability. The Board found the treating doctor's opinion regarding extent of permanent disability unpersuasive because he reported in a closing examination that the claimant had no chronic condition in a particular body part but then testified that the claimant did have a chronic condition in the same body part. The inconsistency lay in the doctor's contradictory opinions. We do not find the refinement of Dr. Brett's diagnoses, which developed with the aid of ongoing imaging studies, to be inconsistent.

In his initial examination, Dr. Brett, claimant's treating neurosurgeon, noted that claimant had had mechanical low back discomfort over the years without radicular pain. Dr. Brett also noted that claimant developed immediate right-sided pain and stiffness in the low back when he lifted six five-gallon paint cans into the back of a customer's pickup truck, which, over the next week, began to radiate into the right leg as far as the foot. Dr. Brett's initial impression, based on his examination and x-rays, was that claimant had radicular pain in the L5 distribution and that he "likely has a disc herniation on the right at L4-5." (Ex. 8-2).

Dr. Brett ordered an MRI, which showed a large disc herniation at L3-4 and multi-level spondylotic change, particularly involving the right L5 root. (Ex. 12). Dr. Brett then ordered a lumbar myelogram with weight bearing and disc loading. (Id.) The myelogram revealed marked spondylotic change at L3-4, L4-5 and L5-S1 with impingement of the right L4 root in the lateral recess at the L3-4 level. (Ex. 14). Dr. Brett reassessed claimant's condition after reviewing the myelogram and a delayed CT scan. He reported that claimant had a significant disc protrusion at L3-4 centrally and to the right with impingement of the right L4 root in the lateral recess, resulting in his right leg radicular pain. (Ex. 15-1). Dr. Brett opined that the major cause of claimant's disability and need for treatment was his work injury, which, in all medical probability, resulted in a pathological worsening of the annulus at L3-4. (Ex. 15-2). We find no persuasive reason not to defer to Dr. Brett's expert opinion. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $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. Claimant is not entitled to an attorney fee for his counsel's services in defending the penalty award. Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 12, 1996 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the self-insured employer.

In the Matter of the Compensation of
JON T. STREBE, Claimant
WCB Case No. C602694
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Coons, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

On September 26, 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.

Paragraph 8 on page 2 of the CDA provides:

> "No permanent disability benefits have been awarded on the claim; however, the parties agree that claimant sustained the equivalent of 25 percent unscheduled permanent partial disability equal to 80.0 degrees."

We do not interpret this language as granting claimant an award of permanent disability. Rather, we consider this paragraph to be an explanation for one component of the calculation of the total amount of consideration to be paid to claimant under the CDA.[1]

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 awarding permanent 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 D. Chalk, 48 Van Natta 1874, n 1 (1996); 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 disability. Thereafter, they could submit a CDA releasing claimant's future rights to benefits, including permanent disability.

In the Matter of the Compensation of
JUDY A. DOTTINO, Claimant
WCB Case No. 95-06661
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) vacated the April 5, 1995 Order Suspending the Payment of Compensation; and (2) awarded an assessed attorney fee for the employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are the suspension of claimant's compensation benefits and penalties.

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

After the second full paragraph on page 5, we add the following:

"On December 8, 1995, the Board adopted and affirmed Judge Black's June 1, 1995 order. The Court of Appeals affirmed without opinion. 142 Or App 311 (1996)."

We change the quotation of ORS 656.325(1)(a) on pages 5 and 6 in the following manner. In the second sentence, we change the word "that" to "than." In the third sentence, we change the last portion of the sentence to read: "no compensation shall be payable during or for account of such period."

In the first full paragraph on page 6, we change "ORS 656.321(1)(a)" to "ORS 656.325(1)(a)."

On page 7, we change the first paragraph in the section "Compliance with OAR 436-10-100" to read:

"Under former OAR 436-60-095(1) (WCD Admin. Order No. 94-055), the conditions of the independent examination must be consistent with the conditions described in OAR 436-10-100. The rules respectively provide that:"

In the first paragraph on page 9, we change the "November 1993 hearing" to the "November 1994 hearing."

In the second paragraph on page 9, we change the citation to: Senetra Smith-Wampler, 48 Van Natta 593 (1996).

In the first full paragraph on page 11, we change the "November 1995 hearing" to the "November 1994 hearing."

In the last paragraph on page 11, we change the fourth sentence from the "February exam" to the "March 1995 exam."

We briefly recap the facts. On February 17, 1995, the employer sent claimant a Notice of Appointment regarding a March 11, 1995 independent medical examination, stating that the purpose of the examination was "to determine the nature and need for further treatment, causative factors and the compensability of your current condition." (Ex. 69). On March 21, 1995, the employer filed a Request for Suspension of Benefits in accordance with ORS 656.325 and OAR 436-60-095, alleging that claimant had "refused to attend four consecutively scheduled IME's, explaining that she is tired of being harassed." (Ex. 76).

On March 31, 1995, claimant responded that the claim was presently in a closed status and she noted that a hearing was held on November 21, 1994. (Ex. 78). Claimant argued that the purpose of the employer's requested medical examination involved the very issues litigated in the November 21, 1994 hearing. Claimant explained that, although the ALJ left the record open for the employer to cross-examine two medical experts whose opinions had been admitted into evidence, the record was not left open for the employer to obtain additional expert testimony, post-hearing. Claimant contended that, under those circumstances, her current refusal to submit to another independent medical examination was not unreasonable. (Id.)

An Order Suspending Compensation pursuant to ORS 656.325 was issued on April 5, 1995, stating that the employer was entitled to request the examination in question and claimant was obligated to attend. (Ex. 79). Claimant requested a hearing.

The ALJ found that the employer's request for an order suspending compensation did not comply with the requirements under OAR 436-60-095(8)(d). The ALJ determined that the employer's medical examination was intended as a means of gathering evidence regarding the very same compensability question that was presented to another ALJ at the November 1994 hearing. The ALJ concluded that the employer was not entitled to a post-closure medical examination that did not comply with ORS 656.268, particularly when there was no basis for issuing a partial denial.

The ALJ also found that the record did not support a conclusion that claimant had failed to attend four separate medical examinations because she felt harassed. The ALJ reasoned that the evidence did not establish that claimant had improperly failed to attend medical examinations on October 17, 1994, October 26, 1994 and January 10, 1995. Furthermore, the ALJ relied on claimant's testimony that she did not attend the March 11, 1995 medical examination based on the advice of the Department's Ombudsman's office, who advised her that compliance was unnecessary because the claim was closed. (Tr. 45). Finally, the ALJ concluded that the employer's actions constituted an unreasonable resistance to the payment of compensation.

The employer argues that the Department was correct in suspending claimant's benefits for failure to attend an independent medical examination. The employer asserts that it had been requesting an independent medical examination

> "as part of its ongoing attempts to have claimant evaluated, in part because there is an aggravation claim; in part because there may be a question of responsibility for 245 medical benefits in the future. Claimant has been going to Canada seeking treatment with the prospect of possible hip replacement down the road." (Appellant's brief at 3).

As the ALJ pointed out, claimant's aggravation claim was one of the issues in dispute at the November 1994 hearing. (Ex. 80). At the time the employer requested the medical examination on February 17, 1995, the record for the November 1994 hearing had been left open only for the employer to cross-examine two medical experts whose opinions had been admitted into evidence. The record was <u>not</u> left open for the employer to obtain additional expert testimony. Therefore, the employer's contention that a medical examination was warranted on the basis of claimant's aggravation claim is without merit.

Regarding the employer's assertion that there "may" be a medical benefits issue "in the future," we note that the employer's representative testified at hearing that "no one is actually asking us if we will authorize a hip replacement." (Tr. 35). Although claimant's request for medical benefits may result in a justiciable controversy in the future, it is not ripe for review in this proceeding. Moreover, since claimant has not requested medical benefits, the employer's argument that a medical examination was warranted on that basis is also without merit.

The employer contends that claimant has been having ongoing evaluations and the employer is "entitled to have an independent medical examination to check her out further." (Appellant's brief at 5). The employer lists several reasons why it is important for a carrier to be able to obtain an independent medical examination.

We first clarify the issue before us. The issue is not whether the employer has the statutory authority to require claimant to attend a medical examination. Rather, the issue before us is whether claimant's benefits should be suspended under the facts in this case. We agree with the ALJ that the Order Suspending Compensation should be vacated.

ORS 656.325(1)(a) allows a carrier to suspend benefits if a worker refuses to submit to a medical examination. ORS 656.325(1)(a) provides:

> "Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker <u>as may be provided by the rules of the director</u>. However, no

> more than three examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period. The provisions of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268." (Emphasis added).

Consistent with the aforementioned statute, former OAR 436-10-100(5)(a) (WCD Admin. Order No. 94-064) provides that when a worker is required to attend an examination by a physician of the insurer's choice, the insurer "shall * * * [c]omply with the notification requirements contained in OAR 436-60-095." (Emphasis added). Former OAR 436-60-095(1) (WCD Admin. Order No. 94-055) provides, in part:

> "The Division will suspend compensation by order under conditions set forth in this rule. The worker shall have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension when the worker refuses or fails to submit to, or otherwise obstructs, a medical examination reasonably requested by the insurer or the Director. * * * The Division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination." (Emphasis added).

Former OAR 436-60-095(3) provides that a "worker shall submit to medical examinations reasonably requested by the insurer or the Director." (Emphasis added).

We agree with the ALJ that the employer's request for an order suspending compensation did not comply with the requirements under former OAR 436-60-095(8)(d) because it did not contain a statement that no approvals by the Director had been given.[1] See Sharon S. Webster, 46 Van Natta 2438 (1994) (carrier's notice of appointment did not comply with former OAR 436-60-095(2)(b)). Moreover, we conclude that, for all of the reasons discussed in the ALJ's well-reasoned order, the medical examination requested by the employer was not "reasonably requested" pursuant to former OAR 436-60-095(1) or OAR 436-60-095(3). See Sharon S. Webster, supra. Under these circumstances, we agree with the ALJ that the Director did not have the statutory and administrative authority to suspend claimant's benefits.[2]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the suspension of benefits issue is $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 and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 11, 1996 is affirmed. For services on review, claimant's attorney is awarded $500, payable by the self-insured employer.

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[1] Former OAR 436-60-095(8)(d) provides that a request for suspension "shall" provide particular information, including "[a] copy of any approvals given by the Director, or a statement that no approvals have been given, whichever is appropriate."

[2] In any event, even if we assume the examination was "reasonably requested," we conclude that "special circumstances" existed that would not warrant suspension of compensation for failure to attend the examination. Cheryl A. Hampton, 46 Van Natta 920 (1994) ("special circumstances" and "reasonable cause" existed under former OAR 436-60-085(1)(a) and OAR 436-60-095(4) for the claimant's failure to comply with conditions of the independent medical examination). Claimant's aggravation claim had already been litigated and there was no current controversy concerning claimant's medical treatment.

Board Member Haynes specially concurring.

I write separately to respond briefly to the employer's concerns about its ability to request independent medical examinations. The employer asserts that it was fully entitled to monitor claimant's

ongoing medical condition in order to keep control of this claim. The employer questions whether the effect of the ALJ's order (and our order) is to decide that the employer cannot send claimant for an evaluation at its own expense in order to check out her "current condition."

I agree with the lead opinion that the issue before the Board is not whether the employer has the statutory authority to require claimant to attend a medical examination. In this case, we do not attempt to define the limitations of a carrier's right to request an independent medical examination. Rather, the only issue we are addressing is whether claimant's benefits should be suspended. Based on the facts in this case, I agree with the lead opinion that claimant's benefits should not have been suspended.

October 7, 1996 Cite as 48 Van Natta 2106 (1996)

In the Matter of the Compensation of
LEO A. MONTGOMERY, Claimant
WCB Case No. 95-13643
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a depression and ulcer condition. On review, claimant also contends that he is entitled to penalties and attorney fees for an allegedly unreasonable denial and an alleged discovery violation. Claimant also moves for remand to the ALJ for the taking of additional evidence. On review, the issues are remand, compensability, and penalties and attorney fees. We deny the motion for remand and affirm the ALJ's order.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, claimant requests that this matter be remanded to the ALJ for further evidence taking. Claimant contends that remand is appropriate because the employer withheld a medical report which was not provided until after the ALJ's order had issued. Claimant also argues that his emotional state limited his ability to assist in his claim. Finally, claimant argues that, in light of these facts, his former counsel was not prepared to litigate the case.

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).

Here, the employer contends that it did not provide the medical report to claimant's counsel prior to hearing because the report pertained to claimant's November 1995 elbow claim, rather than to this claim for an ulcer and depression condition. Consistent with the Board's policy of full and complete disclosure, we are inclined to find that a psychological report which discusses claimant's psychological state and possible ulcer condition should have been disclosed. See OAR 438-007-0015(5); Oswald F. Kuznik, 45 Van Natta 1194 (1993). We need not resolve that issue, here, however, as we conclude that the medical report does not merit remand. We base this conclusion on the following reasoning.

We do not find that the report is reasonably likely to affect the outcome of the case. The report does not provide new information regarding the stressors identified by claimant or a different description of his working conditions than has been provided in other exhibits considered by the ALJ.

Additionally, the psychologist who conducted the exam did not provide a psychological diagnosis or an opinion on the issue of causation of claimant's depression and ulcer conditions. Accordingly, we do not find that the attached report provides a basis for remand.

Claimant also argues that he was not emotionally capable of assisting his former counsel in preparing the case. However, claimant has not provided any reasoning or evidence to support this contention. Finally, claimant argues that his former counsel was not adequately prepared and did not sufficiently develop the record by calling certain witnesses. Such an argument, however, does not establish that the evidence was not obtainable at the time of hearing, nor has there been a showing that such evidence would likely affect the outcome of the case. Consequently, for the aforementioned reasons, we deny claimant's motion for remand.

Compensability

We adopt the ALJ's "Conclusions of Law and Opinion" on the issue of compensability.

Penalties and Attorney Fees

Claimant argues that he is entitled to penalties and related attorney fees for an allegedly unreasonable denial. The penalty issue was not raised at the time of hearing. (Tr. 1). Accordingly, we are not inclined to address the issue for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Alternatively, even if the issue had been raised, we have not found the claim to be compensable, and therefore, no basis exists for a penalty award. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991). Similarly, even if we determined that the employer's refusal to provide discovery was unreasonable, there is no basis for a penalty or attorney fee award. Boehr, supra; SAIF v. Condon, 119 Or App 194 (1993).

ORDER

The ALJ's order dated April 8, 1996 is affirmed.

October 7, 1996 Cite as 48 Van Natta 2107 (1996)

In the Matter of the Compensation of
RONALD E. ROGERS, Claimant
WCB Case Nos. 95-01825, 94-14661 & 93-11544
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Cobb & Woodworth, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

CIGNA requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's claim for the same condition. In its brief, CIGNA contends that claimant's claim is time-barred. CIGNA also argues that the ALJ abused his discretion by denying its request for a continuance and by declining to admit an examining physician's deposition into evidence. Liberty cross-requests review of those portions of the ALJ's order that: (1) assessed a penalty for allegedly unreasonable claims processing; and (2) awarded an assessed attorney fee. On review, the issues are timeliness, evidence, compensability, responsibility, penalties, and attorney fees. We affirm in part and reverse in part.

PRELIMINARY MATTER

In his brief, claimant argues that Liberty's brief was untimely filed and should not be considered. We disagree. OAR 438-011-0020(2) provides that any party who has filed a cross-request for review must include its cross-appellant's opening brief as part of its respondent's brief. Additionally, the rule provides that the responding brief is due within 21 days after the opening brief is mailed. Here, Liberty's respondent/cross-appellant's brief was filed within 21 days after CIGNA's opening brief was mailed. Accordingly, Liberty's brief was timely filed and has been considered on review.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness

On review, CIGNA and Liberty argue that claimant's occupational disease claim was not timely, pursuant to ORS 656.807(1). We adopt the ALJ's conclusions and opinion on the applicability of ORS 656.807(1), and agree with the ALJ that claimant's claim was not barred due to an untimely filing.

The ALJ further found that amended ORS 656.319(6) did not apply, as SB 369 cannot be retroactively applied to extend or shorten a procedural time limitation. 1995 Or Laws Ch 332, sec. 39. The statute provides that a "hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred." ORS 656.319(6). At hearing, CIGNA and Liberty argued that, because claimant's claim was made in 1979, the new statute barred claimant from requesting a hearing on the joint arthritis condition. We agree with the ALJ that the new statute does not apply, however, we base our conclusion on the following reasoning.

In Gillander v. SAIF, 140 Or App 210 (1996), issued subsequent to the ALJ's order, the court declined to decide whether ORS 656.319 applied retroactively to a claim. In Gillander, the claimant argued that the Board should have considered whether her hearing request was timely under ORS 656.319(6). However, the court found that it did not need to address the retroactivity issue, as the text and context of the statute showed that it applied to challenges of the insurer's processing of a claim, rather than pertaining to a substantive denial of the claim. Gillander, supra.

Here, we conclude that the dispute over the compensability of claimant's occupational disease claim 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 reject the insurers' contentions that claimant's occupational disease claim was untimely.

Evidence

CIGNA contends that the ALJ abused his discretion by denying its request for a continuance to obtain the deposition of Dr. Peterson. In reaching his conclusion that CIGNA had not exercised due diligence in obtaining Dr. Peterson's deposition prior to hearing, the ALJ relied on the Board's rules, former OAR 438-06-081 and OAR 438-06-091 and Georgia Pacific v. Kight, 126 Or App 244 (1994). Although the ALJ declined to admit or consider Dr. Peterson's deposition, the deposition has been included in the record for purposes of review.

We need not resolve this issue because we conclude that, even if Dr. Peterson's deposition is considered, it would not change the outcome of this case. For the reasons explained below, we agree with the ALJ that the most persuasive medical opinion has been provided by claimant's treating doctor, rather than the examining doctors, including Dr. Peterson, who saw claimant on only one occasion.

Compensability

We adopt the ALJ's Conclusions of Law and Opinion on the issue of compensability, with the following supplementation.

CIGNA contends that, in finding claimant's claim compensable, the ALJ erred by relying on the opinion of Dr. Manley, claimant's treating physician. Specifically, CIGNA argues that Dr. Manley did not have an accurate history of claimant's prior shoulder problems or his physical off-the-job activities. CIGNA also contends that Dr. Manley was not aware of claimant's work requirements. We disagree.

Dr. Manley has been claimant's treating doctor since 1979. In deposition, Dr. Manley testified that he had visited claimant's workplace and was familiar with the different jobs and work activity performed for the employer. (Ex. 133-11). Additionally, when informed of prior shoulder problems and claimant's off-work physical activity, Dr. Manley continued to maintain his opinion that work was the major cause of claimant's shoulder condition. (Ex. 133-82). Under the circumstances, we do not find that Dr. Manley had an incomplete or inaccurate history.

CIGNA next argues that Dr. Manley's opinion is not persuasive because Dr. Manley agreed that the scientific or medical literature did not establish that heavy use of the acromioclavicular (AC) joint caused degenerative arthritis. However, Dr. Manley, who specializes in orthopedics, testified that his opinion was based on his observation and treatment of claimant, claimant's history, the lack of other contributors, and his consideration of claimant's work activity. (Ex. 133-59, 60, 80). Accordingly, because a medical opinion expressed with reasonable certainty is sufficient, and Dr. Manley's opinion has been rendered with reasonable certainty, we find that Dr. Manley's opinion is both persuasive and meets the major contributing cause standard. See e.g. Gormley v. SAIF, 52 Or App 1055 (1981).

Finally, CIGNA contends that, because Dr. Manley has continued to maintain his position that claimant's condition is work-related, and because Dr. Manley has authorized temporary disability benefits for claimant, Dr. Manley has become an advocate for claimant. After reviewing Dr. Manley's reports and deposition, we do not agree that there is any evidence that Dr. Manley has become claimant's "advocate." Accordingly, we decline to discount his opinion on that basis.

Consequently, we affirm the ALJ's decision on the issue of compensability.

Responsibility

We adopt the ALJ's Conclusions of Law and Opinion on the issue of responsibility.

Penalties and Attorney Fees

The ALJ assessed Liberty a penalty and related fee for its allegedly unreasonable "de facto" denial of claimant's right shoulder claim. The ALJ found that claimant had made a claim for his right shoulder in 1979, yet no denial had been issued by Liberty until January 1995.

On review, Liberty contends that the penalty issue is controlled by amended ORS 656.319(6), which provides that a "hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred."

In enacting Senate Bill 369, the legislature amended ORS 656.319, which provides for time limitations within which a hearing must be requested. In the absence of a specific exception, the changes to the Workers' Compensation Law made by SB 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995). Because there has been no final decision in this matter and because none of the other exceptions to retroactive application of the statute are applicable, we conclude that amended ORS 656.319 applies to the present case.

Here, unlike the issue of compensability of claimant's occupational disease claim, the issue involve claims processing, i.e., Liberty's failure to accept or deny claimant's shoulder claim. Thus, the time limits imposed by ORS 656.319(6) apply to this case. Liberty's action, or inaction, occurred in 1979. Consequently, claimant's request for hearing on the penalty issue is proscribed by the two year time limitation set forth in amended ORS 656.319(6). Therefore, claimant's request for penalties and related attorney fees regarding this issue cannot be granted. Thus, the ALJ's penalty award is reversed.

Assessed Attorney Fee

The ALJ awarded claimant an assessed attorney fee for prevailing over Liberty's "de facto" denial of an occupational disease. On review, Liberty argues that, pursuant to amended ORS 656.386(1), there is no basis for an attorney fee award when a "de facto" denial is involved.

Liberty argues that it did not expressly deny claimant's claim in 1979, nor did it refuse to pay compensation on the express ground that claimant's condition was not compensable. Rather, Liberty informed claimant's physician that claimant would have to file a claim for benefits prior to Liberty paying for treatment. Additionally, Liberty argues, claimant did not file an 801 form, nor did his doctor file an 827 form.

ORS 656.386(1) is the statutory provision for attorney fees in cases involving "denied claims." For purposes of that section, a "denied claim" is one which the carrier "refuses to pay on the express ground that the injury or condition 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 order 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 claimant's request for hearing stating the "claimant is entitled to no relief." We found such evidence does not constitute proof that the carrier questioned causation and, thus, an assessed attorney fee was not warranted. 48 Van Natta 351-52. On the other hand, we concluded din Emily M. Bowman, 48 Van Natta 1199 (1996), that a carrier's response to a requested for hearing denying that claimant sustained a work-related injury or occupational disease was a refusal to pay compensation on the express ground that the condition was not compensable. Hence, we found that claimant was entitled to a fee under ORS 656.386(1).

We find Bowman similar to the present case. Here, in written closing arguments submitted to the ALJ, Liberty contended that it "relies upon Dr. Peterson's report that finds claimant's degenerative arthritis of the AC joint is not related to his work, and therefore, is not compensable." Liberty's Closing Argument at pg. 4. Similarly, on review, Liberty has stated that there was "no indication that claimant's shoulder condition was related to his employment." Liberty's Appellant's Brief at pg. 4. Under the circumstances, we find that there was a "denied claim," as defined by the statute. We therefore affirm the ALJ's attorney fee award.

Attorney fee/services on review

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

ORDER

The ALJ's order dated September 29, 1995 is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a penalty against Liberty is reversed. The remainder of the ALJ's order is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by CIGNA.

October 7, 1996 Cite as 48 Van Natta 2110 (1996)

In the Matter of the Compensation of
FRED VIOEN, Claimant
Own Motion No. 95-0469M
OWN MOTION ORDER
Robert Dolton, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for claimant's compensable right shoulder strain injury. Claimant's aggravation rights expired on November 15, 1994. SAIF denied the compensability of claimant's current condition and need for treatment. In addition, SAIF opposed reopening on the grounds that: (1) claimant's current condition has not worsened requiring surgery or hospitalization; (2) it is not responsible for claimant's current condition; (3) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (4) claimant was not in the work force at the time of disability. Claimant requested a hearing with the Hearings Division. (WCB Case No. 95-11991).

On November 14, 1995, the Board consolidated the own motion matter with the hearing pending the outcome of that litigation. On June 25, 1996, Administrative Law Judge (ALJ) Hoguet issued an Opinion and Order which set aside SAIF's September 11, 1995 denial. That order was not

appealed and has become final by operation of law. In addition, ALJ Hoguet made findings of fact and conclusions of law and opinion regarding whether claimant was in the work force at the time of current disability.

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

On June 20, 1995, Dr. Cook, claimant's treating physician, requested authorization to perform a left total shoulder arthroplasty. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

SAIF contends that claimant was not in the work force at the time of disability. Claimant contends that, although "trying to get retired," he was working at his owner-operated restaurant at the time of disability. Claimant has the burden of proof on this issue.

The record indicates that claimant owned and operated a restaurant since 1981. The record also establishes that claimant was "trying to get retired," but was unable to sell that restaurant until September 1995. In his June 25, 1996 order, ALJ Hoguet applied the principles set forth in Weyerhaeuser v. Kepford, supra, and Dawkins v. Pacific Motor Trucking, supra, in order to reach his conclusion that, because claimant's compensable left shoulder condition worsened requiring surgery in June 1995, and as of that date, claimant was apparently still running his restaurant, claimant was in the work force in June 1995. Additionally, ALJ Hoguet noted that "[c]laimant's subsequent 'trying to get retired' does not negate this conclusion." Although we agree with the ALJ's findings of fact in this case, his conclusions of law fail to consider the statutory prerequisites for payment of temporary disability under ORS 656.278. We find that we are unable to authorize the payment of temporary disability compensation due to the following reasoning.

We have found that claimant's compensable condition worsened requiring surgery in June 1995. However, temporary disability compensation is not due under ORS 656.278 until claimant actually enters the hospital for surgery. Here, the record does not demonstrate that claimant underwent surgery prior to September 1995, when he retired, nor that he had undergone surgery by June 25, 1996, when the ALJ issued his order. Further, claimant has provided no evidence that he did not retire, or that he retired because of the compensable injury, nor do we find evidence that he returned to the work force prior to any surgery. Therefore, we must conclude that he voluntarily removed himself from the work force before his surgery for reasons other than the compensable injury. If claimant has voluntarily removed himself from the work force, no work time would be missed when he entered the hospital for surgery, and therefore, no temporary disability would be due.

The ALJ found that, because claimant was working in June 1995 and was "trying to retire," that he remained in the work force in June 1995, when his physician requested surgery. We agree. However, because claimant retired after the September 1995 sale of his business, and had not undergone surgery as of the date of the ALJ's order, we are unable to authorize the payment of temporary disability compensation, as he is not currently eligible for time loss. See ORS 656.278(1); John R. Johanson, 46 Van Natta 2463 (1994).

Claimant has the burden of proof on this issue. See ORS 656.266. Therefore, for the reasons cited above, we are unable to authorize the reopening of claimant's own motion claim for the payment of temporary disability compensation because, although the record establishes that claimant was in the work force at the time his condition worsened, the record does not establish that he was entitled to temporary disability when he entered the hospital for surgery. ORS 656.278(1)(a).

Accordingly, claimant's request for temporary disability compensation is denied. We will reconsider this order if additional evidence regarding the "work force / retirement" issue is forthcoming within 30 days after the date of this order.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

October 8, 1996 Cite as 48 Van Natta 2112 (1996)

In the Matter of the Compensation of
TIMOTHY J. KRIEG, Claimant
WCB Case No. 95-03447
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its partial denial of claimant's psychological condition; and (2) assessed a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability and penalties and attorney fees.

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

The ALJ determined that the opinions of Drs. Proano and Gallegos, claimant's treating psychiatrist and osteopathic physician, established that claimant's work injury at the employer was the major contributing cause of his psychological condition under ORS 656.005(7)(a)(A). We agree.

On review, the insurer urges us to rely on the opinion of Dr. Klecan, who examined claimant for the insurer. Dr. Klecan opined that claimant's choice to adopt an angry victim role and to view himself as helpless and passive, plus secondary gain factors, were the major cause of claimant's adjustment disorder. (Ex. 31). The insurer further asserts that, because claimant's condition was caused by his reactions to claims processing, his psychological condition is not compensable under Baar v. Fairview Training Center, 139 Or App 196 (1996); Zimbelman v. Roseburg Forest Products, 136 Or App 75 (1995); and Ronald R. Zimbelman, 47 Van Natta 177 (1996).

In contrast, Dr. Proano, who treated claimant for seven therapy sessions in addition to the initial psychiatric evaluation, diagnosed major depression, based on a clinical interview and three psychological tests (the Self-Rating Depression Scale Index, or Zung Test; the Psychiatric Questionnaire and the Self-ideas Sentence Completion Test). Dr. Proano's report took into consideration the findings and data obtained in all of those procedures, which correlated with claimant's complaints of sadness, crying spells, sleep disturbances, weight loss, tiredness, lack of enthusiasm for life, inability to concentrate, and suicidal ideation. He attributed claimant's depression to the pain and worsening of his back problem, his inability to return to work and make a living for his family, and feelings of helplessness and hopelessness about his future. Dr. Proano also noted that, in addition to claimant's depression, claimant's tolerance for frustration had decreased significantly.[1] (Ex. 22).

We find Dr. Proano's well-reasoned and complete analysis of the cause of claimant's depression more persuasive than that of Dr. Klecan, who performed no psychological tests and who opined, in constrast to Dr. Proano's report, that claimant's chief symptoms were merely "irritability and a negative attitude." Weiland v. SAIF, 64 Or App 810, 814 (1983); Somers v. SAIF, 77 Or App 259 (1986). Thus, we are not persuaded that claimant's depression was caused by his reactions to claims processing and conclude that Baar, supra; Zimbelman v. Roseburg Forest Products, supra; and Ronald R. Zimbelman, supra, are not applicable in this case.

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[1] Dr. Proano prescribed Prozac, an anti-depressant, which was effective in decreasing claimant's depression and making him less irritable. Claimant stopped taking the medication in June 1995 because he could no longer afford it; his depression, inability to concentrate, and short temper returned. (Ex. 31-3).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,500, 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 January 29, 1996, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

October 8, 1996 Cite as 48 Van Natta 2113 (1996)

In the Matter of the Compensation of
GEORGE J. PEACHEY, Claimant
WCB Case No. 95-05338
ORDER ON REVIEW
James L. Francesconi, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Johnstone's order that set aside its partial denial of claimant's L4-5 herniated disc condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the exception of the first full paragraph on page 4 and with the following supplementation.[1]

Based on the opinion of Dr. Thomas, claimant's attending physician since 1985, the ALJ concluded that claimant had established that his 1984 injury was the major contributing cause of his herniated disc at L4-5. SAIF contends on review that we should instead rely on Dr. Fuller's opinion. We disagree.

We begin by recapping the relevant facts. In October 1984, claimant compensably injured his low back while working for SAIF's insured. (Ex. 1, Tr. 17). SAIF accepted a back strain. (Ex. 3). Claimant was taken off work for a period of three months and treated with physical therapy without significant improvement. (Exs. 2, 3a, 5). Subsequent to his return to work in March 1985 at a different job as a truck driver, claimant experienced recurrent back pain and left thigh throbbing and numbness. (Id.) A CT scan revealed disc material in the foramina, suggestive of an L4-5 disc lesion. (Exs. 3a, 3b, 3c). Dr. Thomas referred claimant to Dr. Rosenbaum for surgical evaluation. A myelogram confirmed annular bulging at L4-5, but not a surgical lesion. (Ex. 3b). Claimant continued to experience flare-ups of back pain. (Exs. 3c, 3d). On December 29, 1986, Dr. Thomas declared claimant medically stationary, although claimant continued to experience ongoing pain in his back and into his buttocks. (Ex. 4). A February 20, 1987 Determination Order closed the claim with an unscheduled permanent disability award of 25 percent, which was subsequently increased to a total of 32.5 percent. (Exs. 5, 6).

Subsequent to claim closure, claimant continued to experience flare-ups of back pain, with numbness in his buttocks. (Exs. 7, 9-3). In February 1990, claimant returned to Dr. Thomas for an acute exacerbation of back pain with leg radiation. (Exs. 7, 8). Dr. Thomas diagnosed a lumbosacral strain superimposed on mild degenerative disc disease (DDD) at L5-S1, as revealed by x-rays. (Ex. 8). Drs. McKillop and Watson, who examined claimant for SAIF, noted minimal degenerative changes in claimant's low back, and diagnosed chronic lumbosacral strain and mild DDD at L5-S1. The physicians attributed claimant's acute flare-up to his 1984 injury. (Ex. 9-5).

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[1] We also add the following correction: Claimant was examined for SAIF by Drs. Duff and Smith, rather than Drs. Duff and Watson, on April 8, 1995. (Ex. 16).

Claimant continued to experience recurrent symptoms. (Ex. 11). In May 1993, claimant experienced another acute flare-up of his low back condition without radiculopathy, which Dr. Thomas attributed to the L5-S1 area. (Id.).

On January 12, 1995, claimant sought treatment for low back pain with radiation down the left leg into the foot. (Ex. 13). An MRI revealed diffuse degenerative changes in the lumbar spine, with a large herniated disc fragment extending the length of L4 on the left, arising from L4-5. (Exs. 14, 15-3). Dr. Thomas referred claimant to Dr. Berkeley for surgical evaluation. (Exs. 14a, 14b, 15).

Dr. Fuller examined claimant and reviewed his medical records.[2] (Ex. 21). Dr. Fuller concluded that claimant's 1984 injury was not the cause of his 1994 disc herniation. Dr. Fuller based his conclusion on his findings that there was no disc pathology revealed by the 1985 CT scan or myelogram and no progressive DDD in claimant's low back as revealed by x-rays performed over the next few years.[3]

In contrast, Dr. Thomas based his opinion that the 1984 injury was the cause of claimant's herniated disc on the severity of claimant's 1984 injury, which resulted in claimant's initially being taken off work for three months, and on the 1985 CT scan and myelogram which revealed an abnormal protruding disc at L4-5. (Ex. 22). Dr. Thomas opined that the abnormal disc at L4-5 was at risk for complete herniation in the future. (Id.) Unlike Dr. Fuller's findings of a normal back in 1985, Dr. Thomas' findings of an abnormal disc are supported by contemporary medical records. (See Exs. 3a, 3b, 3c). Consequently, we agree with the ALJ's deference to the opinion of Dr. Thomas. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Moreover, Dr. Thomas' opinion is supported by that of Dr. Berkeley, neurosurgeon. Dr. Berkeley had an accurate history of the onset of claimant's low back and left leg symptoms as a result of the 1984 injury and was cognizant of the degenerative changes in claimant's lumbar spine. (Ex. 15; compare Exs. 3a, 3b, 3c, 3d, 4, 7, 8, 9, 11). After reviewing claimant's medical records and Dr. Thomas' report attributing the cause of claimant's condition to the compensable 1984 injury, Dr. Berkeley concurred in all respects with Dr. Thomas' opinion and further opined that the 1984 incident was the major contributing cause of claimant's current herniated disc. (Ex. 23).

Because Dr. Thomas' well-reasoned opinion on causation is persuasive, and because Dr. Berkeley had an adequate understanding of the etiology of claimant's condition, it follows that Dr. Berkeley's concurrence with that opinion is also persuasive. See Marta I. Gomez, 46 Van Natta 1654 (1994) (a concurring opinion may include citation to explanations and rationale available elsewhere in the record; the persuasiveness of the expert's opinion depends on the persuasiveness of the foundation on which the opinion is based).

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 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 March 4, 1996, is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the SAIF Corporation.

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[2] Dr. Fuller reported that he had a January 1995 MRI and x-rays from 1990 and 1995 for review. (Ex. 21-5).

[3] The 1990 x-rays showed a disc space narrowing at L5-S1, which was discussed in the contemporary reports of Dr. Thomas (Ex. 8) and Drs. McKillop and Watson, who also noted degenerative changes at other levels (Ex. 9-5).

In the Matter of the Compensation of
GEORGE J. PEACHEY, Claimant
Own Motion No. 95-0219M
OWN MOTION ORDER
James L. Francesconi, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable low back strain injury. Claimant's aggravation rights in his 1984 claim expired on February 20, 1992. On April 26, 1995, SAIF denied the compensability of claimant's current herniated disc with free fragment at L4-5 condition. In addition, SAIF opposed reopening on the grounds that: (1) surgery or hospitalization is not reasonable and necessary for the compensable injury; (2) claimant has not sustained a worsening of the compensable injury; and (3) claimant was not in the work force at the time of disability. Claimant requested a hearing with the Hearings Division. (WCB Case No. 95-05338).

On May 23, 1995, the Board consolidated the own motion matter with the hearing pending the outcome of that litigation. On March 4, 1996, Administrative Law Judge (ALJ) Johnstone issued an Opinion and Order which set aside SAIF's April 26, 1995 denial of claimant's current condition, but declined to award a penalty for unreasonable claims processing. In addition, ALJ Johnstone issued a separate, unappealable Own Motion Recommendation, in which he made findings of fact and conclusions of law and opinion regarding whether claimant was in the work force at the time of his current disability. SAIF requested Board review of that portion of the ALJ's order which set aside its denial of claimant's herniated disc condition, and, by order issued this date, we affirmed the ALJ's March 4, 1996 order.

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

On February 6, 1995, claimant was evaluated by Dr. Berkeley, neurosurgeon, pursuant to a surgical consultation. Dr. Berkeley recommended a surgical decompression and left L4-5 microdiscectomy. Thus, we find that claimant's compensable condition worsened requiring surgery.

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

SAIF contends that claimant was not in the work force at the time of disability. Claimant contends that he was working when his compensable injury worsened requiring surgery. Claimant has the burden of proof on this issue.

We adopt the ALJ's Findings of Fact and Conclusions of Law and Opinion as contained in his Own Motion recommendation, with the following supplementation.

The ALJ concluded that the unrebutted testimony of claimant and his mother established that, at the time of his current disability, claimant was working for his mother and stepfather at Bob Pattison Dump Trucks, Inc. Claimant was receiving some wages, as well as room and board. In addition, the ALJ found that claimant was investigating available dump trucks for purchase in order to begin his own company. Finally, the ALJ determined that, on June 9, 1995, claimant took delivery of a dump truck and began his own company, George Peachey Trucking.

SAIF contends that employment with claimant's family, at partial wages and room and board, is not sufficient to establish that claimant was in the work force. Citing Danell L. Sweisberger, 44 Van Natta 913 (1992), SAIF argues that the Board held that, because claimant was helping her mother at a tire store but received only lunches and tire service (and no "pay"), claimant's remuneration in that case

did not rise to the level of "gainful employment." In his recommendation, the ALJ concluded that, because this claimant was receiving some pay, as well as room and board, claimant was gainfully employed and in the work force at the time of disability. However, more recent case law supports claimant's position that room and board, with or without pay, can equal wages.

In James L. Emerich, 45 Van Natta 1701 (1993), we concluded that the claimant's "work" as a watchperson for a storage business, although he received no salary for his services, qualified as gainful employment because the claimant was provided the use of a trailer to live in and all of his utilities. Thus, we found that room and board, without a stipend, constitute "wages."

In Debbie K. Craft, 47 Van Natta 1346 (1995), the claimant received room and board (valued by her employer at $300 per month) and a $20 weekly stipend. There, the insurer also argued that, if we should find that room and board equal "wages," the claimant's "income" was unaffected by her recent surgery, and thus, no time loss would be due. However, the claimant's employer explained that the claimant was unable to completely fulfill her responsibilities because of her disability (she "missed" work time). Therefore, because we had concluded that the claimant was eligible for temporary disability compensation, we declined to establish an amount of compensation due the claimant, as that must be determined by the insurer according to statute. ORS 656.210.

In Orvel L. Chaney, 48 Van Natta 612 (1996), we again concluded that the claimant was in the work force because he was providing a service (in-home care for his parents) in exchange for room and board. There, we relied on amended ORS 656.005(29), in which "wages" are currently defined to include the "reasonable value of board, rent, housing, lodging or similar advantage received from the employer." In the alternative, the carrier argued that if room and board qualified as wages, the claimant required medical documentation which explained a medical need for the claimant to provide care for his parents. We disagreed, and concluded that the dispositive question was whether the claimant received remuneration for services as set forth in ORS 656.005(30, not whether such services were required.

In the present case, based on the Chaney, Craft, and Emerich holdings we find that claimant has established that he was working for remuneration at the time of his current disability, and thus, qualifies for temporary disability benefits under his 1984 claim with SAIF.

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

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

IT IS SO ORDERED.

October 8, 1996 Cite as 48 Van Natta 2116 (1996)

In the Matter of the Compensation of
ROSENDO B. SANCHEZ, Claimant
WCB Case No. 96-04787
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Lipton's order that declined to award additional temporary disability. On review, the issue is temporary disability.

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

The ALJ found that since a Notice of Closure had issued, this matter concerned claimant's substantive entitlement to temporary disability benefits. Consequently, the ALJ declined to award additional temporary disability beyond that awarded by the Notice of Closure.

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

In Yoakum, we established the criteria for distinguishing whether the dispute concerned procedural entitlement to temporary disability benefits. First, the hearing request must be filed before the claim is closed. Second, the request must raise issues regarding the carrier's "pre-closure" conduct. Third, the claimant must not be seeking a greater temporary disability award than that granted by the Notice of Closure or Determination Order.

Here, claimant's hearing request was filed before the claim was closed. In addition, claimant's hearing request raised issues regarding the carrier's "pre-closure" conduct. However, claimant is seeking a temporary disability award that is greater than that awarded by the Notice of Closure. Under such circumstances, this dispute involves entitlement to substantive temporary disability. Galvin C. Yoakum, supra. Accordingly, we agree that the ALJ lacked authority to award substantive temporary disability beyond that granted by the Notice of Closure.

We emphasize to claimant, however, that he is not precluded from challenging the temporary disability award or the carrier's conduct. Rather, the appropriate way to challenge the temporary disability award is through a direct appeal of the Notice of Closure.

ORDER

- The ALJ's order dated July 16, 1996 is affirmed.

October 9, 1996 Cite as 48 Van Natta 2117 (1996)

In the Matter of the Compensation of
JOSEPH S. BAGGETT, Claimant
WCB Case No. 92-13133
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Johnstone's order that increased claimant's unscheduled permanent disability award for a low back injury from 43 percent (137.60 degrees), as granted by an Order on Reconsideration, to 54 percent (172.80 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and briefly summarize the pertinent facts as follows:

Claimant compensably injured his low back on November 9, 1990 while working as a machinist. He underwent surgery on November 27, 1990 and again on September 10, 1991. A July 1, 1992 Determination Order awarded 30 percent unscheduled permanent disability, which was affirmed by an September 17, 1992 Order on Reconsideration.

Shortly thereafter, claimant experienced recurrent back pain and the claim was reopened. Claimant underwent two additional low back surgeries, one in May 1994, and another in April 1995. He was found medically stationary on June 29, 1995. An October 16, 1995 Determination Order awarded 37 percent unscheduled permanent disability. A January 9, 1996 Order on Reconsideration increased claimant's total unscheduled permanent disability award to 43 percent, and also awarded 7 percent scheduled permanent disability for loss of use or function of the left leg and 2 percent scheduled permanent disability for loss of use or function of the right leg.

Claimant has been unemployed since his November 9, 1990 injury.

CONCLUSIONS OF LAW AND OPINION

The sole issue before the ALJ was the determination of the Specific Vocational Preparation (SVP)[1] value to be used in calculating claimant's unscheduled permanent disability award. Relying on former OAR 436-35-300(5) (WCD Admin. Order 93-056),[2] the ALJ concluded that claimant's SVP value should be +4 because claimant had not been employed in the five years prior to the January 9, 1996 Order on Reconsideration.

On review, the insurer argues that the ALJ's application of former OAR 436-35-300(5) is improper and inconsistent with ORS 656.283(7), insofar as the statute requires the ALJ to apply the disability rating standards adopted by the Director. We agree.[3]

ORS 656.283(7) provides that the "[e]valuation of the worker's disability shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268." As the insurer asserts, this statute also provides that the ALJ "shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726." The Director's standards in effect at the time of the January 9, 1996 Order on Reconsideration provided that a worker's SVP value is determined as follows: "A value for a worker's Specific Vocational Preparation (SVP) time is allowed based on the job(s) the worker has performed during the five (5) years preceding the time of determination." Former OAR 436-35-300(3) (WCD Admin. Order 93-056) (Emphasis added). In addition, the term "time of determination" is defined in the applicable standards as "the mailing date of the Determination Order or Notice of Closure issued pursuant to ORS 656.268." See former OAR 436-35-005(12) (WCD Admin. Order No. 6-1992).[4]

Accordingly, pursuant to ORS 656.283(7) and former OAR 436-35-300(3), the ALJ was required to calculate claimant's SVP value based on the jobs claimant had performed during the five years preceding the Determination Order, rather than the five years preceding the date of issuance of the Order on Reconsideration. The Determination Order issued on October 16, 1995. Although claimant has not worked since his November 9, 1990 injury, he had performed the job of machinist (DOT Code 600.280-022, SVP 7) during the five years preceding the Determination Order. Therefore, his SVP value should be based on this job. Pursuant to former OAR 436-35-300(4), claimant is entitled to an SVP value of +1 (SVP of 7 = +1 value).

We note that in Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), the court, relying on ORS 656.283(7), held that a claimant's disability should be rated as of the date of issuance of the reconsideration order rather than the time of the determination order. The Smith court did not, however, address that part of ORS 656.283(7) requiring the ALJ to apply the Director's rules, nor the specific administrative rule at issue in this case, which expressly requires that a worker's SVP value be determined based on the jobs the worker has performed during the five years preceding the "time of determination." We therefore do not consider Smith to be binding precedent.[5]

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[1] SVP is the amount of lapsed time required by a typical worker to learn and perform the skills needed for average performance in a specific job-worker situation. The SVP range is from 1 (lowest) to 9 (highest) and is associated with each DOT Code. See former OAR 436-35-300(3)(a); OAR 436-035-0300(3)(a).

[2] This rule, which is identical to OAR 436-035-0300(5) (WCB Admin. Order 96-051), provides as follows: "For those workers who have not met the specific vocational preparation training time for any job, a value of +4 shall be granted."

[3] Because we decide the case on this issue, we do not address the insurer's alternate request to remand the matter to the Director for promulgation of a temporary rule.

[4] The current rules provide that the SVP value is based on the job(s) the worker has performed during the five years preceding the "time of closure" and similarly define "time of closure" as the mailing date of the Determination Order or Notice of Closure issued pursuant to ORS 656.268. See OAR 436-035-0300(3) and 436-035-0005(15).

[5] As noted above, ORS 656.283(7) requires that the worker's disability be "evaluated" as of the date of issuance of the reconsideration order. However, the requirement that a worker's disability be "evaluated" as of a certain date does not preclude the Director's use of a different date or time period as the basis for assigning a SVP value under the standards. Therefore, we do not consider former OAR 436-35-300(3) as applied in this case to be inconsistent with or contrary to the statute.

In summary, we reverse the ALJ's order which based claimant's SVP value on the five year period preceding the Order on Reconsideration and awarded a value of +4 pursuant to former OAR 436-35-300(5). We find, as did the Appellate Review Unit on reconsideration, that in the five year period preceding the time of determination, the highest skill level that claimant had achieved was an SVP of 7 (equivalent to a value of +1) for his job as a machinist. We therefore reinstate and affirm the Order on Reconsideration.

ORDER

The ALJ's order dated May 10, 1996 is reversed. The January 6, 1996 Order on Reconsideration, granted an unscheduled permanent disability award of 43 percent (137.60 degrees), is reinstated and affirmed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

October 9, 1996 Cite as 48 Van Natta 2119 (1996)

In the Matter of the Compensation of
JOHN C. KANADY, Claimant
WCB Case No. 95-11485
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that set aside its partial denial of claimant's depression claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the last sentence in that section.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had established that his compensable low back injury was the major contributing cause of his depression condition. For the following reasons, we disagree.

Here, claimant seeks to establish the compensability of his depression condition as a consequence of his accepted 1994 lumbosacral strain/sprain injury. Accordingly, claimant must prove that the compensable 1994 work injury is the major contributing cause of the depression condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

In establishing the "major contributing cause" standard, claimant must establish that the compensable injury contributed more to his depression condition and need for treatment than all other factors combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 298, 309-310 (1983). In evaluating the medical evidence concerning causation, we consider all potential contributors to claimant's current condition, not just the precipitating cause. See Dietz v. Ramuda, 130 Or App 397 (1994).

The only medical opinion to support claimant's depression claim has been provided by Dr. Schults, who saw claimant on referral from Dr. Gordon. Dr. Schults reported that claimant's current troubles with depression did not appear to be ongoing from his trouble in the past but "are more associated with his troubles with pain and change in his ability to work * * *." (Ex. 52). Dr. Schults also stated that, on both occasions that he had met with claimant, he had encouraged him to reconsider his plans to live in the woods in Alaska. (Ex. 52).

After considering Dr. Schults' opinion, we do not find it persuasive. Dr. Schults has acknowledged claimant's prior depression condition, but has not discussed or explained why the current depression condition is different. The medical record shows that claimant had experienced depression five or six years prior to the current incident of depression (Exs. 19, 38-1). For his prior condition,

claimant received two and a half years of counseling and medical treatment. (Ex. 40-1). At least one medical opinion in the record identifies claimant's preexisting depression condition as the cause of his current condition. (Ex. 47-9). Under such circumstances, we conclude that Dr. Schults' opinion is unexplained and conclusory in its reference to claimant's past depression condition.

Furthermore, Dr. Schults has not discussed the remaining possible causal factors identified by other doctors who have examined claimant. Dr. Gordon, M.D. diagnosed claimant with a depression condition and identified factors which included "chronic pain, recent move, distance from his two children, isolated environment." (Ex. 38-3). When he was examined by Dr. Lowenstein on behalf of the insurer, claimant attributed his depression, in part, to the death of his father in April 1994. (Ex. 47-6). Dr. Lowenstein diagnosed a depressive disorder, with lumbosacral strain and mild to moderate stressors of living in the bush in Alaska, and interactions with children and an ex-spouse. Dr. Lowenstein reported that claimant's depression was preexisting, with other social factors, such as the death of his father and the move to Alaska, contributing to claimant's condition. (Ex. 47-9).

We discount Dr. Schults' opinion, as we find that he did not discuss the numerous other potential causative factors that have been identified in the medical record. For example, Dr. Schults' report expresses his concern with claimant's remote living conditions, which has also been noted by other medical examiners, yet Dr. Schults has not explained whether that factor contributes to claimant's depression or if not, why he recommends that claimant change his living situation. Finally, the other factors identified, such as claimant's personal relationships and the death of his father in the spring of 1994, have not been discussed by Dr. Schults.

Consequently, for the aforementioned reasons, we decline to rely on the opinion provided by Dr. Schults. See Somers v. SAIF, 77 Or App 259 (1986). As we have found above, the remaining medical opinions in the record do not support compensability of the depression claim. Therefore, we reverse the ALJ's order.

ORDER

The ALJ's order dated April 18, 1996 is reversed in part. The insurer's partial denial of claimant's depression claim is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

October 9, 1996 Cite as 48 Van Natta 2120 (1996)

In the Matter of the Compensation of
JAMES M. KING, Claimant
WCB Case No. 93-06873
SECOND ORDER ON REMAND
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.

On August 28, 1996, we withdrew our August 8, 1996 order for reconsideration and allowed SAIF an opportunity to respond to claimant's arguments. Having received SAIF's response and claimant's reply, we proceed with our reconsideration.

As a preliminary matter, we note that the closing arguments were not submitted as part of the hearing record. There is no requirement that closing arguments at hearing be recorded and/or transcribed. Furthermore, it is a long-standing Board policy that closing arguments are not transcribed at the Board's expense unless requested by the ALJ. Albert W. Van Slyke, 42 Van Natta 2811 (1990), aff'd mem 108 Or App 493 (1991). Here, there is no evidence that the ALJ ordered the transcription of the closing argument. (Tr. 23). Under these circumstances, the closing argument would be considered part of the hearing record only if a party obtains a transcription of the closing argument and submits it

as part of the hearing record. Compare Roberto Rocha-Barrancas, 48 Van Natta 1462 (1996) (the claimant's submission of transcribed closing arguments obtained at his expense were included in the record and considered on review). Here, neither party submitted the transcribed closing arguments as part of the hearing record.[1] Therefore, we are not inclined to consider the closing arguments.

In any event, even if we considered the disputed closing argument, we do not agree that it represents a "concession" from SAIF that claimant's left leg blood clot condition is compensable or that SAIF would lose if it was precluded from relitigating compensability of the CAD. We have determined that, in order to constitute a concession, the matter "conceded" must be expressly and specifically stated. Howard L. Rose, 47 Van Natta 345 (1995) (where the insurer did not expressly concede compensability of the claimant's aggravation claim, the insurer's denial was a denial of compensability as well as responsibility); James McGougan, 46 Van Natta 1639 (1994) (where the insurer's language expressly conceded compensability and specifically denied only responsibility, denial was limited to responsibility).

During the initial part of his closing argument, SAIF's attorney argued that SAIF was not precluded from relitigating compensability of the CAD, a condition that had previously been found compensable pursuant to an order issued by ALJ Thye. During SAIF's attorney's argument on that point, the following colloquy occurred:

> "[ALJ Galton]: If I say [ALJ] Thye's Order is the law of the case and I don't relitigate compensability of the CAD, does the denial get set aside?
>
> "[SAIF's Attorney]: Oh, I think -- yes, I think I lose, yes. But I'm saying that you've got to -- you have to relitigate that issue of claim preclusion." Appendix "A" at 27.

We do not find that SAIF's attorney's statement that he "thinks" he loses if the ALJ does not adopt his argument regarding claim preclusion is a "concession" regarding compensability of the left leg condition. In this regard, we agree with SAIF that this statement connotes speculation, not a concession. In other words, the disputed language does not constitute an express, specific statement of a concession. Howard L. Rose, supra; James McGougan, supra. In addition, SAIF's attorney also argued in his closing argument that, on the merits, the persuasive medical evidence did not support compensability of the left leg condition. Appendix "A", pp 30-32. Addressing the merits does not comport with a "concession" that the denial should be set aside if SAIF's claim preclusion argument does not prevail. Joyce M. Russell, 46 Van Natta 1716 (1994) (Board found that the carrier's admission that it had "de facto" denied the contested conditions did not constitute a "concession" that those conditions were compensable, especially since the carrier subsequently argued on the merits that the contested conditions were not compensable). Thus, even if we considered the closing argument, we would not find that SAIF conceded the compensability of the left leg condition or conceded that its denial of that condition should be set aside if its claim preclusion argument was rejected.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 8, 1996 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] SAIF attached a copy of a transcription of its closing argument as Appendix "A" to its brief responding to claimant's motion for reconsideration. However, SAIF stated that this attachment was "solely for the purpose of defending against claimant's motion for reconsideration. SAIF is not requesting that the transcription be made part of the record." Response to Motion for Reconsideration, page 2, fn 1.

In the Matter of the Compensation of
KENNETH A. MUTZEL, Claimant
WCB Case No. 95-10714
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) vacated an Order on Reconsideration awarding 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of the right knee; and (2) remanded the claim to the Director for promulgation of a temporary rule. In his brief, claimant asserts that, if we do not remand to the Director, his award of scheduled permanent disability should be increased. On review, the issues are remand and extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant has an accepted claim for right knee chondromalacia, grades III and IV. A Notice of Closure awarded 15 percent scheduled permanent disability. Claimant requested reconsideration with the Department, asking it to promulgate a temporary rule based on evidence from claimant's treating physician that claimant was impaired from two right knee surgeries. Finding that claimant's impairment was addressed by the standards, the Order on Reconsideration affirmed the Notice of Closure.

At hearing, claimant requested that the ALJ remand the claim to the Department to enact a temporary rule. The ALJ agreed that claimant had proved impairment that was not addressed by the standards and allowed the motion to remand. On review, the employer challenges this action, arguing that claimant did not provide persuasive evidence of impairment not addressed by the standards.

ORS 656.726(3)(f)(C) provides that, during reconsideration before the Director, when "it is found that the worker's disability is not addressed by the standards," the Director must stay the proceeding and "adopt temporary rules amending the standards to accommodate the worker's impairment." The Board may remand a claim to the Director for promulgation of a temporary rule when a disability is not addressed by the existing standards. Gallino v. Pontiac-Buick-GMC, 124 Or App 538, 541-42 (1993). Thus, we address whether claimant carried his burden for remanding to the Director.

Dr. Farris, examining orthopedist, reported that claimant's "impairment is described in the physical examination and Dr. Laycoe's operative record [which noted 'slight swelling, full range of motion and no ligament laxity']." (Ex. 13-6). Dr. Laycoe, treating orthopedic surgeon, concurred with Dr. Farris' report. (Ex. 14).

After the Notice of Closure issued, claimant's attorney sent a report to Dr. Laycoe explaining that the standards provided values for certain surgeries, none of which had been performed on claimant; the report further noted that claimant had undergone other "unlisted" surgeries. (Ex. 17A-4). The report asked Dr. Laycoe whether claimant "incurred any impairment as a consequence of any of the unlisted surgeries specified below as compared with the residual impairment values specified in the Standards for the listed surgeries[.]" (Id.) (Emphasis in original.) In response, Dr. Laycoe provided "5%" each after "Chondroplasty, Medial Femoral Condyle" and "Chondroplasty, Lateral Tibial Plateau." (Id.)

We agree with the insurer that the latter report does not provide persuasive evidence of "disability not addressed by the standards." When Dr. Laycoe concurred with Dr. Farris' report, he did not indicate any additional impairment. Because Dr. Laycoe provided no explanation for indicating "5%" after both surgeries, it is not clear whether such impairment was in addition to or represented some portion of that already found by Dr. Farris. In view of this ambiguity, we do not find Dr. Laycoe's "check-the-box" report provides persuasive evidence of impairment outside the standards. Thus, we find no basis for remanding the claim to the Director. Gallino v. Pontiac-Buick-GMC, supra; Valorie L. Leslie, 46 Van Natta 1919, 1920 (1994) (Board found no authority to remand claim to Director since record supported finding that any disability was addressed by the existing standards).

Extent of Scheduled Permanent Disability

Claimant asserts that he is entitled to additional impairment because there is evidence of injury or disease in the left knee and, therefore, the range of motion in the right knee should not be compared with that in the left knee. According to claimant, he is entitled to 17 percent scheduled permanent disability.

Former OAR 436-35-007(16) (WCD Admin. Order 6-1992) provides:

> "The range of motion or laxity in the injured joint shall be compared to the contralateral joint except when the contralateral joint has a history of injury or disease. In such a case, the injured joint impairment shall be valued proportionately to the full motion of the contralateral joint, unless the contralateral joint motion exceeds the normals established under these rules. * * * When the contralateral joint does not have a history of injury or disease, the injured joint shall be valued based upon the ranges of motion established under these rules."

In asserting that claimant has a history of injury or disease in his left knee, claimant relies on medical evidence that claimant exhibited crepitation in the left knee and was diagnosed with bilateral chondromalacia of the patella.

We agree that, during two examinations, physicians noted crepitation in the left knee. (Exs. 5-1, 8-2). Claimant's first treating orthopedist, Dr. Hayes, also indicated a diagnosis of bilateral chondromalacia (Ex. 6). We are not convinced, however, that such evidence shows a history of disease in the left knee. Numerous physicians examined claimant, including Dr. Hayes, family physician Dr. Smith, Dr. Laycoe, and Dr. Farris. Only Dr. Hayes in the report previously discussed referred to any diagnosis for the left knee. Dr. Farris, on the hand, conducted a comprehensive examination of both claimant's right and left knees. (Ex. 13-5 through 6). Dr. Farris noted several abnormal findings regarding claimant's right knee, by no similar findings with regard to the left knee. Dr. Laycoe concurred with that report. (Ex. 14).

Thus, in the absence of persuasive evidence of a history of injury or disease in the left knee, we find that the range of motion of the right knee properly was compared with the left knee. Former OAR 436-35-007(16). Because claimant does not otherwise challenge the permanent disability awarded by the Order on Reconsideration, we affirm it.

ORDER

The ALJ's order dated December 28, 1995 is reversed. The Order on Reconsideration is affirmed.

October 9, 1996 Cite as 48 Van Natta 2123 (1996)

In the Matter of the Compensation of
DONALD L. STRONG, Claimant
WCB Case Nos. 96-00100 & 95-06631
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall, Christian and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for toxic exposure. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact except for the finding that claimant "remained away from the building work area" after April 7, 1995. Instead, we find that claimant worked in the office for two hours on March 31, 1994, three hours on April 4, 1995, three hours on April 7, 1995, seven and a half hours on April 10, 1995, and three and a half hours on April 14, 1995. (Ex. 6).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant proved that he was exposed at work to carbon monoxide and developed carbon monoxide poisoning. Thus, the ALJ found that claimant proved a compensable occupational disease. We agree with the ALJ and reject SAIF's challenge to the ALJ's order.

During the last week of March 1995, claimant began suffering from dizziness, headaches, and burning eyes while working in the office. Several coworkers experienced the same symptoms at this time. After the office manager filed an incident report, the office was evacuated.

On April 1, 1995, claimant's blood was tested; the level of carbon monoxide was found to be elevated. The record contains medical evidence that claimant's condition was caused by exposure at work to carbon monoxide. (Ex. 25).

We agree with the ALJ that claimant proved legal and medical causation. First, the blood test shows that claimant had carbon monoxide poisoning. A coworker who worked in the same office underwent blood work at the same time as claimant; her blood also showed an elevated level of carbon monoxide. (Ex. 25, Tr. 35). Furthermore, many workers in claimant's office, as well as offices in the same building complex, experienced symptoms that were similar to those of claimant. (Exs. 4, 5).

We find that claimant's blood test showing carbon monoxide poisoning, along with the coworker's same blood results and the many people in the office complex who had symptoms similar to those of claimant, provide compelling evidence that claimant was exposed to carbon monoxide at his work, resulting in carbon monoxide poisoning.[1]

Finally, the only medical opinion that does not support compensability is based on an understanding that claimant was not exposed to carbon monoxide at his office. Thus, we find this report is not reliable. Somers v. SAIF, 77 Or App 259 (1986). Consequently, because claimant showed that he was exposed to carbon monoxide at his work, and there is medical evidence supporting a causal relationship between claimant's work and his condition, we conclude that claimant proved compensability. ORS 656.802.

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 May 1, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the SAIF Corporation.

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[1] We acknowledge the report from Mr. Stengel discussed by the dissent. We have considered this evidence, as required by our de novo review. Based on the entire record, and specifically the facts discussed in the order, we find a preponderance of evidence showing that claimant was exposed to carbon monoxide at his office.

Board Member Haynes dissenting.

I disagree with the majority's decision that claimant proved he was exposed to carbon monoxide at work. In reaching this conclusion, the majority finds "compelling" evidence that a blood tests showed elevated levels of carbon monoxide and other employees experienced similar symptoms.

If this was the only evidence on the record, perhaps I could agree with the majority that claimant proved legal causation between his condition and work conditions. The majority fails to discuss, however, the remaining evidence relating to this issue.

First, there are the air quality tests. It appears that the fire department was contacted with concerns of the presence of toxic substances in claimant's office; apparently, on March 29, 1995, it conducted an air quality test. (Tr. 23, 36; Ex. 24-6). Testing also appears to have been performed at the IRS office, which is in the same building complex as claimant's office. (Tr. 36; Ex. 24-6). Unfortunately, the record does not contain any reports from the organizations that conducted the tests. Some medical reports state that the testing found the presence of carbon monoxide. (Exs. 8-1, 19, 20-1). These reports, however, were based on information from claimant. Claimant's testimony failed to demonstrate how he obtained such information and, thus, there is no basis for finding it reliable.

The most detailed information concerning the testing is from Dr. Burton, who examined claimant on behalf of SAIF. His report states that "a very small amount of carbon monoxide may have been present due to cigarette smokers" at the IRS office. (Ex. 24-7). His report further indicates that the fire department also tested "but no detectable carbon monoxide was found." (Id.)

In short, the state of the record concerning this testing is confused and contradictory. What is more certain is that Corbet Stengel of OR-OSHA tested for carbon monoxide at claimant's office on April 7, 1995. He detected no levels of the substance. (Ex. 13-1). Furthermore, his inspection of the building found no "equipment in the building or near the building's air intake that would introduce CO into the building." (Ex. 16-2). Mr. Stengel reported that he could not "explain the reason or the source of the employee's exposure" to carbon monoxide since the "office environment does not lend itself to any production of" carbon monoxide. (Id. at 3). Mr. Stengel found it possible that the employees "are being exposed prior to coming to work or outside the office environment." (Id.)

The evidence from Mr. Stengel that the office complex had no source of carbon monoxide is unrebutted. He concluded that any exposure to carbon monoxide was not from the building; he made this conclusion with the understanding that testing during the first week of April detected carbon monoxide and blood tests of employees indicated carbon monoxide poisoning. (Exs. 13-1, 16-1).

I simply do not understand how the majority can decide that the blood tests and group symptoms constitute a preponderance of evidence proving that claimant was exposed to carbon monoxide in his office, when an expert in such matters, with the additional understanding that testing detected carbon monoxide, could not do so. Because this record persuasively shows that the office building did not produce carbon monoxide, and there is an absence of reliable evidence that testing detected carbon monoxide, I find the blood tests and group symptoms inadequate to carry claimant's burden of proof. For these reasons, I would conclude that claimant did not prove legal causation and, thus, failed to prove compensability.

October 10, 1996 Cite as 48 Van Natta 2125 (1996)

In the Matter of the Compensation of
DONNA L. DEWALD, Claimant
WCB Case No. 95-05724
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Christian, Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Yeager's order that upheld Liberty Northwest Insurance Corporation's denial of claimant's claim for her current L4-5 disc condition. On review, the issue is compensability.

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

On review, claimant argues that the ALJ erred by characterizing the case as a "responsibility only" case.[1] Claimant disagrees with the ALJ's decision that, for purposes of determining whether

[1] The later employer, Driftwood Shores, and its insurer, the SAIF Corporation, which had been previously joined in this matter, entered into a Disputed Claim Settlement (DCS) with claimant prior to the record closing.

Liberty was responsible for claimant's L4-5 condition, it would be assumed that claimant's condition was compensable. We agree that compensability has not been conceded in this case. Accordingly, we address the issue on review.

As noted, claimant entered into a DCS with SAIF and the later employer, Driftwood Shores. Although the DCS is not a part of the record, we may take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(b); Lola K. Springer, 46 Van Natta 2213 (1994) (Board takes official notice of disputed claim settlement).

With respect to the issue of compensability, the court has held that, in such cases, we must examine the language in the DCS to determine whether claimant agreed that her work with the employer (Driftwood Shores) did not contribute in any way to her condition. Bennett v. Liberty Northwest Insurance Corp., 128 Or App 71 (1994); see Jon O. Norstadt, 48 Van Natta 253, on recon 48 Van Natta 1103 (1996).

Here, claimant agreed that Driftwood Shores' denial, as supplemented by the employer's contentions in the agreement, "shall remain in full force and effect." The DCS further provided that the employer contended that claimant did not injure her low back during her employment with Driftwood Shores, and claimant's back condition, including "paresthesia, degenerative disc disease at L4-5, central disc herniation at L4-5, and recurrent radicular symptoms in the left leg," did not arise from her employment at Driftwood Shores. Additionally, the employer contended that the aforementioned conditions "developed as a result of claimant's off-work activities or preexisting idiopathic conditions."[2]

Based on Bennett, supra, we find that claimant's DCS with Driftwood Shores evidenced an agreement by claimant that her work with that employment "did not contribute in any way" to her current low back condition. See Kristin Montgomery, 47 Van Natta 961 (1995). Therefore, claimant cannot rely on her employment activities with Driftwood Shores from February 1994 through November 1994 to establish the compensability of her condition. Rather, claimant must prove that her 1992 compensable lumbar strain condition with Liberty was the major contributing cause of her disc herniation.[3] ORS 656.005(7)(a)(A).

The ALJ relied on the opinion of claimant's treating doctor, Dr. Gallo. We agree with the ALJ's reliance on Dr. Gallo's opinion. Furthermore, we adopt the ALJ's summary of Dr. Gallo's reports and testimony which establish that the November 1994 incident with SAIF's insured, Driftwood Shores, was the major contributing cause of claimant's current herniated L4-5 disc. Accordingly, we conclude that, because we cannot consider claimant's employment conditions with SAIF's insured, claimant has failed to prove that her prior injury with Liberty's insured (which is the only remaining basis for compensability argued by claimant) is the major contributing cause of her herniated disc.

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[2] Contrary to the dissent's arguments, the DCS terms in this case are distinguishable from those in Bennett v. Liberty Northwest Insurance Corp., supra. In Bennett, the claimant agreed that the "claim shall remain in its denied status and that he shall take no workers' compensation benefits on account thereof." 128 Or App at 74. Although the carrier denied the claim on the basis that the "claimant's condition did not arise out of or in the course and scope of his employment" and that he had "untimely filed the claim[,]" the claimant in Bennett did not specifically agree to the terms of the denial.

Here, in contrast, claimant agreed that the denial and employer's contentions in the agreement would "remain in full force and effect." As we have noted, claimant agreed with the employer's contention that she did not injure her back during her employment with Driftwood Shores and her back condition did not arise from her employment. Moreover, claimant agreed with the employer's contention that her back conditions developed as a result of off-work or idiopathic activities. By agreeing that the denial and employer's contentions would "remain in full force and effect[,]" claimant agreed that her employment with Driftwood Shores was not causally related, and did not contribute to her back condition. For that reason, claimant cannot rely on that employment to prove compensability.

[3] We conclude that claimant must establish compensability, as we do not find that Liberty accepted claimant's L4-5 disc at the time it accepted claimant's lumbar strain in 1992. Based on the fact that an L4-5 disc was not diagnosed until late 1994, and an MRI first showed the L4-5 herniation in 1995, in addition to Dr. Gallo's opinion regarding causation, we conclude that Liberty did not initially accept claimant's L4-5 herniated disc. SAIF v. Tull, 113 Or App 449 (1992).

We, therefore, affirm the order of the ALJ.

ORDER

The ALJ's order dated March 28, 1996, is affirmed.

Board Chair Hall dissenting.

While I disagree with the majority's analysis and evaluation of the medical opinions, I dissent more specifically because the majority has misinterpreted the terms of the parties' DCS and misapplied Bennett v. Liberty Northwest Insurance Corp., 128 Or App 71 (1994).

In Bennett, the parties stipulated, in part, that the claim was denied for the reason that the claimant's condition did not arise out of or in the course and scope of employment, that there existed a bona fide dispute with the parties each having evidence to support their respective positions, and, in consideration for a certain sum, the claimant agreed "that his claim shall remain in its denied status and that he shall take no workers' compensation benefits on account thereof." Bennett, supra at 73, 74. The court found that the agreement did not, by its terms, indicate that the claimant agreed that work for the employer subject to the DCS did not contribute in any way to his condition. Id. at 78.

Here, the DCS similarly sets forth the basis of the denial, including the employer's contentions that claimant's condition did not occur during the course and scope of employment and did not arise from that employment. Similarly, the parties agreed that a bona fide dispute existed, with each party having evidence to support its position. In addition, the parties similarly agreed that the denial "shall remain in full force and effect." Under Bennett, such language does not mean that, by signing the DCS, claimant agreed that her back condition is unrelated to her work for the insured in the responsibility context.

In light of the similarity between the DCS terms here and in Bennett, there is no basis to distinguish this case from Bennett, let alone to rely on Bennett to reach a contrary result. Nonetheless, the majority relies on Bennett to conclude that this DCS (unlike the Bennett DCS) forecloses claimant from arguing that work for the employer subject to the DCS contributed to her current condition.

Because the majority misinterprets the parties' agreement and misapplies Bennett, (and the claim is compensable on the merits), I must respectfully dissent.

October 10, 1996 Cite as 48 Van Natta 2127 (1996)

In the Matter of the Compensation of
DARRELL D. EISELE, Claimant
WCB Case No. C602284
ORDER DENYING RECONSIDERATION CLAIM DISPOSITION AGREEMENT
Gatti, et al, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Member Haynes & Hall.

On August 23, 1996, the Board approved the parties' Claim Disposition Agreement (CDA). Pursuant to that agreement, in consideration of the payment of a stated sum, claimant released his rights to future workers' compensation benefits except medical services, for his compensable injury.

On September 23, 1996, we received claimant's letter expressing dissatisfaction with his former attorney and with the CDA. (Since it is unclear whether the insurer and claimant's former attorney received copies of the letter, copies are being provided to those parties with their copy of this order). We interpret claimant's letter as a motion for reconsideration of the CDA.

In order to be considered, a motion for reconsideration of the CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Here, the CDA was approved in final order on August 23, 1996. We received claimant's letter requesting reconsideration of the CDA on September 23, 1996, one month after mailing of the final order. Inasmuch as the motion for reconsideration was untimely, we cannot consider it. Paul J. LaFrance, 48 Van Natta 306 (1996); Carl E. Worley, 47 Van Natta 1636 (1995).

Moreover, we approved the CDA in a final order pursuant to ORS 656.236. The approved CDA is final and is not subject to review. ORS 656.236(2). Consequently, we are without statutory authority to alter the previously approved CDA.

Finally, even if we were authorized to reconsider the CDA, we note that an order approving a CDA would not have issued had we found the agreement unreasonable as a matter of law or based on an intentional misrepresentation of material fact or had any party requested disapproval within 30 days of submission of the CDA. ORS 656.236(1). Because the CDA in question was approved, we conclude there was no evidence of impropriety regarding the terms of the CDA. Thus, we would find no basis for setting aside the CDA.[1] See Brian A. Haskie, 47 Van Natta 2171 (1995); Russel C. Terry, 47 Van Natta 304 (1995).

IT IS SO ORDERED.

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[1] In reaching these conclusions, we acknowledge claimant's frustration with his former attorney, the insurer's claims examiner and the workers' compensation system. However, under these circumstances, (where the CDA has been approved and the 10 day reconsideration period has expired), we are without statutory authority to reconsider or modify the CDA. However, we would remind claimant that he retains all of his rights to medical services attributable to his compensable injury.

In the Matter of the Compensation of
JEFFREY T. KNUDSON, Claimant
Own Motion No. 94-0439M
OWN MOTION ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has requested reconsideration of our August 23, 1996 Own Motion Order in which we: (1) ordered SAIF to comply with our March 8, 1996 Own Motion Order reopening claimant's claim for the payment of temporary disability compensation (TTD), recommencing on February 2, 1995 until it is authorized to terminate TTD; (2) awarded a penalty for SAIF's unreasonable refusal to pay compensation, payable in equal shares to claimant and his attorney; and (3) allowed an approved attorney fee in the amount of 25 percent of the increased temporary disability compensation awarded under our order, not to exceed $1,050. Specifically, SAIF requests that the Board reconsider that portion of our order which assessed a penalty for its failure to timely pay "prospective" temporary disability compensation between March 28, 1996 and our August 23, 1996 order.

On September 17, 1996, the Board issued its Own Motion Order of Abatement, in which we requested that claimant respond to SAIF's motion within 14 days of the date of that order. The parties arguments and supporting evidence have been received. On reconsideration, we modify our prior order as follows.

On August 28, 1996, SAIF submitted a claim payment schedule, which indicates that: (1) on April 1, 1996, SAIF issued retroactive time loss payments and claimant's approved attorney's fee for the period of July 11, 1994 through February 1, 1995; (2) on April 15, 1996, SAIF issued two time loss checks to claimant, covering the periods from February 1, 1995 through March 15, 1995, and from January 31, 1996 through April 9, 1996; (3) beginning April 29, 1996 through August 30, 1996, SAIF issued bi-weekly time loss checks to claimant covering the periods from April 9, 1996 through August 28, 1996; and (4) on August 20, 1996, SAIF issued a check to claimant covering the retroactive time loss period from March 15, 1995 through January 31, 1996.

SAIF argues that it does not owe claimant a penalty because it paid all temporary disability compensation timely. Claimant contends that, on April 12, 1996, he submitted his request for retroactive time loss for the period from March 15, 1995 through April 11, 1996, but that the payment was not rendered until August 20, 1996. However, in our prior order we concluded that SAIF's failure to pay temporary disability, prior to March 28, 1996, was not unreasonable and we continue to adhere to that conclusion. The issue presented by SAIF's request for reconsideration is whether a penalty was appropriate for SAIF's alleged failure to pay temporary disability benefits after March 28, 1996.

In our August 23, 1996 Findings of Fact, we noted that, as of July 1, 1996, claimant had not received "any additional payment of temporary disability after SAIF's April 1, 1996 payment of time loss covering the period of July 11, 1994 to February 1, 1995." Based on SAIF's pay schedule, contrary to claimant's contention, SAIF timely paid to claimant all time loss, including payment through July 1, 1996, with the exception of the period covering March 15, 1995 through January 31, 1996. Therefore, we modify our August 23, 1996 Findings of Fact accordingly.

Here, SAIF has established that it paid timely all benefits ordered by the Board pursuant to our March 8, 1996 order reopening the claim and our August 23, 1996 enforcement order. In arriving at this conclusion, we note that our August 23, 1996 order found that, until the date of our order excluding ORS 656.262(4)(f) as an appropriate statute allowing a carrier to terminate benefits under ORS 656.278, SAIF could have relied on ORS 656.262(4)(f) to terminate benefits in this case due to the lack of a physician's authorization for retroactive time loss. We further concluded that SAIF unreasonably failed to recommence TTD on March 28, 1996, pursuant to Dr. Salib's contemporary authorization for those benefits. However, on reconsideration, we have found that, on April 15, 1996, SAIF paid time loss from January 31, 1996 through April 9, 1996, and continued the timely payment of contemporary TTD thereafter. Furthermore, on August 20, 1996, SAIF paid retroactive temporary disability compensation from March 15, 1995 through January 31, 1996. Our order awarded penalties on those contemporary amounts authorized by Dr. Salib from March 28, 1996 through the date of our order.

Our August 23, 1996 order assessed a penalty on unpaid "prospective" time loss, "post-March 28, 1996" through the date of our order. SAIF has established that it timely made those payments. Consequently, we conclude that temporary disability was paid timely in this claim pursuant to our order, and, therefore, a penalty is not appropriate.

Accordingly, we modify that portion of our August 23, 1996 order that assessed a penalty for SAIF's unreasonable failure to pay temporary disability benefits. On reconsideration, we withdraw that portion of our order which required SAIF to pay to claimant and his attorney a penalty for unreasonable refusal to pay "prospective" compensation between March 28, 1996 and August 23, 1996, the date of our order. All other portions of our order are republished in their entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 10, 1996 Cite as 48 Van Natta 2129 (1996)

In the Matter of the Compensation of
LAVERNE W. MOORE, Claimant
Own Motion No. 94-0403M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Dennis O'Malley, Claimant Attorney
VavRosky, et al, Defense Attorneys

Claimant requests review of the self-insured employer's March 26, 1996 Notice of Closure, as corrected on April 4, 1996, which closed her claim with an award of temporary disability compensation from July 28, 1992 through March 14, 1996. The employer declared claimant medically stationary as of February 23, 1996. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

FINDINGS OF FACT

Claimant sustained a compensable low back injury with the employer on April 9, 1985. Claimant's aggravation rights expired on July 14, 1991.

On July 28, 1992, Dr. Hoppert, claimant's then-treating physician, performed a left laminotomy and discectomy. On March 8, 1995, Dr. Hoppert examined claimant, but felt that she should have a panel examination to determine whether she was medically stationary. At that time, Dr. Hoppert noted that if claimant was found to be medically stationary by the panel, he would probably agree with the decision. Dr. Hoppert reported that claimant had a left lateral disc herniation at L3-4 which was not deemed operable, as well as persistent low back pain and left-sided leg pain.

Claimant began treating with Dr. Grewe in June 1995. At that time, Dr. Grewe ordered a lumbar myelogram and a CT scan. Both Dr. Grewe and Dr. Greene, radiologist, interpreted the results as minimal/mild posterior disc bulge at L4-5. Dr. Grewe noted a "slight blunting of the nerve root sleeve on the left at L5-S1." Dr. Greene reported a laminectomy defect on the left at the L4 level.

On February 23, 1996, Dr. Mayhall, orthopedic surgeon and Dr. Glass, psychiatrist, evaluated claimant, serving as the "panel" requested by Dr. Hoppert a year earlier. Dr. Glass administered a Minnesota Multiphasic Personality Inventory, and diagnosed a psychogenic pain disorder with depression symptoms, unrelated to her 1985 injury. Dr. Mayhall examined claimant, and reviewed her history and medical records. Noting that claimant "gave essentially zero effort" in the examination, Dr. Mayhall recommended no further active or passive treatment modalities.

In a March 5, 1996 medical report, Dr. Grewe noted claimant's continued low back pain, and reported concern that claimant might not have had adequate decompression with her 1992 surgery. Dr. Grewe ordered an MRI study. In a March 25, 1996 chart note, Dr. Grewe noted that claimant had "clinical findings of significant losses in the L5 nerve root distribution." Ordering a differential spinal block and intrathecal analgesia trial for pain evaluation, Dr. Grewe considered the possibility of mechanical impingement, and noted that claimant's pain could also be neuropathic in nature.

In a March 21, 1996 "check-the-box" response, Dr. Hoppert indicated that he concurred with Dr. Mayhall's medical report.

On March 26, 1996, the employer closed claimant's claim. On April 4, 1996, the employer issued a "Corrected" Notice of Closure.

In a May 17, 1996 medical report, Dr. Grewe reviewed the results of the differential spinal block carried out by Dr. Stuart, noting that, although a sympathetic block did not produce significant change, a somatic block relieved claimant's pain significantly. In reviewing claimant's physical findings, Dr. Grewe reported that claimant's sensory deficit corresponded to the L5 nerve root area. Further noting that, as a general rule, removal of the source of pain (e. g., disc and scar tissue) has more definitive results than pain modification, Dr. Grewe recommended a repeat laminectomy, decompression and probable removal of the L4-5 disc.

On June 18, 1996, the employer notified Dr. Grewe that he was not an "approved provider" under the managed care organization, and that it would not authorize the proposed procedure. On June 27, 1996, Dr. Grewe performed the surgical procedure. During the surgery, Dr. Grewe found a 7-8 millimeter bursa close to the L4-L5 joint, posterior to the nerve root. Dr. Grewe performed "considerable decompression" and removed additional bursae as well as the nucleus pulposis at L4-L5.

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 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 4, 1996 Corrected Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. 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) If there is a reasonable expectation of improvement with surgery, the criteria for being declared medically stationary have not been met. ORS 656.005(17); Richard Uhing, 48 Van Natta 465 (1996). We will consider the opinions of non-MCO treating physicians whose opinions are both well-reasoned and supported by medical evidence. Patrick E. Kelly, 48 Van Natta 1772 (1996); Marsha Brown, 47 Van Natta 1465 (1995).

The employer asks that the Board not consider Dr. Grewe's records concerning this issue because "[h]e is not claimant's attending physician nor is he an approved provider under [the employer's] MCO." Arguing that the sole basis for Dr. Grewe's surgery recommendation was claimant's pain complaints, the employer asserts that Dr. Grewe lacked supportive evidence that surgery would reasonably improve claimant's condition. The employer further contends that Dr. Grewe was not familiar with claimant's psychiatric evaluation prior to surgery, and that claimant's pain was psychogenic in origin. Finally, contending that Dr. Grewe's surgical findings "confirm the lack of need for the surgery," the employer asks the Board to compare Dr. Grewe's postoperative diagnosis with the substance of his surgical report.

We rely on Dr. Grewe's opinion due to the following reasoning. Regardless of whether or not Dr. Grewe was "MCO approved," he did, in fact, provide treatment to claimant and was familiar with claimant's condition. Patrick E. Kelly, supra; Marsha Brown, supra. Dr. Grewe began treating claimant in June 1995; claimant was last examined by Dr. Hoppert in March 1995. Dr. Grewe considered surgery prior to claim closure, and ordered further tests to confirm his diagnosis of L4-L5 nerve root involvement.

The "panel" of IME physicians examined claimant only once. Dr. Mayhall stated that, because of "zero effort" on claimant's part, the motor findings in the tests he administered were invalid; likewise, he suggested that the sensory findings in relation to the motor findings were "inconclusive at best." From the results of the MMPI, Dr. Glass diagnosed claimant with a psychogenic pain disorder, possible malingering and / or conversion hysteria. Dr. Glass noted that claimant's mother had recently died, that she was overweight, and that she spoke of divorce. Apparently, based on these recent occurrences, Dr. Glass opined that claimant's psychogenic pain or depressive symptoms were not as a result of her back injury and pain, and, rather than being physical in origin, her back pain was a result of non-injury-related emotional distress. Dr. Glass further reviewed claimant's history of complaints and noted that "there is no clear objective evidence that something is surgically able to be fixed." However, Dr. Glass reviewed results from tests and examinations performed by Drs. Mayhall and Hoppert. He did not have access to objective findings reported by Dr. Grewe.

On March 5, 1996, Dr. Grewe opined that, because claimant had no improvement in back pain following her 1992 laminectomy, she might not have had adequate decompression on the L4-5 nerve. However, Dr. Grewe decided that, prior to recommending further treatment, it was first necessary to determine if claimant had a central pain pattern "or if this is a regional problem."

In a March 25, 1996 chart note, Dr. Grewe noted that a March 14, 1996 MRI showed "only a mild to moderate amount of enhancing scar [tissue] at the L4-L5 level on the left without any true evidence of recurrent disc." Dr. Grewe further opined that:

> "I think the next step in the investigation [of the cause of claimant's pain] should include a differential spinal block and intrathecal analgesia trial for further pain evaluation. Since much of [claimant's] pain has a burning quality to it, this may be a true, neuropathic type of pain and it is difficult to convince ones self that a reoperation of her back would solve the problem unless there is a fairly straightforward finding on her pain evaluation tests.
>
> "I do believe she hurts and I do believe she has clinical evidence of L5 nerve root involvement, and there certainly is a suggestion of mechanical impingement. However, one must rule out a central pain problem and establish a more specific diagnosis regarding the type of pain and cause, and then come to a conclusion about what might be beneficial."

On May 17, 1996, Dr. Grewe reviewed the results of the differential spinal block carried out by Dr. Rosenblum, and determined that the sympathetic block had little to no effect on claimant's pain, whereas the somatic block almost totally relieved claimant's pain. These results indicated to Dr. Grewe that claimant's pain was due to organic causes. Dr. Grewe further reviewed claimant's physical findings and tests, and opined that claimant did not have a central pain pattern, and that there was a "reasonable chance of improvement" with a surgical removal of scar tissue and disk material. Dr. Grewe's surgery recommendation was based on his interpretation of the clinical findings, and his assessment that a

reasonable improvement could be expected was based on providing a surgical treatment to alleviate claimant's pain. Richard Uhing, supra. Further, because Dr. Grewe determined that claimant's pain was localized, we are not persuaded that he would have diagnosed claimant's condition any differently had he reviewed Dr. Glass' opinion regarding a psychogenic cause for claimant's pain.

We are also persuaded that Dr. Grewe was not "armed with a complete lack of supporting evidence," as the employer suggests. Dr. Grewe ordered contemporary tests, including an MRI and a differential spinal block, as well as a myelogram and a post-myelogram CT scan in June of 1995. Dr. Greene also interpreted the 1995 test results as indicating minimal posterior disc bulging at L4-5 causing a slight indentation on the thecal sac, as well as a laminectomy defect on the left at the L4 level. Although the results of these tests were inconclusive as to what was causing the pain, Dr. Grewe reasoned that, because claimant did not have a central pain pattern, and because the MRI showed scar tissue and a bulging annulus at L4-5, the pain had a physical cause associated with the nerve roots around that area. We are persuaded that Dr. Grewe applied objective results and sound reasoning in formulating his diagnosis. Weiland v. SAIF, supra; Somers v. SAIF, supra.

On June 27, 1996, Dr. Grewe performed a lumbar laminectomy with bilateral nerve root decompression. During that operation, Dr. Grewe found a "bursa" sac which measured "approximately 7-8 mm in diameter (approximately the size of a large hen's egg) located just posterior to the nerve root probably an extension from the joint at L4-L5." Dr. Grewe removed several bursae as well as some bone material, and tested the nerve roots for adequate room. Thus, we are not persuaded that Dr. Grewe's surgical findings confirmed the "lack of need for surgery" the employer suggests. Scheuning v. J.R. Simplot & Co., supra. We are persuaded that Dr. Grewe's pre-closure surgery recommendation supports claimant's contention that she was not medically stationary at claim closure. ORS 656.005(17); Richard Uhing, supra.

On the record, we are persuaded that claimant's compensable low back condition was not medically stationary on April 4, 1996, the date of the employer's "corrected" claim closure.

Accordingly, we set aside the employer's Notice of Closure as premature. When appropriate, the claim shall be closed by the employer 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 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
THOMAS R. SMITH, Claimant
WCB Case Nos. 95-07260 & 95-07259
CORRECTED ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Mannix, Nielsen, et al, Defense Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Galton's order which upheld Liberty Northwest's denial of claimant's occupational disease/injury claims for a L5-S1 herniated disc condition issued on behalf of Liberty's insureds (Foster Wheeler Constructors and Raytheon Engineers & Constructors). Liberty/Foster cross-requests review of that portion of the ALJ's order that declined to admit several proposed exhibits. Claimant moves to strike those portions of Liberty/Foster's cross-reply brief that discuss the compensability and responsibility issues. On review, the issues are motion to strike, the ALJ's evidentiary ruling, compensability and, potentially, responsibility.[1] We grant claimant's motion, reverse in part, and affirm in part.

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[1] Claimant has also filed a motion for expedited review. In light of our issuance of this order, it is unnecessary to address claimant's request.

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

Motion to Strike

Liberty/Foster filed its cross-request for review challenging the ALJ's exclusion of proposed exhibits 93-97. Claimant responded to Liberty/Foster's argument in his reply/cross-respondent's brief. While Liberty/Foster was entitled to respond to claimant's argument regarding the ALJ's evidentiary ruling in its cross-reply brief, it also improperly discussed the compensability and responsibility issues in responding to claimant's reply/cross-respondent's brief.

We agree with claimant that Liberty/Foster's cross-reply brief should have been limited to the evidentiary issue that it raised in its cross-request for review. To do otherwise, would allow Liberty/Foster to submit the final argument on the compensability and responsibility issues raised by claimant in his request for review of the ALJ's compensability decision. Consequently, we grant claimant's motion to strike and have only considered that portion of Liberty/Foster's cross-reply brief which addresses the evidentiary issue.

Evidentiary Ruling

Claimant was employed as an electrician by Foster Wheeler from May 11, 1994 through June 1, 1994. He was thereafter employed as a union electrician in Alaska and Washington until being employed at Raytheon from February 22, 1995 through April 27, 1995. On May 3, 1995, he filed a claim against Foster Wheeler for an injury to his hip, leg, foot and back. The form 801 stated that the injury date was unknown, but referenced a specific incident in which claimant allegedly sustained an injury while pulling out wire from a conduit.[2] (Ex. 40).

On May 17, 1995, Liberty issued a denial on behalf of Foster Wheeler. (Ex. 47). The denial letter stated that claimant's allegation was that his diagnosed condition was the "result of either an injury or exposure" while employed by Foster Wheeler. However, the stated reason for the denial was that "information on file" did not indicate that claimant had sustained "an injury" to his back, hip, leg and foot as a result of his work activities. The denial also asserted that Liberty had been prejudiced by the late filing of the claim.

Claimant requested a hearing contesting the May 17, 1995 denial, as well as a denial issued on June 1, 1995 by Liberty on behalf of Raytheon. The hearing was scheduled for September 19, 1995.

Shortly before the hearing, claimant submitted medical reports from his attending physicians, Drs. Lewis and Feinberg. After counsel for Liberty/Foster and Liberty/Raytheon requested cross-examination, the hearing was postponed for depositions of the two physicians.

The depositions occurred on October 17, 1995 and October 18, 1995. After the depositions, which Liberty/Foster considered to have raised an occupational disease issue, Liberty/Foster arranged an "IME" with Dr. Rosenbaum on January 15, 1996 to address the potential occupational disease claim. On January 19, 1996, Liberty/Foster submitted the report of Dr. Rosenbaum's examination, as well as his "curriculum vitae." (proposed exhibits 94 and 95). On November 20, 1995, Liberty/Foster had submitted a November 15, 1995 medical report from a Dr. Vassall (clarifying a chart note referred to in one of the depositions) for inclusion in the record. (proposed exhibit 93).

In a January 28, 1996 "interim order," the ALJ stated that he had a "clear and independent" recollection that the parties had agreed that the record was "frozen" except for the depositions. Finding no reason to "unfreeze" the record, the ALJ declined to admit the proposed exhibits into evidence.

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[2] On May 18, 1995, claimant also filed a form 801 alleging that he had injured his lower back, hip, leg and right foot at Raytheon. No specific incident was identified in that employment. Ex. 48).

At the January 30, 1996 hearing, claimant's sole legal theory was that the claim was compensable as an occupational disease. (Tr. 14). The ALJ declined to admit into evidence Liberty/Foster's January 19, 1996 denial of an occupational disease claim (proposed exhibit 96 submitted on January 23, 1996) and a January 26, 1996 form 1502 (proposed exhibit 97 submitted on January 30, 1996). (Tr. 11).

On the merits, the ALJ determined that the language of Liberty/Foster's denial raised both the issue of an accidental injury and an occupational disease. The ALJ then upheld both Liberty/Foster's and Liberty/Raytheon's denials, concluding that claimant had failed to prove legal and medical causation. In reaching this conclusion, the ALJ determined that claimant was not a credible or reliable witness on "important issues" and that no physician had an accurate history on which to base an opinion on causation.

On review, Liberty/Foster contends that the ALJ should have admitted Exhibits 93 through 97 because claimant raised an issue of occupational disease during the depositions of Drs. Lewis and Feinberg. We need not resolve this evidentiary ruling because even if we considered the evidence on which Liberty/Foster relies, we would continue to conclude that claimant has established a compensable occupational disease claim against Liberty/Foster. We base this conclusion on the following reasoning.

Claimant contends that the ALJ should have held that he proved a compensable occupational disease claim for his L5-S1 disc herniation because he has proven legal and medical causation. In particular, claimant asserts that the ALJ's factual findings (that his work as an electrician is heavy and routinely involves working in awkward positions and doing much lifting, twisting and bending) establishes legal causation under Coday v. Willamette Tug & Barge, 250 Or 39 (1968) (an injured worker's usual exertion sufficient to establish legal causation in an injury claim). With respect to medical causation, claimant argues that the medical opinions of Drs. Lewis and Feinberg satisfy his obligation to prove medical causation.

At the outset, we address the ALJ's credibility finding. The ALJ determined that claimant was not credible or reliable on "important issues." However, the ALJ did not specify on what issues claimant was not credible, nor did the ALJ indicate whether this was a demeanor-based finding or whether it was based on inconsistencies in the record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987) (when the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility).

Claimant testified that he had two specific incidents of injury at Foster Wheeler, one when he was pulling wire and another when he allegedly fell off the steps of a ladder onto an I-beam. (Trs. 23-4). However, claimant did not file a claim for an injury at Foster Wheeler until nearly a year after his last day of work for Foster Wheeler. (Ex. 40). Moreover, Liberty/Foster produced several witnesses that testified that they were unaware that claimant sustained an injury while employed at Foster Wheeler. (Trs. 98, 108, 113, 114, 147, 175). On this record, we are not persuaded that claimant sustained an injury while working for Foster Wheeler. However, claimant is not pursuing an injury claim, but rather one for occupational disease.

The ALJ found as a fact that claimant's work as an electrician was heavy and routinely involves working in awkward positions, as well as doing much lifting, twisting and bending. No party disputes that finding, which we have adopted on review. Accordingly, we conclude that claimant has established legal causation with respect to an occupational disease claim. See Coday v. Willamette Tug & Barge, supra. In addition, while claimant may not have sustained a compensable injury while working at Foster-Wheeler and may not be a credible witness with respect to the occurrence of an injury, he may still be able to establish a compensable occupational disease. See Taylor v. Multnomah School District # 1, 109 Or App 499, 501 (1991); Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984).

In Silveira v. Larch Enterprises, 133 Or App 297 (1995), the Court of Appeals held that for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws. The court cited Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994), which had held that in determining whether a disease is work related, the rule of proof aspect of last injurious exposure rule allows consideration of all employments, even those that could not ultimately be held responsible for the claim. The court also relied on Progress Quarries v. Vaandering, 80 Or App 160 (1986), for the proposition that a claimant is not required to file a claim with other potentially causative out-of-state employers in order to receive compensation in Oregon.

This is the initial claim for claimant's herniated disc condition. Based on Silveira v. Larch Enterprises, supra, claimant may rely on all of his employments, even those not subject to Oregon's workers' compensation laws, for purposes of establishing that his L5-S1 disc condition is work related. Moreover, the medical evidence does not establish that claimant's herniated disc condition preceded his electrician's employment, which began in 1986. Therefore, there is no L5-S1 condition that preexisted the initial onset of this claim. Claimant's occupational disease claim is not based on the worsening or combining of a preexisting disease or condition. Consequently, neither amended ORS 656.802(2)(b) nor ORS 656.005(7)(a)(B) apply to this case.

Thus, to establish the compensability of his L5-S1 disc condition, claimant must prove that his overall employment as an electrician, including employment for out-of-state employers in Alaska and Washington, was the major contributing cause of his low back condition. ORS 656.802(2)(a).

There are five physicians who address the causation issue: Dr. Battalia, Dr. Ewings, Dr. Feinberg, Dr. Lewis and Dr. Rosenbaum. Dr. Battalia performed a records review at the request of counsel for Raytheon and opined that the "major need" for claimant's treatment was not related to his work at either Foster Wheeler or Raytheon. (Ex. 88-7). Dr. Battalia strongly suspected the validity of claimant's pain complaints. However, we give little weight to Dr. Battalia's opinion because he had not reviewed the June 7, 1995 MRI scan which revealed a herniated disc at L5-S1. (Ex. 65). Moreover, Dr. Battalia's report is conclusory and, therefore, entitled to little weight. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory opinion).

Dr. Ewings, a chiropractor, treated claimant four times in May and June 1994. Dr. Ewings diagnosed a lumbosacral strain, but was unaware that claimant had a herniated disc. Although Dr. Ewings concluded that claimant's multiple incidents of low back trauma could well have created a "worsening condition," he did not explain his conclusion. (Ex. 90). For this reason, we also give his opinion little weight. Somers v. SAIF, 77 Or App 259 (1986) (greatest weight given to well-reasoned opinions based on complete and accurate information).

Dr. Feinberg, also a chiropractor, treated claimant while he worked for Foster Wheeler and Raytheon. On February 22, 1995, Dr. Feinberg diagnosed a disc lesion of which claimant's employment in early 1995 was the major contributing cause. (Ex. 89-3). Dr. Feinberg was then deposed.

Dr. Feinberg testified that claimant's L5-S1 disc worsened during a one to two month period prior to February 22, 1995. (Ex. 92-26). However, Dr. Feinberg also testified that claimant's herniated disc was the "result of doing the kind of work that [claimant] has been doing for a lot of years." (Ex. 92-34). Dr. Feinberg confirmed that claimant's overall work activities as an electrician were the major contributing cause of his low back condition. (Ex. 92-36).

Dr. Feinberg stated that he was familiar with the work of an electrician and was aware that it was heavy, vigorous work. (Ex. 92-29). Moreover, Dr. Feinberg treated claimant during his employment at Foster Wheeler and Raytheon. However, Dr. Feinberg did not have access to all medical records and exhibits. (Ex. 92-6). Moreover, it is not clear that Dr. Feinberg was aware or considered that claimant's most severe pain occurred on April 29, 1995 (after claimant's employment at Raytheon had terminated) while claimant was driving from Seattle to Boise. Because Dr. Feinberg did not have all the medical records, and because it appears that Dr. Feinberg was not aware of an important piece of claimant's history, we give less weight to Dr. Feinberg's opinion. Somers v. SAIF, supra.

Dr. Lewis first examined claimant on May 9, 1995. (Ex. 44). In an August 28, 1995 report, he concluded that claimant's herniated disc was the direct result of claimant's work as an electrician. (Ex. 87). Dr. Lewis was also deposed.

Dr. Lewis had access to all medical records, which he reviewed prior to the deposition. (Ex. 91-4, 5). Dr. Lewis was aware that claimant's most severe pain occurred after his employment with Raytheon had ended and was driving to Boise via Umatilla. Id. Familiar with the work of an electrician, Dr. Lewis testified that claimant's herniated disc most likely herniated in May 1994 and that claimant's overall work as an electrician was the major contributing cause of the herniated disc. (Ex. 91-64). Dr. Lewis explained that it was the lifting, bending and unrestricted motion required in claimant's work that caused the gradual degeneration of his L5-S1 disc. (Ex. 91-60-4).

The ALJ's contrary conclusion notwithstanding, we find that Dr. Lewis had an accurate and complete history. In addition, we find Dr. Lewis' opinion most persuasive because it was well-reasoned, thoroughly explained and was based on an accurate understanding of claimant's employment duties. It establishes that claimant's work as electrician was the major contributing cause of his herniated disc at L5-S1. Claimant's low back condition is compensable as an occupational disease.[3]

Responsibility

No carrier has accepted claimant's herniated disc condition. Therefore, ORS 656.308 does not apply. SAIF v. Yokum, 132 Or App 18, 23 (1994). Instead, we analyze this case under the last injurious exposure rule (LIER). LIER 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); Renee M. Willshire, 47 Van Natta 1339 (1995).

Liberty/Raytheon contends that, if claimant's L5-S1 herniated disc condition is compensable, then Liberty/Foster is responsible because claimant's employment at Foster Wheeler "actually caused" claimant's herniated disc. Liberty/Raytheon cites testimony from Dr. Lewis that claimant's "injury" in May 1994 is more responsible for claimant's disc herniation than any other factor. (Ex. 91-52). We disagree, however, with Liberty/Raytheon's contention that "actual causation" has been established.

Dr. Lewis testified that claimant's disc herniation most likely occurred in May 1994. (Ex. 91-58). However, Dr. Lewis emphasized that the major contributing cause of claimant's herniated disc was his overall employment as an electrician. (Ex. 91-63, 64). Dr. Lewis explained that the normal activities of daily living were unlikely to cause a herniated disc, but the demands of claimant's long-term employment as an electrician (which involved excessive strains of twisting, turning and lifting in unusual positions) caused the L5-S1 disc to gradually degenerate. (Id.). Considering the totality of Dr. Lewis' testimony, we do not find that actual causation has been established with regard to a particular employment.

We now proceed to a determination of the responsible carrier under LIER. LIER provides that, 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, 241 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984), rev den 299 Or 203 (1985). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, supra, 293 Or at 248.

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

Based on Dr. Lewis' persuasive medical opinion, we conclude that claimant first sought medical treatment for the symptoms of his herniated disc condition in May 1994, while employed by Foster Wheeler. (Exs. 16, 17). Thus, initial responsibility is assigned to Liberty/Foster. Because Liberty/Foster is presumptively responsible for claimant's herniated disc condition, it can shift responsibility to

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[3] We recognize that Dr. Rosenbaum concluded that claimant does not have an occupational disease, reasoning that a lumbar disc herniation is not considered an occupational disease. (Ex. 94-6). However, we find Dr. Lewis' detailed explanation of how claimant's overall employment as an electrician resulted in the gradual deterioration of the L5-S1 disc to be more cogent than Dr. Rosenbaum's less detailed explanation regarding why claimant's herniated disc should not be considered an occupational disease.

Liberty/Raytheon only if employment conditions at Raytheon contributed to the cause of, aggravated or exacerbated the underlying disease. Bracke v. Baza'r, supra, 293 Or at 250; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (later employment conditions must actually contribute to a worsening of the condition). A claimant must experience more than a mere increase in symptoms. Timm v. Maley, supra, 134 Or App at 249.

Dr. Lewis testified that claimant's work at Raytheon "could have" contributed to claimant's herniated disc condition. (Ex. 91-65). However, we do not find that this testimony establishes to a degree of medical probability that claimant's last employment in 1995 for Raytheon actually contributed to the cause of claimant's herniated disc condition. Therefore, we find that Liberty/Foster has failed to sustain its burden of shifting responsibility to Liberty/Raytheon. Consequently, Liberty/Foster remains responsible for claimant's L5-S1 herniated disc.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(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 $6,500, payable by Liberty/Foster. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, counsel's statement of services, Liberty/Foster's objections and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

By virtue of this order, Liberty/Foster's responsibility denial has also been overturned. Inasmuch as claimant has finally prevailed against Liberty/Foster's responsibility denial, claimant's counsel is also entitled to an attorney fee pursuant to ORS 656.308(2)(d). See 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. The $1,000 attorney fee limitation under ORS 656.308(2)(d) is cumulative for all levels of litigation. Tammy Locke, 48 Van Natta 250 (1996).

We conclude that, considering the factors set forth in OAR 438-015-0010(4), such as the time devoted to the issue (as represented by the record, counsel's statement of services and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved, claimant is entitled to a $1,000 attorney fee for services at hearing and on review regarding the responsibility issue, payable by Liberty/Foster.[4]

ORDER

The ALJ's order dated February 14, 1996 is reversed in part and affirmed in part. Liberty/Foster's compensability and responsibility denials (including the January 19, 1996 denial of occupational disease) are set aside and the claim is remanded to Libery/Foster for processing in accordance with law. Liberty/Raytheon's denial is upheld. For services at hearing and on review, claimant's counsel is awarded a total assessed fee of $7,500, payable by Liberty/Foster.

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[4] Claimant has not requested an "extraordinary" attorney fee. However, even if he did, we would not find "extraordinary circumstances" present to justify a greater attorney fee award under ORS 656.308(2)(d). Although the record includes a 197 page transcript and 2 lengthy depositions, the majority of the litigation concerned the compensability issue for which we have already awarded a fee. Furthermore, claimant's briefs are almost entirely devoted to the compensability and evidentiary issues.

In the Matter of the Compensation of
JULIO FILIPPI, Claimant
WCB Case Nos. 96-00397, 96-00383, 95-04502 & 95-07470
ORDER ON REVIEW
Maureen McCormmach, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Wausau Insurance Company (Wausau) requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its denial of claimant's aggravation claim for an L4-5 disc condition; (2) upheld the SAIF Corporation's denial on behalf of Oregon Parks and Recreation (SAIF/Parks) of claimant's medical services claim for the same condition; and (3) upheld SAIF's denial of claimant's "new injury/occupational disease" claim for the same condition on behalf of Circle C Farms (SAIF/Circle C). On review, the issue is responsibility.

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

The ALJ found that Wausau, as the last insurer with an accepted claim for claimant's L4-5 disc condition, remained responsible for that condition under ORS 656.308(1). We agree.

In 1993, Wausau accepted claimant's condition as a "temporary aggravation of a previously herniated disc at L4-5 resulting in mechanical low back pain." As the carrier with the last accepted claim for an L4-5 disc herniation, Wausau remains responsible for that condition unless claimant sustains a new compensable injury involving the same condition at a subsequent employment. See Roger D. Jobe, 46 Van Natta 1812 (1994); Bonni J. Mead, 46 Van Natta 1185 (1994).

In Mead, the claimant sustained a compensable lumbosacral strain injury while working for AIAC's insured. Approximately a year later, the claimant sustained a second compensable injury while Liberty was on the risk. Liberty accepted the claim for a "temporary exacerbation of chronic lumbosacral strain." We held that by accepting claimant's claim, Liberty conceded that a new compensable injury had occurred. We further held that the AIAC and Liberty claims involved the same condition, lumbosacral strain. Under such circumstances, we found that Liberty remained responsible under ORS 656.308(1) for future compensable medical services and disability for the compensable condition.

Here, claimant had accepted claims for L4-5 disc herniations dating from his 1986 and 1987 compensable injuries with SAIF/Parks. Claimant reinjured his back in 1992 while working for Wausau's insured. Wausau accepted a "temporary aggravation of a previously herniated disc at L4-5." As in Mead, we conclude that Wausau's acceptance is a concession that a new compensable injury occurred. In addition, both the SAIF/Parks and Wausau accepted claims involve L4-5 disc herniations. Thus, Wausau's accepted claim involves the "same condition" as the SAIF/Parks claims. Under such circumstances, we agree with the ALJ that responsibility for claimant's L4-5 disc herniation remains with Wausau as the last carrier with an accepted claim for that condition. See Larry A. Harnsberger, 48 Van Natta 310 (1996).

On review, Wausau takes the position that this case involves a "combined" condition under ORS 656.005(7)(a)(B) and that its injury was the major contributing cause of the L4-5 disc condition, but that the 1992 injury has now ceased to be the major contributing cause of claimant's disability and need for treatment. On the basis of this argument, Wausau asserts that it may deny continuing responsibility for claimant's L4-5 disc condition under ORS 656.262(6)(c).[1]

Because we find ORS 656.005(7)(a)(B) and 656.262(6)(c) to be inapplicable, we disagree with Wausau's contention. In order for ORS 656.005(7)(a)(B) to apply, a compensable injury must combine

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[1] ORS 656.262(6)(c) allows a carrier to deny a previously accepted "combined condition," provided that the otherwise compensable injury "ceases" to be the major contributing cause of the combined condition. See Harry L Lyda, 48 Van Natta 1300 (1996).

with the preexisting condition. Claimant's L4-5 disc herniation was accepted by Wausau. Thus, there is no preexisting condition; only claimant's compensable L4-5 disc herniation which Wausau has previously accepted. Moreover, there is no evidence that the compensable disc herniation combined with any other preexisting condition. Consequently, ORS 656.005(7)(a)(B) does not apply to this case. James M. King, 47 Van Natta 2563, 1564 (1995) (where coronary artery disease was ordered accepted by court, there was no "combined" condition and ORS 656.005(7)(a)(B) and 656.262(6)(c) did not apply); see also Ronald L. Ledbetter, 47 Van Natta 1461, 1462 (1995).

Wausau next argues that its denial was a permissible "back-up" denial under ORS 656.262(6)(a). This "back-up" denial issue was not raised before the ALJ and is raised for the first time on Board review. We have consistently held that we will not consider an issue raised for the first time on appeal. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Assuming that Wausau's argument could be characterized as merely a different theory for defending its denial, we would still decline to address this late-raised theory. Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue. See Robert L. Tegge, 47 Van Natta 1973 (1995); Gunther H. Jacobi, 41 Van Natta 1031 (1989). Here, if we addressed the "back-up" denial issue on review, SAIF/Parks, SAIF/Circle C and claimant (the other parties to this proceeding) would be denied the opportunity to present evidence on the "back-up" denial issue because they had no notice of this issue. Accordingly, we decline to raise Wausau's late-raised "back-up" denial theory. See also Clive G. Osbourne, 47 Van Natta 2291 (1995) (Board declined to address carrier's argument, raised for the first time on review, that its "back-up" denial should be upheld under former ORS 656.262(6), when carrier argued at hearing that its "back-up" denial should be upheld under the rule in Bauman v. SAIF, 295 Or 788 (1983)).

Based on this record, we agree with the ALJ that responsibility for claimant's L4-5 disc condition remains with Wausau under ORS 656.308(1).

ORDER

The ALJ's order dated March 19, 1996 is affirmed.

October 11, 1996 Cite as 48 Van Natta 2139 (1996)

In the Matter of the Compensation of
MARIA E. JIMENEZ-MENERA, Claimant
WCB Case No. 95-11506
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McKean's order that affirmed an Order on Reconsideration that awarded no scheduled permanent disability for claimant's left leg. On review, the issue is extent of scheduled permanent disability.

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

Claimant challenges the ALJ's conclusion that claimant is not entitled to a 5 percent chronic condition award for loss of repetitive use of the left leg due to referred pain from a lumbar spine injury. Claimant relies on the treating physician's affirmative response to a detailed questionnaire addressing whether claimant was unable to repetitively run, crouch, crawl and twist. The ALJ found that these limitations were attributable to claimant's underlying lumbar condition rather than to referred pain in the left leg. We do not agree that the limitations identified by the treating physician are attributable to the underlying lumbar condition. The narrative immediately preceding the treating physician's response clearly asks for his opinion regarding a loss of repetitive use of the left leg. We find that the response to that question was given in regard to the left leg.

Nevertheless, we otherwise agree with the ALJ that the treating physician's questionnaire response is conclusory, and that the preponderance of the medical evidence does not support a chronic condition award. In particular, the record does not establish that the treating physician's limitations reflect claimant's actual inability to repetitively use her left leg, as distinguished from a recommendation to limit use to prevent increased pain or reinjury. See Eilene E. Harding, 45 Van Natta 1484 (1993); Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

ORDER

The ALJ's order dated February 29, 1996 is affirmed.

October 11, 1996 Cite as 48 Van Natta 2140 (1996)

In the Matter of the Compensation of
RONALD E. ROGERS, Claimant
WCB Case Nos. 95-01825, 94-14661 & 93-11544
ORDER OF ABATEMENT
Pozzi, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Cobb & Woodworth, Defense Attorneys

On October 7, 1996, we issued an order which, among other decisions, reversed that portion of an Administrative Law Judge's (ALJ's) order that assessed a penalty under ORS 656.262(11) against Liberty Northwest Insurance Corporation for unreasonable claim processing. Relying on amended ORS 656.319(6), we concluded that, since Liberty's allegedly unreasonable claim processing action or inaction arose more than 2 years from the filing of claimant's hearing request, we were without authority to grant the penalty request.

On our own motion, we wish to further consider the question of whether retroactive application of amended ORS 656.319(6) is prohibited by Section 66(6) of Or Laws 332 in that the statute effectively alters a procedural time limitation. See Motel 6 v. McMasters, 135 Or App 583, 587 (1995); Brian D. Shipley, 48 Van Natta 994, 995 (1996), abated 48 Van Natta 1025 (1996). To assist us in conducting our further consideration of this question, the parties are granted an opportunity to file supplemental briefs. To be considered, each of those supplemental briefs must be filed within 14 days from the date of this order.

Accordingly, we withdraw our October 7, 1996 order. Following completion of the aforementioned briefing schedule, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD G. LASLEY, Claimant
WCB Case No. 95-13818
ORDER ON REVIEW
Bogardus & Nichols, Claimant Attorneys
Leah Sideras, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's partial denial of claimant's injury claim for a torn left rotator cuff. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On March 16, 1995, claimant fractured his left elbow when he slipped dismounting from his loader at work. Claimant dangled momentarily by his left arm until he felt a "pop" in his left elbow and dropped to the ground.

Claimant treated with Dr. Strieby, who instructed him not to use the injured arm. Claimant kept his left arm immobile, usually in a sling, for about a month.

On April 21, 1995, claimant first described "periodic" left shoulder pain in a pain diagram annotated for examining physicians. (Ex. 25-2). He returned to work on April 24, 1995. As his elbow condition improved, his preexisting left finger and hand numbness and tingling (probably related to a preexisting cervical condition) resurfaced and increased and his left shoulder pain progressively worsened. (See Tr. 11-12).

On June 13, 1995, the insurer accepted a fracture of the left elbow coronoid process. (Ex. 11).

On December 18, 1996, the insurer issued a partial denial of claimant's left shoulder torn rotator cuff. (Ex. 12).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to prove that his torn left rotator cuff is compensably related to his March 16, 1995 injury, because Dr. Casey's opinion is unpersuasive due to inconsistencies with claimant's testimony. We disagree.

It is undisputed that the mechanism of claimant's injury is consistent with a traumatic rotator cuff tear. However, several doctors, including Dr. Strieby, opined that claimant's tear is probably degenerative, rather than traumatic, because left shoulder symptoms are not discussed in the medical reports until November 6, 1995, when the torn cuff was discovered. (See Ex. 16-1). We are not persuaded by the examining physicians' opinions that their post-injury elbow examinations would have disclosed any then-existing shoulder problems. (See Ex. 23-2). Instead, we are convinced by Dr. Strieby's opinion that claimant's preexisting neck and injury-related elbow symptoms "could over shadow the pain of a rotator cuff tear." (Ex. 22).

At hearing, claimant described the April 1995 onset of left shoulder symptoms in the context of the healing elbow fracture and his return to work. He did not notice left shoulder pain between March 17 and April 24, 1995. However, when he returned to arm intensive work, claimant testified that it "seemed like after my elbow got better then I could -- I noticed my shoulder starting to hurt and it just kept progressing." (Tr. 12). He told Dr. Strieby: "Simply my arm was bothering me. I called it my arm. I'm a logger, I'm not a doctor. I didn't realize it was my shoulder." (Tr. 14-15).

Dr. Strieby referred claimant to Dr. Casey, who first examined claimant on December 20, 1995. Dr. Casey recorded that claimant's left shoulder symptoms became troublesome in April (i.e., when claimant described them on the pain diagram and began using his left arm regularly upon his return to work). In our view, Dr. Casey's history is entirely consistent with claimant's testimony regarding his symptoms. (See Ex. 21, Tr. 12). We find it reasonable that claimant would not notice shoulder problems while his arm was immobile in a sling and his very painful fractured elbow was healing.

Moreover, considering claimant's preexisting cervical condition, we find the delayed identification of the left shoulder as the source of continuing and worsening left upper extremity problems to be understandable and reasonable. Claimant is an entirely straightforward examinee, exhibiting no inconsistencies. (See Ex. 7-5).

Under these circumstances, we find no persuasive reason to discount the opinion of Dr. Casey, current treating physician, which is well-reasoned and based on an accurate history. According to Dr. Casey, the March 1995 work incident caused the left shoulder torn rotator cuff condition. Accordingly, based on that opinion, we find the claim compensable. See ORS 656.005(7)(a).

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 brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 11, 1996, as reconsidered May 20, 1996, is reversed. The insurer's partial denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $4,000 attorney fee, payable by the insurer.

October 15, 1996 Cite as 48 Van Natta 2142 (1996)

In the Matter of the Compensation of
RODNEY G. McALENY, Claimant
WCB Case No. 95-09821
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the SAIF Corporation's denial of claimant's right knee lateral meniscus tear. On review, the issue is compensability.

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

Claimant compensably injured her right knee in December 1994, which resulted in a partial lateral and medial meniscectomy. The claim was closed by a May 10, 1995 Notice of Closure with an award of scheduled permanent disability. Seeking to increase her scheduled permanent disability award, claimant requested reconsideration and a medical arbiter examination. During the medical arbiter examination, the medical arbiter hyperextended claimant's right leg, causing a lateral meniscus tear.

The ALJ found that claimant's meniscus tear was a consequential condition and a direct result of an activity that would not have occurred but for her compensable injury. The ALJ concluded, however, that claimant's compensable injury was not the major contributing cause of the consequential condition because the medical arbiter's examination was an intervening event independent of the original compensable injury. In so concluding, the ALJ relied on Kathleen A. Robinson, 46 Van Natta 833, on recon 46 Van Natta 1677 (1994).

The court has since affirmed our reasoning and conclusion in Robinson. In Robinson v. Nabisco, Inc., 143 Or App 59 (1996), the court held that in order for an injury occurring during an independent medical examination (IME) to be compensable as a consequence of the compensable injury, it must be established that the original injury was the major contributing cause of the consequential condition. Where the major contributing cause of the new injury is the activities that occurred during the IME and not the original injury itself, the consequential condition is not compensable.

In this case, we agree with the ALJ that the persuasive medical evidence establishes that the major contributing cause of claimant's consequential condition was the injury sustained during the medical arbiter's examination, and not the original compensable injury. Therefore, claimant's worsened condition is not compensable. Robinson v. Nabisco, Inc., supra,

Claimant contends on review that ORS 656.018 and amended ORS 656.268 violate Article I, section 10, of the Oregon Constitution. In particular, claimant argues that he was injured during the course of a required medical arbiter examination and that, because the medical arbiter is exempt from liability under ORS 656.018, he is prohibited from bringing civil actions for his injury. Given that the ALJ found his aggravation claim not compensable, claimant therefore concludes he is left without a remedy. For the following reasons, we reject claimant's argument.

At the outset of the hearing, claimant stated that the issues were extent of disability and, in the alternative, aggravation. Claimant did not raise the constitutional issue until closing arguments. We will not consider a new issue first raised during closing arguments. Leslie Thomas, 44 Van Natta 200 (1992); Edward A. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2135 (1989).

Alternatively, even if claimant had properly raised his constitutional challenge, we would not consider the issue because claimant has not demonstrated that he has been injured by operation of ORS 656.018 and amended ORS 656.268. See Jim M. Greene, 47 Van Natta 2245 (1995) (before challenging that amended ORS 656.018 deprived him a remedy in violation of Article I, section 10 of Oregon Constitution, the claimant failed to demonstrate he was prohibited from bringing a civil action regarding his injuries). We adhere to the fundamental rule that a case shall not be decided on constitutional grounds unless absolutely necessary to determination of the issue before it. See Gary W. Benson, 48 Van Natta 1161 (1996) (declining to consider Article I, Section 10 challenge to "major contributing cause" standard applied in conjunction with ORS 656.018); Rex Brink, 48 Van Natta 916 (1996) (same).

ORDER

The ALJ's order dated January 16, 1996 is affirmed.

October 15, 1996 Cite as 48 Van Natta 2143 (1996)

In the Matter of the Compensation of
WILLADO PENA, Claimant
WCB Case No. 93-01902
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Baker's order that upheld the SAIF Corporation's denial, on behalf of the noncomplying employer, of claimant's pelvic and abdominal injury claim. On review, the issue is compensability (subjectivity).

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

Claimant has not established that his activity at the time of the injury was in the "course of the trade, business or profession of the employer." ORS 656.027(3)(a)(A). In addition, even assuming employment at the time of injury, we find that claimant has not established that such employment was anything other than "casual."[1] See ORS 656.027(3)(a), (b). See Jesus Fletes, 48 Van Natta 197 (1996). Under these two circumstances, claimant was not a subject worker when injured and he is therefore not entitled to benefits under ORS Chapter 656.

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[1] Specifically, we find it more likely than not that work for the employer "in any 30-day period, without regard for the number of workers employed, involve[d] a total labor cost of less than $500." ORS 656.027(3)(b). In other words, even assuming there was an employment "contract" between claimant and the NCE (and the NCE had subject employees), we do not find persuasive evidence that the NCE's total labor costs in any 30-day period were equal to or greater than $500.

ORDER

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

In the Matter of the Compensation of
DAVID L. ROLFE, Claimant
WCB Case No. 95-12532
ORDER ON REVIEW
Charles D. Beshears, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's injury claim for a low back condition, including degenerative disc disease. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on July 26, 1986 and was diagnosed with a moderate lumbar sprain/strain. (Ex. 2). A CT scan performed on January 12, 1987 showed very mild degenerative disease within the posterior elements of the L5-S1 disc. (Ex. 14). The claim was closed by a March 31, 1987 Determination Order that awarded 15 percent unscheduled permanent partial disability. (Ex. 27A).

On July 22, 1995, claimant compensably injured his low back while dismounting truck tires. A lumbar spine x-ray taken that day showed some hypertrophic changes of the facet joints at L4-5 and a possible pars defect at L5. (Ex. 36). Dr. Finley diagnosed claimant with a lower dorsal and lumbar sprain/strain with neuralgia and paresthesias complicated by suspected disc pathology. (Ex. 39). An MRI scan on August 8, 1995 showed a minimal central posterior disc bulge at L5-S1 without encroachment upon the nerve roots. (Ex. 43).

Dr. Finley referred claimant to Dr. Baum, who diagnosed lumbar strain with left leg radiculopathy. (Ex. 50). Claimant was treated with a lumbar epidural steroid injection.

On October 9, 1995, SAIF accepted a disabling lumbosacral strain. (Ex. 55). The following day, SAIF issued a partial denial of claimant's preexisting degenerative arthritic changes and degenerative disc disease in his back. (Ex. 56).

The ALJ concluded that, based on Dr. Finley's opinion, claimant's July 22, 1995 injury was the major contributing cause of a pathological worsening of his preexisting degenerative lumbar condition.

SAIF argues that the ALJ applied the incorrect standard of proof. SAIF contends that the correct standard requires claimant to prove that the July 1995 injury is the major contributing cause of claimant's current condition itself, not just the major contributing cause of a worsening of that condition.

Claimant does not dispute that the lumbar degenerative disc disease preexisted the July 22, 1995 injury. The condition for which claimant seeks compensation is the combination of the accepted lumbosacral strain and the preexisting degenerative disc disease, which claimant asserts was pathologically worsened by the work injury. The medical evidence establishes that the July 1995 work injury combined with claimant's preexisting degenerative disc disease to cause or prolong disability or a need for treatment. (Exs. 53, 58, 62, 63-3, 63A). Therefore, claimant must establish that the July 1995 work injury is the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B).

Claimant relies on Dr. Finley's opinion. On November 25, 1995, Dr. Finley opined:

> "In any event, since [claimant] was far more restricted in forward flexion following his 22 July 1995 injury than his 31 July 1986 injury and also demonstrated relatively more significant SLR findings, his abnormal L5-S1 disc significantly worsened and in combination with a new intervening superseding lumbar sprain of 22 July 1995, required medical care and his being off regular work. Again, the major cause of all of that was his 22 July 1995 industrial injury." (Ex. 63-3).

Dr. Finley reported that claimant's July 22, 1995 lumbar sprain injury combined with the abnormal L5-S1 disc condition and was the major cause of claimant's need for medical care. Dr. Finley's opinion establishes that claimant's July 22, 1995 injury was the "major contributing cause" of the disability or need for treatment of the combined condition. In addition, Dr. Finley indicated that claimant's abnormal L5-S1 disc "significantly worsened." (Id.)

SAIF argues that Dr. Finley's opinion is not persuasive because he denied that claimant had a preexisting degenerative disc condition. In responding to questions from claimant's attorney concerning Dr. Scheinberg's October 3, 1995 report, Dr. Finley wrote:

> "There is a comment in item 5, page 5, that there is pre-existing degenerative arthritic change or degenerative disc disease, if this were true, then it would have been an on-going situation and he would have had ongoing low back complaints with an inability to change truck tires which weighed more than he does. His work record indicates and his testimony indicates that his low back was not a problem prior to his injury and he had a perfect work record." (Ex. 63-5).

On page 5 of his report, Dr. Scheinberg stated :

> "My feeling is that if [claimant] indeed sustained a musculoligamentous strain of his lumbosacral spine on 7/22/95, that strain should have resolved by the time of this examination and any continuing complaints would related to the pre-existing degenerative arthritic change or degenerative disc disease." (Ex. 53-5).

Taken in context, Dr. Finley's comments about Dr. Scheinberg's report indicated his disagreement with Dr. Scheinberg's opinion that claimant's current complaints related to his preexisting condition. In contrast, Dr. Finley's report indicated that claimant's current symptoms related to his degenerative condition, which had significantly worsened as a result of the July 22, 1995 injury. Since Dr. Finley referred twice to the worsening of claimant's "abnormal L5-S1 disc" condition (Exs. 63-1, 63-3), we disagree with SAIF's contention that Dr. Finley denied that claimant had a preexisting degenerative disc condition.

Dr. Finley's opinion that claimant's July 22, 1995 lumbar sprain injury was the major cause of claimant's combined condition is supported by Dr. Baum. Dr. Baum reported that claimant's July 22, 1995 injury was the major contributing cause of claimant's need for treatment and disability. (Ex. 62). Dr. Baum also concurred with Dr. Finley's November 25, 1995 report. (Ex. 66-3).

SAIF relies on the opinion of Dr. Scheinberg. As we mentioned earlier, Dr. Scheinberg believed that claimant's current complaints related to his preexisting degenerative condition rather than the July 22, 1995 injury. (Ex 53-5). In preparing his report, Dr. Scheinberg did not review any imaging studies. (Ex. 53-4). In a later report, Dr. Scheinberg reported that there had been no worsening of claimant's degenerative disc disease. (Ex. 63A). Dr. Scheinberg commented:

> "The degenerative changes were present prior to the 1986 injury and would in and of themselves naturally have progressed. However, the 1986 injury did worsen the degeneration and, in my opinion, increase the progression." (Id.)

We agree with the ALJ that Dr. Scheinberg's opinion is not persuasive. Although Dr. Scheinberg stated that claimant's degenerative changes were present before the 1986 injury, there is no evidence that claimant's degenerative condition preexisted the 1986 injury. To the contrary, Dr. Duncan reported on October 21, 1986 that he had reviewed claimant's x-rays and an MRI scan and found "normal lumbar films." (Ex. 9-4). Dr. Duncan reported that the posterior facet joints showed no evidence of sclerosis or degenerative changes and he found no evidence of spondylolisis or spondylolisthesis. (Id.)

Furthermore, we are not persuaded by Dr. Scheinberg's opinion because it is contradictory. On the one hand, Dr. Scheinberg opined that claimant's degenerative changes were idiopathic, not related to work activity and had not worsened. (Exs. 53-5, 63A). On the other hand, Dr. Scheinberg reported that claimant's 1986 injury worsened the degeneration and increased the progression. (Ex. 63A). Because Dr. Scheinberg's opinion is contradictory and confusing, it is entitled to little weight.

When medical evidence is divided, we generally give greater weight to the conclusions of a claimant's treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we agree with the ALJ that Dr. Finley's opinion is more persuasive than that of Dr. Scheinberg. Based on Dr. Finley's opinion, as supported by Dr. Baum, we conclude that claimant has established that the July 1995 work injury is the major contributing cause of the disability or need for treatment of the combined condition, which consists of the lumbosacral strain and the degenerative disc disease. To the extent claimant's current degenerative disc disease is a part of the "combined condition," it is compensable. See Christopher L. Lander, 48 Van Natta 1035 (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 SAIF Corporation. 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 April 25, 1996, as reconsidered May 22, 1996, is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the SAIF Corporation.

Board Member Haynes specially concurring.

Although the parties frame the issue in this case as the compensability of claimant's degenerative disc disease, I want to emphasize that is not the precise issue before us. This claim was not litigated as an occupational disease. (Tr. I-16, 33). Rather, this is an injury claim. SAIF has already accepted a disabling lumbosacral strain as a result of claimant's July 22, 1995 injury. In this proceeding, the condition for which claimant seeks compensation is the combination of the accepted lumbosacral strain and the preexisting degenerative disc disease, which claimant asserts was pathologically worsened by the work injury.

We have determined that claimant's July 1995 work injury is the major contributing cause of the disability or need for treatment of the combined condition, which consists of the lumbosacral strain and the degenerative disc disease. We have not decided that claimant's preexisting degenerative disc disease is compensable, in and of itself. Rather, we have concluded that, to the extent claimant's current degenerative disc disease is a part of the "combined condition," it is compensable. A combined condition is only compensable "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. ORS 656.005(7)(a)(B). Conversely, when the "otherwise compensable injury" ceases to be the major contributing cause of the combined condition, the combined condition is no longer compensable. ORS 656.262(6)(c).[1] If that situation occurs at some point in the future, SAIF may consider issuing a denial of the combined condition.

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[1] ORS 656.262(6)(c) provides:

"An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

In the Matter of the Compensation of
TERRI L. VEACH, Claimant
WCB Case No. 95-09478
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) awarded an assessed attorney fee pursuant to ORS 656.382(1) for the insurer's alleged failure to timely provide discovery; and (2) awarded an attorney fee pursuant to ORS 656.386(1) for claimant's counsel's efforts in overturning a "de facto" denial. On review, the issues are penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we briefly summarize as follows. On May 22, 1995, claimant filed an occupational disease claim for left carpal tunnel syndrome (CTS) with the insurer. (Ex. 4). On August 21, 1995, claimant filed a request for hearing alleging a "de facto" denial of claimant's left CTS. The request for hearing made demand for copies of all medical reports and all other documents pertaining to the claim. (Ex. 5). The insurer received claims documents on July 27, 1995 and September 6, 1995. On September 13, 1995, the insurer accepted the left CTS syndrome. A hearing was held on November 15, 1995. The insurer provided claimant with the requested claims information at hearing. The insurer had paid all compensation to which claimant was entitled through the time of hearing. (Tr. 9).

CONCLUSIONS OF LAW AND OPINION

Attorney Fee - ORS 656.382(1)

The ALJ found that the insurer's failure to timely provide claims documents was unreasonable. However, because there were no "amounts due" on claimant's claim, he awarded a $1,000 attorney fee under ORS 656.382(1), which authorizes an attorney fee if a carrier unreasonably resists the payment of compensation.

The insurer contends that, since no compensation was unpaid,[1] it could not have unreasonably resisted the payment of compensation under ORS 656.382(1). We agree.

Even if the insurer's failure to timely provide claims documents 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 Michael J. Pelcin, 47 Van Natta 1380 (1995); Bruce Hardee, 46 Van Natta 2261 (1994) (in the 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)). Therefore, we reverse the ALJ's $1,000 attorney fee award.

Attorney Fee - ORS 656.386(1)

The ALJ awarded a $750 attorney fee under ORS 656.386(1) for claimant's counsel's efforts in obtaining compensation for claimant without a hearing. The insurer contends that claimant's left CTS claim is not a "denied claim" and that no attorney fee was awardable under that statute.[2] We agree.

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[1] The ALJ found that "no compensation is due on the claim." (Opinion and Order at 2). No one contests that finding.

[2] The insurer also objected to the ALJ's application of ORS 656.262(7) to this matter, as claimant's left CTS claim was not a "new condition" in an accepted claim, but was instead a new, independent claim. We need not address this issue, as it would have no effect on the outcome of this case.

Under 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 must, therefore, determine whether claimant's left carpal tunnel condition claim was a "denied claim." ORS 656.386(1) defines a "denied claim" as a "claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation.

In Michael J. Galbraith, 48 Van Natta 351 (1996), we held 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. Instead, the parties agreed that the insurer had paid all compensation to which claimant was entitled through the date of hearing. Moreover, there is nothing in the record to establish that the insurer questioned causation of claimant's left CTS condition. Under such circumstances, we conclude that a "denied claim" has not been established. Accordingly, an attorney fee may not be awarded under ORS 656.386(1).[3] Michael J. Galbraith, supra; Jerome M. Baldock, 48 Van Natta 355 (1996) (an attorney fee may not be awarded under ORS 656.386(1) where a "denied claim" has not been established).[4]

ORDER

The ALJ's order dated January 5, 1996 is reversed. The ALJ's attorney fee awards are reversed.

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[3] The insurer also argues that the ALJ erred in finding that its acceptance was untimely. We need not address this issue, as it would have no effect on the outcome of this case.

[4] In her reply brief, claimant argues that to the extent that Senate Bill 369, Michael J. Galbraith, supra, and Jerome M. Baldock, supra, operate to deprive claimant of attorney fees, their application is in violation of the Americans with Disability Act, 42 USC § 12132; the Oregon Constitution, Article 1, section 10; and the Fourteenth Amendment of the United States Constitution. Claimant does not elaborate or explain her statutory and constitutional arguments. Because claimant's arguments are not adequately developed for our review, we are not inclined to address them. See Ronald B. Olson, 44 Van Natta 100 (1992) (Board declined to address unspecified constitutional challenges to the 1990 amendments).

In the Matter of the Compensation of
BRIAN W. ANDREWS, Claimant
WCB Case Nos. 93-08329 & 93-05174
ORDER ON REMAND
Peter O. Hansen, Claimant Attorney
Stoel, Rives, et al, Defense Attorneys
Jim Thwing (Saif), Defense Attorney

This matter is on remand from the Supreme Court. Andrews v. Tektronix, 323 Or 154 (1996). The court reversed the Court of Appeals' decision, Andrews v. Tektronix, 134 Or App 628 (1995), which had affirmed without opinion our order finding that claimant was not injured in the course and scope of his employment. Brian W. Andrews, 46 Van Natta 1622 (1994). The Court has remanded to the Board for further proceedings concerning the issue of whether claimant's injury was connected to his work.

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact except for the following sentence: "Both claimant and Mr. Scovil testified that it was common practice, among workers from different companies to give each other a hand, on occasion, when making deliveries."

We replace it with the following: Richard Scovel, who worked for a coffee company, testified that, when necessary to unload supplies, he asked for assistance from noncoworkers and would provide help to noncoworkers when requested.

CONCLUSIONS OF LAW AND OPINION

In May 1992, claimant began working for the SAIF Corporation's insured, a plumbing company, purchasing and delivering parts and acting as a plumbing assistant. In October 1992, claimant informed the employer that he had a history of back problems. At that time, the employer verbally restricted claimant from heavy lifting. The employer communicated this restriction to its main supplier, saying that, when claimant arrived to pick up supplies, the supplier, and not claimant, would have to load the supplies.

On March 24, 1993, claimant delivered some plumbing supplies to a coworker who was installing plumbing at a newly constructed restaurant. When claimant arrived, the coworker was away at lunch. While claimant awaited his coworker's return, an employee of a coffee company asked claimant to help him carry a 200-pound espresso machine into the restaurant. When claimant assisted the noncoworker, he injured his low back and left leg.

Applying the factors enunciated in Jordan v. Western Electric, 1 Or App 441 (1970), the ALJ found that claimant's injury arose out of and in the course of his employment. In reaching this conclusion, the ALJ largely relied on evidence that it was custom and practice for noncoworkers to assist each other in loading and unloading supplies at construction sites.

On review, we reversed. Brian W. Andrews, supra. We first found that claimant engaged in "misconduct" by violating the employer's no-lifting restriction when he helped move the espresso machine. 46 Van Natta at 1623. We then applied Professor Larson's "ultimate work" test; such analysis deems "misconduct" that oversteps the boundaries defining the "ultimate work" to be outside the course of employment and "misconduct" that violates regulations relating to the method of accomplishing the ultimate work to be within the course of employment. Larson, 1A Workmen's Compensation Law § 31.00 at 6-10. Finding that "claimant's violation of the employer's heavy lifting rule involved a prohibited overstepping of the boundaries defining his ultimate work," we concluded that claimant's injuries were outside the course and scope of his employment. 46 Van Natta at 1623. The Court of Appeals affirmed without opinion. Andrews v. Tektronix, supra.

The Supreme Court first analyzed whether the "ultimate work" test was consistent with a determination that the connection between the injury and employment is sufficient to warrant compensation. The Court decided that "Professor Larson's rule, as adopted by the Board, does little, if anything, to alter the basic work-connectedness test of compensation that our workers' compensation statute requires." 323 Or at 164. The Court, however, disapproved of our "particular gloss on that rule," finding that "the Board treated its determination that claimant had disobeyed his employer's instruction as a complete substitution for an analysis of work connectedness." Id. Specifically, the Court rejected the idea that an employee's violation of an employment rule rendered the worker's claim per se noncompensable. Id. at 166.

Finally, the Court instructed us that we properly "should have decided the question of compensability by deciding, in the first instance, whether claimant was engaged in an activity that was within the boundaries of his ultimate work." Such a determination includes consideration

> "that an employer has instructed a worker to avoid certain work, and that the worker's injury occurred when he or she disregarded that instruction * * *. Among the additional factors are the degree of connection between what the worker is authorized to do and is forbidden to do, the degree of judgment and latitude normally given the worker, workplace customs and practices, the relative risk to the worker when compared to the benefit to the employer, and the like. Moreover, 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." Id. at 165. (Emphasis in original.)

Consequently, we proceed with our reconsideration pursuant to the Court's instructions.

The testimony at hearing shows that part of claimant's job was to pick up supplies and deliver them to the appropriate site. (Tr. 24). When the employer, Dana Marshall, learned of claimant's history of back injuries, he verbally restricted claimant from lifting. (Id. at 53). Mr. Marshall also contacted his major supplier and informed it that its employees, rather than claimant, were to load

supplies for claimant. (Id. at 26, 54-55). Testimony also shows that both claimant and Mr. Marshall understood that claimant was to obtain assistance when unloading heavy supplies at the work site. (Id. at 27-28, 59). According to claimant, it was customary for him to ask coworkers or, if coworkers were not available, noncoworkers, for help in unloading the supplies. (Id. at 28, 33).

Based on such evidence, we find that claimant and his employer understood that claimant was restricted from loading supplies from at least one supplier and he was to seek assistance when unloading supplies. Claimant's work boundaries concerning his assistance of nonemployees in unloading their supplies, however, is less clear. Mr. Marshall did not explicitly tell claimant that he was prohibited from such conduct. (Tr. 45). Claimant testified, however, that Mr. Marshall would not have allowed or expected claimant to help with the espresso machine. (Id. at 34). Mr. Marshall similarly testified that he would not have approved of claimant's assistance in unloading the espresso machine because it required claimant to lift. (Id. at 56). Claimant agreed on cross-examination that he was "the kind of guy who just sort of jumps in and helps[.]" (Id. at 34).

In light of the evidence of claimant's lifting restrictions and the testimony from claimant and Mr. Marshall concerning their understanding that Mr. Marshall would not approve of claimant's assistance with the espresso machine, we conclude that the preponderance of evidence shows that claimant was not authorized to lift and carry the espresso machine and that claimant was outside the scope of his work boundaries when he engaged in such activity.

As previously discussed, the ALJ found that it was industry "custom and practice" for noncoworkers to assist each other in unloading supplies at construction sites. The ALJ relied upon this finding in concluding that claimant's injury was within the course and scope of employment. There was testimony from the coffee company employee that it was "kind of an unwritten law" to assist in unloading supplies when asked by noncoworkers at a construction site. (Tr. 12). When claimant was asked, however, whether it was his "custom to help other tradespeople at building sites," claimant responded that he was "more in the custom of having people help me[.]" (Id. at 33). Claimant further stated that he did help move the espresso machine and that at times he assisted noncoworkers in loading supplies when he picked up materials to be delivered. (Id. at 33-34).

Based on this testimony, we find that, whether or not it is industry practice and custom for noncoworkers to assist each other in unloading supplies, claimant did not participate in such a custom. Claimant assisted a noncoworker in unloading supplies only one time when he helped lift and carry the espresso machine. Thus, because the record shows that there was only a single occasion when claimant assisted a noncoworker in unloading supplies at a construction site, we conclude that any such industry practice and custom had little, if any, effect on the boundaries of claimant's ultimate work.

We also consider the following factors. Claimant's activity in unloading and carrying the espresso machine provided no benefit to the employer. Claimant was paid for the time he spent in lifting and carrying the espresso machine. Mr. Marshall did not discipline claimant for engaging in the conduct. Finally, claimant's activity carried the risk of injuring claimant, especially since claimant had a long history of back injury.

After considering the relevant factors, we hold that claimant's activity in lifting and carrying the espresso machine was outside the boundaries of his job. In reaching this conclusion, we particularly rely on our finding that claimant and his employer both understood that claimant's job did not include assisting noncoworkers in unloading supplies at a construction site. Furthermore, it was not claimant's custom and practice to deviate from this procedure. We emphasize that, consistent with the Court's opinion, our inquiry has not been to determine whether claimant engaged in misconduct, but rather, to decide whether claimant's activity was within the boundaries of his ultimate work.

Because claimant's injury resulted from his activity in lifting and carrying the espresso machine and such conduct was not a job-related activity, we find an insufficient connection between claimant's work and his employment to warrant compensation. Andrews v. Tektronix, 323 Or at 162. Accordingly, on reconsideration, the ALJ's order dated October 29, 1993 is reversed in part and affirmed in part. The SAIF Corporation's denial is reinstated and upheld in its entirety. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

IT IS SO ORDERED.

Board Chair Hall dissenting.

The majority concludes that claimant's injury is not compensable because he was outside the scope of his work when he assisted a noncoworker in lifting and carrying an espresso machine at the work site. Because I believe that the majority too narrowly defines the concept of work boundaries and, in doing so, improperly focuses on whether the injurious activity was forbidden or condoned, I dissent.

In its opinion, the Court states that Professor Larson's "ultimate work" test is consistent with the "basic work-connectedness test of compensability that our workers' compensation statute requires," since Professor Larson's inquiry determines whether, "regardless whether it is forbidden or condoned, an activity that is outside the boundaries of a claimant's job is not part of the claimant's job." Andrews v. Tektronix, 323 Or 154, 164 (1996). According to the Court, compensability is determined by first deciding "whether claimant was engaged in an activity that was within the boundaries of his ultimate work." Id. at 166.

In carrying out this instruction, the majority herein analyzes the record to determine whether each facet of claimant's job activity was approved (either explicitly or implicitly) by the employer, and if claimant exceeded the employer's approval of such activity. Finding that "claimant was not authorized to lift and carry the espresso machine," the majority finds that "claimant was outside the scope of his work boundaries when he engaged in such activity." I view the Court's instructions differently: compensability depends on the general nature of the employment (boundaries defining a claimant's "ultimate work") and the connection between the injury and the employment.[1] As the Court stated:

> "Even when a worker is injured while engaged in a task that the employer appears to have removed from the worker's job description, the injury still may bear a sufficient connection to the worker's assigned tasks to warrant a conclusion that the injury is compensable." 323 Or at 164.

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[1] In the present case, the Court did not rewrite the "test" for determining whether an injury "arose out of and in the course of" employment. Instead, the Court once again recognized and affirmed the fundamental inquiry:

> "Although both elements [arising out of and in the course of] 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 connection between the injury and the employment is sufficient to warrant compensation. Rogers v. SAIF, 289 Or 633, 642, 616 P. 2d 485 (1980). [Footnote omitted.]
>
> "In particular factual circumstances, various tests may prove helpful in measuring and conceptualizing the strength of the connection between the claimant's injury and employment. Still, the ultimate test is the same: Considering all the pertinent circumstances, are the temporal, spatial, circumstantial, and causal connections between the claimant's injury and employment sufficient to justify compensation, when sufficiency is evaluated in the light of the Act's policy of providing financial protection to workers who are injured in the course of employment, regardless of fault? Thus, when confronted with a test that purports to determine whether an injury sustained under a particular set of factual circumstances is compensable, we must ask, 'Is the test compatible with that formulation?'
>
> "* * * * *
>
> "* * * Although it is true that, for general purposes, the Workers' Compensation Act defines the term 'worker' in terms of the employer's 'direction and control,' [Footnote omitted] it is also clear that, for purposes of determining whether a claimant's injury is compensable, his or her status as a worker does not depend on demonstrable submission to the employer's right of direction and control at the precise moment in time that the injury was sustained. * * *." 323 Or at 1612-163.

Here, part of claimant's job was to pick up and deliver materials to work sites.[2] When claimant assisted in carrying the espresso machine, albeit for a noncoworker at the work site, his activity was consistent with those work duties. Thus, I would conclude that claimant was injured while involved in activities sufficiently connected to his assigned tasks as to warrant a conclusion that the injury is compensable.

The Court's opinion repeatedly states that a worker's violation of an employment rule does not render the claim per se noncompensable. By focusing so much on whether the employer approved of particular activities, I believe that the majority's conclusion is, once again, based on a determination that claimant engaged in misconduct (though the majority disclaims the use of such terminology and analysis). As discussed above, because I would hold that claimant's injury is sufficiently connected to his work to warrant compensation, I would find the claim compensable.

[2] I agree with the ALJ that it was industry "custom and practice" for noncoworkers to assist each other in the loading and unloading of supplies at construction sites. (Tr. 12). Claimant himself testified that he participated in such custom by asking coworkers or, if coworkers were not available, noncoworkers for help in unloading claimant's supplies. (Tr. 28, 33). Claimant also participated in the custom by assisting noncoworkers in the loading of supplies. (Tr. 33-34). The majority recognizes this fact, but then narrowly focuses on whether claimant has previously assisted a noncoworker unload supplies. The majority makes a distinction, at least implicitly, between a custom of loading versus unloading and then relies on the "single occasion when claimant assisted a noncoworker in unloading supplies" to conclude that industry practice and custom had little, if any, effect on the boundaries of claimant's ultimate work. I disagree with the majority's narrow focus and the attempt to distinguish loading from unloading.

In the Matter of the Compensation of
REESE BLACKNALL, Claimant
WCB Case No. 95-03571
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall, Christian and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's claim for a right wrist 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 $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 9, 1996 is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the employer.

Member Haynes dissenting.

In adopting and affirming the ALJ's order, the majority holds that claimant established the compensability of his right wrist tendinitis as an accidental injury. Unlike the majority, I find that numerous inconsistencies in the record render claimant's reported history and testimony unreliable, and the medical opinions based thereon insufficient to sustain his burden of proof. Therefore, I respectfully dissent.

Claimant sought treatment for right wrist pain on November 11, 1994. At the time, he was working part-time for the employer performing janitorial duties. Claimant was also working approximately 25-30 hours a week at a Plaid Pantry store, as a cashier. The emergency room physician recorded a history of claimant having two weeks persistent pain in the right wrist. This history is consistent with claimant's supervisor's contemporaneous incident report, but inconsistent with claimant's testimony. At hearing, claimant maintained that his right wrist symptoms began as he was wiping down a bathroom counter on November 11, 1994. (Tr. 7).

Claimant testified that he was working for the employer between six and eight hours a day, and between 20 to 35 hours a week at the time of the November 11, 1994 incident (Tr. 6), yet the employer's time records indicate that claimant only worked ten days between his initial hire date of October 19, 1994 and November 11, as an on-call substitute.[1] (Ex. G, Tr. 51). Claimant also testified that he did not tell his treating and examining doctors about his contemporaneous employment with the Plaid Pantry because, at the time of the November 11, 1994 incident, he was not working that often. (Tr. 3, 40). The Plaid Pantry's payroll records indicate otherwise, however. Claimant's gross earnings were $245.44 for the period of November 5 to November 18, 1994, and between September 9, 1994 and November 18, 1994 his Plaid Pantry earnings averaged more than $230 for each two week pay period.[2] (Ex. F). Moreover, claimant's own testimony concerning the nature of his employment duties at Plaid Pantry was not consistent. On the one hand, claimant denied that this employment involved repetitive action involving his hands (Tr. 41) or that it had anything to do with his wrist problems, yet he also testified that he operated the cash register, straightened shelves and stocked inventory (Tr. 32) and that, during the course of his employment (between September and mid-December 1994), he worked between 25 to 30 hours a week. (Tr. 31).

In addition to doubting the reliability of claimant's testimony, I also consider the medical opinions supporting the compensability of claimant's right wrist condition to be based on an incomplete and inaccurate history. For example, Dr. Aversano, who first saw claimant two months after the initial incident, initially opined that claimant's wrist symptoms were of unknown etiology, that from an anatomical point of view, the findings on examination were not possible, and that all nerve conduction tests were normal. (Exs, 34, 38). Dr. Aversano later concluded that the major contributing cause of claimant's extensor de Quervain's tendinitis was the work injury of November 11, 1994. Dr. Aversano explained that his opinion was premised on his understanding that there was a "specific incident" at work on November 11, 1994 involving claimant's right arm, therefore claimant's prior work history was not pertinent. Dr. Aversano nevertheless assumed that claimant had been working for the employer for three or more weeks and performing strenuous cleaning activities involving his hands, wrists arms and shoulders, and that claimant's contemporaneous work for Plaid Pantry was neither strenuous nor repetitive and did not contribute to his symptomatology at all.[3] (Ex. 62).

Although claimant reported that his symptoms began suddenly on November 11, 1994, there is no evidence of a specific injurious incident. Claimant testified at hearing that his right wrist started burning as he was wiping down a counter, but he did not describe, nor do the contemporaneous medical records evidence, any specific injurious incident.[4] (See, e.g., Exs. 5, 6, 8).

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[1] For example, according to the employer's records, for the period of November 1 through November 15, 1994, claimant worked a total of 19 hours: six hours on November 7, six hours on November 8, four hours on November 11 and three hours on November 15. (Ex. G).

[2] Claimant also continued working part-time at the Plaid Pantry through December 16, 1995 (Ex. F), yet he testified at hearing that he did not tell Dr. Browning about his work at Plaid Pantry because he was not working there at that particular time. (Tr. 40).

[3] Dr. Aversano reported in December 1995 that he had been aware "all along" that claimant had been working two jobs at the time of his injury (Ex. 62), but this history is not set forth in Dr. Aversano's contemporaneous chart notes. Dr. Aversano's awareness is also inconsistent with claimant's testimony that he did not tell any of his doctors about his work at Plaid Pantry. (Tr. 32-33, 41).

[4] For example, a November 17, 1995 occupational therapy note states: Date of injury, 11/11/94; Janitorial work; patient notes decreased sensation, with numbness, tingling in hand, cause unknown. (Ex. 8-1).

I also am unpersuaded by Dr. Browning's opinion to the extent it supports the compensability of claimant's right wrist condition. After reviewing the reports of Drs. Long, Hamlin and Wyman (which revealed no consistently identifiable tendinitis of the right wrist) Dr. Browning reported on June 12, 1995 that there was "not sufficient documentation by a specialist" to support her initial diagnosis of ongoing work-related flexor tendinitis or de Quervain's tendinitis. She concluded that she could not, on a more probable than not basis, relate claimant's current complaints to his work activities with the employer. (Ex. 56-3). Then, following a telephone conference with claimant's attorney, Dr. Browing reported that, assuming claimant's history was accurate, the major contributing cause of claimant's wrist condition up to December 14, 1994 was his work activities with the employer.[5] Dr. Browning also noted, however, that she could not rule out entirely some degree of functional overlay from the beginning. (Ex. 57). Dr. Browning's change of opinion is unexplained. This opinion is also unpersuasive because it is premised on the accuracy of claimant's history, which I would find incomplete and unreliable.[6]

In summary, I believe the discrepancies and inconsistencies in the record are significant, and undermine claimant's credibility and the history on which his treating doctors relied. Unlike the majority, I would rely on the expert medical opinions of the orthopedic specialists, Drs. Long, Wyman and Stanford, who found insufficient objective evidence to support a diagnosis of tendinitis, and/or no relationship between claimant's right hand symptoms and his specific work activity on November 11, 1995.

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[5] It is unclear whether these "work activities" refer to the act of wiping a counter on November 11, 1994, or claimant's janitorial work in general.

[6] Indeed, Dr. Browning was never advised of claimant's contemporaneous employment with the Plaid Pantry.

In the Matter of the Compensation of
BILL D. COLEMAN, Claimant
WCB Case Nos. 95-06819 & 94-14304
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Craig A. Staples, Defense Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

Aetna Casualty & Surety Company (Aetna), as insurer for U. S. Plywood, requests review of those portions of Administrative Law Judge (ALJ) Martha Brown's order that: (1) found that the Hearings Division had jurisdiction over claimant's aggravation claim, concluding that the aggravation rights on the low back claim accepted by Aetna had not expired; (2) set aside Aetna's denial of claimant's aggravation claim for a low back condition; (3) upheld the self-insured employer's (Georgia Pacific's) denial of claimant's "new injury" claim for the same condition; (4) assessed a penalty under ORS 656.262(11) for Aetna's alleged unreasonable claims processing in failing to timely accept or deny the aggravation claim and failing to pay interim compensation; and (5) awarded an attorney fee under ORS 656.386(1) for prevailing over Aetna's aggravation denial. On review, the issues are jurisdiction, responsibility, penalties, and attorney fees. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, replacement, and supplementation. We do not adopt the first sentence of the second paragraph of the findings of fact.

We replace the second sentence of the fifth paragraph with the following: On November 11, 1992, Aetna also issued a 1502 form which provided that claimant's claim had first been accepted as nondisabling and Aetna was "converting [the] claim to disabling for disability rating." (Ex. 33B).

It is more probable than not that claimant received the May 22, 1987 801 form with appeal rights on the reverse side in plenty of time to seek reclassification of his claim within a year of the date of the May 19, 1987 injury.

On January 15, 1993, a Determination Order issued regarding claimant's compensable May 19, 1987 low back injury claim with Aetna. (Ex. 37). This Determination Order awarded claimant temporary disability benefits from May 25, 1987 through June 26, 1987, and 40 percent unscheduled permanent disability benefits for the low back injury.

After experiencing about a six month exacerbation in his low back pain, claimant was taken off work to participate in a back rehabilitation program from June 13, 1994 through July 1, 1994. (Exs. 52, 57, 59, 61, 62, 63, 64, 65, 66, 67, 68, 69). Claimant was followed by Dr. Holmes, M.D., during this back rehabilitation program. A week after this rehabilitation program ended, claimant was released to light work, with a 25 pound lifting limit. (Ex. 69-4).

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the same mill since February 1957. The mill has changed ownership several times during claimant's employment. On May 19, 1987, claimant compensably injured his low back. At the time of claimant's May 1987 injury, the mill was owned by Aetna's insured, U. S. Plywood. In approximately August 1987, Georgia Pacific, a self-insured employer, purchased the mill.

On May 22, 1987, Aetna's representative signed an 801 form accepting claimant's claim as a nondisabling injury. (Ex. 3). From 1987 through 1992, claimant continued to perform his job and continued to experience low back pain.

On November 17, 1992, Aetna issued a Notice of Claim Acceptance that accepted claimant's May 19, 1987 claim as a disabling left lumbar strain. (Ex. 34). On that same date, Aetna issued a 1502 form that provided that claimant's claim had first been accepted as nondisabling and Aetna was "converting [the] claim to disabling for permanent disability rating." (Ex. 33B). On January 15, 1993, a Determination Order issued which: (1) found claimant's claim medically stationary on June 26, 1987; (2) awarded temporary disability benefits from May 25, 1987 through June 26, 1987; and (3) awarded 40 percent unscheduled permanent disability for claimant's low back condition. (Ex. 37).

In December 1993, claimant experienced increased low back pain. After experiencing about a six month exacerbation in his low back pain, claimant was taken off work to participate in an inpatient back rehabilitation program from June 13, 1994 through July 1, 1994. (Exs. 52, 57, 59, 61, 62, 63, 64, 65, 66, 67, 68, 69, 71-3). A week after this rehabilitation program ended, claimant was released to light work, with a 25 pound lifting limit and assistance in performing his job. (Ex. 69-4). Claimant attempted to return to work in July 1994. However, claimant was unable to perform his job and was taken off work by Georgia Pacific's safety coordinator, who noted there were no jobs available within claimant's limitations. (Ex. 70A).

In August 1994, Dr. Thomson, attending physician, submitted a 827 form to Aetna on claimant's behalf, which stated that claimant's condition had aggravated. (Ex. 71). On September 13, 1994, claimant underwent a discography performed by Dr. Karasek, surgeon, who determined that claimant had painful discs at L4-5 and L5-S1 due to internal disc derangement. Dr. Hacker, neurosurgeon, subsequently performed a surgical consultation and determined that if continued physical therapy and a return to work within the limitations determined after that therapy was not a satisfactory option, then fusion surgery at L4-5 and L5-S1 could be considered as a last alternative. (Ex. 81). Claimant continued to have ongoing, severe low back pain that was not responsive to conservative treatments that had worked in the past.

On December 1, 1994, Aetna disclaimed responsibility. As a result, claimant filed a claim against Georgia Pacific, which disclaimed responsibility on February 9, 1995. On February 13, 1995, Aetna issued a second disclaimer and a denial of claimant's condition.

Jurisdiction

Relying on Carmen C. Neill, 47 Van Natta 2371 (1995), the ALJ found that the Hearings Division had jurisdiction over claimant's aggravation claim with Aetna regarding the accepted May 1987 low back injury. We disagree.

A claim for aggravation must be filed within five years after the first claim closure made under ORS 656.268; however, if the injury has been in nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury. ORS 656.273(4)(a) and (b). A worsening that occurs after a worker's aggravation rights have expired, is within the exclusive jurisdiction of the Board in its own motion authority. ORS 656.278; SAIF v. Reddekopp, 137 Or App 102, 105 (1995); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Therefore, if claimant's May 19, 1987 injury is found to be responsible for his current disability and need for treatment, the "aggravation" claim may or may not be within the jurisdiction of the Hearings Division, depending on whether the aggravation rights are calculated from the date of injury or the date of the January 15, 1993 Determination Order. For the following reasons, we find that the aggravation rights for the May 19, 1987 injury are calculated from the date of injury.

A carrier may accept a claim by checking a box on an 801 form. U. S. Bakery v. DuVal, 86 Or App 120 (1987); Nancy V. Storey, 41 Van Natta 1951 (1989); Alfredo G. Bustamate, 42 Van Natta 2358 (1990); Patrick A. Getty, 42 Van Natta 1197 (1990). However, the carrier must still comply with the requirements of ORS 656.262(6)[1] regarding, inter alia, notification of the right to appeal a carrier's classification of the claim as "nondisabling." Degrauw v. Columbia Knit, Inc., 118 Or App 277 (1993); Carmen C. Neill, supra.

Pursuant to ORS 656.277, a claimant has one year from the date of injury to seek reclassification of his or her claim. See Donald R. Dodgin, 45 Van Natta 1642 (1993). If a request for reclassification is not made within the one year time period, the claim cannot be reclassified and a claimant must make a claim for aggravation pursuant to ORS 656.273. ORS 656.277(1) and (2); Charles B. Tyler, 45 Van Natta 972 (1992). However, claimant must be notified of the classification of the claim, as well as the right to challenge that classification, within a sufficient time period that would allow the status of the claim to be challenged. ORS 656.262(6)(b) & (c); Degrauw v. Columbia Knit, Inc., supra; Carmen C. Neill, supra. Claimant has the burden to establish a timely aggravation claim. ORS 656.266; Normandeau v. Aetna Casualty & Surety Co., 120 Or App 184, 187 (1993) (claimant has the burden to establish a misclassification).

Ms. Greer, a claim representative who has worked for Aetna since 1968 and has worked with Aetna's Workers' Compensation claims since 1983, testified as to Aetna's standard practice in May 1987 regarding 801 claim forms. (Tr. 85-92, 98-101). Ms. Greer testified that, at the time of claimant's May 1987 injury, once a claim was accepted, Aetna's standard practice was to mail copy number three of the 801 form to the claimant, with the claim determination indicated on the bottom of the form. (Tr. 87, 90). She also testified that the reverse side of copy number three of the 801 form contained the rights regarding a challenge to a nondisabling classification. She identified Exhibit 98A as a blank 801 form that showed the information regarding the right to request reclassification on the reverse side.

Ms. Greer also testified that there was nothing in claimant's claim file to indicate that Aetna's standard practice was not followed. In this regard, she noted that there was no evidence that copy number three was returned with insufficient or incorrect address or that copy number three remained in claimant's file, as would be the case if it had not been sent to claimant. (Tr. 90-92).

Claimant testified that he did not recall but it was "possible" that he received Aetna's May 22, 1987 801 form accepting claimant's claim as a nondisabling injury and providing reclassification rights on the reverse side. (Tr. 23, 40-41, 45, 65-66).

Although we are not bound by formal rules of evidence, we find the Oregon Evidence Code (OEC) helpful when dealing with matters such as presumptions and burdens of persuasion. James L. Sampson, 37 Van Natta 1549 (1985), aff'd mem 87 Or App 57 (1987). OEC 311(m) provides a presumption that the ordinary course of business has been followed. ORS 40.135(1)(m). OEC 308 provides that a party against whom a presumption operates has the burden of proving that the nonexistence of the presumed fact is more probable than its existence. ORS 40.120.

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[1] ORS 656.262(6) was amended in 1995; however, those amendments are not relevant to the issues before us.

Given the presumption that the ordinary course of business has been followed and Ms. Greer's unrebutted testimony that Aetna's ordinary course of business included sending an injured worker a copy of the 801 form with the claim determination on the front and claim classification appeal rights on the back when the claim was accepted, and claimant's testimony that he did not recall but it was "possible" that he received Aetna's 801 form, we conclude that it is more probable than not that claimant received the May 22, 1987 801 form and it contained appeal rights on the reverse side. Here, claimant has the burden of proving the nonexistence of the presumed fact is more probable than its existence. OEC 308. Claimant's testimony that he did not recall but that it was "possible" that he received the 801 form containing appeal rights does not meet claimant's burden of proof. See Charles L. Simons, 47 Van Natta 908 (1995).

Claimant relies on Madewell v. Salvation Army, 49 Or App 713 (1980), in support of his argument that Aetna failed to prove it mailed the completed 801 form to claimant. In Madewell, the issue was whether the claimant filed a timely request for hearing from a denial. The carrier's denial letter was dated, but there was no evidence of the date on which the denial letter was mailed. The court held that while there is a presumption that a writing is truly dated, and that a letter directed and mailed was received in the regular course of mail, there is no presumption that a letter was mailed on the day it is dated or written. Because the carrier put on no evidence to show the filing of the claimant's claim was untimely, the court treated it as timely.

We find Madewell distinguishable. Madewell did not address the presumption that the ordinary course of business was followed. Furthermore, here, Aetna put on evidence to show the filing of claimant's aggravation claim was untimely through its claims examiner's testimony regarding its ordinary course of business. Here, Aetna established that its ordinary course of business was, once a claim was accepted, to send a copy of the 801 form to the worker with the determination indicated on the front of the 801 form and the classification appeal rights listed on the reverse side. The claim was accepted as a nondisabling injury by Aetna on May 22, 1987. (Ex. 3). Since Aetna's ordinary course of business was to send the claimant's copy of the 801 form once the claim was accepted, it follows that the 801 form was presumed to be sent within a reasonable period after May 22, 1987. As noted above, claimant's testimony that he did not recall but it was "possible" that he received the 801 form with classification rights on the reverse side does not rebut the presumption that the ordinary course of business was followed. Therefore, based on the above presumption regarding the ordinary course of business, we find that it is more probable than not that claimant received the May 22, 1987 801 form with appeal rights on the reverse side in plenty of time to seek reclassification of his claim within a year of the date of the May 19, 1987 injury.

In making this determination, we distinguish Carmen C. Neill, supra. In Neill, the injury was accepted by the employer by a letter that informed the claimant that her claim was nondisabling but did not provide her with notice of her right to seek reclassification of her claim within one year of the date of injury. The claimant was not notified of her right to object to her claim classification until the employer issued a Notice of Acceptance more than three years later, following an ALJ's Opinion and Order. Because the initial acceptance did not inform the claimant that she could challenge the classification of her claim, we found that claimant was precluded, through no fault of her own, from seeking reclassification within the statutory time period. Consequently, we determined that, since an objection to claim classification is a matter "concerning a claim," the Hearings Division had authority over the claimant's objection to her initial claim classification. ORS 656.283(1); Neill, supra, 47 Van Natta at 2371.

Here, unlike Neill, we have found that claimant was informed of his right to challenge the classification of his claim on the May 22, 1987 801 form, the initial acceptance, in plenty of time to request reclassification within one year from the date of injury. Therefore, here, claimant was not precluded, through no fault of his own, from seeking reclassification within the statutory time period. Furthermore, claimant did not seek reclassification of his injury from nondisabling to disabling within one year of his injury. Therefore, any claim relating to the May 19, 1987 injury must be made as an aggravation, and claimant's aggravation rights expired on May 19, 1992, five years from the date of injury. ORS 656.273(4)(b). Furthermore, because claimant's aggravation claim was made in August 1994, after the expiration of his aggravation rights, claimant's request for reopening of the May 1987 injury claim is within the Board's own motion jurisdiction.

However, claimant argues that Aetna's subsequent November 17, 1992 Notice of Acceptance[2] wherein Aetna accepted the May 19, 1987 injury as a "disabling left lumbar strain" represents a concession by Aetna that it initially misclassified claimant's claim as nondisabling. On that basis, claimant argues that the January 15, 1993 Determination Order properly determined that claimant's aggravation rights run from the date of that Determination Order, the first closure of his original disabling claim. Therefore, claimant argues, his aggravation rights will not expire until January 15, 1998, five years from the date of the first closure. We disagree.

First, the filing requirements of ORS 656.273 are jurisdictional. SM Motor Co. v. Mather, 117 Or App 176 (1992); Timothy D. Beard, 43 Van Natta 432 (1991); Denise A. Robinson, 42 Van Natta 2514 (1990). A claim for additional compensation made outside the time limits of ORS 656.273 is within the Board's own motion jurisdiction. See Miltenberger v. Howard's Plumbing, supra. Neither the Board nor the court may waive jurisdictional requirements. See Nelson v. SAIF, 43 Or App 155 (1979) (an ALJ is without jurisdiction to extend a claimant's statutory time limits for filing a request for hearing). It necessarily follows that the parties may not waive such requirements. Here, as discussed above, claimant's aggravation rights expired May 19, 1992, almost six months before Aetna's November 17, 1992 Notice of Claim Acceptance; therefore, any subsequent activity relating to claimant's May 1987 injury claim is in the Board's own motion jurisdiction. A carrier may voluntarily reopen a claim after a claimant's aggravation rights have run; however, such voluntary reopening does not give the Hearings Division jurisdiction it would not otherwise have.[3] ORS 656.278(5); Timothy D. Beard, supra.

Second, claimant appears to rely on a distinction in the Workers' Compensation Law that no longer exists. Prior to the 1990 amendments, a distinction was drawn between a claim that an injury was misclassified at the outset and a claim that a nondisabling injury had become disabling. In the latter instance, the claim was subject to the one year time limitation set forth in former ORS 656.262(12) while a claim that a injury had been disabling at the outset was not subject to a one year time limitation. Davison v. SAIF, 80 Or App 541, modified on recon 82 Or App 546 (1986). However, this distinction was eliminated after the 1990 amendments to ORS 656.273(4)(b) and the addition of ORS 656.277, changes that were retroactively applicable.[4] Gregory S. Myers, 44 Van Natta 1759 (1992). Therefore, after the passage of one year, both claims must be made as aggravation claims. Id.

Finally, claimant acknowledges that if a Determination Order provides an incorrect date from which aggravation rights run, that date is not controlling. Miltenberger v. Howard's Plumbing, supra. By the same token, we find that an award of temporary and permanent disability benefits by a Determination Order after the expiration of aggravation rights is not controlling. In this regard, as noted above, a carrier may voluntarily open a claim after expiration of aggravation rights. However, such a voluntary reopening does not serve to extend the aggravation rights. Timothy D. Beard, supra. In addition, neither the Department nor the Board may extend statutory time limits. Nelson v. SAIF, supra.

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[2] Claimant argues that the November 17, 1992 Notice of Claim Acceptance was the only proper notice of acceptance in that it provided a notification of rights regarding claim reclassification. However, claimant argues, because the November 17, 1992 Notice of Claim Acceptance properly accepted his claim as "disabling," he had no reason to contest that classification. As explained above, we reject claimant's underlying premise that the November 1992 notice was the only proper notice of acceptance and find that the May 22 1987 801 form constituted a proper notice of acceptance, including notice of classification rights.

[3] Such a voluntary opening must be authorized by the Board in its own motion capacity in order for the carrier to qualify for reimbursement from the Reopened Claim Reserve Fund. Allan E. Orton, 42 Van Natta 924 (1990). In addition, any voluntary opening after the expiration of aggravation rights is closed pursuant to ORS 656.278, not ORS 656.268. OAR 438-012-0055; Timothy D. Beard, supra. Incorrectly closing an own motion claim pursuant to ORS 656.268 by issuance of a Determination Order does not extend aggravation rights and create jurisdiction in the Hearings Division where none otherwise existed. Id. In addition, because the requirements of ORS 656.273 are jurisdictional, Aetna's failure to appeal the November 17, 1993 Determination Order does not prevent it from subsequently raising the aggravation rights issue. See Oliver M. Payton, 43 Van Natta 2738 (1991) (the requirements of ORS 656.273 are jurisdictional; therefore, failure to raise the issue in a prior hearing is not controlling).

[4] In 1995, the legislature amended ORS 656.277 but made no changes to ORS 656.273(4). However, we need not address whether these changes are to be applied retroactively because the result would be the same under either version of the statute.

Accordingly, we conclude that the November 17, 1992 acceptance[5] does not extend claimant's aggravation rights, nor does it validate the January 15, 1993 Determination Order and somehow extend claimant's aggravation rights in that manner. As discussed above, claimant's aggravation rights expired on May 19, 1992. Because claimant's aggravation claim regarding the May 1987 low back injury claim was filed in August 1994, after the expiration of claimant's aggravation rights, that "aggravation" claim is in the Board's own motion jurisdiction. Accordingly, the Hearings Division did not have jurisdiction over claimant's "aggravation" claim.

In light of our finding that the Hearings Division lacked jurisdiction over claimant's "aggravation" claim relating to the May 1987 injury, we also find that the Hearings Division lacked jurisdiction over the following related issues: (1) compensability of claimant's aggravation claim pursuant to ORS 656.273;[6] (2) interim compensation relating to the May 1987 injury claim; (3) penalties and attorney fees relating to interim compensation and processing of the "aggravation" claim under the May 1987 injury claim. Timothy D. Beard, supra; compare Dewey W. Kennedy, 48 Van Natta 897 (1996) (where jurisdiction over an issue resides with the Director, jurisdiction over a penalty relating to that issue also resides with the Director).

Responsibility

Although the Hearings Division lacked jurisdiction over claimant's "aggravation" claim relating to the May 1987 injury and related issues, as discussed above, it had jurisdiction over the issue of responsibility for the current condition. In other words, the Hearings Division had jurisdiction to determine whether claimant's current condition and need for treatment was related to the May 1987 injury or claimant's subsequent work activities. Unlike the May 1987 injury "aggravation" claim, the responsibility issue is not subject to a jurisdictional statute. Compare ORS 656.308 with ORS 656.273(4). Accordingly, the ALJ had jurisdiction over the responsibility issue.

We adopt the ALJ's reasoning and conclusions regarding the responsibility issue.

Attorney Fees

Pursuant to ORS 656.386(1), the ALJ awarded a $2,800 fee for claimant's attorney's services at hearing in prevailing over the aggravation denial. However, as discussed above, the "aggravation" issue regarding the 1987 injury was not within the ALJ's jurisdiction. Therefore, claimant necessarily did not prevail over the "aggravation" denial. Accordingly, we reverse the ALJ's $2,800 attorney fee award under ORS 656.386(1).

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[5] We note that a recent court case determined that, if a claim is not in nondisabling status at the time it is initially accepted as disabling, ORS 656.273(4)(a) applies and aggravation rights run from the date of the first closure. Liberty Northwest Ins. Corp. v. Koitzsch, 140 Or App 194 (1996). In Koitzsch, in response to a Board order, the carrier initially accepted a condition as disabling almost two years after the date of injury. We find Koitzsch distinguishable. Here, unlike Koitzsch, the claim was in nondisabling status at the time of Aetna's November 17, 1993 Notice of Acceptance. Therefore, the reasoning in Koitzsch does not apply to bring this claim under ORS 656.273(4)(a). Here, because the claim remained in nondisabling status for more than a year after the date of injury, ORS 656.273(4)(b) applies and aggravation rights run from the date of injury.

Finally, we note that we recently held that where a carrier accepted an aggravation claim as "nondisabling" and the claimant subsequently requested a hearing before the Board's Hearings Division seeking reclassification of the aggravation claim as disabling under ORS 656.277(2), the Hearings Division had jurisdiction over the issue and, by accepting the aggravation claim, the carrier necessarily conceded the injury had become disabling. Jean B. Rogers, 48 Van Natta 1307 (1996). We find Rogers distinguishable on its facts. In Rogers, the aggravation acceptance occurred within two years from the date of injury; therefore, there was no jurisdictional issue in Rogers. Furthermore, our decision in Rogers was limited to aggravation claims asserted pursuant to ORS 656.277(2) in the context of a request for claim reclassification. None of those factors are present in the current case.

[6] An "aggravation" claim filed after the expiration of aggravation rights must meet the requirements of ORS 656.278, the requirements of ORS 656.273 do not apply to claims within the Board's own motion jurisdiction. Jody Crompton, 48 Van Natta 1183 (1996).

Nevertheless, claimant's counsel is entitled to a reasonable attorney fee pursuant to ORS 656.308(2)(d) for his active and meaningful participation in finally prevailing against Aetna's responsibility denial. Except in cases involving extraordinary circumstances, ORS 656.308(2)(d) limits claimant to a maximum cumulative attorney fee of $1,000 for services at all levels of litigation for "finally prevailing against a responsibility denial." Tammy Locke, 48 Van Natta 250 (1996).

Here, although the jurisdiction issue was somewhat unusual, the responsibility issue was of the standard type. The hearing lasted three hours and produced a 103 page transcript. There were two witnesses and the record consisted of 186 exhibits, some of which were procured by claimant's counsel. In addition, there was a 53 page deposition in which claimant's counsel participated. Claimant filed a 15-page respondent's brief which addressed the responsibility issue. However, much of the brief was devoted to the jurisdiction issue. Claimant advocated a position that Aetna was the responsible carrier. However, although that "responsibility" position was ultimately successful, because claimant did not prevail on the jurisdictional issue, the result is that claimant's current low back condition is within the Board's own motion jurisdiction. Consequently, claimant is ultimately entitled to fewer potential benefits.[7] Based on this record, particularly the limited value of the benefit obtained for claimant, we conclude that there were no "extraordinary circumstances" to justify a greater fee than the statutory maximum.

We conclude that, considering the factors set forth in OAR 438-015-0010(4), such as the time devoted to the case (as represented by the record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved, claimant is entitled to a $1,000 attorney fee for services at hearing and on review regarding the responsibility issue, payable by Aetna. ORS 656.308(2)(d); Tammy Locke, supra.

ORDER

The ALJ's order dated January 8, 1996, as corrected on January 12, 1996, is vacated in part and affirmed in part. Those portions of the order that found the Hearings Division had jurisdiction over the May 19, 1987 injury "aggravation" claim and addressed issues relating to interim compensation regarding the May 1987 injury claim and penalties and attorney fees regarding interim compensation and processing of the "aggravation" claim under the May 19, 1987 injury claim are vacated. The ALJ's award of an attorney fee of $2,800 under ORS 656.386(1) is also vacated. The remainder of the ALJ's order (regarding the responsibility issue) is affirmed. For services at hearing and on Board review regarding the responsibility issue, claimant's attorney is awarded $1,000.

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[7] Because the 1987 injury claim is in own motion status, temporary disability is the only potential future monetary compensation available for that claim. ORS 656.278(1)(a) and (2); Independent Paper Stock v. Wincer, 100 Or App 625 (1990) (effective January 1, 1988, the legislature removed the Board's authority to grant additional permanent disability compensation in its own motion capacity). Furthermore, the Board's own motion authority to award temporary disability benefits is contingent upon the compensable condition requiring surgery or inpatient hospitalization. Id. Here, there is no evidence that either of these events has either occurred or been requested. However, we note that the own motion status of the 1987 claim does not affect claimant's entitlement to medical services, because such entitlement is governed by ORS 656.245.

In the Matter of the Compensation of
WILLIAM J. DELOREY, Claimant
WCB Case No. 95-06144
ORDER ON RECONSIDERATION (REMANDING)
Ernest M. Jenks, Claimant Attorney
G. Joseph Gorciak III, Defense Attorney

On September 12, 1996, we abated our August 14, 1996 Order on Review (Remanding), which remanded for the admission of additional evidence regarding claimant's treatment with Dr. O'Neill. We took this action to consider claimant's motion for reconsideration. Having received the insurer's response, we proceed with our reconsideration.

On review, the insurer argued that claimant was not credible and asserted that he provided an inaccurate history to the various physicians. The insurer also moved to remand 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. In response, claimant argued that remand was not appropriate because the insurer did not use due diligence to obtain information regarding Dr. O'Neill's treatments.

In our previous order, we found that it was not clear whether claimant actually had any reports or documents from Dr. O'Neill. Nevertheless, we found that claimant failed to disclose Dr. O'Neill's involvement at hearing when the insurer's attorney asked him how many different physicians he had seen since March 8, 1995. We found 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. We concluded that, since claimant's credibility was a central consideration, his failure to disclose the existence of Dr. O'Neill may affect the ALJ's determination of claimant's credibility. We also found that Dr. O'Neill's opinion was reasonably likely to affect the outcome of the case. Therefore, we granted the insurer's motion to remand for the admission of additional evidence regarding claimant's treatment with Dr. O'Neill.

On reconsideration, 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. Claimant argues that there is a presumption that Dr. O'Neill submitted his records and billings to the insurer before the employer/insurer's alleged date of knowledge in March 1996.

In claimant's previous response to the insurer's motion to remand, he did not raise an argument concerning a "presumption" that the insurer had received Dr. O'Neill's records. Rather, claimant asserted on review that Dr. O'Neill's treatment for his "disputed condition" did not begin until after August 18, 1995, the date of the hearing. Similarly, claimant did not request a bifurcated proceeding in order to determine when records were provided from Dr. O'Neill's office to the employer/insurer. We generally do not consider issues raised for the first time on review or reconsideration. See Vogel v. Liberty Northwest Ins. Corp., 132 Or App 7, 13 (1994) (Board has discretion not to address issue raised for first time on reconsideration); Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Under these circumstances, we do not address claimant's request for a bifurcated proceeding.

Nonetheless, on reconsideration, we modify the reasoning used in deciding that remand is warranted. We conclude that 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. Since the insurer has not established a failure to comply with the request for documents, remand on that basis is not appropriate.

Nevertheless, we adhere to our previous conclusion that claimant should have more fully answered the insurer's questions at hearing concerning his physicians and health providers. In our previous order, we found that claimant failed to disclose Dr. O'Neill's involvement at hearing 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). It is uncontested that claimant did not provide any information at hearing regarding his treatment by Dr. O'Neill.

On reconsideration, we find that the insurer exercised due diligence by questioning claimant at hearing about his physicians and health providers. However, the ALJ was unaware of Dr. O'Neill's involvement in the case. Claimant's credibility was a central consideration in the insurer's defense and the ALJ's conclusions. Under such circumstances, claimant's failure to disclose the existence of Dr. O'Neill may affect the ALJ's determination of claimant's credibility. Furthermore, we adhere to our earlier conclusion that Dr. O'Neill's opinion is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our August 14, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 16, 1996 Cite as 48 Van Natta 2162 (1996)

In the Matter of the Compensation of
STEVE D. EDWARDS, Claimant
WCB Case No. 94-13780
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) found that claimant's lead poisoning occupational disease claim was not untimely; and (2) set aside the employer's denial of the claim. In his respondent's brief, claimant contests that portion of the ALJ's order that declined to assess a penalty for the employer's allegedly unreasonable denial. On review, the issues are timeliness of claim, compensability and penalties.[1] 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

Compensability

The employer raises several arguments on review, including the contention that the ALJ erred by relying on the reports of Dr. Morton. Because we find that issue dispositive, we do not address the employer's remaining arguments.

The employer asserts that the ALJ erred by relying on the reports of Dr. Morton, whom the ALJ found to be claimant's treating physician. The employer asserts that, because Dr. Morton was not claimant's treating physician, he was not entitled to deference as such.

The employer contends that Dr. Burton's opinion is the most persuasive. Dr. Burton reported that claimant's symptoms were non-specific and lacked objective findings. (Ex. 102-9). Claimant did not have complaints of "colic, numbness, tingling or distal extremity weakness, typically associated with

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[1] Subsequent to the filing of Board briefs, the employer submitted a supplemental memorandum addressing the impact of Andrews v. Tektronix, Inc., 323 Or 154 (1996), on this case. Claimant objects to the employer's supplemental argument. Any party may provide supplemental authorities to assist the Board in its review of a case, but only if the case was not in existence until after the time of briefing. Margaret B. Sparkes, 47 Van Natta 1365 (1995). We do not, however, consider any supplemental submissions to the extent they contain additional argument. Id. Therefore, we will consider the parties' submissions to the extent they advise us of recent developments in the law. However, we do not consider the employer's supplemental argument.

lead toxicity." Id. Furthermore, claimant did not have objective findings of lead intoxication "such as abnormal neurologic findings, hypertension or evidence of renal dysfunction." Id. Dr. Burton found it most important that there was no temporal relation of worsened symptoms at peak blood lead levels. Id. To the contrary, Dr. Burton commented:

> "in spite of removal from lead exposure and a consistent decline in his blood lead level, his expression of symptoms has increased. Such a temporal relationship between exposure, declining blood lead levels and lead toxicity is inconsistent with a true lead effect." Id.

Claimant told Dr. Burton that he had used methamphetamine "every way you can use it" and spent a year in prison for possession of it. (Ex. 102-2). Dr. Burton commented that "[s]treet methamphetamine has been shown to occasionally contain lead, which can result in toxicity when injected by the user." (Ex. 102-9).

Dr. Burton concluded that claimant did "not currently have any lead-induced illness and is not expected to develop any." (Ex. 102-10). Although claimant was exposed to lead at the employer, Dr. Burton believed that claimant's "lead exposure is unrelated to his expression of symptoms and his recent need for medical treatment." Id.

Claimant relies on the opinion of his "treating physician," Dr. Morton. When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810, 814 (1983). We accord such deference because the attending physician generally has had a better opportunity to observe and evaluate a claimant's condition over an extended period of time.

Here, we conclude that Dr. Morton's opinion is not entitled to any deference as a treating physician because he only saw claimant on one occasion. Moreover, we conclude that Dr. Morton's opinion is not persuasive because it is conclusory.

Dr. Morton found that claimant's symptoms were all "typical symptoms of lead poisoning." (Ex. 103-1). Dr. Morton concluded that claimant had chronic lead poisoning over a period of several years and "his work activities during 1990-94 for [the employer] were the major contributing cause of his lead poisoning because of his known poorly protected exposure there, and the onset of his symptoms while employed there." (Ex. 103-2).

We are not persuaded by Dr. Morton's conclusory, poorly analyzed opinion. Dr. Morton failed to explain why claimant's symptoms increased after he stopped working for the employer. Dr. Morton offered no explanation for the increase of claimant's symptoms despite his removal from lead exposure and a consistent decline in his blood lead level. Furthermore, Dr. Morton failed to consider claimant's use of methamphetamine. We conclude that Dr. Morton's reports are insufficient to establish the compensability of claimant's lead poisoning claim.

Penalties

Claimant contests that portion of the ALJ's order that declined to assess a penalty for the employer's allegedly unreasonable denial. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Accordingly, claimant is not entitled to a penalty.

ORDER

The ALJ's order dated November 22, 1995 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

In the Matter of the Compensation of
ROBERTA S. HAMRICK, Claimant
WCB Case No. 95-03166
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Claimant requests reconsideration of our September 19, 1996 Order on Review which adopted and affirmed, with supplementation, Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denial of her low back injury claim. Specifically, claimant objects to that portion of our order that construed the failure to call members of claimant's work crew against claimant.

On reconsideration, claimant acknowledges that she has the burden of proof, but, she argues that the evidence which the employer generated about claimant's work activities was impeachment evidence. Therefore, she argues, the employer's evidence should be "considered not only by weighing its credibility, but also considering whether there was stronger more satisfactory evidence to establish those points." Id. In support of her argument, claimant cites ORS 10.095(7) and (8),[1] which are jury instructions. Claimant also argues that the employer "alone had the ability to produce better evidence and failed to do that."

Perhaps due to our brief supplementation in response to her evidentiary arguments on review, claimant misperceives the basis for our decision. Like the ALJ, we concluded on review that claimant's claim was not proven by a preponderance of the evidence. The issue of claimant's ongoing work activities was one factor leading to that conclusion. In addition, as the ALJ found, claimant's statements to medical providers were sufficiently inconsistent to weigh against compensability. So, too, the lifting incident on the final day of her employment cast doubt as to the work-relatedness of her claim. Therefore, even if we were to conclude that the employer's evidence concerning her work activities should be given little weight, we would still conclude that claimant had failed to sustain her burden of proof.

Accordingly, we withdraw our September 19, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our September 19, 1996 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] ORS 10.095(7) and (8) provide:

"The jury, subject to the control of the court, in the cases specified by statute, are the judges of the effect or value of evidence addressed to them, except when it is thereby declared to be conclusive. They are, however, to be instructed by the court on all proper occasions:

" * * * *

"(7) That evidence is to be estimated, not only by its intrinsic weight, but also according to the evidence which is in the power of one side to produce and of the other to contradict; and, therefore,

"(8) That if weaker and less satisfactory evidence is offered when it appears that stronger and more satisfactory was within the power of the party, the evidence offered should be viewed with distrust."

In the Matter of the Compensation of
THERESA G. PETERSON, Claimant
WCB Case No. 95-13095
ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

Claimant requests reconsideration of our September 18, 1996 Order on Review, contending that we failed to award an assessed attorney fee for her attorney's services at hearing and on review for defending against the self-insured employer's request for hearing, in which it sought to set aside an Order on Reconsideration finding that claimant's claim had been prematurely closed.

The employer has responded to claimant's motion and opposes the award of an attorney fee; alternatively, the employer contends that, if a fee is awarded, it should be limited to services rendered at hearing.

ORS 656.382(2) provides for an assessed attorney fee award if a carrier requests a hearing and it is found that the compensation awarded to claimant should not be disallowed or reduced. See Kordon v. Mercer Industries, 308 Or 290 (1989).

Here, the insurer requested a hearing seeking to set aside the Order on Reconsideration which had found claimant's claim prematurely closed. The finding of premature closure necessarily entitled claimant to further temporary disability benefits. The ALJ reversed the Order on Reconsideration, reinstating the closure of the claim. Thus, no attorney fee was awarded under ORS 656.382(2).

Our order reversed the ALJ's order and reinstated and affirmed the Order on Reconsideration. However, we neglected to grant an attorney fee under ORS 656.382(2) for claimant's services at hearing for defending against the insurer's request for hearing from the Order on Reconsideration. Therefore, inasmuch as the insurer requested a hearing and claimant's compensation was ultimately not disallowed or reduced, claimant is entitled to an attorney fee pursuant to ORS 656.382(2). However, that award is limited to claimant's attorney's services at the hearings level. See Patricia L. McVay, 48 Van Natta 317 (1996); Thomas R. Yon, Jr., 47 Van Natta 1475 (1995).

In determining a reasonable fee for claimant's attorney's services rendered at the hearing level, we consider the factors set forth in OAR 438-015-0010(4). Those factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The file consists of 13 exhibits that were presented at the reconsideration process. The hearing record consists of 10 pages of transcript. No witnesses were called. Oral arguments were presented. Claimant seeks an attorney fee of $3,000 for services at hearing and on review; however, her counsel has not provided a statement of services.

The issue in this case involves premature claim closure. Such an issue presents a medical question of a complexity similar to those generally submitted. The value of the interest to claimant is high, in that her claim has been reopened and surgery is likely. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner, identifying the relevant factual and legal issues for resolution. Finally, there was a risk that claimant's counsel's efforts in defending the Order on Reconsideration's claim reopening might have gone uncompensated.

After consideration of the aforementioned factors and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is $2,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the premature closure issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, the nature of the proceeding, and the risk that claimant's counsel might have gone uncompensated. Finally, we have not considered claimant's counsel's services rendered on Board review.

Accordingly, we withdraw our September 18, 1996 order. On reconsideration, as supplemented and modified herein, we republish our September 18, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 16, 1996 Cite as 48 Van Natta 2166 (1996)

In the Matter of the Compensation of
JANET S. RAY, Claimant
WCB Case No. 96-01164
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that awarded 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of the right leg and 4 percent (6 degrees) for loss of use or function of the left leg, whereas an Order on Reconsideration had awarded no scheduled permanent disability. On review, the issue is the extent of scheduled permanent disability.

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

Claimant has an accepted claim for bilateral knee strains and contusions. The claim was closed by a Notice of Closure on May 11, 1995 which awarded no permanent disability. A January 26, 1996 Order on Reconsideration affirmed the Notice of Closure. Claimant requested a hearing.

The ALJ relied on the medical arbiter's opinion to rate claimant's permanent disability. On review, the insurer asserts that Dr. Rand, the medical arbiter, did not attribute the lost range of motion findings in claimant's knees to the compensable injury. We disagree.

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 Manuel G. Garcia, 48 Van Natta 1139, 1140 (1996); Kim E. Danboise, 47 Van Natta 2163, 2164 (1995). However, where the medical arbiter attributes 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).

Here, the medical arbiter does not relate the range of motion findings to causes other than the injury. In fact, at the beginning of his report, the arbiter specifically indicates that the arbiter examination concerns the accepted condition of bilateral knee strains. Moreover, the lost range of motion findings appear consistent with claimant's accepted injury and were not reported as invalid. Given the fact that the arbiter did not attribute the findings to causes other than the injury, those findings are construed as being due to the injury. Kim E. Danboise, supra.

When specifically addressing claimant's residual functional capacity, Dr. Rand stated:

> "Based on the worker's history today, examination and review of the record supplied at the time of examination, it is my medical opinion that she has suffered no problem subsequent to the bilateral knee strains. Based on her body habitus, gender and age, I would place her, at this time, in a medium work activity with no restrictions."

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[1] The Board finds that the ALJ's "findings of fact" run from the second paragraph on page one through the first full paragraph of page two of the order. The remainder of the ALJ's order constitutes the "conclusions of law and opinion" section of the order.

On the basis of this quoted language, the insurer argues that Dr. Rand did not believe that claimant had suffered any impairment as a result of the injury. We disagree. Dr. Rand's statement pertained to claimant's residual functional capacity. Nothing in the quoted language refers to the range of motion findings or suggests that those findings are unrelated to claimant's bilateral knee strains. Under such circumstances, we are not persuaded that Dr. Rand was attributing the range of motion findings to causes other than the compensable injury.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(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 attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 21, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the insurer.

In the Matter of the Compensation of
RANDY S. GIRARD, Claimant
WCB Case No. 95-13206
ORDER ON REVIEW
Bogardus & Nichols, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's bilateral carpal tunnel syndrome (CTS) claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant, who has been an insulin-dependent diabetic since age eight, has primarily worked as a cowboy. He had no problems with his wrists or arms. Beginning in July 1995, claimant worked for the employer as a molder feeder and tie off person, which required continual, repetitive gripping on a production line for seven hours a day, five days a week. After several weeks of this work, claimant began to experience numbness in his arms and hands; after two more weeks, he sought medical treatment from Dr. Richards and was diagnosed with bilateral CTS. Claimant quit this job on August 25, 1995, and his bilateral arm symptoms improved.

In September 1995, claimant went to work for an employer not a party to this claim as a ranch hand, working six days a week, 10 to 12 hours a day. His work duties during the haying season included driving a swather, which required operating a steering wheel with the left hand and four hydraulic levers with the right hand. His job duties after haying season required the use of hand tools to build fences and corrals and to service equipment. Claimant's symptoms increased with his new work activities.

Claimant was examined by Drs. Neumann, Rich, and Curosh; Dr. Weller performed a medical records review.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinions of claimant's attending physician, Dr. Richards, and Dr. Neumann, orthopedist, the ALJ concluded that claimant's bilateral CTS condition was compensable. On review, the employer contends that the preponderance of medical opinion does not support compensability. We disagree.

Claimant has the burden of proving that his condition is compensable by the preponderance of the medical evidence. ORS 656.266. Because of the multiple potential causal factors, the causation issue is a complex medical question which must be resolved on the basis of expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). We generally defer to the opinion of the treating physician unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons to do otherwise.

Opinions regarding the cause of claimant's bilateral CTS condition were provided by Drs. Neumann, Rich, Curosh, Weller and Richards.

Dr. Weller, neurologist, who performed a records review for the employer, concluded that claimant's diabetes was the major cause of his CTS. He based his opinion on the persistence of claimant's symptoms after changing jobs and on Dr. Richards' suggestion that claimant's diabetes was poorly controlled. (Ex. 9). In contrast, Dr. Curosh, endocrinologist, ruled out diabetes as the major cause of claimant's CTS. Dr. Curosh examined claimant and found it unlikely that he had diabetic neuropathy affecting his upper extremities. Moreover, she declined to change her opinion even if claimant's diabetes had been uncontrolled. (Ex. 16). As an endocrinologist, Dr. Curosh has special training and expertise in evaluating the extent of claimant's diabetic neuropathy and the relationship between claimant's diabetes and his CTS. Moreover, because her opinion regarding that relationship is complete and well-reasoned, we find it more persuasive than that of Dr. Weller. Somers v. SAIF, 77 Or App 429, 433 (1980).

Dr. Curosh, however, was unwilling to find claimant's work activity at the employer the major cause of his condition because claimant's symptoms had not abated with its cessation. Dr. Curosh was not aware of the reduction in symptoms claimant experienced during the hiatus between working at the employer and his return to work as a ranchhand. Moreover, Dr. Curosh was not aware of the hand-intensive work claimant continued to do as a ranchhand. Because Dr. Curosh based her opinion on an incorrect history, we do not find this portion of her report persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Drs. Neumann, orthopedist, and Rich, neurologist, initially agreed regarding the cause of claimant's CTS. (Ex. 8). In their report, they noted that claimant's diabetes provided a propensity for the development of CTS. They also evaluated the contribution of claimant's relatively brief period of work exposure and concluded that claimant's work activities with the employer were the major contributing cause of his condition. (Id.).

However, after reviewing Dr. Richards' and Dr. Weller's medical reports, Dr. Rich changed his mind regarding causation, primarily based on Dr. Weller's opinion, concluding that it was impossible, in the absence of further nerve conduction studies, to determine the major cause of claimant's CTS, given claimant's short period of work with the employer and long-standing diabetes. Dr. Rich also apparently based his changed opinion on the fact that the employer, rather than claimant, had provided the details of claimant's work history at the employer. We do not find Dr. Rich's opinion persuasive, since it is so heavily dependent on Dr. Weller's assumption that the major cause of claimant's CTS is his diabetes, which we found unpersuasive for the reasons stated above.

Dr. Richards, in contrast, opined that, although claimant's diabetes is a predisposing factor and can contribute to the development of CTS and can prolong disability, the major contributing cause of claimant's CTS was his work activities at the employer, because of the repetitive use of claimant's wrists on the job. (Exs. 17, 19).[1]

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[1] We do not find that Dr. Richards based his opinion on a temporal relationship alone. See Bronco Cleaners v. Velazquez, 141 Or App 295 (1996) (A claimant may not solely rely on the deductive reasoning that, because the condition did not occur until after the exposure to the work environment and cannot be proven to have been caused by another causative agent, it must have been caused by the work environment). Here, Dr. Richards evaluated the effect of claimant's diabetes, as well as the work activities themselves, on the onset of his CTS condition. (Exs. 1, 4, 5, 7, 12, 17, 19).

Moreover, as noted above, Dr. Neumann, who also was aware of the length of time claimant worked at the employer and of his diabetes (which, he noted, predisposed claimant to the development of CTS), also concluded that the major contributing cause of claimant's CTS condition was his work activities at the employer. (Ex. 8).

Based on the persuasive opinions of Dr. Richards and Dr. Neumann, we conclude that claimant's work activities at the employer were the major contributing cause of his bilateral CTS condition. Claimant has accordingly proven his claim 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 $1,500, 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 May 28, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by the self-insured employer.

October 16, 1996 Cite as 48 Van Natta 2169 (1996)

In the Matter of the Compensation of
SHANNON L. MATHEWS, Claimant
WCB Case No. 96-00328
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Claimant and the self-insured employer request reconsideration of our September 19, 1996 Order on Review which: (1) set aside the self-insured employer's denial of claimant's occupational disease claim for a bilateral carpal tunnel condition; and (2) awarded a $3,500 employer-paid attorney fee. Contending that our attorney fee award was inadequate, claimant asks that the award be increased to $5,000. Asserting that the majority of the persuasive medical evidence does not satisfy claimant's requisite burden of proof, the employer requests that we reconsider our compensability decision.

In order to further consider these matters, we withdraw our September 19, 1996 order. Each of the parties are allowed 14 days from the date of this order to respond to the other party's recent submission. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES S. GROVE, Claimant
WCB Case No. 95-11189
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that set aside its partial denial of claimant's right triceps 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 that there was no evidence that claimant's right triceps muscle was directly injured during the February 14, 1994 work injury that resulted in a compensable injury to claimant's right biceps muscle. Therefore, the ALJ concluded that, if the right triceps condition [weakness] is compensable, it is compensable as a consequential condition resulting from the compensable right biceps injury, with claimant having the burden of proving that the compensable right biceps injury was the major contributing cause of the consequential right triceps condition. Amended ORS 656.005(7)(a)(A). We adopt the ALJ's reasoning and conclusions to this point in her order.[1] However, the ALJ also found that claimant met his burden of proof. We disagree. For the following reasons, we find that claimant failed to meet his burden of proof.

Dr. Kopp, claimant's attending physician, provides the only medical opinion regarding the cause of claimant's right triceps weakness. Specifically, Dr. Kopp stated:

> "[Claimant sustained a forklift injury at Prairie Wood Products in February 1994. He ruptured his biceps tendon requiring repair of the tendon. He has had subsequent loss of strength in the triceps musculature and [claimant's attorney] is asking me to, in my own words, state that the resultant loss of his triceps musculature strength was due in material part by the incident of February 1994, and I agreed that it has been. I feel that it is a compensable component of the injury in 1994. The primary problem was his biceps rupture, however[,] he did have a significant injury throughout the arm and probably more than likely has lost strength in that, both from injury and secondary to non-use and disuse, not due to nerve injury." (Ex. 21).

Claimant argues that Dr. Kopp's opinion, as quoted above, establishes that the right biceps injury is the major contributing cause of the consequential right triceps condition. We disagree.

We acknowledge that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided that the opinion otherwise meets the appropriate legal standard. See Freightliner Corp. v. Arnold, 142 Or App 98 (1996); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). However, Dr. Kopp's opinion does not meet that standard.

Dr. Kopp specifically states that the "loss of [claimant's] triceps musculature strength was due in material part" to the compensable biceps injury. (Ex. 21, emphasis added). Moreover, nothing in Dr. Kopp's remaining causation opinion negates this specific "material cause" statement and rises to the level of "major cause." Compare Freightliner Corp. v. Arnold, supra (physician's testimony otherwise established the requisite major contributing cause standard, even though he used the term "material" in addressing causation). Thus, even though Dr. Kopp is not required to incant "major contributing cause," Dr. Kopp's opinion does not otherwise meet the major contributing cause standard. Furthermore, we are without the medical expertise to reformulate Dr. Kopp's opinion to satisfy the major contributing cause standard when the doctor's opinion itself does not satisfy that standard.

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[1] On review, claimant agrees that amended ORS 656.005(7)(a)(A) applies to his right triceps condition claim.

Given the fact that Dr. Kopp's causation opinion is insufficient to meet claimant's burden of proof and there is no other evidence in the record regarding the cause of the triceps condition, we are unable to conclude that the record as a whole meets claimant's requisite burden of proof. See Freightliner Corp. v. Arnold, supra. Accordingly, SAIF's denial of the triceps condition is upheld. In addition, the ALJ's award of a $3,000 attorney fee pursuant to ORS 656.386(1) for prevailing over a denied claim is reversed.

ORDER

The ALJ's order dated February 7, 1996 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

October 17, 1996 Cite as 48 Van Natta 2171 (1996)

In the Matter of the Compensation of
NANCY A. KISSELL, Claimant
WCB Case No. 95-10811
ORDER ON REVIEW
Ormsbee & Gorrigall, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl, Christian and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Yeager's order that upheld the insurer's denial of her claim for a left hip condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and briefly summarize the pertinent facts as follows:

Claimant, a waitress, had an extremely busy day at work on March 28, 1995, when she had to assist a new waitress and cover two stations. Several hours into her shift, she noticed worsening pain in her left hip. She sought treatment a few days later, complaining of back pain and pain in her left hip and leg. She was initially diagnosed with degenerative disc disease and sciatica.[1]

Claimant's pain continued, and she was unable to continue working after April 22, 1995. In May, claimant was referred to Dr. Davis, an orthopedic surgeon, who diagnosed trochanteric bursitis. She was treated with steroid injections, which provided little relief. By late June 1995, much of claimant's leg pain had resolved, but her left hip pain continued. Claimant began treating with Dr. Adams, another physician in Dr. Davis' group.

In mid-July, Dr. Adams diagnosed meralgia paresthetica (irritation of the lateral femoral cutaneous nerve). At Dr. Adams' referral, claimant was examined by Dr. Bufton, who found that claimant's lateral burning thigh pain was consistent with meralgia paresthetica, but the pain throughout her hip, groin and buttock was not.

In late August 1995, Dr. Freeman performed a block of claimant's lateral femoral cutaneous nerve, which provided some temporary relief. A September 7, 1995 trigger point injection provided good relief. In October, Dr. Davis performed a surgical release of the nerve, which gave claimant relief. Shortly thereafter, claimant was able to return to work without pain.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, along with other undiagnosed conditions, claimant had meralgia paresthetica which caused her hip pain. The ALJ also found that the meralgia paresthetica was the

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[1] The compensability of claimant's degenerative disc disease at L5-S1 is not at issue in this case.

cause of claimant's need for the surgical release of her left lateral femoral cutaneous nerve, but concluded that claimant had not met the burden of proving that her meralgia paresthetica was caused by her employment.

On review, claimant argues that her testimony along with the expert medical opinions of her treating physicians, Drs. Davis and Adams, establishes by a preponderance of the evidence that her left hip condition (meralgia paresthetica) developed as a result of her work activity on March 28, 1995. We agree.

We find no persuasive reason not to defer to the opinions of claimant's treating doctors. See Weiland v. SAIF, 64 Or App 810, 814 (1983). The record establishes that claimant's symptoms began while she was abnormally active at work on March 28, 1995. Both Drs. Davis and Adams reported that meralgia paresthetica can come on with excessive walking, and opined that claimant's work activities on March 28, 1995 were the likely cause of her left hip condition. (Ex. 3-9, 26-10). Dr. Davis testified that claimant's weight might have been a factor that contributed to the onset of her meralgia paresthetica, but that the major cause was overuse. Dr. Davis also acknowledged that some of claimant's initial symptoms, such as low back pain, numbness radiating down to the foot and pain in the buttocks, were inconsistent with and probably unrelated to claimant's meralgia paresthetica. He explained, however, that in his opinion, the diagnosis of meralgia paresthetica was confirmed by the fact that claimant's left hip symptoms went away after he surgically released the left lateral femoral cutaneous nerve, which he found to be yellowed, somewhat thickened and irritated.[2]

On this record, we are persuaded that had meralgia paresthetica and that the condition was caused by overuse at work on March 28, 1995. Although claimant complained of other symptoms atypical of meralgia paresthetica, that does not disprove the fact that claimant had this condition or that it was the result of excessive walking on the job. We therefore set aside the insurer's denial of claimant's left hip condition.

Finally, claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs and her counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.[3]

ORDER

The ALJ's order dated April 4, 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 $4,500, payable by SAIF.

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[2] We are not persuaded by Dr. Donahoo's opinion which excluded a diagnosis of meralgia paresthetica, because it does not account for the fact that Dr. Davis actually found claimant's left lateral femoral cutaneous nerve to be irritated, or that claimant responded favorably to the release surgery.

[3] We also considered SAIF's objections to claimant's counsel's statement of services.

Member Haynes dissenting.

The majority concludes that a preponderance of the evidence establishes that claimant's left hip condition developed as a result of her work activity on March 28, 1995. While I am persuaded that claimant has meralgia paresthetica, and that this condition was the cause of her need for surgery, I agree with the ALJ that the record does not establish that this condition arose out of her work activity.

First, I consider the expert medical opinions supporting compensability to be couched in terms of possibility rather than probability, which is not legally sufficient. See Gormley v. SAIF, 52 Or App 1055, 1059-60 (1981). For example, in his November 6, 1995 report, Dr. Davis states: "*I think it is possible* that excessive walking did cause her to develop meralgia paresthetica. The symptoms were fairly atypical and I did not make the diagnosis my first time with her. It was only brought up after Dr. Adams had seen her. At my follow up, she seemed to have tenderness in the appropriate areas." (Ex. 22).

Second, I am troubled by the fact that, for three and half months following her busy day at work on March 28, 1995, claimant's complaints were not consistent with or typical of meralgia paresthetica. According to Dr. Davis, meralgia paresthetica is pain caused by irritation of the lateral femoral cutaneous nerve, normally occurring where the nerve exits the pelvis just medial to the anterior superior iliac spine. The nerve irritation causes pain, burning and numbness to the lateral aspect of the thigh. (Ex. 26-7). However, when claimant first sought treatment from Dr. Counts on April 4, 1995, she complained of severe low back pain, radiating down over the left hip and into the left leg into the foot.[1] (Ex. 1-1). One month later, on May 2, 1995, she was still complaining to Dr. Counts of back problems, radiating down to the bottom of her feet.[2] (Ex. 1-2). She was then referred to Dr. Davis, who took a history of claimant experiencing waxing and waning pain in her left hip since a busy work day at the end of March, which had recently worsened during a trip to Eugene. (Ex. 3-1) At that point, five weeks after the March 28, 1995 work activity, claimant complained of waxing and waning hip pain, and Dr. Davis found some tenderness over the greater trochanter, which seemed mostly muscular. Even then, claimant's symptoms were not typical of meralgia paresthetica, and Dr. Davis diagnosed trochanteric bursitis instead.

In his deposition, Dr. Davis explained that it was not until after claimant returned to him for a follow up examination in late September 1995 (after seeing his partner Dr. Adams in July and August) that she was very tender over the lateral femoral cutaneous nerve, and her symptoms became somewhat more typical of meralgia paresthetica. (Exs. 3-9, 26-8). Dr. Davis also admitted that he could not explain the etiology of those symptoms that were inconsistent with meralgia paresthetica. (Ex. 26-17 - 26-20).

Third, like the ALJ, I also believe that Dr. Davis' opinion is based upon a suspect history, because he assumes that claimant's hip and thigh symptoms came on acutely following her one busy work day.[3] Yet, as noted above, the contemporaneous medical records show that claimant's hip and thigh symptoms (those that are the most consistent with meralgia paresthetica) seemed to evolve and worsen after her initial treatment in early April, until they were diagnosed as meralgia paresthetica by Dr. Adams in July.[4]

In short, while I do not doubt that claimant developed meralgia paresthetica, I believe there are just too many unexplained or unanswered questions concerning the progression and development of claimant's left hip symptoms to find that her meralgia paresthetica condition is compensably related to her work activity on March 28, 1995. Since claimant's symptoms at and immediately following her work on March 28, 1995 (low back and buttock pain, radiating down into the left leg and foot) were atypical of meralgia paresthetica, and neither Dr. Davis nor Dr. Donahoo found any evidence of meralgia paresthetica on their initial examinations of claimant, I am not persuaded that claimant's meralgia paresthetica was caused by her work activity. For this reason, I respectfully dissent.

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[1] Claimant also has degenerative disc disease at L5-S1, which her treating doctors initially thought may have been causing her symptoms.

[2] Both Dr. Davis and Dr. Donahoo agree that low back pain, with numbness and tingling radiating down into the left foot and pain in the buttocks is not consistent with meralgia paresthetica. (See Exs. 24, 26-18).

[3] The same is true with Dr. Adams. At first, he did not consider claimant's condition to be work-related. (Ex. 3-6). Then, after consulting a neurology text that reported that meralgia paresthetica can come on with excess walking, he thought that her condition may be related to her work, since it came on after a very busy shift. (Ex. 3-9).

[4] Whereas Dr. Davis found claimant tender over the greater trochanter in May 1995, Dr. Adams noted in July 1995 that she was tender over both the greater trochanter and anterior iliac spine. In August, claimant was still somewhat tender over the trochanter, but more tender over the anterior superior iliac spine. (Ex. 3-9).

In the Matter of the Compensation of
FARADZH SAADIYAYEV, Claimant
WCB Case No. 95-09652
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Schultz's order that upheld the insurer's partial denial of his injury claim for a lumbosacral disc condition. On review, the issue is compensability.

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

In affirming the ALJ's order, we do not rely on the insurer's argument that a medical opinion regarding causation which is based in part on the temporal relationship between a condition and work exposure is legally insufficient to establish compensability. See ORS 656.266; Bronco Cleaners v. Velasquez, 141 Or App 295 (1996) (ORS 656.266 provides that a claimant may not rely solely on the deductive reasoning that, because a condition did not occur until after work exposure and cannot be proven to have been caused by another causative agent, it must have been caused by the work environment).

In addition, we reject the insurer's argument that a diagnosis of a "probable" condition is equivalent to a mere possibility that the condition exists. See Lenox v. SAIF, 54 Or App 551 (1981) (the claimant must carry his burden of proof with evidence of medical probability, rather than mere possibility).

ORDER

The ALJ's order dated March 14, 1996 is affirmed.

In the Matter of the Compensation of
TRICIA C. WAGNER, Claimant
WCB Case Nos. 94-12676
ORDER ON RECONSIDERATION (REMANDING)
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

On July 29, 1996, we withdrew our June 27, 1996 order which affirmed an Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of claimant's occupational disease claim for her psychological condition. On reconsideration, SAIF contends that it has recently obtained newly discovered evidence arising out of claimant's civil action which warrants remand of the matter to the ALJ. We issued an order of abatement and implemented a supplemental briefing schedule. Having now received the parties' supplemental briefs, we proceed with our reconsideration.

By initially affirming the ALJ's order, we agreed with the ALJ that Dr. Heck, a psychiatrist who had examined claimant on behalf of SAIF, had provided the most persuasive opinion regarding the causation of claimant's psychological condition. The ALJ noted that Dr. Heck was "sometimes distrustful of the history," and suspected "misperception" on the part of claimant. Additionally, the ALJ's order set forth that portion of Dr. Heck's report which stated that:

> "Provided the claimant was reporting an honest and reliable history, it is the conclusion of this Examiner that the major contributing cause of her depression is the stress which resulted from her supervisor's harassing interactions." (Ex. 17-16).

With its motion for reconsideration, SAIF has submitted claimant's July 23, 1996 deposition, which was taken for purposes of claimant's civil action against her employer. SAIF argues that several portions of claimant's deposition establish that claimant did not provide an accurate or complete history to the doctors who examined her. Specifically, SAIF contends that claimant informed Dr. Heck that, although she had experienced substance abuse problems in the past, at the time of the exam, her alcohol use was "minimal." (Ex. 17-10). However, in her recent deposition, claimant stated that, in October 1993, she had gone on a three-month drinking period during which she was drinking so much, in combination with taking medication, that she considered the binge to be a suicide attempt.[1]

Claimant also informed Dr. Heck that she had not had any separations in her current marriage. (Ex. 17-12). However, in deposition, claimant testified that during the three month period of heavy drinking, she had been involved with another individual and her husband subsequently left her for four months.

Finally, claimant reported to Dr. Heck that she "did not date or have any romantic relationships with fellow employees." (Ex. 17-2). In deposition, however, claimant testified that she had an extramarital affair with a coworker over a period of two years. Claimant also testified that the coworker was physically and verbally abusive to her during their affair.

Following claimant's recent deposition, SAIF contacted Dr. Heck with the information obtained from claimant's testimony. Dr. Heck reiterated that his conclusion had been based on an assumption that the history was honest and reliable. Dr. Heck further stated that, if the events described (regarding claimant's drinking, her separation from her husband, and her affair with the coworker) were true, it would undermine claimant's credibility, and if it occurred during a relevant time period, it was probable that the affair would have played a major role in the onset of her psychiatric symptoms.

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. Weyerhauser Co., 301 Or 641, 646 (1986).

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[1] Claimant contends that the incidents of harassment or discrimination that she was allegedly subjected to at work began with her transfer into another department in October 1992 and continued through 1993 and 1994.

Here, we conclude that a compelling reason has been shown for remanding. First, the evidence concerns the disability, which is claimant's psychological condition. Next, considering claimant's expressed history and version of relevant events as they existed at the time of hearing, we find that the evidence was not previously obtainable. Although claimant argues that SAIF could have obtained the same evidence with further investigation, we do not agree. Dr. Heck asked claimant specific questions regarding her drinking, her relationship with her spouse, and about any relationships with coworkers. At no time at the hearings level did claimant disclose the information which has been recently obtained in the "post-hearing" deposition for the civil case. Moreover, Dr. Heck's opinion specifically stated that it was contingent on claimant providing an accurate history. See e.g. Jose L. Cervantes, 41 Van Natta 2419 (1989) (In a later hearing, the claimant admitted that, during his testimony in a prior hearing, he had lied about being involved in a fight which resulted in injury. The Board agreed with the insurer that "due diligence is not really a consideration in this situation * * *. It is untenable as a matter of policy or equity to suggest employer should have adduced enough evidence at the first hearing to force claimant to admit he lied." Because the claimant's credibility was a central consideration in the referee's conclusions, the Board remanded the matter for taking of evidence concerning the fight).

Accordingly, in light of Dr. Heck's statements regarding the newly obtained evidence, we conclude that the recent "post-hearing" evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., supra; Jose L. Cervantes, supra.

Having found that SAIF has established a compelling reason, we grant its motion to remand for the admission of additional evidence regarding claimant's recent deposition and Dr. Heck's subsequent report. On remand, 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 August 17, 1995 is vacated. This matter is remanded to ALJ Black for further proceedings consistent with this order.

IT IS SO ORDERED.

Board Chair Hall dissenting.

I disagree with the majority's decision, on reconsideration, to remand this matter for additional evidence. To merit remand for additional evidence, such evidence could not have been obtainable at the time of hearing. Compton v. Weyerhaueser Co., 301 Or 641 (1986); Janice K. Ott-Pettry, 48 Van Natta 525, 526 (1996).

Here, there has been no showing that the evidence SAIF seeks to introduce was not obtainable with due diligence at the time of hearing. SAIF could have obtained claimant's testimony or at least the substance thereof, regarding the matters raised in the civil trial earlier. Because SAIF apparently made no effort to investigate and obtain this information at the time of hearing, remand is inappropriate. Under such circumstances, I would deny the motion for remand.

In the Matter of the Compensation of
DAVID GREY, Claimant
WCB Case No. 95-01235
ORDER OF DISMISSAL
Susak, Dean & Powell, Claimant Attorneys
Virgil Osborn, Department of Justice

Claimant requested Board review of Administrative Law Judge (ALJ) McCullough's July 12, 1995 order which affirmed the Department of Consumer and Business Services' (DCBS) determination that he was not a subject worker. At claimant's request, Board review of this case was suspended to await issuance of the court's decision in Lankford v. Copeland, 141 Or App 138 (1996). Pending Board action, claimant also directly petitioned the Court of Appeals for judicial review of the ALJ's order.

On August 28, 1996, the court affirmed without opinion the ALJ's order. In addition, on remand from the Lankford court, we dismissed a claimant's request for Board review of an ALJ's order affirming a Department "non-subjectivity determination" and remanded the case to the Department for the issuance of an order containing a correct notice of appeal. Cindy Lankford, 48 Van Natta 1870 (1996).

On September 30, 1996, in light of such circumstances, the Board's staff counsel forwarded a letter to claimant's attorney seeking clarification of claimant's position regarding his still-pending request for Board review. Noting that claimant had previously represented that he would withdraw his request for review once the Lankford decision became final, the Board's staff counsel asked claimant's counsel to provide written notification of claimant's future intentions. In response to the Board's request, claimant's counsel has stated that "claimant does not believe that any Board action is required."

Based on the aforementioned chronology of events, we interpret claimant's response as confirmation that he is not opposed to the dismissal of his request for Board review. Alternatively, even if he was so opposed, we would still be required to dismiss his appeal. In accordance with the Lankford holding, we lack appellate authority to consider an appeal from an ALJ's order regarding the Department's "non-subject worker" determination. Furthermore, although we are authorized to remand an ALJ's order to the Department for issuance of a corrected order contained notice of appeal rights, Cindy Lankford, supra, such an action would be unnecessary in this case where claimant has already sought direct appeal of the ALJ's order and the court has affirmed the ALJ's decision.

Accordingly, consistent with the aforementioned reasoning, we dismiss claimant's request for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD W. JENKINS, Claimant
WCB Case No. 95-02777
ORDER ON REVIEW
Foss, Whitty, 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) Baker's order that assessed an attorney fee for prevailing over its denial of claimant's cervical sprain/strain injury and disc condition at C3-4, contending that the fee is excessive. Claimant cross-requests review of that portion of the ALJ's order that upheld SAIF's denial of cervical spondylosis and degenerative disc disease. On review, the issues are compensability and attorney fees.

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

Claimant, age 52 at the time of hearing, compensably injured his neck and back on May 12, 1992. He was standing on a scaffold plank when a crane dropped a heavy beam onto the plank, causing the plank and claimant to bounce up in the air. This bounce produced a compression and axial load on claimant's spinal column, resulting in mid-back and persistent neck pain.

SAIF accepted a thoracic strain. It did not specifically accept a cervical strain, despite claimant's request that it do so. By December 1992, claimant's then-treating doctor, Dr. Adams, noted that claimant's x-rays showed early minimal or mild degenerative changes at C5-6 and C6-7.

Although his neck symptoms continued, claimant did not seek treatment again until mid-1994. At that time, Dr. Adams diagnosed cervical osteoarthritis, degenerative disc disease phenomena or spondylosis, noting these were different terms for the same degenerative cervical condition. In May 1995, claimant began treating with Dr. Bert, another surgeon in the same practice group as Dr. Adams. Dr. Bert obtained an MRI study which showed a bulging or herniated disc at C3-4. Both Dr. Bert and consulting physician, Dr. Serbu, opined that this disc condition was the most likely cause of claimant's symptoms and was attributable to the 1992 industrial injury.

At hearing, the issues were the compensability of claimant's cervical strain, C3-4 disc condition and spondylosis/degenerative disc disease. The ALJ concluded that claimant had proven the compensability of his cervical strain and C3-4 disc condition,[1] but failed to establish the compensability of his underlying cervical spondylosis/degenerative disc disease.

On cross-review, claimant contends that he has persuasively shown that the 1992 industrial injury and/or his work subsequent activities for the employer were the major contributing cause of a pathological worsening of his degenerative disc disease. We disagree.

Where, as here, the expert 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). Unexplained, conclusory opinions are unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980). In this case, several medical experts have offered opinions concerning the cause of claimant's degenerative disc disease. Dr. Bert relates claimant's degenerative condition to his work activities and a pathological worsening of the condition to the 1992 industrial injury. Drs. Adams, Strum, Dinneen and Woolpert, on the other hand, consider claimant's degenerative disease at C4-5 and C5-6 to be a preexisting, unrelated condition, not pathologically worsened by claimant's work activity or the 1992 incident.[2]

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[1] The compensability of claimant's cervical strain and C3-4 disc condition is not at issue on review.

[2] Dr. Adams, claimant's former treating physician, opined that claimant's 1992 work injury would not have caused the degenerative condition, although it may have aggravated the symptoms of cervical osteoarthritis. (Ex. 17). Similarly, in his deposition, Dr. Woolpert reported that claimant's injury may have caused a "symptomatic exacerbation" of the preexisting, underlying degenerative disc condition, although he attributed the disease and its worsening to the natural aging process rather than any trauma from the 1992 injury. (Ex. 37-33).

After reviewing the various medical opinions, we find persuasive reasons not to rely on Dr. Bert's opinion, because it is conclusory and lacking in analysis. For example, Dr. Bert summarily concludes that claimant's 1992 work injury caused a pathological worsening of any preexisting degenerative condition simply because claimant was "asymptomatic before the injury." Dr. Bert also concludes that claimant's employment as a heavy laborer was the major contributing cause of the degenerative disease and its worsening without further explanation or reasoning. In addition, we are unable to tell from Dr. Bert's report whether he was considering the herniated disc at C3-4 (which is a separate, compensable condition) as the pathological worsening resulting from the 1992 injury, or whether he was referring only to the progression of the degenerative spondylosis condition.

In summary, we find Dr. Bert's conclusory opinion insufficient to outweigh the contrary opinions of Drs. Adams, Strum, Dinneen and Woolpert. Like the ALJ, we conclude that claimant has failed to prove the compensability of his degenerative disc disease/cervical spondylosis/osteoarthritis by a preponderance of the evidence.

Lastly, we note that claimant is not entitled to an attorney fee on review for defending the ALJ's attorney fee award. Dotson v. Bohemia Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 29, 1995 is affirmed.

October 23, 1996 Cite as 48 Van Natta 2179 (1996)

In the Matter of the Compensation of
LORETO SALAZAR-GONSALAZ, Claimant
WCB Case No. 96-01826
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) decreased claimant's unscheduled permanent disability for a low back condition from 24 percent (76.8 degrees), as awarded by an Order on Reconsideration, to 21 percent (67.2 degrees); and (2) awarded an attorney fee. On review, the issues are extent of unscheduled permanent disability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

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

Attorney Fees

The ALJ awarded claimant's attorney a $1,000 attorney fee for services at hearing. However, an attorney fee is only authorized under these circumstances if the ALJ does not reduce the claimant's compensation at hearing. See ORS 656.382(2); OAR 438-015-0065. In this case, because the ALJ did reduce claimant's compensation, we reverse the attorney fee awarded at hearing.

Claimant's attorney is entitled to an assessed fee for services on review with regard to the unscheduled 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 concerning this matter 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. Claimant is not entitled to an attorney fee for services on review in responding to the insurer's appeal of the attorney fee issue. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated June 25, 1996 is reversed in part and affirmed in part. That portion of the order that awarded a $1,000 attorney fee is reversed. The remainder of the order is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

October 24, 1996 Cite as 48 Van Natta 2180 (1996)

In the Matter of the Compensation of
JAMES A. GODDEN, Claimant
WCB Case No. 95-13791
ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our September 24, 1996 Order on Review. In that order, we affirmed the Administrative Law Judge's (ALJ'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). SAIF contends that claimant's unscheduled permanent disability award should be 12 percent (10 percent for impairment and 2 percent for non-impairment factors). Having received claimant's response to SAIF's motion, we proceed with our reconsideration.

In finding that claimant was entitled to 16 percent unscheduled permanent disability for his pelvic fracture, the ALJ relied on the opinion of the attending physician, Dr. Welch, who opined that claimant's pelvic fracture was displaced.[1] However, in finding that claimant should receive 10 percent impairment for reduced range of lumbar motion, the ALJ relied on the impairment findings in Dr. Martens' medical arbiter's report.

SAIF asserts that we should have determined claimant's permanent impairment based solely on the opinion of Dr. Martens, who opined that claimant's pelvic fracture healed without displacement or deformity. SAIF argues that, based on Dr. Martens' arbiter's report, claimant's permanent impairment should be 10 percent for reduced range of motion. We disagree.

Upon further consideration of the medical evidence, we continue to find that Dr. Martens' medical arbiter's report is the most thorough, complete and persuasive evaluation of claimant's impairment due to lost range of motion. See Carlos S. Cobian, 45 Van Natta 1582 (1993). However, we continue to conclude that Dr. Welch was in the best position to determine whether claimant's pelvic deformity healed with or without displacement or deformity. Therefore, we conclude once more that the ALJ's evaluation of claimant's permanent impairment was correct.

Claimant's counsel is entitled to an additional attorney fee for time spent responding to SAIF's reconsideration request. 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 $150, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the reconsideration request and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our September 24, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our September 24, 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] A fractured pelvis that heals with displacement results in 5 percent impairment pursuant to OAR 436-35-370(2).

In the Matter of the Compensation of
MARGIE M. GATELY, Claimant
WCB Case No. 96-00781
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that awarded a penalty pursuant to ORS 656.262(11)(a) for an allegedly unreasonable delay in payment of interim compensation. In the event claimant prevails on review, she seeks an assessed attorney fee award under ORS 656.382(2). On review, the issues are penalties and attorney fees.

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

Claimant injured her back at work on January 27, 1995, and filed a claim that same day. The insurer issued a denial on May 26, 1995. On approximately June 14, 1995, the insurer paid interim compensation for the period from February 4, 1995 to May 24, 1995. The insurer concedes that, pursuant to ORS 656.262(4)(a), this compensation was not timely paid.

On review, the insurer renews its contention that the doctrine of claim preclusion bars claimant from asserting her entitlement to penalties because she did not raise the penalty issue at the August 30, 1995 hearing concerning the compensability of her claim.[1] Like the ALJ, we reject this argument.

Under the doctrine of claim preclusion, if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Carr v. Allied Plating, 81 Or App 306, 309 (1986); Restatement (Second) of Judgments, Sections 17-19, 24 (1982). A "claim" is a transaction or series of transactions arising from the same set of operative facts. Carr v. Allied Plating, supra. Claim preclusion does not require actual litigation of an issue of fact or law, but only the opportunity to do so. Thus, if the claim in the second action is based on the same factual transaction that was at issue in the first action, and is of such a nature as could have been joined in the earlier action, it will be precluded. Drews v. EBI Companies, 310 Or 134, 140 (1990); Rennie v. Freeway Transport, 294 Or 319, 323 (1982).

In this case, the determinative issue is whether claimant's penalty claim arises from the same set of operative facts as the compensability of her lumbar strain injury. We conclude that it does not.

The August 30, 1995 hearing concerned the propriety of the insurer's denial of compensation. The operative facts involved the compensability of claimant's injury claim, i.e., whether the unwitnessed injury occurred at work as claimant described. The ALJ found claimant credible, and set aside the denial. The operative facts in the present case arise out of the insurer's processing of the injury claim; specifically, whether it timely paid interim compensation. Since the penalty issue does not arise out of the same factual transaction involved in the compensability hearing, we consider it a separate claim, which is not barred by the doctrine of claim preclusion. See, e.g., Bryan Thompson, 42 Van Natta 1532 (1990) (claim for "de facto" denial of massage therapy did not arise out of the same set of operative facts as previously litigated premature closure, extent of permanent disability, and penalties and attorney fees dispute).

In light of the insurer's concession that the interim compensation was not timely paid, we affirm the ALJ's assessment of a penalty pursuant to ORS 656.262(11)(a). However, we reject claimant's request for an assessed attorney fee on review under ORS 656.382(2). See Saxton v. SAIF, 80 Or App 631 (1986) (penalties are not compensation for purposes of ORS 656.382 (2)).

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[1] Following that hearing, ALJ Peterson found claimant's claim compensable and set aside the insurer's denial in an Opinion and Order issued September 12, 1995.

ORDER

The ALJ's order dated May 8, 1996 is affirmed.

In the Matter of the Compensation of
LARRY P. KARR, Claimant
Own Motion No. 96-0134M
OWN MOTION ORDER DENYING RECONSIDERATION (OF PRIOR ORDER)
Malagon, et al, Claimant Attorneys
Darren Lee, Defense Attorney

The insurer requests reconsideration of our April 11, 1996 Own Motion Order, as reconsidered on April 29, 1996. Specifically, the insurer contends that, because claimant was retired at the time of disability, he is not entitled to temporary disability benefits in this claim. We deny the insurer's request.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there is good cause for the failure to file within 30 days. Because the insurer is the party requesting reconsideration, it has the burden of proving "good cause." The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666; see also Brown v. EBI Companies, 289 Or 455 (1980). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). However, under OAR 438-012-0065(3), the Board may, on its own motion, reconsider any prior Board order if it determines that "extraordinary circumstances" exist which would allow it to make an exception to the deadlines imposed by OAR 438-065-0065(2). See e. g., Jay A. Yowell, 42 Van Natta 1120 (1990) (because the insurer failed to promptly forward the claimant's misdirected request for reconsideration to the Board (former OAR 438-05-075), the Board allowed that "extraordinary circumstances" prevented the claimant's timely filing of the request).

On February 23, 1996, as amended on April 8, 1996, the insurer recommended that the Board reopen claimant's claim for the payment of temporary disability compensation. We issued our order authorizing the reopening of claimant's claim on April 11, 1996. On April 29, 1996, we issued an order on reconsideration, in which we granted claimant's attorney an approved fee. Copies of each of our orders were mailed to claimant, claimant's attorney and the insurer. Each of our orders contained a notice to the parties which provided the reconsideration filing period, as defined in OAR 438-012-0065(2).

The insurer's request for reconsideration of our orders was received on October 3, 1996, more than 60 days after the issuance of our April 11, 1996 and April 29, 1996 orders. See OAR 438-012-0065(2). Moreover, the insurer offers no explanation for its late request. Instead, the insurer contends that it has discovered that claimant has retired, and thus, was not in the work force at the time of disability.[1] Finally, the insurer offers as its evidence regarding the work force issue, information contained in medical reports from December 1995 and January 1996.[2]

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[1] ORS 656.278(1) provides that a claimant is eligible for temporary disability compensation only if the claimant's compensable condition requires surgery or inpatient hospitalization. However, in order to be entitled to the payment of temporary disability compensation, the claimant must establish that he was in the work force at the time of disability. If the claimant is not in the work force, he is not entitled to "time loss" compensation because no work time was "lost." Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). The criteria for qualification as a member of the work force is found in Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). A claimant who voluntarily removes himself from the work force does not qualify for temporary disability compensation. See id.

[2] The insurer also notes that it delayed its response to claimant's August 30, 1996 letter because a settlement had been pending. However, claimant's August 30, 1996 letter was submitted well after the time had expired for appealing our prior orders. Therefore, we do not find that the settlement issue relevant to a "good cause" argument that would excuse the insurer from appealing our orders timely.

We are unable to find that the insurer offers a persuasive explanation for its late request for reconsideration. Further, we conclude that the information regarding the work force issue was available to the insurer "with due diligence" at the time the insurer submitted its recommendations to the Board. Therefore, the insurer has not established good cause for its failure to timely request reconsideration, nor has it provided persuasive evidence that would constitute extraordinary circumstances which would lead us to conclude that an exception outside of the deadlines imposed by OAR 438-012-0065(2) is appropriate. Charles Kurnick, 46 Van Natta 2501 (1994); Jay A. Yowell, supra; Cogswell v. SAIF, supra.

Accordingly, the insurer's request for abatement and reconsideration is denied. The issuance of this order neither "stays" our prior orders nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS ORDERED.

October 24, 1996 Cite as 48 Van Natta 2183 (1996)

In the Matter of the Compensation of
LARRY P. KARR, Claimant
Own Motion No. 96-0134M
OWN MOTION ORDER (ENFORCING PRIOR ORDER)
Malagon, et al, Claimant Attorneys
Darren Lee, Defense Attorney

Claimant requests that the Board enforce its April 11, 1996 Own Motion Order, as reconsidered on April 29, 1996, which authorized the reopening of his 1988 injury claim for the payment of temporary disability compensation (TTD), beginning the date he entered the hospital for surgery. In addition, claimant requests the Board assess a penalty for the insurer's unreasonable refusal to pay compensation.

FINDINGS OF FACT

On April 28, 1988, claimant sustained a compensable left knee strain injury. Claimant's aggravation rights in this claim expired on July 19, 1994.

On February 23, 1996, the insurer submitted an incomplete recommendation to the Board. Although it recommended that we reopen claimant's claim, the Board forwarded a current Carrier's Own Motion Recommendation form to the insurer, and requested that the insurer return a completed recommendation to the Board.

Claimant underwent surgery sometime between February 23, 1996 and May 6, 1996.[1] On April 8, 1996, the insurer forwarded its completed recommendation form to the Board. The insurer agreed that: (1) claimant's current condition has worsened requiring surgery or inpatient hospitalization; (2) claimant's 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 claimant's compensable condition; and (5) claimant was in the work force at the time of disability.

On April 11, 1996, we issued our Own Motion Order authorizing the reopening of claimant's claim for the payment of temporary disability compensation. On April 29, 1996, we issued an Own Motion Order on Reconsideration, which authorized an approved fee of 25 percent of the increased temporary disability compensation awarded to claimant (not to exceed $1,050) as a result of his services culminating in our April 11, 1996 order.

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[1] There is no surgical report in the record. Our record indicates that on February 23, 1996, the date of the insurer's submission of an "incomplete" recommendation to the Board, it agreed that arthroscopic surgery was requested, but it "[had not] received a date [of surgery] yet." The next medical report in the record is a May 6, 1996 chart note in which Dr. Singer, claimant's treating orthopedic surgeon, noted that claimant still had some knee discomfort medially, but that the "puncture sites are benign." Nonetheless, the insurer in this claim was required to pay temporary disability compensation beginning the date claimant entered the hospital for surgery unless it timely requested reconsideration of our order.

On August 30, 1996, claimant requested that the Board enforce its April 11, 1996 order by ordering the insurer to pay claimant time loss benefits from the date of surgery through his medically stationary date. Claimant further requested that the Board assess a penalty for the insurer's unreasonable delay in the payment of those benefits. Finally, claimant requested a separate attorney fee pursuant to ORS 656.382 for the insurer's failure to provide discoverable information in a timely fashion. The discovery issue in this case has been resolved by the parties' Settlement Stipulation, signed by the Board on this date, attached hereto and incorporated by reference herein.

On September 25, 1996, the insurer requested reconsideration of our April 11, 1996 order, as reconsidered on April 29, 1996. Citing information contained in December 1995 and January 1996 medical documents, the insurer contended that claimant was retired, and, thus, not in the work force at the time of his current disability. The insurer offered no explanation for its untimely request for reconsideration of our April 1996 orders. In an order issued on today's date, we have denied the insurer's request for reconsideration due to its lack of evidence and argument supporting "good cause" for its untimely request for reconsideration.

FINDINGS OF ULTIMATE FACT

The insurer failed to timely request reconsideration of our orders pursuant to OAR 438-012-0065. Claimant is entitled to temporary disability compensation in this claim, beginning the date he was hospitalized for surgery.

CONCLUSIONS OF LAW AND OPINION

Enforcement

The Board has exclusive jurisdiction to authorize the reopening of a claim under ORS 656.278 and OAR Chapter 438, Division 012. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Moreover, the Board's authority extends to enforcing its own motion orders. See Jeffrey T. Knudson, 48 Van Natta 1708 (1996); Thomas L. Abel, 45 Van Natta 1768 (1993); David L. Waasdorp, 38 Van Natta 81 (1986).

Here, pursuant to ORS 656.278(1), we authorized the reopening of claimant's 1988 left knee claim for the payment of temporary disability, commencing the date he underwent surgery. Our April 11, 1996 order, as reconsidered on April 29, 1996, became final on May 29, 1996. Although we are not aware of the actual date of surgery, it occurred sometime before May 6, 1996, so that retroactive temporary disability was due by the time our order became final. The insurer was required to pay temporary disability 14 days after our order became final, or by June 12, 1996. The insurer did not request reconsideration before that date. The insurer had not yet paid TTD by the date of claimant's August 30, 1996 enforcement request. Because August 30, 1996 is more than 14 days after the date of our final order, we conclude that the insurer failed to comply with our order reopening this claim.

Accordingly, pursuant to our April 11, 1996 order reopening claimant's claim (as reconsidered on April 29, 1996), we order the insurer to pay temporary disability compensation beginning the date claimant underwent arthroscopic surgery. Further, pursuant to our April 29, 1996 order, we direct the insurer to pay to claimant's attorney an approved fee, in the amount of 25 percent of the increased temporary disability compensation awarded by our April 11, 1996 order, not to exceed $1,050. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Penalty

To be entitled to a penalty in this claim, claimant must establish that the insurer unreasonably refused the payment of temporary disability compensation. Under ORS 656.262(11)(a), if the insurer "unreasonably delays or unreasonably refuses to pay compensation," it shall be liable for an additional amount of 25 percent of the amounts "then due." Here, we find the insurer's conduct to be in violation of that statute as well as the Board's rules. The insurer did not timely request reconsideration of our

orders, it did not timely pay compensation pursuant to our orders, nor does it offer any explanation for its failure to do so.[2]

Therefore, under ORS 656.262(11)(a), we find that claimant is entitled to, and we are authorized to assess, a 25 percent penalty of the amounts "then due" claimant beginning the date claimant entered the hospital for surgery, through the date of this order (unless said compensation could be lawfully terminated under OAR 438-012-0035 prior to this order), payable in equal shares to claimant and his attorney.

IT IS SO ORDERED.

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[2] The insurer contends that the Board should disallow the payment of temporary disability benefits, contending that claimant was not in the work force at the time of disability. The insurer further contends that claimant has produced no evidence that he remained willing to work at the time of disability, nor that he had not voluntarily removed himself from the work force at that time. Although the insurer could have argued the work force issue on the merits within the appropriate time for appeal, because we have found that it did not timely appeal our order (which was based, in part, on the insurer's recommendation that it agreed that claimant was in the work force at the time of disability), it cannot now request that we reconsider an order which has become final by operation of law. See Own Motion Order Denying Reconsideration in this claim, issued on today's date.

October 24, 1996 Cite as 48 Van Natta 2185 (1996)

In the Matter of the Compensation of
CHERYL A. LOSLI, Claimant
WCB Case No. 95-00049
ORDER ON RECONSIDERATION
Pamela A. Schultz, Claimant Attorney
Wallace & Klor, Defense Attorneys

On May 20, 1996, we withdrew our April 19, 1996 order which, among other decisions, had upheld the insurer's denial of claimant's current low back condition and reversed an Administrative Law Judge's (ALJ's) attorney fee awards of $2,250 under ORS 656.386(1) and $250 under ORS 656.382(1). We took this action in response to claimant's announcement that the parties were attempting to resolve their dispute. On July 31, 1996, we approved the parties' Claim Disposition Agreement, in which claimant released, with the exception of medical services, all further rights to benefits arising under her August 1993 claim. Consistent with the approval of the parties' CDA, as well as in conjunction with an ALJ-approved settlement in WCB Case Nos. 96-01932 & 96-04251 (cases which were pending before the Hearings Division), claimant has now provided notification of her withdrawal of her motion for reconsideration.

In light of such circumstances, as supplemented herein, we republish our April 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
SALVADOR QUINTERO, Claimant
WCB Case No. 95-09236
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McKean's order that declined to award an attorney fee under ORS 656.382(2). The self-insured employer cross-requests review of that portion of the order that awarded 28 percent (89.6 degrees) unscheduled permanent disability for a right shoulder injury. On review, the issues are extent of unscheduled permanent disability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Permanent Partial Disability

A July 1995 Order on Reconsideration awarded 31 percent unscheduled permanent disability (PPD). Claimant requested, and the employer cross- requested, a hearing. The ALJ decreased the impairment value for loss of muscle strength (in accordance with the parties' agreement that the Appellate Review Unit (ARU) had erred in calculating that value), awarded claimant an additional impairment value for resection of the right clavicle, and affirmed the adaptability value (3) assigned by the ARU. As a result, the ALJ found claimant entitled to 28 percent unscheduled PPD.

On review, the employer contends the PPD award should be reduced to 17 percent. Specifically, the employer challenges the award for resection of the right clavicle and contends that claimant's adaptability value is 1.

The extent of claimant's permanent disability is determined by an application of the "standards." Claimant became medically stationary on March 7, 1995, and his claim was closed on March 28, 1995. Accordingly, the disability standards in Workers' Compensation Department Administrative Orders Nos. 6-1992, 93-056, and 96-068 apply to claimant's claim. OAR 436-035-0003(1), (2), and (3).

Impairment

The ARU awarded a value of 5 percent for resection of the right acromion. See former OAR 436-35-330(14). At hearing, claimant challenged the ARU's failure also to award 5 percent for resection of the right clavicle. See former OAR 436-35-330(13). Concluding that removal of a spur off the inferior aspect of the clavicle constituted a resection of the clavicle itself, the ALJ awarded the value sought. On review, the employer does not dispute the award for resection of the acromion. The employer contends, however, that because there is no evidence of resection of any part of the clavicle, claimant is not entitled to an award under former OAR 436-35-330(13). For the following reasons, we agree.

Claimant injured his right shoulder in September 1993. An April 1994 MRI revealed significant degenerative changes in the acromioclavicular (AC) joint, an anomaly of the acromion, and a large spur off the inferior aspect of the clavicle. The employer accepted a disabling right shoulder strain. In an August 24, 1995 preoperative chart note, Dr. Baskin, claimant's treating orthopedic surgeon, expressly commented that, given claimant's lack of significant symptoms in the AC joint, during the acromioplasty he would "not need to resect the distal end of his clavicle, just remove the spurs at the inferior aspect of the AC joint." On August 25, 1995, Dr. Baskin performed an "Arthroscopic Neer acromioplasty with resection spur inferior aspect of the clavicle, right." The operative report confirms Dr. Baskin reshaped the acromion and removed a spur off the inferior aspect of the clavicle.

Based on Dr. Baskin's description of the surgery he performed, we find there was no resection of any part of claimant's clavicle. Claimant is not, therefore, entitled to an impairment value under former OAR 436-35-330(13).

The parties do not dispute the values for resection of the right acromion (5), loss of muscle strength (8), and loss of range of motion (1). Combining these values, claimant's unscheduled impairment equals 14 percent.

Adaptability

On the basis of a medical arbiter panel's findings, the ALJ concluded that claimant's residual functional capacity (RFC) is "medium/light" with restrictions, or the equivalent of "light." Consequently, in view of the parties' agreement that claimant's base functional capacity (BFC) was "medium," the ALJ held that claimant's adaptability value is 3. We adopt and affirm the ALJ's reasoning and conclusion regarding this issue, with the following comment.

The employer contends the adaptability value is 1. In this regard, the employer argues that the preponderance of the evidence establishes that claimant was released to perform "medium" work after he became medically stationary. After considering the evidence relied on by the employer, we do not agree.

"'Medium (M)' means the worker can occasionally lift 50 pounds and can lift or carry objects weighing up to 25 pounds frequently." OAR 436-035-0310(3)(h).

Dr. Baskin opined that claimant could return to work with a "35 lb weight limit restriction." Similarly, the medical arbiter panel explained that claimant's "lifting capacity is less than 35 pounds," and further recommended that he "avoid excessive climbing, reaching overhead, pushing or pulling more than 35 pounds." Thus, contrary to the employer's argument, no physician found claimant capable of "medium" work after he became medically stationary.

Accordingly, we conclude that the ALJ correctly found that claimant is capable of performing work in the light category. See OAR 436-035-0310(3)(g); 436-035-0310(7). Comparing claimant's BFC (medium) to his RFC (light) results in an adaptability value of 3, the value assigned by the ALJ. OAR 436-035-0310(6). We therefore affirm the ALJ's decision on the issue of adaptability.

The parties do not dispute the age (1) and education (2) values. We assemble all the factors as follows: Adding claimant's age and education values equals 3. Former OAR 436-35-280(4). Multiplying that sum by claimant's adaptability value (3) equals 9. Former OAR 436-35-280(6). Finally, we add that sum to claimant's impairment value (14), for a total of 23 percent unscheduled permanent disability. Former OAR 436-35-280(7). We modify the Order on Reconsideration and the ALJ's order accordingly.

ORS 656.382(2) Attorney Fee

Claimant contends that, because the ALJ did not reduce the Order on Reconsideration award below the 28 percent the parties "agreed" is due after correction of the calculation error by the Appellate Review, he is entitled to an attorney fee under ORS 656.382(2). See Tommy V. Drennen, 47 Van Natta 1524 (1995).

Inasmuch as we have herein reduced the PPD award to 23 percent, claimant has not successfully defended the Order on Reconsideration award (31 percent) against the employer's request for hearing. Consequently, we conclude that an ORS 656.382(2) attorney fee is not warranted under the facts of this case.

ORDER

The ALJ's order dated May 7, 1996 is modified. In lieu of the Order on Reconsideration award of 31 percent (99.2 degrees) and the ALJ's order awarding 28 percent (89.6 degrees), claimant is awarded 23 percent (73.6 degrees) unscheduled permanent partial disability. The ALJ's out-of-compensation attorney fee award is adjusted accordingly. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
TREVOR E. SHAW, Claimant
WCB Case No. 95-01654
SECOND ORDER ON RECONSIDERATION
Schneider, Hooton, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our July 30, 1996 order, as reconsidered on August 27, 1996, in which we found that the insurer was not obligated to pay additional temporary disability compensation pursuant to a final Board order. Subsequent to the issuance of our July 30, 1996 order, the Court of Appeals issued Jeld-Wen, Inc. v. Bartz, 142 Or App 433 (1996), which claimant contends is applicable in this case.

In order to consider claimant's motion, we withdrew our prior orders on September 24, 1996. The insurer has submitted a response in opposition to claimant's request for reconsideration. The insurer specifically contends that claimant untimely raised the argument that a collateral attack on a final order is impermissible. We disagree.

Claimant raised the issue of enforcement of a final Board order at hearing. (Tr. 1; O&O at 2; Amended O&O at 2). In his May 24, 1995 Opinion and Order, the ALJ formulated claimant's argument as follows: "[D]efendant may not collaterally attack an order that is final by operation of law." (O&O at 2). We conclude that claimant properly raised the argument below. We now turn to claimant's motion.

We briefly summarize the relevant procedural history. Claimant compensably injured his low back on April 30, 1993. On June 4, 1993, the insurer stopped temporary disability payments. In a November 4, 1993 order, ALJ Menashe held that the insurer had no statutory authority to terminate temporary disability payments 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. 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 that portion of the November 4, 1993 order finding that the insurer had no statutory authority to terminate temporary disability payments after June 4, 1993. The Board further concluded that the insurer had no statutory authority to terminate temporary disability payments on June 20, 1993. In addition to the ALJ's temporary disability award between June 4, 1993 to June 20, 1993, the Board accordingly ordered payment of additional temporary disability from June 20, 1993 until such benefits could be lawfully terminated and assessed a penalty based on those amounts. The insurer appealed the Board's order, but withdrew its petition for judicial review in January 1995. The insurer paid no temporary disability compensation or penalties pursuant to the Board's final order.

In the interim, the insurer had issued a January 17, 1994 Notice of Closure, declaring claimant medically stationary on January 7, 1994 and awarding substantive temporary disability benefits through June 6, 1993. An Order on Reconsideration affirmed the medically stationary date, but awarded temporary disability through June 20, 1993. A December 15, 1994 order found claimant medically stationary on June 7, 1993 and claimant's entitlement to substantive temporary disability benefits to end the same date.

When the insurer failed to pay the compensation and penalties awarded under the Board's September 8, 1994 final order, claimant brought this enforcement proceeding. The present ALJ declined to order the insurer to pay temporary disability or penalties pursuant to our September 8, 1994 final order, reasoning that the insurer had properly stayed payment of temporary disability benefits under the November 4, 1993 order pending its appeal to the Board. Then, 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). We affirmed the ALJ's opinion on this issue.

In Bartz, as in the case before us, the issue was the enforcement of a final order. In Bartz, an employer denied a claim filed in 1991. In January 1993, the Board overturned the denial and remanded the claim to the employer for "processing according to law." The employer sought judicial review of the Board's order, but failed to process the claim. The court affirmed the Board's order.

The claimant requested a hearing on her entitlement to benefits during the pendency of judicial review. In October 1993, an ALJ ordered the employer to pay temporary disability benefits from January 14, 1993, the date following the Board order requiring processing of the claim, until either the claim was lawfully closed or the Board's order was reversed, as required under former ORS 656.313(1).[1]

On October 30, 1993, the employer issued a Notice of Closure declaring claimant medically stationary as of September 9, 1992 and paid temporary disability benefits through that date. The employer did not pay benefits from January 14, 1993, through October 30, 1993, the date of closure.

On May 17, 1994, the Board affirmed the ALJ's October 1993 order requiring the employer to pay temporary disability benefits pursuant to ORS 656.313(1). The employer neither requested judicial review of the Board's order nor paid the temporary disability benefits as ordered. The claimant then initiated an action to enforce the Board's May 17, 1994 order.

On December 1, 1994, an ALJ ordered the employer to pay temporary disability benefits from January 14, 1993 through October 30, 1993. The Board affirmed, and the employer sought judicial review. The court concluded that the employer was required to pay benefits as ordered by the Board's May 17, 1994 order, because the order requiring the payment of such benefits became final and is not subject to collateral challenge. Jeld-Wen, Inc. v. Bartz, 142 Or App at 436.

Here, unlike in Bartz, the benefits awarded under the November 4, 1993 order and the benefits awarded under our September 8, 1994 order had been lawfully stayed. However, when our September 8, 1994 order became final as a result of the court's dismissal of the insurer's request for judicial review, the stay was lifted. Thus, by virtue of our September 8, 1994 final order, the insurer is required to pay the temporary disability benefits (from June 4, 1993 to the January 17, 1994 date of closure) and related penalties as ordered. Jeld-Wen v. Bartz, supra (A final Board order requiring the payment of benefits is not subject to collateral challenge). Accordingly, the insurer is ordered to pay claimant temporary disability benefits from June 4, 1993 to January 17, 1994, and the 25 percent penalty based on those amounts, payable in equal shares to claimant and his attorney. Claimant's attorney is awarded an out-of-compensation attorney fee of 25 percent of the additional compensation granted by this order, not to exceed $3,800, payable directly to claimant's attorney.

We distinguish the analysis in this case from that in Lebanon Plywood v. Seiber, 113 Or App 651 (1992). In Seiber, supra, the employer accepted the claimant's aggravation claim. The claimant later became medically stationary and, after approximately six months of "processing delays," the claim was closed by a Determination Order with an award of permanent partial disability. The employer had not paid temporary disability benefits through the date of the determination order. The claimant sought a hearing; ultimately, the Board awarded him temporary disability benefits through the date of the determination order. On appeal, the court held that the Board did not have authority to order temporary benefits beyond the date the claimant became medically stationary.

Here, in contrast to the circumstances in Seiber, we are not ordering an overpayment of benefits to which claimant was procedurally but not substantively entitled. Claimant's entitlement to temporary disability benefits was decided in our September 8, 1994 order. Here, as the court did in Bartz, regardless of the medically stationary date, we are requiring the employer to pay the temporary disability compensation and penalties ordered by a final Board order. To do otherwise would be to permit an impermissible collateral attack on our final order.

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[1] Former 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[.]"

Accordingly, we withdraw our July 30, 1996 order, as reconsidered on August 27, 1996, in its entirety. On reconsideration, as modified herein, we republish our July 30, 1996 order, as reconsidered on August 27, 1996. 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
DOROTHY I. ADAMS, Claimant
WCB Case No. 95-10003
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Johnstone's order which: (1) found that the employer's notice of acceptance did not encompass a thoracic strain; (2) set aside the employer's "de facto" denial of a thoracic strain; and (3) awarded a $2,500 employer-paid attorney fee under ORS 656.386(1). Contending that the employer's request for review was defective and untimely filed, claimant moves for dismissal of the appeal. On review, the issues are claimant's motion to dismiss, claim processing and attorney fees. We deny the motion and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

On September 5, 1995 and on November 30, 1995, claimant filed hearing requests regarding the employer's alleged failure to accept all of her compensable conditions arising from a March 18, 1994 injury. Claimant alleged "de facto" denials of her "headache and bilateral shoulders, i.e., scapula, trapezius and rhomboids," and "disc bulge C5-6, chronic dorsal sprain, chronic thoracic sprain and lumbar sprain." On January 10, 1996, claimant filed a hearing request contesting the reconsideration order of November 30, 1995.

On May 7, 1995, the ALJ issued a "Deferral Order" that deferred issues raised in the January 10, 1996 request for hearing pending resolution of the issues in claimant's other hearing requests. The January 10, 1996 hearing request was assigned WCB case number 96-03672.

The ALJ also issued an Opinion and Order on May 7, 1996 (WCB case number 96-10003) which addressed the issues raised in claimant's other hearing requests. Concluding that the employer's notice of acceptance did not include all compensable conditions, the ALJ set aside the employer's "de facto" denial of claimant's thoracic strain. The ALJ also awarded an attorney fee.

On May 13, 1996, erroneously identifying the ALJ's order of May 7, 1996 as WCB case No. 96-03672, the employer moved for reconsideration. In a May 15, 1996 letter, the ALJ advised that the employer's motion was denied.

On May 31, 1996, the employer requested "Board review of the Opinion & Order entered on May 7, 1996 issued by Administrative Law Judge Johnstone, on the ground that attorney fees should not have been awarded." The employer's request was filed by certified mail and indicated that the WCB case number was 96-03672. The certificate of service indicated that a copy of the request had been mailed to claimant and her attorney.

On June 6, 1996, the Board mailed a computer-generated acknowledgment of claimant's request for review . The acknowledgment, which listed the case as WCB Case No. 95-10003, noted that the request had been received on June 3, 1996.

Contending that a copy of the employer's request for review was not received in claimant's attorney's office until June 17, 1996, more than 30 days after the ALJ's May 7, 1996 Opinion and Order, claimant has moved to dismiss the employer's request for review. Claimant further contends that the employer's request for review was defective because it requested review of WCB Case No. 96-03672, the case that had been deferred. We hold that the employer's request was not defective.

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 the 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 May 7, 1996 order was June 6, 1996. Inasmuch as the employer's request for review was mailed by certified mail on May 31, 1996 to a permanently staffed office of the Board, it was timely filed. See ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b). In reaching this conclusion, we emphasize that the parties' receipt of a copy of the employer's appeal is not determinative; instead, the pivotal issue is when a copy of the request was mailed to the Board and the parties. Patrick L. Oswalt, 48 Van Natta 1556 (1996); Juan A. Hernandez, 47 Van Natta 2421 (1995); Judy W. Louie, 47 Van Natta 383 (1995).

Citing Debra A. Hergert, 48 Van Natta 1052 (1996) (the claimant's request filed timely with the Board, but notice not timely provided to the "parties"), claimant's attorney contends that, because he did not receive a copy of the employer's request for review until June 17, 1996, the employer's request for review is untimely. We disagree. Claimant's attorney is not a "party" in the proceeding. Robert Casperson, supra. In any event, the employer's May 31, 1996 request for review indicated that all "parties" to the proceeding were copied, by certified mail, with its request on May 31, 1996. The employer's service by mail upon claimant is uncontested. Therefore, the employer's certified mailing of its request for review on May 31, 1996 establishes that the employer timely notified claimant and the other parties to the proceeding of its request for review. Patrick L. Oswalt, supra; Juan A. Hernandez, supra; Judy W. Louie, supra.

Claimant also contends that, because the employer's request for review of the ALJ's order indicated that the WCB case number was "96-03672" (the May 7, 1996 Deferral Order) rather than "95-10003" (the May 7, 1996 Opinion and Order), the employer's appeal was defective. However, the employer's May 31, 1996 request for review clearly states that the employer requested review of the May 7, 1996 Opinion and Order on the ground that attorney fees should not have been awarded. The only order which fits that description carries the case number of WCB 95-10003. It is well-established that our appellate authority is based on appealed ALJ orders, not WCB case numbers. See Grover Johnson, 41 Van Natta 88 (1989). That authority necessarily includes determining the order to which the employer's appeal was directed (irrespective of whether the WCB case number noted in the employer's request corresponds to one or more of the case numbers listed in one or both ALJ orders). See Shawn C. Mann, 47 Van Natta 855 (1995).

In summary, the ALJ's order issued on May 7, 1996 was clearly the subject of the employer's request for review. Thus, the employer's failure to include the correct WCB number is not fatal to its appeal. Consequently, we retain jurisdiction to consider the employer's appeal. Claimant's motion to dismiss is, therefore, denied. We now proceed with our analysis of the substantive issue presented for review.

"De Facto" Denial

The ALJ set aside the employer's alleged "de facto" denial of claimant's thoracic strain and awarded claimant's counsel an assessed fee pursuant to ORS 656.386(1). In doing so, the ALJ noted that the employer had accepted "thoracic segmental dysfunction" based on the diagnosis by Dr. Day, claimant's initial attending physician, while other physicians had subsequently diagnosed "thoracic strain." Finding no medical evidence that "thoracic segmental dysfunction" is the same diagnosis as "thoracic strain," the ALJ concluded that the employer's acceptance did not encompass claimant's compensable thoracic strain.

On review, the employer contends that the ALJ improperly found that it "de facto" denied claimant's thoracic strain and that, therefore, the ALJ incorrectly assessed a carrier-paid attorney fee under ORS 656.386(1). We agree.

Whether an acceptance occurs is a question of fact to be decided based on all the evidence. SAIF v. Tull, 113 Or App 449, 454 (1992). An examining physician, Dr. Fuller, provided the only medical evidence clarifying the relationship between thoracic segmental dysfunction and thoracic strain. He opined that thoracic segmental dysfunction is "generally synonymous" with a thoracic strain. (Ex. 96-6). Given this unrebutted medical evidence, we find that claimant's thoracic strain is the same condition that the employer accepted, even though different medical terminology (thoracic segmental dysfunction) was used as the basis of the employer's acceptance. Cf. Leslie C. Muto, 46 Van Natta 1685 (1994), aff'd mem 133 Or App 770 (1995) (no "de facto" denial when the claimant's condition was the same as that accepted by the carrier even though different medical terminology used to describe the condition).

Claimant asserts, however, that Dr. Fuller's opinion should be discounted because he allegedly had an inaccurate history and incorrectly believed that claimant did not injure his thoracic spine. Claimant's contention is unpersuasive. Even assuming that Dr. Fuller's history was inaccurate and that his opinion that claimant's thoracic spine was not injured is contrary to the employer's express acceptance of a thoracic condition, these concerns are not relevant to that portion of Dr. Fuller's opinion which establishes that thoracic segmental dysfunction and thoracic strain are interchangeable diagnoses. Thus, we find no persuasive reason not to accept Dr. Fuller's unchallenged comments clarifying the medical terminology used in this claim.[1]

In conclusion, inasmuch as a "thoracic strain" is part of the accepted claim, we find no "de facto" denial in this case. Consequently, we reverse the ALJ's award of an assessed attorney fee under ORS 656.386(1).

ORDER

The ALJ's order dated May 7, 1996 is reversed in part and affirmed in part. That portion which set aside the employer's alleged "de facto" denial of a thoracic strain and awarded an assessed attorney fee under ORS 656.386(1) is reversed. The remainder of the ALJ's order is affirmed.

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[1] We note that an Order on Reconsideration stated that the carrier had accepted a "thoracic strain." (Ex. 93A-4). Although not determinative, this reference in the reconsideration order is further evidence that the employer accepted a thoracic strain.

In the Matter of the Compensation of
WILLIAM I. LONG, Claimant
WCB Case No. 96-05526
ORDER OF DISMISSAL (REMANDING)
Carney, et al, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Claimant has requested, and the SAIF Corporation has cross-requested, Board review of Administrative Law Judge (ALJ) Podnar's October 9, 1996 order. We have also received claimant's and SAIF's motions for dismissal of the review without prejudice. Because we conclude that jurisdiction rests with the Hearings Division, we withdraw our acknowledgments of the parties' appeals and return this case to ALJ Podnar.

FINDINGS OF FACT

On October 9, 1996, ALJ Podnar issued an Opinion and Order that: (1) set aside SAIF's denial insofar as it pertained to claimant's preexisting sacroiliac joint pain, decreased bone density, spondylolisthesis, disc degeneration at the L4-5 and L5-6 levels, compression fracture at the L1 level, and weight loss; (2) upheld that portion of SAIF's denial of claimant's current condition; and (3) awarded a $1,200 attorney fee.

On October 16, 1996, ALJ Podnar abated his October 9, 1996 order to consider SAIF's motion for reconsideration and to allow claimant an opportunity to respond. That same day, claimant mailed, by certified mail, his request for Board review of the ALJ's October 9, 1996 order.

On October 17, 1996, the Board received claimant's request for Board review. On October 18, 1996, the Board mailed its computer-generated letter acknowledging claimant's request for Board review of ALJ Podnar's order.

On October 21, 1996, the Board received SAIF's October 18, 1996 cross-request for review of the ALJ's order. On October 21, 1996, the Board also received claimant's October 18, 1996 request for dismissal of the Board review. On October 22, 1996, the Board mailed its computer-generated letter acknowledging SAIF's cross-request for Board review of ALJ Podnar's order. On October 23, 1996, the Board received SAIF's October 22, 1996 request to dismiss its cross-request for Board review of the ALJ's October 9, 1996 order.

CONCLUSIONS OF LAW AND OPINION

The Board has consistently held that where simultaneous acts affect the vesting of jurisdiction, in the interest of administrative economy and substantial justice, the Board will give effect to the act that results in the resolution of the controversy at the lowest possible level. See James D. Whitney, 37 Van Natta 1463 (1985).

Here, claimant's request for Board review of the ALJ's October 9, 1996 order was mailed by certified mail. Thus, the request was filed on October 16, 1996. See OAR 438-005-0046(1)(b). Also on October 16, 1996, the ALJ abated his October 9, 1996 order. Because the ALJ abated his October 9, 1996 order simultaneously with the filing of claimant's request for review, as well as prior to the filing of SAIF's October 18, 1996 cross-request, jurisdiction to consider this matter remains with the Hearings Division. See James D. Whitney, supra.

In light of such circumstances, claimant's request, as well as SAIF's cross-request, for Board review are dismissed as premature. See David L. Rolfe, 48 Van Natta 1031 (1996). Accordingly, this matter is remanded to ALJ Podnar for further proceedings consistent with the October 16, 1996 abatement order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TINA L. FISCHER, Claimant
WCB Case No. 96-01153
ORDER ON REVIEW
Anthony V. Albertazzi, Claimant Attorney
Bottini, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Baker's order which: (1) affirmed the Order on Reconsideration's award of 67 percent (90.45 degrees) scheduled permanent disability for loss of use or function of claimant's left foot; and (2) awarded an assessed fee of $1,500 pursuant to ORS 656.382(2). On review, the issues are extent of scheduled permanent disability and attorney fees. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable left foot injury on September 9, 1993. The claim was eventually accepted for a contusion of the left great toe, tendonitis of the left foot and reflex sympathetic dystrophy. The claim was closed by Determination Order on September 28, 1995, with an award of 5 percent scheduled permanent disability for the left foot.

Claimant requested reconsideration and a medical arbiter, Dr. James, was appointed to evaluate permanent disability due to claimant's compensable injury. Based on Dr. James' report, an Order on Reconsideration of January 5, 1996 increased claimant's scheduled award to 67 percent.[1] The employer requested a hearing contesting the Order on Reconsideration.

The ALJ affirmed the award of scheduled permanent disability for loss of use or function of claimant's left foot, relying on the impairment rating of Dr. James, the medical arbiter. The ALJ also awarded an assessed fee of $1,500 under ORS 656.382(2) because the employer had failed to reduce claimant's permanent disability award as a result of its request for hearing.

CONCLUSIONS OF LAW AND OPINION

On review, the employer contends that the award of scheduled permanent disability should be reduced.[2] In addition, it argues that the ALJ's attorney fee award was excessive. For the following reasons, we find that claimant's permanent disability award should not be reduced. Moreover, we find that claimant's attorney fee was reasonable.

We first address the permanent disability issue. The ALJ affirmed the reconsideration order's award of 30 percent impairment for loss of strength based on the arbiter's muscle strength finding of 0/5. (Ex. 46-3). The employer contends that this was error because the arbiter failed to identify the cause of claimant's loss of strength. We disagree.

To be entitled to a rating for loss of strength, claimant must demonstrate that the loss of strength is caused by peripheral nerve injury, loss of muscle, or disruption of the musculotendonous unit. OAR 436-35-230(9), (10). It is claimant's burden to prove the extent of her disability. ORS 656.266; Valden H. Brickley, 48 Van Natta 944 (1996); Harriet Olson, 47 Van Natta 1917 (1995). All disability ratings shall be made on the basis of medical evidence that is supported by objective findings from the attending physician or medical arbiter, if one is appointed. OAR 436-35-010(1); 436-35-007(9).

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[1] The award in the reconsideration order was based on 5 percent impairment for a "chronic condition" limiting repetitive use of the left foot, 15 percent impairment for inability to walk/stand for more than 2 hours in an 8 hour period, 30 percent impairment for loss of strength, 30 percent impairment for absent left ankle motion, and 72 percent impairment for reduced motion of the toes of the left foot, which was converted to 19 percent impairment of the left foot. These values were "combined" for a total of 67 percent scheduled permanent disability for the left foot.

[2] The employer does not dispute the impairment awarded in the reconsideration order for the limitation on repetitive use of the left foot (5 percent) or the impairment based on claimant's inability to walk/stand for greater than 2 hours in an 8 hour period (15 percent).

Here, the attending physician, Dr. Buchholz, did not rate claimant's impairment. (Exs. 32, 36). However, Dr. James, the medical arbiter, was requested to specifically rate loss of muscle strength, if any, due to the compensable injury. (Ex. 45-2). Dr. James complied with the Department's instructions, reported that claimant had no active range of motion in the ankle and toes of the left foot, and noted that claimant had muscle atrophy of the leg. (Ex. 46-3). Dr. James, therefore, rated claimant's muscle strength as "0/5." Id.

Inasmuch as Dr. James' rating of permanent impairment based on loss of muscle strength is supported by his finding of muscle atrophy, and because Dr. James confirmed that claimant's strength loss was due to the compensable injury in accordance with the Department's instructions, we conclude that claimant is entitled to the 30 percent impairment rating for loss of muscle strength.

The employer also contests the reconsideration order's award of 30 percent impairment for the absence of left ankle motion and the 19 percent impairment for reduced motion in the toes of claimant's left foot. Dr. James reported that claimant had no demonstrable active motion in either her left ankle or in the toes of her left foot. (Ex. 46-2). The employer contends that these impairment awards should be eliminated because claimant's inability to use her left foot "may be" volitional. We decline to do so given Dr. James' comment that his findings were valid and consistent with the diagnosis of severe reflex sympathetic dystrophy. (Ex. 46-3).[3]

Accordingly, we agree with the ALJ that the Order on Reconsideration correctly calculated claimant's permanent disability.[4] We, therefore, uphold the ALJ's decision to affirm the reconsideration order.

We now turn to the attorney fee issue. As previously noted, the ALJ awarded claimant's counsel an attorney fee of $1,500 pursuant to ORS 656.382(2) because claimant's scheduled permanent disability award was not reduced as a result of the employer's request for hearing. The employer argues that the award was excessive. We disagree.

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 is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the significant value of the permanent disability interest involved.

Moreover, because we have not reduced claimant's award of permanent disability as a result of the employer's request for review, claimant's counsel is also entitled to an attorney fee for services on review regarding the extent of 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 regarding the extent of disability 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.

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[3] The employer alternatively contends that the 30 percent award for absent ankle motion should be reduced to 16 percent, noting claimant's "passive" range of plantar flexion was 75 degrees which would result in no disability for reduced plantar flexion under OAR 436-35-190(8). However, range of motion in a joint is measured in active degrees of motion. OAR 436-35-007(17) (WCD Admin. Order 95-060, 8/23/95). Since we have approved Dr. James' finding that claimant has no active motion in the left ankle, we decline to reduce this aspect of claimant's permanent disability award. The employer also contends that the reconsideration order's 19 percent award for toe motion of the left foot should be reduced to 16 percent. Once again, we disagree. The employer's calculation omitted impairment for absent flexion of the IP joint of the great toe (45 percent). See OAR 436-35-150(1). When this value is combined with 34 percent impairment for absent MP dorsiflexion in the great toe and 21 percent impairment for absent MP plantar flexion in the great toe, the impairment value for the great toe is 72 percent. This converts to 11 percent of the foot, as opposed to 8 percent as the employer contends. OAR 436-35-180(2). When added to the other impairment values for the second through fifth toes (totaling 8 percent of the left foot), claimant's scheduled permanent disability for the left foot is 19 percent, as found by the reconsideration order.

[4] In her brief, claimant referred to a medical treatise that describes her medical condition. The employer argues that we should not consider that portion of claimant's brief because of claimant's failure to lay a proper foundation for consideration of this evidence. Regardless of whether we consider claimant's reference to the medical treatise, our calculation of claimant's permanent disability would be the same.

ORDER

The ALJ's order dated June 17, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the employer.

October 28, 1996 Cite as 48 Van Natta 2196 (1996)

In the Matter of the Compensation of
KATHERINE A. WOOD, Claimant
WCB Case No. 95-10064
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Christian and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its partial denial of claimant's claim for her current low back condition; and (2) awarded claimant 31 percent (99.2 degrees) unscheduled permanent disability for a low back injury, whereas none was awarded by an Order on Reconsideration. On review, the issues are compensability and extent of unscheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We begin with a summary of the relevant facts. Claimant, a certified nurse's aide, compensably injured her low back on or about October 4, 1995 due to extensive lifting at work. She was treated conservatively for low back pain with numbness and tingling in the right leg. A lumbar MRI scan in November 1993 showed mild disc bulging at L4-5 and L5-S1 and early degenerative changes at L5-S1. A lumbar CT scan in January 1994 showed disc bulging at L3-4, L4-5 and L5-S1, with some effacement of the epidural fat surrounding the right S1 nerve root. Claimant continued to experience waxing and waning symptoms in her low back and right leg after the injury. Her condition was diagnosed as a lumbosacral strain and probable facet syndrome.

The employer denied claimant's low back injury claim by letter dated January 6, 1994. By Opinion and Order dated September 1, 1994, a prior ALJ set aside the denial, holding that claimant had established a compensable injury claim for her then-current low back condition. The order became final by operation of law.

Claimant continued to suffer waxing and waning pain in the low back which occasionally radiated into the right leg. In December 1994 she came under the care of Dr. Thompson who diagnosed chronic back pain and lumbar disc disease. In August 1995, claimant was examined by Drs. Thomas and Wilson at the employer's request. They diagnosed a lumbosacral strain superimposed on preexisting degenerative arthritic changes, and attributed claimant's symptoms in major part to the degenerative changes. Dr. Thompson concurred with Drs. Thomas and Wilson's report.

By letter dated August 31, 1995, the employer issued a "partial denial of [claimant's] need for treatment and any related disability with regard to [her] pre-existing degenerative condition." Claimant appealed the denial.

The ALJ concluded that the prior ALJ's Opinion and Order in September 1994 barred the employer from denying the compensability of claimant's current low back condition. The ALJ reasoned that the current low back condition is the same condition which was finally determined to be a compensable injury by the prior ALJ. On review, the employer contends that the compensability of a lumbosacral strain was the only issue litigated in 1994 and, therefore, the prior order does not bar its current partial denial of a preexisting degenerative back condition. We disagree.

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 1994 was the compensability of claimant's then-current low back condition and resultant disability and need for treatment. Moreover, the prior ALJ's determination that the condition is compensable was essential to his decision setting aside the employer's 1994 denial. In determining whether issue preclusion applies here, we focus on whether the current low back condition is the same condition which was actually litigated before the prior ALJ in 1994. We are persuaded it is the same condition, based on the following reasoning.

In support of its current partial denial, the employer expressly relied on medical information indicating that claimant had been diagnosed with preexisting degenerative arthritic changes which were not caused or worsened by employment. (Ex. 28). That diagnosis was made by Drs. Thomas and Wilson on the basis of the November 1993 MRI scan and the January 1994 CT scan. (Ex. 26-7). Those imaging studies pre-date the prior ALJ's order and were actually considered by the prior ALJ in his final determination. (Ex. 20A-3). Thus, the employer's current denial is based on the same diagnostic studies that were considered in the prior litigation.

Furthermore, the record shows that claimant has experienced waxing and waning symptoms of the same chronic low back condition since the October 1993 injury. We find no evidence of any change in claimant's condition. The only change has been in the diagnosis of the condition. We have held, however, that the preclusive effect of a prior, final determination may not be avoided by presenting new medical evidence concerning the diagnosis of a previously-litigated condition. See David R. Sills, 48 Van Natta 1621 (1996); Katherine T. Hecker, 46 Van Natta 156 (1994). By presenting new medical evidence relating claimant's low back condition to preexisting degenerative arthritic changes, the employer is seeking to avoid the preclusive effect of the final determination in 1994. It is barred from doing so.

Next, the employer contends that its current denial was authorized by ORS 656.262(6)(c), which 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."

This statutory provision does not support the employer's denial for the following reasons. The provision is expressly applicable where there is an "acceptance of a combined or consequential condition." Here, the prior ALJ concluded the current low back condition was compensable under the material contributing cause standard. (Ex. 20A-3). There was no prior determination that claimant's low back condition was either a "combined condition" or "consequential condition." Because the condition that the employer was ordered to accept was not determined to be a combined or consequential condition, we conclude ORS 656.262(6)(c) does not apply in this case.[1]

In addition, we have previously held that, as a condition precedent to issuance of a denial pursuant to ORS 656.262(6)(c), there must be a change in claimant's condition or a change of circumstances such that the compensable injury is no longer the major contributing cause of the combined condition. Harry L. Lyda, 48 Van Natta 1300, 1302 (1996); Elsa S. Wong, 48 Van Natta 444, 445 n 1 (1996). As we discussed above, the employer's denial was based primarily on the report of Drs. Thomas and Wilson, who considered the same imaging studies and low back symptoms that were considered in the prior litigation. In the face of such evidence, we reject the employer's argument that a

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[1] The employer has submitted with its Appellant's Brief a copy of its Notice of Acceptance which was not offered into the record at hearing. The employer requests that we take official notice of the acceptance notice. Claimant objects to the submission. We need not address the admissibility of the acceptance notice, or whether we may take official notice of it, because we conclude the result in this case would be the same even if we considered the additional evidence. In this regard, we emphasize that our "issue preclusion" analysis turned on the scope of the prior ALJ's final determination, not the scope of the employer's acceptance notice.

change in either condition or circumstances was shown by the declaration of claimant's condition as medically stationary and the processing of her claim to closure. Consequently, we are not persuaded there was a change in claimant's condition or a change in circumstances sufficient to support a denial pursuant to ORS 656.262(6)(c).

Claimant's attorney is entitled to an assessed fee for services rendered on review concerning the compensability issue. See ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services concerning the compensability 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.

Extent of Disability

Subsequent to claimant's medically stationary date, there were two examinations performed for the purpose of rating the extent of her permanent disability due to the compensable injury. The first examination was performed by Drs. Thomas and Wilson on August 10, 1995. They found reduced ranges of lumbar motion and other physical restrictions, but related their findings, in major part, to preexisting degenerative arthritic changes. (Ex. 26). Dr. Thompson, claimant's attending physician at the time of claim closure, initially concurred with Drs. Thomas and Wilson's report without reservation. (Ex. 27). However, Dr. Thompson later wrote that the compensable injury was the "single most significant factor" in claimant's chronic back problem, but he did not withdraw his concurrence with the impairment findings made by Drs. Thomas and Wilson. (Ex. 31).

The other examination was performed by the medical arbiters, Drs. Ballard, Brown and Scheinberg, on November 18, 1995. They found restricted ranges of lumbar motion; however, based on signs of exaggerated pain behavior, non-anatomic physical findings, and the absence of significant objective findings of impairment, they concluded their impairment findings were not valid. (Ex. 32).

The ALJ awarded claimant 31 percent unscheduled permanent disability based on the impairment findings made in both examinations, reasoning that they were "so similar that they accurately reflect claimant's permanent impairment due to the compensable injury." The ALJ further reasoned that the medical arbiters rejected claimant's impairment findings based on the mistaken assumption that her impairment was due to the preexisting degenerative condition. We modify the ALJ's permanent disability award based on the following opinion.

The medical arbiters did not relate claimant's impairment findings to her degenerative back condition. Rather, they concluded their impairment findings were invalid based on signs of pain behavior, non-anatomic physical findings, and the absence of significant objective physical findings. (Ex. 32-4). Given their conclusion, we decline to adopt any of their impairment findings.

Drs. Thomas and Wilson made impairment findings, with which the attending physician, Dr. Thompson, concurred. Although Drs. Thomas and Wilson noted some pain behavior, they concluded that claimant is medically stationary with physical restrictions. (Ex. 26-8). They did not indicate that the physical restrictions were invalid. Accordingly, we adopt the impairment findings made by Drs. Thomas and Wilson and ratified by Dr. Thompson.

Drs. Thomas and Wilson found the following ranges of motion in the lumbar spine: 55 degrees of flexion; 4 degrees of extension; 16 degrees of right lateral bending; and 18 degrees of left lateral bending. Those findings result in a total impairment value of 11 percent, (i.e., the sum of 3.5, 2.6, 2.8 and 2.4 is 11.3, which is rounded down to 11 percent). See former OAR 436-35-360(7), (8), (9).[2]

Turning to the non-impairment factors, it is undisputed that the sum of claimant's age and education values is 5. Regarding the adaptability factor, the ALJ relied on the release to light work by Dr. Boyd in March 1994. (Ex. 4-7). However, Dr. Boyd was not claimant's attending physician at the time of claim closure (September 1, 1995); at that time, claimant's attending physician was Dr. Thompson. We adopt the finding by Drs. Thomas and Wilson, which was ratified by Dr. Thompson,

[2] Based on the September 1, 1995 issuance date of the Notice of Closure in this case, we conclude the applicable standards for rating claimant's disability are set forth in WCD Admin. Order 6-1992, as amended by WCD Admin. Orders 93-056, 95-060 and 96-068. See OAR 436-035-0003(2), (3).

that claimant is currently restricted from performing heavy lifting and from recurrent bending and stooping. (Ex. 26-8). Again, we note that, although Drs. Thomas and Wilson attributed that finding to a preexisting degenerative back condition, we rely on Dr. Thompson's opinion that the compensable injury was the primary factor in claimant's back condition (Ex. 31).

Based on the restriction from heavy lifting, we find that claimant's residual functional capacity (RFC) is medium.[3] It is undisputed that claimant's base functional capacity (BFC), (i.e., claimant's demonstrated physical capacity before the compensable injury), is medium. Because claimant's BFC and RFC are medium, she is entitled to an adaptability value of 1. OAR 436-035-0310(6) (DCBS Admin. Order 96-068). Assembling the factors, we multiply the sum of the age and education values (5) by the adaptability value (1), then add the impairment value (11), for a total award of 16 percent unscheduled permanent disability. The ALJ's order shall be modified accordingly.

ORDER

The ALJ's order dated March 20, 1996 is modified in part and affirmed in part. In lieu of the ALJ's unscheduled permanent disability award, claimant is awarded 16 percent (51.2 degrees) unscheduled permanent disability. The ALJ's out-of-compensation attorney fee award is adjusted accordingly. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the self-insured employer.

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[3] The restriction from recurrent bending and stooping is not sufficient to qualify as "restrictions" under former OAR 436-35-310(3)(l)(C) (WCD Admin. Order 93-056). Under the rule, "bending" and "stooping" are treated as a single activity, and a restriction from frequently performing a single activity is not sufficient to prove claimant has "restrictions" within the meaning of the rule.

In the Matter of the Compensation of
MICHAEL D. COX, Claimant
WCB Case No. 95-11670
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," as clarified and supplemented.

We replace the sixth sentence in the first paragraph with: "Claimant has had episodes of mid and low back pain, popping and spasms from time to time since 1992 for which he has sought and received conservative treatment including, since January 1994, physical therapy."

Claimant was first diagnosed with and treated for a low back strain in July 1992. (Ex. 43-25). Claimant again experienced low back pain when he began working for SAIF's insured in July 1993.

Claimant sought treatment for an off-work low back strain in early 1994. When his low back pain proved recalcitrant to conservative treatment, Dr. Kitchel, claimant's-then attending physician, obtained x-ray studies and an MRI. June 1994 x-rays revealed disc degeneration at L1-2 and L5-S1. (Ex. 8). The July 1994 MRI showed early degenerative disc disease with desiccation of the L4-5 and L5-S1 discs, without evidence of disc herniation or nerve root impingement. (Exs. 9;10).

Claimant sustained the low back strain at issue in June 1995. The effects of that injury combined with his preexisting degenerative condition. The June 1995 injury was not the major contributing cause of the combined condition.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's reasoning and conclusion, with the exception of the third and fourth paragraphs,[1] and with the following comment and clarification.

Finding that claimant had a preexisting condition which combined with the work strain, the ALJ concluded: "Claimant must prove the June 28 incident was the major contributing cause of any subsequent treatment or disability." The ALJ defined "major" causation in accordance with the case law, analyzed the competing medical opinions, and ultimately concluded: "When weighed against each other the two opinions are at best in equipoise which does not allow claimant to carry his substantial burden of proof."

Claimant contends that by his reference to "substantial," the ALJ "assigned a more difficult burden" of proof to claimant than is proper under the workers' compensation law. We do not agree. Rather, when read in context, we find that the ALJ was merely referring to the considerable task of proving major causation. Notwithstanding our conclusion that the ALJ did not apply an incorrect burden of proof, in the interest of clarity, we delete the reference to "substantial" from the second sentence of the last paragraph of the order.

ORDER

The ALJ's order dated April 15, 1996 is affirmed.

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[1] Inasmuch as the ALJ found, and we agree, that claimant sustained a work injury on June 28, 1995, we need not determine whether claimant notified his supervisor that he sustained an injury at work.

October 29, 1996 Cite as 48 Van Natta 2200 (1996)

In the Matter of the Compensation of
HENRY F. DOWNS, Claimant
WCB Case No. 95-13394
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
John Pitcher, Defense Attorney

Claimant requests reconsideration of our October 2, 1996 Order on Review that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral hearing loss condition. On reconsideration, claimant argues that we should have deferred to the opinion of Dr. Ediger, examining clinical audiologist. Claimant contends that Dr. Ediger's opinion is better reasoned and based on more complete facts. Furthermore, claimant contends that Dr. Ediger is "a medical expert of comparable credentials and expertise," and there is no basis for our deference to the opinion of Dr. Hodgson, examining otolaryngologist, on the basis of his specialized expertise as an otolaryngologist.

We disagree with both contentions. First, as an otolaryngologist, Dr. Hodgson is a medical doctor specializing in the treatment of diseases of the ear, nose, and throat. We find that, as such, Dr. Hodgson has specialized expertise over that of Dr. Ediger, a clinical audiologist. Therefore, we find it appropriate to defer to Dr. Hodgson's specialized expertise. See Abbott v. SAIF, 45 Or App 657, 661 (1980). In addition, as explained in our order, we find that Dr. Hodgson presents a well-reasoned opinion based on a complete history of claimant's work-related noise exposure. (Ex. 6). Furthermore, as addressed in our order, both Drs. Hodgson and Ediger noted that claimant's pattern of hearing loss was more typical of presbycusis than loss due to noise exposure, with Dr. Ediger noting that this pattern was apparent in claimant's hearing loss by age 49. (Exs. 3-5, 6-3).

Finally, claimant argues that we did not address his contentions that, based on Dr. Ediger's deposition responses, presbycusis does not fit within the statutory definition of a "preexisting condition" under ORS 656.005(24); and, therefore, ORS 656.005(7)(a)(B) does not apply to his claim. We disagree.

In our order, we explained that, assuming arguendo that claimant's contentions were correct, and ORS 656.005(7)(a)(B) did not apply to his claim, claimant still failed to establish a compensable hearing loss claim pursuant to ORS 656.802(2)(a). After conducting our reconsideration, we have nothing further to add to our prior discussion of this issue.

Accordingly, we withdraw our October 2, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our October 2, 1996 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 29, 1996 Cite as 48 Van Natta 2201 (1996)

In the Matter of the Compensation of
GILBERTO GARCIA-ORTEGA, Claimant
WCB Case No. 96-02900
ORDER ON REVIEW
SAFECO Legal, Defense Attorney

Reviewed by Board Members Haynes and Hall.

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

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

Claimant signed a retainer agreement employing his then-attorney of record to represent him in connection with his workers' compensation claim. On March 20, 1996, claimant, through his then-attorney of record, requested a hearing raising the issues of aggravation, "de facto" denial of an aggravation claim, penalties, and attorney fees. A hearing was eventually scheduled for June 12, 1996. (WCB Case No. 96-02900).

By letters dated June 7, 1996 and June 11, 1996, claimant's then-attorney of record withdrew claimant's hearing request regarding WCB Case No. 96-02900. On June 25, 1996, the ALJ dismissed claimant's hearing request.

By letter dated July 24, 1996, claimant requested review of the ALJ's dismissal order from claimant. Specifically, claimant requested that the Board remand this case to the Hearings Division for a hearing, contending that he did not know or understand that his then-attorney had requested withdrawal of his hearing request. In addition, claimant notified the Board that he was seeking other counsel.

On July 25, 1996, claimant signed a retainer agreement employing his current attorney to represent him in connection with his workers' compensation claim. On August 1, 1996, the Board received a brief from claimant's current attorney, arguing that "[t]he right to a hearing belongs to the worker, not to the attorney. When errors in communication occur, it is the worker's position[,] not the attorney's which controls." Because claimant acted within a reasonable time to correct "this misunderstanding," claimant's current attorney argues that "[s]ubstantial justice requires that [claimant] be allowed a hearing on the merits of his claim." In addition, claimant's current attorney requests that we remand the matter to the ALJ "to develop a full evidentiary record regarding the miscommunication which precipitated the dismissal."

While we agree that the right to a hearing belongs to the worker, not the worker's attorney, the fact remains that the retainer agreement between claimant and his then-attorney regarding this claim authorized claimant's then-attorney to act on claimant's behalf. The record establishes that claimant's former attorney acted on claimant's behalf by withdrawing claimant's request for hearing. Thereafter, claimant's hearing request was dismissed in response to his then-attorney's express withdrawal of the request. Claimant does not dispute that his then-attorney had authority to act on his behalf or that the ALJ dismissed the hearing request in response to his then-attorney's withdrawal of the hearing request.

William A. Martin, 46 Van Natta 1704 (1994); Verita A. Ware, 44 Van Natta 464 (1992). Under these circumstances, we find no reason to alter the ALJ's dismissal order.[1]

In addition, we deny claimant's current attorney's request for remand for hearing "to develop a full evidentiary record regarding the miscommunication which precipitated the dismissal." We may remand to the ALJ should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

In previous cases regarding the issue of whether a hearing request should have been dismissed, on occasion, we have remanded the matter to the ALJ with instructions to conduct further proceedings to determine whether the dismissal was justified. Tamara Riddle, 41 Van Natta 971 (1989); Robert J. Buckley, 41 Van Natta 1761 (1989); Donald R. Roth, 42 Van Natta 1091 (1990). Those cases have involved situations where the ALJ has dismissed a claimant's request for hearing and the record does not contain any motions, correspondence, records of telephonic conversations, testimony, or other exhibits concerning the dismissal of the claimant's hearing request.

Here, in contrast to Riddle and its progeny, the record contains a motion from claimant's then-attorney withdrawing claimant's hearing request. See also, Jerry R. Testerman, 46 Van Natta 1114 (1994) (Board denied the claimant's request for remand for an evidentiary hearing regarding whether the claimant understood the significance of his former attorney's action in withdrawing the claimant's hearing request, finding that the proper inquiry was not the claimant's state of mind at the time the hearing request was withdrawn but whether the claimant's former attorney represented him at hearing and whether the former attorney withdrew the hearing request). Therefore, we do not find the record insufficiently developed regarding the issue of the propriety of the ALJ's dismissal. In other words, there is no need to remand this case because, even if claimant's former attorney misunderstood claimant's intentions, the former attorney was authorized to withdraw claimant's hearing request; therefore, the result would not change. Accordingly, we deny claimant's request for remand. Guadalupe Valadez, 48 Van Natta 500 (1996).

ORDER

The ALJ's order dated June 25, 1996 is affirmed.

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[1] If claimant has a disagreement with his former attorney's actions, that disagreement may be a matter for another forum. However, such a disagreement is not an adequate ground for altering the ALJ's dismissal order under the circumstances of this case.

In the Matter of the Compensation of
ROBERT D. HYATT, Claimant
Own Motion No. 96-0497M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for his compensable medial collateral ligament sprain, anterior cruciate ligament injury of the left leg, and left arm strain injury. Claimant's aggravation rights expired on January 15, 1987. SAIF offers "to defer [to the Board] the determination of reopening for time loss" regarding whether 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 October 4, 1996, Dr. Chamberlain, claimant's treating surgeon, requested authorization to perform claimant's left total knee replacement. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

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

SAIF proposes to defer the decision regarding the work force issue to the Board. Claimant contends that he qualifies for temporary disability compensation because, although retired, he has been working part-time for the past two years.[1] Claimant has the burden of proof on this issue and must provide persuasive evidence that he was in the work force at the time of disability.

In a signed October 11, 1996 letter, claimant stated that his current employer is Frito Lay Corporation. Claimant provided a supervisor's name to whom SAIF might refer for confirmation that he was / is employed. As proof of employment during the past two years, claimant submitted Wage and Tax Statements from 1994 and 1995. Here, although SAIF contends that claimant has "retired," because he continues to work, we conclude that claimant meets the first standard of the Dawkins criteria set forth above. See id.

On this record, we conclude that claimant has established that he was in the work force at the time of disability.[2]

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date he is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] If a qualified claimant establishes that he / she was working part-time at the time of disability, he / she is entitled to temporary partial disability beginning the date of surgery or inpatient hospitalization.

[2] Pursuant to OAR 438-012-0020(1), all own motion claims "shall first be directed to and processed by the insurer." Further, OAR 438-012-0030(1) prescribes that:

> "[T]he own motion insurer shall, within 90 days after receiving an own motion claim, submit to the Board a written recommendation as to whether the claim should be reopened or denied, on a form prescribed by the Board, accompanied by the required evidence supporting the recommendation. The own motion insurer shall supply all information and evidence required by the form."

Here, SAIF has submitted the Carrier's Own Motion Recommendation form (Form 440-2806 (10/95/WCB)) as required by our rules, but it has essentially asked the Board to intercede on its behalf, and to make its recommendation regarding the work force issue. Because the evidence in this matter clearly indicates that claimant was in the work force at the time of disability (he is working, albeit part-time), we will decide the matter on the merits. However, because we allow the insurer 90 days to process a claimant's request, it is the responsibility of the insurer to make recommendations based on its investigation. OAR 438-012-0020; 438-012-0030. In the future, we notify SAIF that it is obliged to process these requests pursuant to our rules.

In the Matter of the Compensation of
MICHAEL P. McCOLLUM, Claimant
WCB Case No. 95-12062
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that affirmed an Order on Reconsideration declining to reclassify claimant's claim for a left index finger injury from nondisabling to disabling. On review, the issue is claim classification.

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

Finding that the medical evidence did not establish a reasonable expectation of permanent disability, the ALJ declined to reclassify claimant's claim as disabling. Based on the following analysis, we agree with the ALJ's conclusion.

For an injury to be disabling, there must be an entitlement to temporary disability or a "reasonable expectation of permanent disability." ORS 656.005(7)(c); Karren S. Maldonado, 47 Van Natta 1535 (1995).

Here, claimant lost no time from work; therefore, no entitlement to temporary disability has been established. Thus, claimant's claim is only disabling if there is a reasonable expectation of permanent disability.

Two physicians give opinions regarding the likelihood of a permanent disability award. Dr. Pliska treated claimant's lacerated left finger. He indicated that impairment was undetermined, but expressed doubt that there would be permanent disability as a result of the injury. (Ex. 8). Dr. Saldivar also treated claimant. Dr. Saldivar indicated that claimant had hypersensitivity to touch as a result of his accepted injury. When asked whether the hypersensitivity was likely to continue, Dr. Saldivar indicated that "full maturity/stabilization of healing may extend to 18 months. Eventual function evaluation should be delayed until then, but aforementioned disabilities exist at this time." (Ex. 11).

After reviewing the record, we are not persuaded that a reasonable expectation of permanent disability due to the finger injury has been established. Dr. Saldivar does not indicate whether permanent disability is expected or likely to result. His opinion suggests that claimant's hypersensitivity could resolve within the 18 month period. At most, Dr. Saldivar's opinion supports a possibility that the hypersensitivity might continue past 18 months. Furthermore, it has not been established that the hypersensitivity, even if permanent, would entitle claimant to an award of permanent disability under the standards. Accordingly, based on this record, we conclude that a reasonable expectation of permanent disability has not been established. See Kathlene M. York, 48 Van Natta 932 (1996).

ORDER

The ALJ's order dated February 22, 1996 is affirmed.

October 30, 1996 Cite as 48 Van Natta 2204 (1996)

In the Matter of the Compensation of
RICHARD L. MARKUM, Claimant
WCB Case No. 95-08075
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of claimant's current psychiatric conditions. On review, the issue is compensability.

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

Claimant compensably injured his back on April 22, 1974. A 1976 Determination Order awarded claimant 5 percent unscheduled permanent partial disability for his back condition. In 1977, claimant sought treatment for depression and paranoid schizophrenia. The employer denied claimant's psychiatric conditions pursuant to a May 1977 aggravation denial. Claimant's psychiatrist opined that claimant's 1974 injury precipitated his psychiatric conditions.

By an Opinion and Order dated August 3, 1977, the employer was ordered to reopen claimant's claim. The employer then began paying for claimant's psychiatric treatments and time loss. On December 8, 1981, the Workers' Compensation Department issued a Determination Order finding claimant permanently and totally disabled as of November 4, 1981.

The employer continued to pay for claimant's psychiatric treatments and permanent total disability compensation through June 30, 1995. On that date, it denied claimant's "current physical and mental disorder conditions" based upon recent changes in the workers' compensation laws and recently received medical opinions. Claimant requested a hearing.

The ALJ found that claimant's current psychiatric conditions were not compensably related to his 1974 industrial injury, and upheld the employer's denial of those conditions as a "current condition" denial under ORS 656.262(6)(c).

On review, claimant renews his contention that the employer's denial constitutes an impermissible "back-up" denial of conditions it accepted long ago. Citing Melvin E. Schneider, 47 Van Natta 1024 (1995), claimant argues that his current conditions are the same as his prior accepted conditions and that the employer is precluded from challenging their compensability.

The employer, on the other hand, contends that it never formally accepted claimant's psychiatric conditions and it is not now precluded from denying them. Alternatively, the employer argues that even if it accepted these conditions, it did so as consequential conditions of claimant's 1974 industrial injury. Therefore, it may issue a current condition denial pursuant to ORS 656.262(6)(c).[1]

Whether an acceptance occurs is an issue of fact. SAIF v. Tull, 113 Or App 449, 454 (1992). Acceptance is an act through which the insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law. Gene C. Dalton, 43 Van Natta 1191 (1991); see Jannette I. Shue, 42 Van Natta 1750 (1990).

Like the ALJ, we find the record is ambiguous concerning whether or not the employer voluntarily accepted claimant's psychiatric conditions, especially since there is no notice of acceptance of these conditions in the record and in May 1977, the employer denied that claimant's psychiatric conditions resulted from his industrial injury. (Ex. 57). In August 1977, however, this psychiatric condition denial was set aside and the employer was ordered to reopen claimant's claim and pay benefits arising out of claimant's psychiatric care. That Opinion and Order specifically found that claimant had sustained a severe psychological problem as a consequence of his compensable low back injury.[2] (Ex. 310-1). Claimant was later determined to be permanently and totally disabled (Ex. 85) and the employer has paid claimant's psychiatric expenses and permanent total disability compensation for more than 18 years. While the mere payment of compensation cannot be considered an acceptance of these conditions, see amended ORS 656.262(10), we conclude the employer was ordered to accept claimant's underlying psychiatric conditions by virtue of the August 1977 Opinion and Order.[3]

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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] Prior to the 1990 enactment of ORS 656.005(7)(a)(A), the standard of proof for a consequential psychiatric condition was material cause. See, e.g., Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985). In 1977, when the parties were litigating the extent of claimant's disability arising out of his 1974 back injury and the purported "aggravation" denial of claimant's psychiatric conditions, the consensus of the medical experts was that the 1974 injury precipitated a paranoid, delusional state in claimant, who at the time had underlying asymptomatic schizophrenia. (See, e.g., Ex. 311-2). Thus, under the law in effect at that time, claimant's psychiatric conditions were compensable.

[3] ORS 656.262(6)(c) is premised on the carrier's "acceptance" of a combined or consequential condition under ORS 656.005(7), whether that acceptance is voluntary or as a result of a judgment or order. Here, had the employer not been ordered to reopen the claim and pay benefits arising out of claimant's psychiatric conditions, it may well have been precluded from later denying these conditions under Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), since it did not contest the December 1981 Determination Order finding claimant permanently and totally disabled due to a combination of his compensable back injury and consequential psychiatric conditions. See, e.g., Patricia A. Landers, 48 Van Natta 1720, 1722 (1996) (the employer was precluded from denying compensability of the claimant's chondromalacia since it failed to contest orders awarding permanent disability benefits for that condition; ORS 656.262(6)(c) inapplicable because employer never accepted the chondromalacia condition).

As noted above, ORS 656.262(6)(c) allows an employer to subsequently deny a previously accepted "combined or consequential" condition[4] if the "otherwise compensable injury ceases to be the major contributing cause" of that condition.[5] In this case, Dr. Proano testified that claimant's injury "triggered off" and contributed to the emerging symptomatology of claimant's psychosis (Tr. 100). He did not, however, opine that the injury remained the major contributing cause.[6] In fact, Dr. Proano testified that schizophrenia is a hereditary disorder and was not caused by claimant's 1974 injury. He further explained that the physical discomfort claimant experienced following the injury precipitated claimant's paranoid response, but that biological factors that preexisted the injury predisposed claimant to develop the disorder. (Tr. 93-95, 100, 118). With regard to claimant's depression, Dr. Proano reported that claimant's current mood disorder was "related to" and could be "traced back to what happened in 1974." (Tr. 95, 97). Dr. Proano acknowledged, however, that other preexisting and intervening factors, including claimant's schizophrenia and antipsychotic medication, contributed to his current diagnosis of major depression.

Dr. Turco, who examined claimant at the employer's request, agreed that claimant's 1974 injury may have triggered symptoms of his preexisting latent schizophrenia. (Tr. 190, 204). Like Dr. Proano, Dr. Turco opined that the 1974 injury did not cause or worsen the underlying thought disorder. Dr. Turco further explained that to the extent the 1974 injury did trigger symptoms of schizophrenia, that injury has ceased to be a cause of the schizophrenia because the injury has long since resolved. (Tr. 225). Unlike Dr. Proano, Dr. Turco opined that claimant's 1974 injury did not cause or even precipitate claimant's current diagnosis of major depression. Instead, Dr. Turco opined that claimant's depression stemmed from his difficult childhood and his years of alcohol and drug use. (Tr. 223-224).

On this record, we agree with the ALJ that a preponderance of the medical evidence establishes that, to the extent that claimant's 1974 injury was a cause, it has ceased to be the major contributing cause of his schizophrenia and his major depression.[7] We therefore uphold the employer's denial pursuant to ORS 656.262(6)(c).

ORDER

The ALJ's order dated December 5, 1995 is affirmed.

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[4] ORS 656.262(6)(c) is limited to "combined or consequential" conditions and does not permit a denial where the accepted condition has not combined with another condition or disease. See Ronald L. Ledbetter, 47 Van Natta 1461 (1995). In this case, however, the medical evidence establishes that claimant's psychiatric conditions constitute combined or consequential conditions.

[5] As we explained in Anthony J. McGee, 48 Van Natta 1695 (1996), the word "cease" in amended ORS 656.262(6)(c) presumes a change in circumstances or a change in causation so that the compensable condition is not the major cause of the current combined or consequential condition. See also Harry L. Lyda, 48 Van Natta 1300 (1996); Elsa S. Wong, 48 Van Natta 444, 445, n 1 (1996).

[6] Dr. Proano agreed with Dr. Turco's diagnostic impression of claimant's current mental condition, but disagreed with Dr. Turco's conclusion that claimant's condition was unrelated to the 1974 industrial injury. (Tr. 99-100).

[7] With regard to the causes of claimant's current depression, we need not decide which physician's opinion is more persuasive because even Dr. Proano did not testify that claimant's 1974 injury remained the major contributing cause, as required by ORS 656.005(7)(a)(A).

In the Matter of the Compensation of
JOHN B. SHAW, SR., Claimant
WCB Case Nos. 95-08430, 95-04424 & 94-10682
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Roberts, et al, Defense Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Sedgwick James, Inc., on behalf of the then self-insured employer, requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) set aside its denials of claimant's current cervical condition, diagnosed as C5 compression fracture, cervical spondylosis C5-6, C6-7, cervical radiculopathy and degenerative disc disease and spondylolisthesis; and (2) upheld Travelers' denial of the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and summarize the pertinent facts as follows:

Claimant, age 61 at the time of hearing, worked for the employer, a heavy equipment manufacturer, for more than 25 years. For approximately 18 years, claimant worked as a "press brake" operator on a 600 ton capacity press. This position required that he place heavy pieces of flat metal, some of which weighed up to a ton, on his machine. Although he used a lifting device (sometimes called a "glommer") to place the metal on the press, he also regularly positioned the metal pieces into place on his own. Later in his career, claimant operated a 250 ton capacity press, which used lighter raw materials and was less physically demanding. He retired from employment in October 1994.

In 1955, claimant was involved in a non-work related motor vehicle accident, in which he sustained a laceration above his right eye. The car in which he was a passenger struck a parked car, causing claimant's head to strike the dashboard.

At work on October 4, 1968, claimant was in the process of placing a 250 pound piece of steel onto a press when the metal slipped from the glommer and hit him directly on top of his head. The blow from the steel knocked claimant to the ground and lacerated his head. Claimant got up from the floor and resumed his work duties until he realized he had blood trickling down his neck. He went to a nearby emergency room, where the cut was sutured, and he returned to work. No x-rays were taken.

On October 8, 1968, he filed a workers' compensation claim for a head injury. At that time, the employer was insured by Travelers, who accepted a "medical only" claim. Although claimant had no neck pain prior to October 1968, he began experiencing posterior neck pain and headaches shortly after the accident. Claimant did not, however, relate these symptoms to the October 4, 1968 incident, but instead to tension and stress. He sought treatment for his neck pain and headaches from Dr. Noerhen.

In February 1971 and again in September 1972, claimant sought treatment through Kaiser Permanente for chronic occipital headaches, taut muscles in the trapezius, neck and pectoral areas and pain radiating down the back of the neck. In June 1975, claimant returned to Kaiser complaining of headaches, upper torso muscle pain and radiating neck pain. Claimant still did not relate his symptoms to the October 1968 incident, and did not advise his Kaiser doctors that he had sustained a head injury.

Claimant sustained a compensable disabling bilateral crushing injury to his hands in 1976. In 1985, he sustained a low back injury at work and sought chiropractic treatment. At all times, claimant continued to experience ongoing neck pain and headaches.

In November 1987, claimant returned to the chiropractor complaining of left arm, elbow and forearm pain. The chiropractor referred him to a neurologist. In December 1987, the neurologist, Dr. Mertens, noted that radiological studies demonstrated a probable old compression fracture of C5 and degenerative cervical changes.

Claimant completed an 801 on January 11, 1988 for an occupational disease relating to his left hand, elbow and shoulder and neck symptoms. He listed November 24, 1987 as the date of onset. At the time, the employer was self-insured, and was processing its claims through Fred S. James & Co. (now Sedgwick James, Inc.) The employer initially deferred claimant's claim, and later accepted it as nondisabling, although no formal acceptance was issued.

During 1988 and 1989, claimant continued to receive treatment through Kaiser for symptoms related to neck pain, shoulder pain and arm weakness. In April 1989, claimant returned to Kaiser complaining of left mid-back pain, low back pain radiating down to the left leg, and continuing left shoulder pain. He was placed on modified duty. In May 1989, claimant was examined by Dr. Barnhouse, who diagnosed cervical spondylosis with osteophytes of the left C5-6 level causing left shoulder symptoms and lumbosacral strain and first degree spondylolisthesis. Dr. Barnhouse recommended that claimant be permanently restricted from operating a press brake. Claimant was then transferred to a less strenuous position.

In December 1992, claimant sought treatment for cervical discomfort and was referred to Dr. Franks, a neurosurgeon. Claimant advised Dr. Franks of his 1955 motor vehicle accident and the October 1968 incident in which the heavy steel plate fell on his head. A December 7, 1992 MRI showed a decrease in the height of the C5 body, narrowing of the disc space at C5-6, spurring at C5-6, and a bulge at C6-7. Dr. Franks diagnosed "double crush syndrome," nerve root compression from cervical spondylosis of post-traumatic nature at C5-6 and C6-7, and possible carpal tunnel syndrome.

Claimant continued to treat with Dr. Franks for neck pain and numbness of his upper extremities. In the fall of 1993, Dr. Franks performed bilateral carpal tunnel releases. Claimant continued to complain of cervical pain, however, and did not obtain much relief from the carpal tunnel release surgeries. In October 1994, claimant underwent a complete spinal myelogram. The radiologist, Dr. Schieble, found a compression deformity of the C5 vertebral body consistent with the history of remote trauma involving an axial load. On December 13, 1994, Dr. Franks performed surgery on claimant's neck.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant failed to prove by a preponderance of the evidence that his C5 compression fracture occurred as a result of the October 4, 1968 incident. The ALJ found, however, that claimant's C5 fracture and other ongoing cervical conditions were nevertheless accepted as part of claimant's 1988 occupational disease claim, and were therefore compensable as to the employer (through its claims processor, Sedgwick).[1] The ALJ further found that Sedgwick[2] remained responsible for claimant's current cervical condition under ORS 656.308(1), since it failed to prove that claimant sustained a new compensable injury or occupational disease involving the same condition.

On review, Sedgwick argues that the ALJ erred by concluding that claimant's current condition was "deemed accepted" by its acceptance of claimant's 1988 claim because the then-contemporaneous medical records did not relate claimant's symptoms to his old C5 fracture.[3] Sedgwick further contends that Travelers is responsible for claimant's current condition because the persuasive medical evidence establishes that the October 1968 work injury was the major cause of claimant's C5 fracture and resultant cervical degeneration. Alternatively, Sedgwick argues that, under the last injurious exposure rule, Zurich Insurance is responsible for claimant's current condition, since Zurich was the carrier on the risk at the time claimant sought treatment in 1992.

We defer to the ALJ's demeanor-based credibility finding and adopt and affirm the ALJ's conclusion that Dr. Franks' opinion is persuasive and entitled to the deference generally accorded to a claimant's treating physician.[4] Unlike the ALJ, however, we agree with Sedgwick that a preponderance of the evidence establishes that claimant's C5 compression fracture and C5-6 degenerative disc disease is

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[1] In so finding, the ALJ relied on the rule of Georgia Pacific v. Piwowar, 305 Or 494 (1988), i.e., that a carrier's acceptance of symptoms of an underlying condition is an acceptance of the disease causing the symptoms.

[2] To avoid unnecessary confusion, we refer to the then self-insured employer by the name of its claims processing agent, Sedgwick.

[3] In its appellant's brief, Sedgwick concedes that it accepted claimant's occupational disease claim for left neck, shoulder and arm discomfort in 1987 through 1989, but argues that its acceptance is limited to the specific condition that caused these symptoms, claimant's C5-6 cervical spondylosis, without myleopathy or radiculopathy. (App. Br. at 7)

[4] We also find that the contrary causation opinions of Drs. Ziven, Donahoo and Eusterman are unpersuasive because they are based on an incomplete and inaccurate history (i.e., that claimant did not experience any head and neck pain until 1987).

compensably related to his October 1968 work injury.[5] We nevertheless conclude, for the reasons set forth below, that Sedgwick is responsible for claimant's current condition under ORS 656.308(1) and Piwowar, supra.

As noted above, Piwowar holds that if a carrier accepts a claim for symptoms, that acceptance encompasses the cause of the symptoms. Sedgwick argues that, because claimant's (then-treating) doctors related his symptoms in 1987 through 1989 to the cervical C5-6 spondylosis and narrowing of the C5-6 root canal rather than the C5 fracture, it did not accept the compression fracture as part of the 1988 claim. We reject this contention because we are persuaded by Dr. Franks' expert opinion that the compression of the C5 body was the major contributing cause of the degenerative disc disease and arthritic changes at C5-6 (including cervical spondylosis and osteophytes) which, in turn, caused the symptoms accepted by Sedgwick in 1988.

Dr. Franks explained that although the aging process and claimant's work activities since 1968 contributed to the development of bony changes in the cervical spine, the October 1968 incident resulted in the traumatic compression of the C5 vertebral body and injury to the C5-6 disc below. The injury to the disc led to the bulging at C5-6 and the bony, arthritic changes, which were the major cause of claimant's ongoing cervical symptoms and his need for surgery in 1994. (Ex. 99, at pp. 21, 22, 31, 32, 38).

Back in 1968, Travelers accepted a head injury claim arising out of the October 4, 1968 incident in which claimant sustained the C5 compression fracture. Then, in 1988, Sedgwick accepted an occupational disease claim which included cervical symptoms.[6] Sedgwick concedes that degenerative changes at C5-6 were the cause of claimant's symptoms at that time. Since Sedgwick has accepted the symptoms of the arthritic changes resulting from the 1968 industrial injury, we conclude, as did the ALJ, that its acceptance encompassed the cause of those symptoms, including the compression of the C5 body.[7]

Having accepted claimant's cervical condition in 1988, Sedgwick remains responsible under ORS 656.308(1) unless it can prove that claimant sustained a new compensable injury or that his subsequent employment activities were the major contributing cause of a worsening of his condition. The record fails to establish that claimant sustained any new cervical injury or that his work activities subsequent to 1989 were the major contributing cause of a worsening of his condition. Therefore, like the ALJ, we conclude that current responsibility for claimant's cervical condition rests with Sedgwick.

ORDER

The ALJ's order dated April 4, 1996 is affirmed.

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[5] Claimant credibly testified as to the mechanism of injury involved in the 1955 automobile accident, where his head hit the dash board and he sustained a cut above his right eyebrow, versus the October 1968 work incident, when a 200-plus pound sheet of metal fell from a glommer and struck him on top of the head, lacerating his scalp and knocking him to the ground. Based on this history of the two incidents and the radiographic studies showing an old compression-type fracture, Dr. Franks opined that claimant more than likely sustained the C5 fracture in the 1968 industrial accident, because that was more of a vertex-weight loading type of injury. (Ex. 99-13). Dr. Franks explained that claimant's C5 body was severely flattened, which was consistent with an axial loading of the spine from a remote, traumatic injury. (Ex. 99-14). Dr. Franks also opined that the ongoing symptoms claimant experienced following the 1968 incident, such as occipital headaches, neck pain and muscle tightness, were consistent with a compression fracture and arthritic changes resulting from a spinal cord compression. (Ex. 99-28).

[6] We reject Sedgwick's argument that Piwowar is inapplicable because its acceptance was limited to a specific condition (C5-6 cervical spondylosis, without myelopathy or radiculopathy). The 801 form as well as Sedgwick's own records indicate that it accepted discomfort of the neck, left arm and shoulder, a set of symptoms rather than a specific condition. (See Exs. 20, 86; Tr. 89).

[7] Since we have found that Sedgwick accepted claimant's compression injury by operation of law, we do not address Sedgwick's "last injurious exposure rule" argument, as that rule applies only in the absence of an accepted condition.

In the Matter of the Compensation of
WILLIAM M. BEARDSLEY, Claimant
WCB Case No. 96-01470
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order which: (1) affirmed an Order on Reconsideration's award of 35.78 percent (68.69 degrees) scheduled permanent disability for claimant's binaural hearing loss; and (2) declined to consider claimant's testimony on the extent of disability issue. On review, the issues are the admissibility of claimant's testimony and extent of scheduled permanent disability.

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

In a hearing held on April 30, 1996, the ALJ declined to consider claimant's testimony regarding the extent of disability issue. See Joe R. Ray, 48 Van Natta 325 (1996) (evidence not submitted at reconsideration, and not made part of the reconsideration record, is not admissible at a subsequent hearing concerning extent of permanent disability under amended ORS 656.283(7)); but see Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996) ("post-reconsideration" testimony considered on review when properly admitted at "pre-Senate Bill 369" hearing); Dean J. Evans, 48 Van Natta 1092 (1996) (adhering to Ray holding in hearing held after June 7, 1995). Claimant requests that we stay further proceedings until the court reviews the evidentiary issue decided in Ray.[1]

We decline to hold a matter in abeyance indefinitely pending resolution of the pending court appeal in another case. See e.g. Weston C. Foucher, 47 Van Natta 1518 (1995). As we explained in Foucher, as an adjudicative body, our function is to resolve disputes brought to us by the litigants. In performing these duties, we apply the relevant statutory, administrative, and judicial precedents as they exist at the time of our review. Were we to follow claimant's suggestion and hold this matter in abeyance, resolution of this dispute, as well as numerous others, would be deferred for an indeterminate period awaiting another appellate forum's decision. We do not consider such an action consistent with our statutory role as a decision-maker. Accordingly, we deny claimant's request to stay our review. See also Alonso S. Alvarado, 43 Van Natta 1303 (1991).

ORDER

The ALJ's order dated May 6, 1996 is affirmed.

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[1] In contesting the ALJ's affirmance of the reconsideration order's award of scheduled permanent disability for binaural hearing loss, claimant refers to OAR 436-35-250(2)(a), which allows an offset for preexisting hearing loss in the determination of permanent disability due to a compensable injury. Specifically, he alleges that this rule is inapplicable because there was no baseline audiogram obtained within 180 days of his assignment to a high-noise environment. We need not resolve that question because the medical evidence does not establish that claimant's post-employment hearing loss is due to his compensable condition.

In the Matter of the Compensation of
KAY A. BLACKSTOCK, Claimant
WCB Case No. 96-00514
CORRECTED ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Hall, Christian and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's back and shoulder injury claim. On review, the issue is whether claimant's injury arose in the course and scope of her employment.

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

Claimant "clocked out" for her unpaid mandatory lunch break and left the store where she worked to go home and eat. Upon discovering ice in the parking lot, claimant returned to the store with the intention to buy food there and eat in the employee lunch room. Shortly after entering the store, claimant slipped and fell in some water on the floor, injuring her back and shoulders.

The ALJ found that claimant's injury arose out of and occurred in the course of her employment. The insurer argues that claimant's injury lacks a causal relationship with her employment and that, essentially, claimant was no different from any other shopper when she was injured.

We agree with the ALJ that claimant's injury is compensable. In Ron M. Mattioli, 47 Van Natta 801 (1995), we found that the claimant's injury was in the course and scope of employment when, while on an unpaid lunch break on the employer's premises, the claimant injured his finger when attempting to retrieve a sandwich from a vending machine. In reaching this conclusion, we particularly relied upon the facts that the claimant's injury "occurred on the [employer's] premises and arose from a premise hazard." 47 Van Natta at 802.

Similarly, in Mark Hoyt, 47 Van Natta 1046 (1995), we found compensable an injury when the claimant, while on a mandatory break, was impaled with a pocket knife by a coworker who was "pestering" the claimant. We first found that the injury occurred in the course of employment because it was during a mandatory lunch break in the employer's lunchroom, the only practical location for such a break. 47 Van Natta at 1047. We further found that the injury arose out of employment because claimant's conditions of employment put him in a position to be injured; those conditions included the facts that the injury was on the employer's premises and the employer had acquiesced in the workers' use of the knives. Id.

We find that Mattioli and Hoyt govern the outcome in this case. Due to the icy conditions, claimant essentially was prevented from leaving the employer's premises for her lunch break. Consequently, because the only practical location for claimant to spend her mandatory lunch break was on the employer's premises, we find that claimant's injury occurred in the course of her employment. Norpac Foods v. Gilmore, 318 Or 363 (1994); Mark Hoyt, supra.

We also find a sufficient causal relationship between the injury and claimant's work to establish that the injury arose out of claimant's employment. Norpac Foods v. Gilmore, supra. Like the claimant in Mattioli, claimant's injury here occurred on the employer's premises and from a premise hazard (i.e., the water on the floor of the store). Thus, we agree with the ALJ that claimant also satisfied this requirement.[1]

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[1] We find further support for our decision in Clark v. U.S. Plywood, 288 Or 255 (1980) (Court held that a worker killed when retrieving his lunch from the top of a hot glue press during a lunch break is compensable if such conduct was expressly or impliedly allowed by the employer); Henderson v. S.D. Deacon Corp., 127 Or App 333 (1994) (worker's injury when she stepped out of an elevator while attempting to leave the building for a lunch break was in the course and scope of employment). SAIF v. Marin, 139 Or App 518 (1996) (worker's injury sustained in employer's parking lot while the attempting to jump start car was not in the course and scope of employment).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, 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 18, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

Board Member Haynes dissenting.

The result reached by the majority shows the accuracy of my dissent in Ron M. Mattioli, 47 Van Natta 801, 803 (1995), stating that the Board currently finds compensable "virtually any injury on an employer-owned [] premises [occurring during lunch]." As I did in Mattioli and Mark Hoyt, 47 Van Natta 1046 (1995), I continue to strongly disagree with such an approach.

I find the court's recent decision in SAIF v. Marin, 139 Or App 518 (1996), to be particularly instructive in this case. There, the claimant was injured in the employer's parking lot while attempting to jump start his car. A supervisor's wife struck a flower box with her car, pushing the flower box against the claimant and pinning him against his vehicle. The Board found the injury arose out of the claimant's employment.

The court first found that the Board "improperly focused only on the fact that [the] claimant was injured by an instrumentality over which the employer had control" and instead it "should have considered whether the totality of the events that gave rise to [the] claimant's injury was causally related to his employment." 139 Or App at 522. The court then categorized the flower box as a "neutral risk," as opposed to a personal risk or employment-related risk, and, thus, explained that the claimant's injury was compensable only if his work conditions caused him to be in a position to be injured by the flower box. Id. at 524-25. Finally, the court concluded that the claimant's efforts to jump start his car and the subsequent events were activities "sufficiently removed from his normal ingress and egress to and from work as to break the causal connection between his normal conditions of employment and his injury." Id. at 525. Thus, the court held that the claimant's injury did not arise out of his employment.

As it did in Marin, the majority again focuses only on whether the employer had control over the instrumentality of the injury rather than looking at the totality of events. Like the flower box, the water in which claimant slipped is a "neutral risk"; it is not a personal risk (inherent to claimant) or an employment-related risk (inherent to claimant's job as a deli clerk while claimant was engaged in her usual employment as a deli clerk). Thus, the appropriate test for determining compensability is whether claimant's work conditions caused her to be in a position to be injured by the water.

In considering the "totality of events," these facts must be considered. Claimant works as a deli clerk and is required to take an unpaid lunch break. Claimant already had "clocked out" and completed her normal egress out of the store when claimant decided to return to the store because she considered it too icy to drive home for lunch. Thus, her reentry into the store was completely removed from any condition of employment as a deli clerk. I think the employer is right in arguing that, at the time of injury, claimant was like any other customer entering the store to buy lunch. This is correct because the causal connection was broken between claimant's normal conditions of employment and her injury.

I think the lesson in Marin is that an injury occurring on an employer's premises does not automatically make it within the course and scope of employment. Unfortunately, as the majority once again shows, the location of the injury is the only factor that it considers when deciding this issue.

In the Matter of the Compensation of
RODNEY V. BOQUA, Claimant
WCB Case No. 96-00805
CORRECTED ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) modified an Order on Reconsideration and awarded claimant 19 percent (60.8 degrees) unscheduled permanent disability, 12 percent (18 degrees) scheduled permanent disability for the left forearm (wrist) and 16 percent (24 degrees) scheduled permanent disability for the right forearm (wrist); and (2) awarded claimant's counsel an assessed attorney fee for defending against the employer's challenge to the right wrist award. Claimant cross-requests review of that portion of the ALJ's order which awarded a $500 assessed attorney fee. On review, the issues are extent of unscheduled and scheduled permanent disability, and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

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

The initial Notice of Closure (NOC) issued October 25, 1994, and awarded 4 percent scheduled permanent disability for the left wrist and 4 percent for the right wrist. Claimant requested reconsideration. A March 31, 1995 Order on Reconsideration (OOR) increased claimant's award to 17 percent unscheduled permanent disability, 17 percent scheduled permanent disability for the left wrist, and 16 percent disability for the right wrist.

The employer's second Notice of Closure issued September 13, 1995. The second Order on Reconsideration issued December 19, 1995.

CONCLUSIONS OF LAW AND OPINION

Extent of unscheduled (right shoulder) and scheduled (right and left wrists) permanent disability

The ALJ essentially held that the amount of claimant's permanent disability awards (13 percent unscheduled permanent disability[1], 12 percent scheduled permanent disability (left wrist) and 16 percent scheduled permanent disability (right wrist)) had been previously established by a prior ALJ's order and by the Board's order which affirmed the prior ALJ, and those amounts were now "the law of the case." Moreover, the ALJ concluded that, by re-rating and reducing claimant's prior permanent disability awards, the employer had effectively set aside the original NOC, whereas the prior ALJ and Board orders held that the employer was not entitled to raise the issue of premature closure. We agree with the ALJ's "Opinion" on the issue of extent, and we add the following supplementation.

On review, the employer argues that the ALJ was not bound by the prior ALJ and Board orders. First, the employer contends that the prior ALJ would not permit the employer to raise the premature closure issue as it was based on an acceptance which took place after the close of the hearing. The employer is apparently arguing that the operative facts in existence after the close of the hearing were not relied on by the prior ALJ in reaching his decision and, therefore, cannot preclude the employer from litigating the issue at this time.

In its prior order, the Board affirmed the ALJ on the premature closure issue. However, the Board further concluded that the employer could not prevail on the merits of its argument. Rodney V. Boqua, 48 Van Natta 357 n 1 (1996). Accordingly, we agree with the ALJ that the issue had been previously decided adversely to the employer. Moreover, the prior ALJ rated claimant's unscheduled

[1] We note that the unscheduled permanent disability award discussed in this section does not include any amounts for claimant's later accepted cervical condition, which is discussed in the following section.

and scheduled permanent disability, and those awards were affirmed in the Board's prior order. Boqua, supra. Therefore, we agree with the ALJ that those amounts have been previously established and cannot be reduced or modified by way of a "re-opening" and "re-rating" of the claim.

In essence, the employer concedes that it "remains the employer's position that the initial closure, in light of the subsequent acceptance of the cervical condition, was invalid." (Appellant's brief, pg. 4). The employer's challenge, therefore, is to our prior order. Under the circumstances, we agree with the ALJ that the employer's subsequent re-rating of claimant's entire claim is contrary to the Board's prior ruling in this matter.

Next, the employer argues that the ALJ was not bound by the prior ALJ and Board decisions because the employer has appealed the prior Board order to the court. We agree that the principles of res judicata do not apply in this case because claimant's prior award is still on appeal. See, e.g., Romilda Williams, 41 Van Natta 1887 (1989) (Because the claimant's first Determination Order, which awarded no permanent disability, had not been appealed, the Board held that, as a matter of law, the referee could not find that the claimant actually had a 20 percent disability, which would be deducted from the current award).

Notwithstanding our above conclusion regarding res judicata, however, we have also held that, for purposes of administrative efficiency, we will give precedential effect to prior non-final litigation orders. See Elmer F. Knauss, 47 Van Natta 826, on recon 47 Van Natta 949, on recon 47 Van Natta 1064 (1995). Under the circumstances, we agree with the ALJ's decision to follow the prior precedent, and we affirm the ALJ's order on this issue.

Extent of unscheduled permanent disability (cervical condition)

On review, the employer disagrees with the ALJ's award of 6 percent unscheduled permanent disability for the cervical condition that was subsequently accepted by the employer following the first NOC and OOR. The employer contends that the ALJ should have relied on the opinion of either Dr. Teal or Dr. Weller, who treated claimant, or upon the opinion of Dr. Donahoo, who examined claimant on behalf of the employer. We agree with the employer that claimant has not established an entitlement to an award for the cervical condition.

With the exception of a medical arbiter, findings concerning a claimant's impairment can be made only by the attending physician at the time of claim closure. Dennis E. Conner, 43 Van Natta 2799 (1991). Medical evidence regarding permanent impairment must come from the findings of the attending physician or other physicians with whom the attending physician agrees. See Roseburg Forest Products v. Owen, 129 Or App 442 (1995); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). Reports of insurer-arranged medical examiners are not admissible for the purpose of rating impairment unless those findings are ratified by the claimant's attending physician. See OAR 436-35-007(8); Tektronix, Inc. v. Watson, 132 Or App 483 (1995).

Here, claimant's treating doctor is Dr. Weller. (Respondent's Brief, pg. 7). Dr. Weller and Dr. Teal, who also treated claimant, concurred with the report of Dr. Donahoo. In his report, Dr. Donahoo found that claimant had symptoms in his neck, but no loss of range of motion. (Ex. 51-9). Accordingly, because claimant's treating doctor concurred with the opinion of Dr. Donahoo, that opinion may be considered for the purpose of rating impairment.

Dr. Marble, the medical arbiter, reported claimant's cervical range of motion findings. However, when questioned about the validity of those findings, Dr. Marble stated that he was "at a loss to explain the limited flexion and rotation to the left in this patient, and question whether those mobility findings could be considered valid in the absence of documented organic pathology." (Ex. 63-4).

In light of Dr. Marble's equivocal statement regarding the validity of the range of motion findings, we are unable to find his opinion persuasive evidence of impairment due to the compensable injury. See Roberto Garcia, 48 Van Natta 879 (1996) (Medical arbiter report that measured loss of range of motion and also indicated no objective evidence of permanent impairment found to contain potential ambiguity and was rejected as nonpersuasive).

Accordingly, we rely on the opinion of the doctors who treated claimant over the past years. Because Drs. Weller and Teal concurred with Dr. Donahoo's report of no cervical range of motion findings, we conclude that a preponderance of the medical evidence establishes that claimant has no cervical impairment due to the compensable injury. Therefore, we reverse the ALJ's award of 6 percent for the cervical condition.

Assessed attorney fee

The ALJ awarded claimant's counsel an assessed attorney fee for defending against the employer's request to reduce claimant's right wrist award. On review, the employer argues that an assessed fee is not appropriate, as the ALJ actually reduced claimant's permanent disability award. We disagree.

The Order on Reconsideration awarded: 23 percent unscheduled permanent disability; 17 percent scheduled permanent disability (left wrist); and 16 percent scheduled permanent disability (right wrist).[2] The ALJ awarded: 19 percent unscheduled permanent disability, 12 percent scheduled permanent disability (left wrist; 16 percent scheduled permanent disability (right wrist).

As we stated in our prior order concerning this case, when conditions are considered separately for purposes of rating permanent disability, the carrier appeals the compensation awarded for every condition, and the compensation for at least one condition is not reduced, we award an assessed attorney fee for the claimant's counsel's efforts with regard to that condition. Rodney V. Boqua, supra (citing Edgar L. Edington, 47 Van Natta 1466, 1467 (1995)), Debra Cooksey, 44 Van Natta 2197, 2198 (1992). We previously held in this case that:

> "claimant's compensable left wrist, right wrist, and right shoulder conditions are considered separately for purposes of rating disability. The employer sought reduction in claimant's awards for all three conditions at hearing. The ALJ reduced the awards for the left wrist and right shoulder, but did not disturb the award for the right wrist. Under these circumstances, claimant is entitled to an assessed attorney fee under ORS 656.382(2) for successfully defending against the employer's challenge to the right wrist award." Id.

In the present case, the ALJ correctly found that claimant had again successfully defended the challenge to the right wrist award. Because we affirm the ALJ's order on that issue, claimant is entitled to an assessed attorney fee for defending on the right wrist condition. ORS 656.382(2); Edington, supra.

Claimant has cross-requested review of the ALJ's attorney fee award, and contends that the attorney fee amount should be increased. After considering the factors set forth in OAR 438-0015-0010(4), and applying them to this case, we find that the ALJ's attorney fee award of $500 for the defense of the wrist condition is reasonable. We, therefore, decline to increase the ALJ's award on review.

Claimant is entitled to an assessed attorney fee for services on review concerning the issues of scheduled permanent disability. ORS 656.382(2). After considering the factors set forth in OAR 438-0015-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review regarding those issues is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We note that no attorney fee is available for claimant's unsuccessful defense of the cervical condition issue, or on the issue of attorney fees. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

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[2] Claimant notes that the December 1995 OOR erroneously reinstated prior permanent disability awards for the unscheduled condition and the left wrist condition, which were corrected by the ALJ. Claimant agrees that the correct amount of the prior unscheduled permanent disability award should be 13 percent.

ORDER

The ALJ's order is modified in part and affirmed in part. That portion of the ALJ's order which awarded claimant 19 (60.8 degrees) percent unscheduled permanent disability is modified. In lieu of the ALJ's award, claimant's total unscheduled permanent disability award to date is 13 percent (41.6 degrees) unscheduled permanent disability award. The ALJ's "out-of-compensation" attorney fee is modified accordingly. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the employer.

October 31, 1996 Cite as 48 Van Natta 2216 (1996)

In the Matter of the Compensation of
JAMES C. ENGLISH, Claimant
WCB Case No. 95-13067
ORDER OF ABATEMENT
Ernest M. Jenks, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our October 1, 1996 order that: (1) set aside its partial denial insofar as it denied claimant's somatic dysfunction of the cervical, dorsal/thoracic and lumbar spine; and (2) awarded an insurer-paid attorney fee of $3,000 under ORS 656.386(1). Contending that we misconstrued its denial and erroneously granted an attorney fee award, SAIF asks that we reinstate its denial in its entirety and rescind our attorney fee award.

In order to further consider this matter, we withdraw our October 1, 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 proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JANICE S. JULUM, Claimant
WCB Case No. 95-11763
ORDER ON REVIEW
Schiro & Baron, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller, Christian and Biehl.

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

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated May 13, 1996 is affirmed.

Board Member Biehl dissenting.

I disagree with the majority that claimant failed to prove compensability of her low back injury. In particular, I find that the better medical evidence carries claimant's burden of proof. Consequently, I dissent.

Claimant is a registered nurse assigned to an intensive care unit. In October 1992, claimant sustained a nonwork-related back injury. On September 15, 1995, claimant was told to assist a patient who was having a pace maker inserted; this procedure required claimant to wear a lead apron weighing approximately 20 pounds. Before the procedure began, claimant was called to the emergency room to assist another patient in cardiac arrest.

Still wearing the lead apron, claimant climbed to the edge of the bed and leaned over the patient to perform chest compressions. After beginning a compression, the patient began flailing his arms, requiring claimant to continue leaning over the patient to hold down the arms. Claimant stayed in this position for about 10 minutes, when the patient stopped flailing. Subsequent to this activity, claimant's back was painful.

On September 18, 1995, while at home, claimant bent from her knees to wipe up a spill from the floor. Claimant's low back pain worsened, and developed into her legs. The next day, claimant sought treatment from her family physician, Dr. Cooley. On November 28, 1995, on Dr. Cooley's referral, Dr. Goodwin, neurosurgeon, examined claimant.

Dr. Cooley found that the September 15 work activity was the major contributing cause of claimant's low back injury. Dr. Goodwin disagreed, indicating that it was "equally conceivable" that the work event or the September 18 activity at home caused claimant's condition. (Ex. 8-3). In any case, Dr. Goodwin could not "ascribe a majority cause of treatment to the work exposure and injury on September 15." (Id.)

The ALJ, whose order the majority adopted and affirmed, found Dr. Goodwin's opinion more persuasive for three reasons: (1) Dr. Goodwin's opinion was based on a more complete and accurate history because he was aware of claimant's previous back symptoms while Dr. Cooley exhibited no such understanding; (2) Dr. Cooley "unrealistically downplay[ed] the incident at home"; and (3) Dr. Goodwin, as a neurosurgeon, had more expertise than Dr. Cooley.

I disagree with the ALJ's reasoning. Dr. Goodwin exhibited an entirely inaccurate understanding of claimant's activity on September 15 since he indicated that claimant "wore a lead apron while watching a patient in x-ray for a prolonged period of time." (Ex. 6-1). Dr. Cooley knew that claimant climbed on a bed and performed cardiac compression while wearing a lead apron. (Exs. 7-2, 10-1).

Furthermore, Dr. Goodwin's opinion is conclusory in that he provided no reason for discounting the September 15 activity as the major contributing cause of claimant's low back injury. Dr. Cooley, on the other hand, explained that the "lead apron shifts the center of gravity, hyperextends the lower back" and that the "added action required for chest compression further extends the stress on the lower back." (Ex. 10-1). In finding that the September 18 home incident was not the major contributing cause, Dr. Cooley stated that "the damage to the muscles was evident shortly after the [September 15] incident" and "cleaning the floor was a small action which further triggered the pain in her back which previously occurred during her work assignment." (Id. at 2).

I find most persuasive those opinions that are well-reasoned and based on an accurate history. Somers v. SAIF, 77 Or App 259 (1986). It is obvious to me that Dr. Cooley's opinion satisfies this test while Dr. Goodwin's opinion was based on an inaccurate history with no explanation to support his conclusion. Thus, I believe that Dr. Cooley's opinion is the most persuasive.

I also disagree with the ALJ's application of ORS 656.005(7)(a)(B). The ALJ did so after finding that claimant's low back symptoms were due at least in part to a preexisting degenerative disc condition. Although Dr. Goodwin noted claimant's preexisting degenerative disc disease, he expressly stated that "the degenerative disc problems may not be likely contributory to her low back and leg symptoms." (Ex. 8-3) (Emphasis added). Thus, there is no basis in the record for finding that claimant's preexisting back condition combined with her injury. Because there is a lack of evidence of contribution from the preexisting condition, I also find that Dr. Cooley's apparent ignorance of such condition does not affect the persuasiveness of her opinion.

In conclusion, I disagree with the majority's evaluation of the medical evidence and the application of ORS 656.005(7)(a)(B). Accordingly, I dissent.

In the Matter of the Compensation of
LAVERNE W. MOORE, Claimant
Own Motion No. 94-0403M
OWN MOTION ORDER OF ABATEMENT
Dennis O'Malley, Claimant Attorney
VavRosky, et al, Defense Attorneys

The self-insured employer requests reconsideration of our October 10, 1996 Own Motion Order Reviewing Carrier Closure, which set aside the employer's April 4, 1996 Notice of Closure as premature.

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
RUSSELL J. PENTURF, Claimant
WCB Case Nos. 95-06908 & 95-04168
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Schultz' order that: (1) found the self-insured employer's acceptance of claimant's injury claim as a "transient respiratory irritant reaction" did not constitute an improper prospective denial; (2) found claimant's claim was not prematurely closed; and (3) upheld the employer's denial of claimant's occupational disease claim for reactive airways disease. On review, the issues are compensability, claim processing and premature closure.

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

Claimant, age 33 at the time of hearing, worked as a truck driver for the employer, transporting liquid and dry agricultural chemicals such as fertilizers and pesticides. The chemicals claimant worked around included Comp-ad, a product used with water to turn crystallized ammonium fertilizers back into a liquid, as well as ammonium phosphate 10-34-0 thiosol and 10-35-0, ammonium nitrate solution, granular ammonium nitrate, Metam and Vepam. Claimant was provided with information on the chemicals and with safety gear, which he wore when necessary.

In late June or early July 1994, claimant was exposed to Comp-ad and fertilizer residue while cleaning fertilizer tanks for the employer. Although he did not suffer any immediate ill effects from cleaning out the tanks, he developed a cough shortly afterwards. In addition, during this same time frame, claimant was asked to clean up a chemical spill in the employer's warehouse. While working in the warehouse, he opened the lid of what he thought to be an empty 55 gallon drum and discovered a broken bottle or plastic jug of some unknown chemical with a strong odor.

Claimant's cough became progressively worse. On July 24, 1994, he saw Dr. Ricketts complaining of chest pain and a bad cough. Dr. Ricketts diagnosed viral bronchitis and prescribed antibiotics and pain medication.

Claimant's cough continued. On August 7, 1994, he developed pressure in his chest, shortness of breath and nausea. He was seen in the emergency room, and released. The next day, at work, claimant experienced the same symptoms. He passed out, and was taken by ambulance to the hospital, where he was treated and released. Claimant did not return to work for the employer following the August 8, 1994 incident.

Claimant began treating with Dr. Flick on August 16, 1994. Dr. Flick initially diagnosed viral bronchitis, for which he prescribed medication. On August 30, 1994, claimant returned to Dr. Flick, who hospitalized him due to the severity of his cough. A bronchoscopy exam was done, which was positive for severe tracheobronchitis and early to moderate tracheomalacia. Biopsies were positive for bacteria, probably oral in origin. Claimant was discharged on September 5, 1994, and continued to follow up with Dr. Flick on several occasions between September 1994 and July 1995.

Prior to his work exposure, claimant had been treated for, among other things, chest tightness, allergies, sneezing, seasonal rhinitis, cough and congestion, acute bronchitis, pneumonia, reactive airway disease and gastroesophagitis. He underwent surgery for chronic severe gastroesophageal reflux with esophagitis and ulceration in 1991. In addition, claimant has a long history of chewing tobacco use.

In September 1994, claimant made a claim for a "respiratory/chemical burn" condition arising out of his exposure to chemicals at work. The employer accepted a disabling claim for a "transient respiratory irritant reaction" condition on January 5, 1995.

On March 17, 1995, the employer closed the claim by a Notice of Closure, which awarded temporary disability only. Claimant requested reconsideration, and a May 17, 1995 Order on

Reconsideration set aside the Notice of Closure as premature. The employer then reclosed the claim by Notice of Closure on August 16, 1995, and claimant again requested reconsideration. An October 20, 1995 Order on Reconsideration set aside the August 1995 closure, finding that claimant still was not medically stationary. The employer requested a hearing.

In the meantime, claimant's cough continued and Dr. Flick concluded that claimant was suffering from "reactive airway disease" plus some other condition or conditions which he could not yet define. On October 13, 1995, the employer issued a denial of claimant's occupational disease claim for reactive airways disease, on the ground claimant's condition was not related to his employment. Claimant requested a hearing on this denial, which was consolidated with the employer's hearing request.

Relying primarily upon the medical opinion of Dr. Montanaro,[1] the ALJ found that claimant's accepted condition, transient respiratory irritant reaction, was medically stationary by June 16, 1995, if not sooner. The ALJ therefore set aside the second Order on Reconsideration and reinstated the employer's August 16, 1995 Notice of Closure. In addition, the ALJ found that claimant failed to establish that his work for the employer was the major contributing cause of his ongoing respiratory problems.

Claimant raises three arguments on review. First, claimant maintains that the employer's acceptance of a "transient" irritant respiratory reaction is an invalid prospective denial. Second, claimant contends that the employer's August 16, 1995 Notice of Closure is improper because he is not medically stationary and the requirements of ORS 656.268(4)(a) have not been satisfied. Third, claimant asserts that the ALJ erred in rejecting Dr. Flick's opinion that claimant has reactive airways disease related to his work exposure with the employer. We reject each argument, for the reasons discussed below.

Prospective Denial

Relying on Gary L. Best, 46 Van Natta 1694 (1994), claimant argues that the employer's acceptance of a "transient" condition improperly allows the employer to deny future responsibility for claimant's irritant respiratory reaction. We disagree.

In Gary L. Best, supra, the carrier accepted the claimant's osteomylitis condition as "resolved." We held that the term "resolved" implied that the carrier was no longer responsible for future benefits for the claimant's condition, and therefore the carrier's notice constituted an improper denial of future responsibility relating to an accepted claim. Subsequent to Gary L. Best, however, we held that an employer's acceptance of a "temporary" condition, when based on the medical treatment evidence, is permissible because the term "temporary" does not represent a conclusion that the employer is not responsible for future benefits related to the accepted condition. Nancie A. Stimler, 47 Van Natta 1114 (1995).[2]

We find this case analogous to Nancie A. Stimler, supra. In December 1994, Dr. Montanaro opined that claimant was exposed to respiratory irritants during his tank cleaning duties for the

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[1] Dr. Montanaro, who examined claimant in December 1994 at the employer's request, determined that claimant was exposed to potential respiratory irritants during his tank cleaning duties (in June and early July 1994) which led to immediate, but transient symptoms of cough, that would have resolved within one to two weeks. Dr. Montanaro further reported that claimant's subsequent episodes (during August 1994) in which he experienced chest tightness and shortness of breath were likely due to "hyperventilatory episodes" and were unrelated to the respiratory irritant reactions occurring several weeks prior. (Ex. 62-6). Dr. Montanaro concluded that claimant's chronic cough was secondary to atopy, chronic rhinosinusitis and possibly gastroesophageal reflux, but was not caused by his work exposure.

[2] In Nancie A. Stimler, the claimant, an x-ray technician with an underlying asthma condition, was exposed to radiologic film developer and fixer fumes at work. The medical reports referred to her respiratory reaction to the chemicals as "transient," "temporary" and "resolved," and concluded that the work exposure did not pathologically worsen her underlying asthmatic conditions. Based on this medical evidence, the employer accepted a "disabling temporary irritant reaction condition."

employer, which led to "immediate, but transient symptoms of cough."[3] (Ex. 62-6). Based on this medical opinion, the employer accepted a disabling "transient" condition.[4] Under these circumstances, the employer's use of the term "transient" does not preclude claimant from subsequently proving future disability or need for treatment arising out of the accepted condition and does not constitute a prohibited prospective denial.

Premature Closure

Under ORS 656.268(4)(a), a carrier may close a claim without the issuance of a determination order when the worker's condition resulting from the accepted disabling injury has become medically stationary, and the worker has returned to work or the worker's attending physician releases claimant to return to regular or modified employment, or when the worker's injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7).

Claimant argues that the employer's August 16, 1995 Notice of Closure is improper because: (1) he is not medically stationary; and (2) to the extent the employer believes that his accepted condition is no longer the major contributing cause of his combined or consequential condition, it was required to issue a current condition denial pursuant to ORS 656.262(7)(b).[5] We find to the contrary.

First, claimant's contention that he is not medically stationary is directly tied to Dr. Flick's opinion that claimant has a progressive condition (reactive airways disease plus an undiagnosed condition), related to his exposure to chemicals at work. In other words, claimant does not contend that his accepted transient irritant respiratory reaction condition is not medically stationary, but rather that his current condition, which he alleges results from the same exposure, is not medically stationary.

For the reasons articulated by the ALJ, we do not find Dr. Flick's opinion persuasive.[6] See Miller v. Granite Construction, 28 Or App 473 (1977) (medical opinion that is not based on a complete and accurate history is less persuasive). Therefore, we do not accept claimant's premise that his current condition is part of, or compensably related to, the accepted claim. Instead, we agree with the ALJ that a preponderance of the evidence establishes that claimant's accepted condition is medically stationary, and has been for quite some time. Because claimant's accepted "transient respiratory irritant reaction" condition is medically stationary and his treating doctor has released him to modified work,[7] we find that the employer properly closed claimant's claim pursuant to ORS 656.268(4)(a).

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[3] Like the ALJ, we are persuaded by the complete and well-reasoned opinion of Dr. Montanaro.

[4] In June 1995, Dr. Barker agreed with Dr. Montanaro that claimant had experienced a "temporary respiratory condition" based on dust or fume exposure or related to a respiratory tract infection. (Ex. 75-5).

[5] This section 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."

[6] As the ALJ found, even though Dr. Flick is claimant's treating physician, his opinion regarding the cause of claimant's respiratory condition is lacking in explanation and reason. For example, Dr. Flick's opinion is based primarily upon the temporal relationship between claimant's exposure to certain chemicals while cleaning the tanks at work in June or July and the onset of his cough and other symptoms, which progressively worsened in August and September 1994. Dr. Flick's opinion does not adequately address the significance of claimant's long history of respiratory problems (that predate his work exposure), and erroneously assumes that claimant worked without adequate protection and that he was continually exposed to harmful chemicals at work throughout June and July 1994, and on August 8, 1994, the day he passed out at work after driving the truck. These assumptions are not supported by the evidence.

[7] In March 1995, Dr. Flick reported that claimant could return to work as a truck driver, as long as he avoided further exposure to volatile chemicals and inhaled irritants. See, e.g., Ex. 64.

Second, we conclude that ORS 656.262(7)(b) does not apply in this situation. As we explained in Elizabeth B. Berntsen, 48 Van Natta 1219 (1996), ORS 656.262(7)(b) applies only to claims involving a "combined condition." Under ORS 656.005(7)(a)(B), a "combined condition" exists when a compensable injury combines with a preexisting condition to cause or prolong disability or need for medical treatment. Here, the employer accepted a claim for a specific condition, "transient respiratory irritant reaction" based on the findings of Dr. Montanaro.[8] Thereafter, claimant developed a chronic respiratory problem, including symptoms of chest pressure, shortness of breath and wheezing, which Dr. Montanaro opined was unrelated to his work exposure. On this record, we are not persuaded that claimant's current reactive airways disease condition is the same "combined condition" (preexisting hypersensitivity to allergens and work exposure to irritants) accepted by the employer. Therefore, ORS 656.262(7)(b) does not apply to the employer's partial denial. See Elizabeth B. Berntsen, supra (ORS 656.262(7)(b) does not apply where the denial is not based on the presence of a preexisting condition or the provisions of ORS 656.005(7)(a)(B)).

Compensability

As the ALJ noted, the only expert opinion supporting compensability comes from Dr. Flick. However, as previously discussed, we do not find this opinion persuasive. Consequently, we adopt and affirm the ALJ's conclusion that claimant has failed to establish the compensability of his occupational disease claim for reactive airways disease.

ORDER

The ALJ's order dated February 8, 1996 is affirmed.

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[8] The medical evidence establishes that this temporary condition resulted from a combination of claimant's preexisting hypersensitivity to allergens and exposure to irritants at work in July 1994. This particular combination did not form the basis of the employer's partial denial, however. Rather, the employer denied claimant's reactive airways disease, a new condition which developed subsequent to the accepted condition, based on Dr. Montanaro's opinion that the new condition was unrelated to his work exposure. (Ex. 62-6).

In the Matter of the Compensation of
JOHN R. WOODS, Claimant
Own Motion No. 95-0508M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Welch, et al, Claimant Attorneys
Douglas Schoen (Liberty NW), Defense Attorney

Claimant requests review of the insurer's March 8, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from May 23, 1994 through February 18, 1996. The insurer declared claimant medically stationary as of February 15, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary with respect to all compensable conditions 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 March 8, 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); Paul E. Voellar, on recon 42 Van Natta 1962 (1990). 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).

In a June 3, 1996 letter, claimant advised the parties that he was "attempting to obtain a response from [his] treating psychiatrist, Dr. Helfing, regarding whether claimant is psychologically / psychiatrically medically stationary as directly relates to his industrial claim." Claimant requested that the record regarding the review of the closure of his claim remain open "for an additional reasonable period of time to allow [Dr. Helfing] to respond." On June 6, 1996, the Board extended the time for submission of the parties' respective positions regarding claimant's request for review of the closure. On September 20, 1996, the Board requested the status of claimant's attempt to obtain and submit a report from Dr. Helfing. On October 2, 1996, claimant responded that, although determined efforts had been made to secure a report from Dr. Helfing, "it appears that we are not going to be successful in obtaining a report." Claimant proposed that:

> "If the Board feels it appropriate to request a report itself, then I would encourage the Board to do so. This is the situation and it is up to the Board to do whatever it feels is appropriate in the above-entitled matter."

On October 8, 1996, we requested the insurer's position regarding claimant's request. On October 18, 1996, the insurer replied that it "would request that the Board proceed with the review of [the insurer's] March 8, 1996 Notice of Closure." The insurer noted that it "does not feel that it would be appropriate for the Board to request a report itself, as suggested by claimant's counsel." After reviewing the record, we conclude that the record contains sufficient medical evidence and opinion for us to proceed with our review. Consequently, consideration of further development of the record is not necessary.

Claimant's claim would be prematurely closed if one or more of his compensable conditions was not medically stationary at claim closure. See e.g., Dennis C. Gross, 48 Van Natta 1125 (1996) (because the claimant's current depression (psychological) condition was not a compensable portion of his injury claim, the claimant was medically stationary with respect to all compensable conditions at claim closure). Here, the record does not establish that claimant's "depression" condition is an accepted component of his 1978 injury claim. Therefore, unless claimant's depression condition is proven to be compensably related to an accepted injury claim, the aforementioned "report" from Dr. Helfing regarding claimant's depression condition would not be relevant to our review of the carrier's closure of this claim. Rogers v. Tri-Met, supra.[1] Therefore, claimant must establish that his compensable low back condition was not medically stationary at claim closure.

Having stated the above proposition, we turn to the medical evidence in the record. In an October 16, 1995 letter, Dr. Flemming, claimant's treating surgeon, opined that:

> "I have not seen [claimant] since January of 1995. Evidently, he has been followed by Dr. Griffiths in regards to management of chronic pain. [Claimant] would probably be felt to be medically stationary from his [May 1994] surgery at about a year; however, he did have a neurologic injury with the surgery, which can take up to two years. For that reason, I would suspect that he would not be medically stationary until about March of 1996. He will undoubtedly need some sort of chronic long-term care that will be palliative in nature."

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[1] However, should claimant provide evidence within 30 days of the date of this order that his depression condition is accepted by an insurer as compensable to an industrial injury claim, the Board would: (1) reconsider this order; (2) consider Dr. Helfing's report (if obtainable); and / or (3) because of the difficulties involved in obtaining the report from Dr. Helfing (claimant is apparently no longer treating with Dr. Helfing), consider a report from claimant's current treating psychiatrist if that report relates to claimant's depression condition at the time of claim closure.

There are no medical opinions from Dr. Griffiths in the record. However, Dr. Flemming opined that claimant's compensable condition should be medically stationary by March 1996 (approximately two years after the date of surgery). Further, we are not persuaded that, although Dr. Flemming opined that ongoing or chronic long-term care would probably be required, this treatment would improve claimant's compensable condition. Rather, using the term "palliative," Dr. Flemming opined that ongoing or chronic care in this claim should be provided for pain "management." Therefore, it follows that long-term care in the form of pain management would not necessarily establish that claimant was not medically stationary. See Maarefi v. SAIF, supra; Robert L Schauss, 48 Van Natta 1601 (1996) (although the insurer consented to a pain center evaluation, the claimant did not establish that his "pain" condition was compensable nor that the provision of ongoing care or "management" care meant that he was not medically stationary at claim closure). Finally, Dr. Flemming did not opine that claimant would not be medically stationary with respect to his compensable back condition in March of 1996.

In a February 15, 1996 IME report, Drs. Fuller and Snodgrass, examining claimant at the insurer's request, opined that claimant was medically stationary with respect to his 1978 injury and May 23, 1994 surgery because "[claimant] has become neither better nor worse over the past year or so."

Based on the unrebutted medical evidence, we find that claimant has not met his burden of proving that his compensable condition 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 March 8, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAN M. CHRISMAN, Claimant
WCB Case Nos. 94-02844, 94-00407 & 94-00406
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Lundeen, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

The self-insured employer (Wal-Mart, Inc.) requests review of those portions of Administrative Law Judge (ALJ) Galton's order that: (1) set aside its compensability and responsibility denials for claimant's occupational disease claim for right carpal tunnel syndrome; and (2) upheld Liberty Northwest Insurance Corporation's compensability and responsibility denials of the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the last two paragraphs. We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant began work for Liberty's insured, Diamond Fruit Growers, in February 1992. Claimant performed computer entry and used a 10-key calculator. After six months of employment, claimant noted numbness and pain on the palmar side of her right hand.

In October 1992, claimant started working part-time as a cashier at Wal-Mart and continued to work full-time for Diamond. While working at Wal-Mart, claimant had right hand numbness, tingling and pain while doing repetitive right hand activities. Claimant left Diamond and began working full-time at Wal-Mart in March 1993. Claimant worked in the cash office where she counted cash, performed computer entry and operated a 10-key calculator.

On October 4, 1993, claimant first sought medical care for her right hand and wrist problems. (Ex. 1-1). Claimant was referred to Dr. Stilinovic. Claimant was diagnosed with right carpal tunnel syndrome (CTS) and right DeQuervain's syndrome. (Ex. 5). On December 3, 1993, Dr. Stilinovic performed surgical releases of the right transverse carpal ligament and the right first dorsal compartment. (Id.) Dr. Stilinovic also removed a lipoma from claimant's right carpal tunnel. (Exs. 5A, 12).

At hearing, the ALJ found that claimant's lipoma played a part in the development of her right CTS. Based on Dr. Stilinovic's opinion, the ALJ concluded that claimant's work exposures were the major contributing cause of her carpal tunnel symptoms and her CTS. The ALJ assigned responsibility to Wal-Mart.

Wal-Mart argues that the ALJ applied the wrong legal standard to claimant's occupational disease claim and it contends that claimant's condition should have been analyzed as a "combined condition" under ORS 656.802(2)(c). Claimant responds that the ALJ adequately dealt with the "combined condition" criteria.

In an occupational disease claim, the worker must prove that employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). However, amended ORS 656.802(2)(c) adds the requirement that occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7). Amended ORS 656.005(7)(a)(B) 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."

Our first inquiry is whether claimant had any preexisting conditions that combined with her CTS to cause or prolong disability or a need for treatment. Our second inquiry is whether claimant's work activities were the major contributing cause of her "combined condition." See Beth D. Moore, 47 Van Natta 2178 (1995).

Because of the gradual development of symptoms over time and claimant's delay in seeking medical treatment, we agree with the ALJ that the causation question is medically complex and requires expert medical opinion to resolve. Barnett v. SAIF, 122 Or App 279, 282 (1993); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

Dr. Stilinovic explained that he found a "space occupying lesion" in claimant's right carpal tunnel at the time of surgery. (Ex. 12). The lesion was diagnosed as a lipoma, which is a benign fatty growth. (Exs. 5A, 12). Dr. Stilinovic reported that the lipoma "obviously had an influence on her median nerve symptoms in her hand as it occupied space within the carpal tunnel which is quite limited." (Ex. 12).

Dr. Stilinovic believed that claimant's lipoma preexisted her work exposure. (Exs. 17-5, -8). There is no contrary medical evidence. Therefore, we conclude that claimant's lipoma constitutes a "preexisting condition" under ORS 656.005(24). Dr. Stilinovic also opined that claimant's lipoma combined with her work activities to cause her right CTS. (Exs. 12, 15-1, 16, 17-8, 18). Thus, claimant must prove that her work activities were the major contributing cause of the disability or need for treatment of her combined condition.

Claimant relies on Dr. Stilinovic's April 10, 1995 opinion, in which he reported:

> "[T]he contributing factors to the carpal tunnel syndrome in [claimant's] right hand was indeed a combination of the space occupying lesion, namely the lipoma, as well as her work related activities necessitating repetitious wrist motion.
>
> "On a more probable than not basis, the repetitious wrist motion is the cause of her syndrome. I base this on the fact that rest of the hand at the time of surgery would result in relief of the symptoms. If the lipoma was the more probable than not cause, rest alone would not relieve the symptoms because rest would have no influence on the space occupying lesion itself.
>
> "Once again, on a more probable than not basis, at the time of the surgery in the right carpal tunnel, the repetitious wrist motion that [claimant] was subjected to at work is the probable cause of her symptoms." (Ex. 16).

At a deposition, Dr. Stilinovic adhered to his April 20, 1995 opinion that the repetitious wrist motion is "the cause" of her syndrome. (Ex. 17-12, -13, -23). Dr. Stilinovic also agreed with claimant's attorney that claimant's work activities were the "major cause" of any ensuing disability that followed the medical care and treatment. (Ex. 17-13).

However, Dr. Stilinovic also testified that, between the lipoma and the repetitious wrist motion at work, he could not determine, based on reasonable medical probability, which factor was the 50 percent or greater cause of her CTS. (Exs. 17-8, -22, -23, 18). Dr. Stilinovic testified that he did not know how much of a factor the lipoma was in claimant's CTS. (Ex. 17-19).

We are not persuaded by Dr. Stilinovic's inconsistent and contradictory opinions. On the one hand, Dr. Stilinovic agreed in the deposition that claimant's work activities were the "major cause" of her disability. (Ex. 17-13). On the other hand, Dr. Stilinovic testified that he could not determine whether the lipoma or the repetitious wrist motion at work was the major contributing cause of her CTS. (Exs. 17-8, -22, -23, 18). In earlier reports, Dr. Stilinovic agreed that claimant's work activities were not the major contributing cause of claimant's condition. (Exs. 6, 15). Dr. Stilinovic's opinions are, at best, confusing. We assign Dr. Stilinovic's opinions little probative weight.

The only other medical opinion is from Dr. Nathan, who concluded that claimant had an underlying, intrinsic neuropathic process, which was the major contributing cause of claimant's symptoms and need for treatment. (Ex. 4-5).

We conclude that claimant has failed to establish that her work activities were the major contributing cause of the disability or need for treatment of her combined condition. Since claimant's CTS is not compensable, it is not necessary to address issues of responsibility.

ORDER

The ALJ's order dated June 7, 1996 is reversed in part and affirmed in part. Wal-Mart, Inc.'s denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

November 5, 1996 Cite as 48 Van Natta 2227 (1996)

In the Matter of the Compensation of
PAUL E. HARGREAVES, Claimant
WCB Case No. 95-01401
ORDER ON RECONSIDERATION
Kirkpatrick & Zeitz, Claimant Attorneys
Roberts, et al, Defense Attorneys

On September 11, 1996, in response to the insurer's request for reconsideration, we abated our August 14, 1996 Order on Review in which we affirmed the ALJ's order that: (1) set aside the insurer's denial of claimant's lumbar disc conditions; and (2) awarded penalties for the insurer's allegedly unreasonable claim processing. The insurer contends that we did not sufficiently respond to its argument that the ALJ improperly assessed a penalty for its failure to timely pay temporary disability. The insurer also contests our determination that the opinion of claimant's attending surgeon, Dr. Mawk, was persuasive with respect to the compensability of claimant's lumbar disc conditions. Having received and considered claimant's response to the insurer's arguments, we now proceed with our reconsideration.

We first address claimant's contention regarding the penalty issue. Citing OAR 436-060-0150(1) (benefits deemed paid when addressed and deposited in the U.S. Mail), the insurer asserts that claimant failed to establish untimely payment of temporary disability by not providing any documentation to support his contention. We disagree.

While claimant did not provide any written documentation to support his contention that the insurer untimely paid temporary disability, claimant credibly testified that he was required to pick up several checks at the insurer's offices. (Tr. 25). We find that this unrebutted testimony was sufficient to establish untimely payment of temporary disability (i.e., that temporary disability checks were not deposited in the U.S. Mail). Therefore, we once again conclude that claimant satisfied his burden of proving that the insurer untimely paid temporary disability.

Finally, we have once more considered the insurer's contentions that Dr. Mawk's medical opinion was unpersuasive because of alleged bias and discrepancies in his opinion. We adhere to our conclusion that Dr. Mawk's opinion is persuasive. As we noted in our order, Dr. Mawk's opinion that claimant's compensable injury was the major contributing cause of his need for surgery was supported by Dr. Geist's testimony. Thus, we continue to conclude that claimant sustained his burden of proving that his "combined condition" is compensable under ORS 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services responding to claimant's arguments on reconsideration 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 reconsideration is $250, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's response to the insurer's arguments regarding the compensability issue), 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 August 14, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 1, 1996 Cite as 48 Van Natta 2228 (1996)

In the Matter of the Compensation of
DANA W. WOOD, Claimant
WCB Case No. 95-13608
ORDER OF ABATEMENT
Scott McNutt, Sr., Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our October 3, 1996 order that affirmed an Administrative Law Judge's (ALJ's) order which set aside its denial of claimant's occupational disease claim for an L4-5 disc condition. Contending that we erroneously found that claimant's work activities were the major contributing cause of her "combined condition," SAIF seeks reconsideration of our decision and reinstatement of its denial.

In order to further consider this matter, we withdraw our October 3, 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 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 RECONSIDERATION
Myrick, Seagraves, et al, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

On August 28, 1996, we withdrew our July 30, 1996 order which had affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside the SAIF Corporation's denial of claimant's psychological condition claim; and (2) awarded an assessed attorney fee of $7,000. We took this action in response to SAIF's announcement that the parties had reached a settlement of their dispute. The parties have now submitted a proposed "Stipulation and Disputed Claim Settlement Agreement," which is designed to resolve all issues raised or raisable between them, in lieu of all prior orders.

Pursuant to the settlement, claimant agrees that SAIF's denial, as supplemented in the agreement, "shall remain in full force and effect." The settlement further provides that claimant withdraws his hearing request. Finally, the agreement states that this "matter is dismissed with prejudice."

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DORINDA A. HOLLOWAY, Claimant
WCB Case No. 96-00463
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McKean's order that upheld the insurer's denial of claimant's left ankle injury claim. On review, the issue is compensability.

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

Claimant objects to the admission of two exhibits, both of which are copied portions of medical manuals. Claimant asserts that they were not timely disclosed before hearing and cannot be considered for substantive purposes.

At hearing, claimant's attorney objected to the admission of the exhibits. (Tr. 1-2). The ALJ stated he would reserve his ruling for a later time. (Tr. 2). Although the ALJ never explicitly ruled on claimant's objection, the exhibits are part of the record on review and the ALJ's order states that they were admitted. Thus, we understand the ALJ as having decided to admit the exhibits.

In deciding that claimant did not prove compensability, however, the ALJ did not refer to or rely on the disputed exhibits. Because the documents do not provide information concerning claimant's specific condition, we find the exhibits to have little or no relevance to the compensability issue. Thus, whether or not the ALJ abused his discretion in admitting the exhibits, we have not considered them on review.

ORDER

The ALJ's order dated May 20, 1996 is affirmed.

In the Matter of the Compensation of
CURTIS A. MILLER, Claimant
WCB Case No. 96-01875
ORDER ON REVIEW
Malagon, Moore, 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) Black's order that awarded an assessed attorney fee under ORS 656.386(1) for the insurer's "pre-hearing" acceptance of several conditions. 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

As a preliminary matter, we note that claimant's respondent's brief was rejected as untimely. Claimant moves for reconsideration of this action, alleging that the brief was untimely filed due to "scrivener's error." Specifically, claimant asserts that his counsel's assistant "posted receipt of Appellant's Brief incorrectly causing counsel's briefing schedule to reflect" an incorrect filing date. We deny claimant's motion. Lester E. Saunders, 46 Van Natta 1153, 1154 (1994) (motion to reconsider rejection of untimely filed brief denied in part because "calendaring error" which caused untimely filing did not constitute "extraordinary circumstances" under OAR 438-0011-0020(3) required for allowing extension of briefing schedule).

In December 1995, the insurer accepted a claim for "low back strain." On January 11, 1996, claimant's attorney wrote to the insurer that the Notice of Acceptance appeared "deficient" because medical evidence showed that claimant also had compensable disc herniations. Claimant's attorney asked the insurer to "expand" its acceptance to include all compensable conditions.

The insurer's claims adjuster responded by asking claimant's attorney to clarify the specific disc levels for which acceptance was requested, indicating that such information was necessary before the insurer could determine whether to change its acceptance. Claimant's attorney, citing to medical evidence, referred to a herniation at L1-2 and again asked that the acceptance be expanded.

After receiving no further correspondence from the insurer, claimant's attorney filed a request for hearing on February 21, 1996, alleging a "de facto" denial of claimant's herniation condition. On February 26, 1996, the insurer accepted an L1-2 disc herniation and, on March 5, 1996, accepted an L3-4 disc herniation.

The ALJ found that claimant's attorney had satisfied ORS 656.262(6)(d)[1] and, thus, "perfect[ed] a claim for attorney fees based on *de facto* denial with the correspondence of January 11, 1996." Apparently deciding that the "de facto" denial also qualified as a "denied claim" under ORS 656.386(1), the ALJ awarded an assessed fee for claimant's attorney's services in obtaining a pre-hearing rescission of the "de facto" denial.

Under ORS 656.386(1), a claimant's attorney is entitled to an attorney fee "in cases involving denied claim" 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

[1] The statute provides that an injured worker who believes that a condition has been incorrectly omitted from a Notice of Acceptance must first communicate in writing to the carrier any objections to the notice. The insurer has 30 days from the receipt of such communication to revise the notice or make other written clarification in response. A worker who fails to comply with the communication requirements may not allege a "de facto" denial at any hearing.

compensable or otherwise does not give rise to an entitlement to compensation." We find no "denied claim" in the absence of evidence of unpaid compensation and a refusal by the insurer to pay compensation based on a lack of causation. E.g., Michael J. Galbraith, 48 Van Natta 351 (1996). This holding is applied whether or not the claimant satisfied the requirements of ORS 656.262(6)(d). Kenneth C. Lane, 48 Van Natta 1027 (1996).

Thus, in this case, we do not find that claimant's attorney is entitled to a fee under ORS 656.386(1) because claimant complied with ORS 656.262(6)(d). Furthermore, there is no contention that any benefits have been unpaid for the two subsequently accepted disc conditions. Finally, the record does not establish that the insurer refused to pay compensation on the express ground that the additional disc conditions were not compensable or did not give rise to an entitlement to compensation. Consequently, we conclude that claimant failed to establish a "denied claim" under ORS 656.386(1) and, thus, he is not entitled to an assessed fee. Michael J. Galbraith, supra; Kenneth C. Lane, supra.

ORDER

The ALJ's order dated May 17, 1996 is reversed. The ALJ's attorney fee award is reversed.

November 4, 1996 Cite as 48 Van Natta 2232 (1996)

In the Matter of the Compensation of
DANIEL S. GRIFFITHS, Claimant
WCB Case No. 94-05901
ORDER ON RECONSIDERATION (REMANDING TO THE DIRECTOR)
Bryant, Emerson et al, Claimant Attorneys
Howes & Brown, Attorneys

On August 8, 1996, we withdrew our July 8, 1996 order that dismissed claimant's request for review and remanded this matter to the Administrative Law Judge (ALJ) to issue a corrected order (on behalf of the Director) with the proper notice of appeal rights. We took this action to reconsider this matter in conjunction with our reconsideration of our holding in Vollina Draper, 48 Van Natta 1505 (1996).

We have now issued our reconsideration order in Draper and remanded that case to the Director. Vollina Draper, on recon, 48 Van Natta 1862 (1996). Accordingly, we proceed with our reconsideration in this case.

For the reasons stated in our July 8, 1996 order, we again conclude that this matter is controlled by the court's decision in Lankford v. Copeland, 141 Or App 138 (1996). Thus, we adhere to our prior decision to dismiss claimant's request for review and remand this matter for the issuance of a corrected order with the proper notice of appeal rights in accordance with ORS 183.482 and Lankford. However, for the reasons expressed in Draper and in Cindy Lankford, 48 Van Natta 1870 (1996), we now remand this matter to the Director rather than to the ALJ (on behalf of the Director).

Accordingly, as modified herein, our July 8, 1996 Order of Dismissal (Remanding) is republished 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
CHARLENE M. RALLS, Claimant
WCB Case Nos. 96-00906 & 96-00905
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its responsibility denial of claimant's "new injury" claim for a right thumb condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's first three findings of fact with the following change. In the second paragraph on page 2 (finding # 3), we change the last sentence to read: "She sought treatment from Dr. Wiltse, who diagnosed a right thumb sprain/dislocation. (Ex. 7)."

CONCLUSIONS OF LAW AND OPINION

On April 22, 1994, claimant compensably injured her right thumb while employed by Liberty's insured. Claimant was sanding a bentwood hardwood bow on a tube sander, when the sander kicked back and struck her right thumb. (Tr. 8). Claimant sought treatment for pain and numbness from Dr. Bolz, who diagnosed a contusion, dorsum of the right thumb. (Ex. 2). Dr. Bolz also diagnosed a probable contusion of a nerve which caused numbness. (Id.) Claimant was treated with a dorsal splint and an ace bandage. On May 2, 1994, Dr. Handley diagnosed "joint pain." (Ex. 5a). Dr. Bolz reported on May 3, 1994 that claimant's contusion had resolved and she could return to work without restriction the following day. (Ex. 2). Claimant testified that her symptoms went away after two or three weeks. (Tr. 11). Liberty accepted a right thumb contusion. (Ex. 6).

In December 1994, claimant had a recurrence of right thumb and hand pain while tying Christmas wreaths at home. Claimant told Dr. Bolz her pain was identical to the injury she suffered in April 1994. (Ex. 2). Claimant also testified that the pain was of the same type and location. (Tr. 11). Dr. Bolz diagnosed probable mild tendinitis and treated claimant with an ace bandage and medication. (Ex. 2). Claimant testified that her symptoms resolved after two weeks. (Tr. 11).

On August 15, 1995, claimant was working for SAIF's insured and injured her right thumb while lifting a basket of fries. Claimant's pain was in the same location, but she had greater pain. (Tr. 12). Claimant was diagnosed with a right thumb sprain/dislocation. (Ex. 7). Claimant was initially treated with a splint for one week, a cast for three weeks, and then had physical therapy. (Ex. 7, Tr. 13). Claimant testified that she had symptoms until her last physical therapy session in February 1996. (Tr. 13).

The only issue at hearing was responsibility. The ALJ concluded that ORS 656.308(1) did not apply, reasoning that since claimant's first injury was a contusion and the second injury was a strain, the same condition was not involved. The ALJ found that the second injury at SAIF's insured was at least a material cause of claimant's need for treatment and he assigned responsibility to SAIF.

SAIF argues that the medical evidence establishes that claimant's 1994 injury and the 1995 injury both involved the same condition. Thus, SAIF asserts that ORS 656.308(1) applies and responsibility should be assigned to Liberty. Liberty contends that the 1995 injury involved conditions that were not present in the 1994 injury and, therefore, did not involve the same condition.

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. * * * 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."

To establish a new injury under ORS 656.308(1), claimant's 1995 injury 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). ORS 656.308, however, applies only if claimant's current condition is the "same condition" as that previously accepted by Liberty in 1994. See Sanford v. Balteau Standard/SAIF Corp., 140 Or App 177 (1996); Smurfit Newsprint v. DeRosset, 118 Or App 371-72, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).

Here, the critical issue is whether claimant's 1995 injury involved the "same condition" as the right thumb contusion accepted by Liberty. We conclude that, although the specific diagnoses are different, the medical opinions establish that claimant's current right thumb condition involves the "same condition" as Liberty's 1994 accepted claim.

Dr. Donahoo, an examining physician, discussed claimant's three right thumb injuries and diagnosed a symptomatic right thumb carpometacarpal joint. (Ex. 13-8). Dr. Donahoo explained:

> "The first onset was in April 1994 while operating a mechanical sander, which kicked a furniture bow back, striking the right thenar area, producing an immediate pain pattern.
>
> "The initial symptoms cleared but she subsequently has had exacerbations involving the same area, first while at home making Christmas wreaths over a weekend with a temporary exacerbation (December 1994), and then the most recent flare in August 1995, while lifting a fryer basket. She developed some radial forearm symptoms associated with the most recent episode.
>
> "Generally speaking, the symptoms have all been localized to the area of the right thumb metacarpal and have been duly recorded by the physicians who have seen her." (Id.)

We agree with SAIF that Dr. Donahoo's references to the "first onset" in April 1994, the "temporary exacerbation" in December 1994 and "the most recent flare" in August 1995 indicate that Dr. Donahoo believed that all three incidents involved the same condition. Furthermore, Dr. Donahoo commented that claimant's symptoms had all been localized to the area of the right thumb metacarpal and he described claimant's right thumb symptoms as "recurrent strains/sprains of the joint." (Ex. 13-8, -9).

Dr. Wiltse, claimant's treating physician for the 1995 injury, concurred with Dr. Donahoo's report. (Ex. 18). In a later report, Dr. Wiltse reported that "had the 1994 injury not occurred, the current problem would not exist." (Ex. 20). Dr. Wiltse agreed in substance with Dr. Donahoo's report and he concluded that claimant's August 1995 injury did not constitute a "new injury." (Id.) Dr. Wiltse's reports and his concurrence with Dr. Donahoo support the conclusion that claimant's 1994 injury and 1995 injury involved the same condition.

The only other medical opinion on causation is from Dr. Button. At the time of Dr. Button's examination, claimant had no specific pain complaints and her examination was normal. (Ex. 22-3). Dr. Button found that claimant had no "objective residuals" and he did not believe that claimant had any pathologic worsening of the original right thumb contusion. (Ex. 22-4). Dr. Button did not specifically comment as to whether claimant's 1994 injury and 1995 injury involved the same condition.

Liberty argues that all of the diagnoses related to the 1995 injury involved more than the thumb pain and numbness associated with the 1994 injury. Liberty referred to the physical therapist's notes that indicated claimant had tenderness in the right forearm and aching in the wrist. (Ex. 11A). Liberty also relies on Dr. Donahoo's report that, in connection with the August 1995 injury, claimant had "instant pain in the same spot and for the first time had pain radiating up the radial aspect of her forearm to the elbow." (Ex. 13-3).

Although claimant had forearm symptoms after the August 1995 injury, there is no evidence that those symptoms occurred at the time of the August 1995 injury. Claimant testified that she did not have any immediate symptoms in her forearm after the August 1995 injury. (Tr. 17, 22, 23). Rather, claimant's forearm pain did not occur until her cast was taken off. (Tr. 17, 23). Claimant did not know whether the fryer basket injury or the cast caused the pain in her forearm. (Tr. 23). Furthermore, Dr. Donahoo reported that claimant's forearm pain had been "at the present level since about one week after her cast was applied[.]" (Ex. 13-4). Based on claimant's testimony and Dr. Donahoo's report, we conclude that claimant did not have forearm symptoms at the time of the August 1995 injury. Rather, claimant's forearm symptoms may have been the result of the treatment for the thumb condition. Consequently, we are not persuaded by Liberty's argument that claimant's forearm symptoms establish that claimant's 1994 injury and 1995 injury did not involve the same condition.

Based on the opinion of Dr. Donahoo, as supported by Dr. Wiltse, we conclude that claimant's 1994 injury and 1995 injury involved the "same condition." Therefore, under ORS 656.308(1), Liberty is presumptively responsible for claimant's current right thumb condition. As we discussed earlier, to establish a "new injury," Liberty must establish that claimant's 1995 injury was the major contributing cause of her disability or need for medical treatment.

The medical opinions, however, do not establish that claimant's 1995 injury was the major contributing cause of her disability or need for medical treatment. To the contrary, Dr. Wiltse stated that claimant's August 1995 injury at SAIF's insured "does not constitute a new injury." (Ex. 20). Dr. Donahoo described the August 1995 incident at SAIF's insured as a "flare" of the original 1994 injury with Liberty's insured. (Ex. 13-8). Dr. Donahoo also opined that claimant's 1994 injury "appears by history to be the most significant injury she has sustained to date." (Ex. 13-9). Dr. Button commented that there had been no pathologic worsening of the original right thumb contusion. (Ex. 22-4). Since the medical evidence does not establish that claimant's 1995 injury was the major contributing cause of her disability or need for medical treatment, Liberty has not established that claimant sustained a new compensable injury in 1995. Consequently, responsibility for claimant's right thumb condition remains with Liberty. See ORS 656.308(1).

ORDER

The ALJ's order dated May 7, 1996 is reversed. The SAIF Corporation's responsibility denial of claimant's right thumb condition is reinstated and upheld. Liberty's denial of claimant's right thumb condition is set aside, and the claim is remanded to Liberty for processing according to law. The ALJ's assessed fee award of $1,000 shall be paid by Liberty, rather than SAIF.

November 5, 1996 Cite as 48 Van Natta 2235 (1996)

In the Matter of the Compensation of
VICKI L. POUNDER, Claimant
WCB Case No. 95-06471 & 95-05364
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McKean's order that awarded no scheduled permanent disability for loss of use or function of the left hand, whereas an Order on Reconsideration had awarded 5 percent (7.5 degrees). On review, the issue is extent of scheduled permanent disability.

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

Claimant requests remand to the Director for promulgation of a temporary rule to address her disability.

Claimant did not request that the Director adopt a temporary rule. Claimant also failed to request remand for this purpose at hearing. Rather, claimant's remand request is made for the first time on Board review. We do not consider issues raised for the first time on review or reconsideration. See Robert K. Warren, 47 Van Natta 1471, 1473 n.4 (1995) (citing Brian G. Vogel, 46 Van Natta 225 (1994)); see also Vogel v. Liberty Northwest Ins. Corp., 132 Or App 7, 13 (1994). Accordingly, claimant's request for remand is denied.

ORDER

The ALJ's order dated June 27, 1996 is affirmed.

November 5, 1996 Cite as 48 Van Natta 2236 (1996)

In the Matter of the Compensation of
CLIFFORD T. UPP, JR., Claimant
WCB Case No. 95-11810
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Craig A. Staples, Defense Attorney

Reviewed by Board Members Haynes and Hall.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked as a truck driver for the employer for nearly 30 years. His job requires frequent shifting of gears and tarping and untarping of loads. Claimant also experiences a constant vibration through his hands while driving. Claimant first experienced symptoms in his hands in 1992 which gradually worsened. Claimant filed a claim for bilateral carpal tunnel syndrome in June 1995 which the employer denied. Claimant requested a hearing concerning the denial.

Finding that claimant's symptoms of carpal tunnel syndrome were the disease, the ALJ reasoned that claimant only had to establish that his work activities were the major contributing cause of his symptoms, and did not have to establish that his work activities were the major contributing cause of his underlying pathology (median neuropathy).

On review, the employer asserts that Georgia Pacific Corp. v. Warren, 103 Or App 275 (1990), the case on which the ALJ based her analysis, was overruled by the 1995 amendments to the workers' compensation law. Specifically, the employer argues that claimant's median nerve neuropathy "preceded the claim" and was therefore a preexisting condition which combined with his work activities. See ORS 656.005(24); 656.005(7)(a)(B). Based on its argument that preexisting median neuropathy combined with claimant's work activities, the employer argues that, under ORS 656.802(2)(b) and 656.005(7)(a)(B), claimant must prove that his work activities were the major contributing cause of both the combined condition and the pathological worsening of the underlying neuropathy condition.

A condition precedent to application of ORS 656.005(7)(a)(B) is a factual finding that an otherwise compensable injury "combined" with a preexisting condition to cause or prolong disability or a need for treatment. See Susan A. Michl, 48 Van Natta 1752 (1996). Here, as will be explained below,

the persuasive medical evidence establishes that claimant's median neuropathy was caused by claimant's work activities. Thus, there was no preexisting condition to combine with claimant's work activities.[1]

The ALJ found the medical evidence insufficient to establish that claimant's underlying median neuropathy was compensable. We disagree with the ALJ's analysis and find that the persuasive medical evidence supports compensability of the underlying pathology (median neuropathy), as well as the carpal tunnel symptoms.

Two physicians, Dr. Goodwin, claimant's treating physician, and Dr. Jewell, an examining physician, addressed the cause of claimant's bilateral carpal tunnel syndrome.

Dr. Jewell, opined that claimant's carpal tunnel syndrome was non-specific in onset and could not be related to claimant's work activities. Specifically, although Dr. Jewell found claimant's work activities repetitious, he opined that they did not involve extreme amounts of force or ergonomics that involved flexion of the fingers and wrists. He believed that claimant's tarping activities increased his already existing carpal tunnel symptoms, but did not advance the disease process.

Dr. Goodwin, on the other hand, believed that the major contributing cause of claimant's carpal tunnel syndrome was his work activities. He opined that vibration and long exposure to driving can cause carpal tunnel syndrome. Dr. Goodwin also believed that claimant's need for treatment was caused by driving and moving tarps. Dr. Goodwin opined that the symptoms of carpal tunnel syndrome were the disease which required treatment.

After reviewing the medical opinions, we find Dr. Goodwin's opinion to be more persuasive than that of Dr. Jewell. Dr. Jewell conceded that claimant's tarping activities involved flexion of the fingers and wrist which could cause carpal tunnel syndrome. (Ex. 15-11). However, Dr. Jewell believed that claimant engaged in tarping activities for only 30 minutes a day. (Ex. 15-13). In actuality, claimant spends 2 or 3 hours a day tarping. Because we find, as did the ALJ, that Dr. Jewell had an inaccurate understanding of claimant's work activities, we find his opinion unpersuasive. Instead, we rely on Dr. Goodwin, claimant's treating physician, whose opinion is both well reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Because we have found that the median neuropathy was not a preexisting condition, claimant must prove that his work activities were the major contributing cause of the carpal tunnel syndrome and median neuropathy. ORS 656.802(2)(a). Furthermore, in light of such circumstances, it is unnecessary to resolve the question of whether the Warren holding has been legislatively overruled by ORS 656.802(2)(b), in conjunction with ORS 656.005(24), and ORS 656.005(7)(a)(B)).

Dr. Goodwin believed that claimant's driving activities and exposure to vibration at work were the major contributing cause of his carpal tunnel syndrome. He further indicated that the major contributing cause of claimant's underlying median neuropathy "probably was the work [activities] but may not have been." (Emphasis added). Based on this statement, the ALJ found that Dr. Goodwin's opinion was insufficient to establish compensability of the underlying median neuropathy. We disagree.

Although a possibility of a causal connection is insufficient to establish compensability, an opinion that rises to the level of a medical probability is sufficient. See Gormley v. SAIF, 52 Or App 1055 (1981); Spencer L. Metcalf, 48 Van Natta 1152 (1996).

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[1] The employer argues that because the median neuropathy preceded the filing of the claim, it was a preexisting condition under ORS 656.005(24). 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 a worsening under ORS 656.273."

Because the medical evidence establishes that the median neuropathy condition was caused in major part by the work activities and because there is no evidence that the condition preexisted claimant's work activities for the employer, we decline to find that the median neuropathy is a preexisting condition.

Here, Dr. Goodwin indicates that the neuropathy was probably caused in major part by the work activities. The term "probable" necessarily suggests that there is a possibility of another cause. We read Dr. Goodwin's statement that the neuropathy "may not" be related to work as suggesting that there is a possibility that the condition is not work-related. There is no requirement that causation be established to a medical certainty. Here, the evidence supports a conclusion that it is medically probable that the major contributing cause of claimant's median neuropathy was her work activities. That is all that is required. Thus, we do not find that Dr. Goodwin's acknowledgment that it was possible that the condition was not related to work detracts from his conclusion regarding what was the probable cause of the condition. Accordingly, claimant has established compensability of his carpal tunnel syndrome, including the underlying median neuropathy.

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 June 18, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the employer.

November 6, 1996 Cite as 48 Van Natta 2238 (1996)

In the Matter of the Compensation of
GUADALUPE BENETIZ, Claimant
WCB Case No. 96-02399
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order that increased claimant's unscheduled permanent disability for a shoulder condition from 5 percent (16 degrees), as awarded by an Order on Reconsideration, to 15 percent (48 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The sole issue at hearing and on review is adaptability. A Determination Order awarded 15 percent unscheduled permanent disability based on an adaptability factor of 2. The Order on Reconsideration found that adaptability was 0 and reduced the award to 5 percent.

The ALJ increased the award back to 15 percent. Specifically, based on evidence from Dr. Leicht, the treating physician, the ALJ found that claimant's Residual Functional Capacity (RFC) was medium/light and his Base Functional Capacity (BFC) was medium, resulting in an adaptability factor of 2. Former OAR 436-35-310(6). The insurer challenges the ALJ's interpretation of Dr. Leicht's opinion and argues that claimant's RFC and BFC both are medium.

Dr. Leicht reported:

> "[Claimant] is essentially able to go back to regular work but I would not recommend that he return to the 'stacker job.' Based on NIOSH data available [sic], anybody performing the 'stacker job' would be at a high risk for injury. I could not, therefore, recommend him (or anybody else for that matter) to perform that job. It did seem, however, that he would be able to perform all other aspects of his job and this seemed to be supported by his PCE." (Ex. 20).

Dr. Hendricks, who performed the closing examination, reported that claimant was capable of returning to his job-at-injury and limited duty was not necessary. (Ex. 17). Dr. Leicht concurred with the report, but referred to his objections concerning the "stacker" position. (Ex. 21). The medical arbiter, Neumann, also found that claimant could return to his job without any restrictions. (Ex. 24-6).

RFC is based on the attending physician's release or a preponderance of medical opinion. OAR 436-035-0310(5)(a), (b) (WCD. Admin. Order 96-068 (Temp)). An RFC of medium/light means that the worker can perform the full range of medium activities, but with restrictions. OAR 436-035-0310(3)(g). A worker has "restrictions" if the preponderance of medical opinion shows that the worker is permanently limited by sitting, standing or walking less than two hours at a time; precluded from working the same number of hours; or frequently performing at least two of certain specified activities. OAR 436-035-0310(3)(l).

We agree with the insurer that claimant did not prove that he has "restrictions" under the standards. Dr. Leicht objected to the "stacker" job because it carried the risk of reinjury for <u>all</u> workers, based on NIOSH data. Such a basis is not included in the standards as a "restriction." Furthermore, Dr. Leicht did not indicate that claimant was permanently limited from performing those activities that do qualify as "restrictions." To the contrary, Dr. Leicht agreed that claimant was capable of performing all work duties.

Consequently, we conclude that the preponderance of medical evidence shows that claimant's RFC is medium. Comparing this to claimant's BFC of medium results in an adaptability factor of 1. OAR 436-035-0270(4)(a), 436-035-0310(6).

The parties do not contest the remaining values of 5 percent for impairment and 5 for age and education. Multiplying the age and education value with adaptability results in a value of 5. OAR 436-35-280(6). Adding that value to the impairment value of 5 results in 10. OAR 436-35-280(7). Thus, claimant is entitled to an award of 10 percent unscheduled permanent disability.

ORDER

The ALJ's order dated June 24, 1996 is modified. In lieu of the ALJ's award and in addition to the Order on Reconsideration award of 5 percent (16 degrees), claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, for a total award of 10 percent (32 degrees) unscheduled permanent disability. Claimant's counsel's out-of-compensation attorney fee is adjusted accordingly.

In the Matter of the Compensation of
TAMMY G. COX, Claimant
WCB Case No. 95-10581
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Christian, Biehl, and Moller.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's left arm injury claim. In her brief, claimant requests 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.

The insurer argues that claimant is not credible due to inconsistencies in her reporting. Therefore, the insurer contends, we should not rely on medical evidence regarding causation which is based on that reporting. We disagree.

Claimant's work duties included assembling header packages, clean-up (moving buckets of nuts and bolts and other equipment, picking up trash), and gathering and relocating usable headers. She performed lifting in the 50-100 pound range.

Claimant had no left arm problems before this employment. On June 7, 1995, while moving hardware and "scrapping" wood at work, claimant injured her left arm. She thought she had pulled a muscle, but she kept working because it was a hectic day. A few minutes before the end of the day, she picked something up and felt a pop in her left elbow and very sharp pain to her finger tips. (Tr. 11-12).

Claimant sought treatment the next day and reported pain in the left elbow which began while she was moving hardware and "scrapping" wood. Her objective findings of injury included reduced grip strength and tenderness over the left cubital tunnel. She described her work activities and the onset of pain consistently on a "First Medical Report" that day.

On June 12, 1995, Dr. Thomas became claimant's treating physician and recorded claimant's history, continuing symptoms, and objective findings.

On August 24, 1995, examining physicians noted that claimant's symptoms were related historically to a June injury, but were unable to "physiologically explain the diffuse worsening [of] symptoms based on her description of the injury episode." (Ex. 12-5).

On October 17, 1995, Dr. Thomas opined that claimant's work activities, specifically the June injury were the major contributing cause of her current ulnar neuropathy. (Ex. 14A).

The insurer contends that claimant is not credible because she did not report the injury to the employer. However, because she sought treatment and filed a claim the next day (especially in light of the fact that she kept working despite her initial symptoms and left work just minutes after they worsened), we do not find that her failure to immediately notify the employer reflects against her credibility.

The insurer also argues that claimant is not credible because she testified that she called the employer to report her injury and that two co-workers witnessed the initial injury (or at least her response to it), but no one corroborates either contention. Again, we do not find that these alleged discrepancies of such importance to cause us to discount her credibility. But see Gloria A. Vaneekhoven, 7 Van Natta 671 (1995).

The insurer further argues that claimant is not credible because she gave conflicting stories about how and when the injury occurred. We disagree. The injury occurred while claimant was performing clean up duties. (See Exs. 1, 3, 7, 9, 16-8). We do not find the variations in claimant's reporting

regarding the particular mechanism of injury significant, especially because claimant experienced two onsets of symptoms, while performing different activities on the same day. Nor do we find claimant's apparent confusion over the exact date of injury troubling, because she sought treatment promptly the next day and exhibited objective signs of injury at that time.

In sum, the insurer relies on alleged inconsistencies and discrepancies in the record which we find "de minimis" compared with claimant's objective signs of injury (the next day) and her treating doctor's opinion regarding its cause. Under these circumstances, we agree with the ALJ that the claim is compensable.

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 $800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 26, 1995 is affirmed. For services on review, claimant is awarded an $800 attorney fee, payable by the insurer.

Board Member Moller dissenting.

The alleged injury in this case was unwitnessed and the claim is utterly uncorroborated.[1] Claimant's descriptions of material matters varied remarkably over time. Her alleged reporting of the injury to the employer is refuted by the record and her symptoms have been either "vague and diffuse" or notably exaggerated. Considering these glaring discrepancies, I am convinced that the claim is not compensable.

Claimant worked for the employer about 6 months before filing this claim. Her prior work history involved a variety of employments lasting from one month to one year. (Ex. 16-3-6; see Ex. 8). She filed at least one previous workers' compensation claim involving her right upper extremity for "basically the same type of [injury]" as this one. (Ex. 16-15-17).

The father of claimant's child also had a prior worker's compensation claim and treated with Dr. Thomas, claimant's current treating physician. Shortly before the date of the alleged onset of claimant's left arm symptoms, the father of claimant's child was fired by the employer and claimant left the work site with him, even though it was a work day for her and her supervisor told her not to leave. (Tr. 22-24; 32-33). On approximately June 8, 1995, claimant attended a safety meeting at work and learned that there would be lay-offs among employees. After the meeting, claimant "was nowhere to be found." (Tr. 33). She did not return to work thereafter, except to pick up her paycheck on June 15.

Claimant testified that she reported the injury by speaking over the telephone to Mrs. Peterson at the employer's main office on June 8, 1995, after leaving a message on the employer's answering machine. (Tr. 15-16). Mrs. Peterson denied talking with claimant that morning or receiving a recorded message from her. (Tr. 45-46). Mrs. Peterson's denial is supported by claimant's recorded statement wherein she mentioned only leaving a message on the machine and talking to Mike Hite, her immediate supervisor, days later. (Ex. 16-7).

Claimant described her alleged injury many different ways at different times. She told the emergency room doctor that she injured herself moving equipment; she told her physician that she did it picking up heavy pieces of wood; she told her physical therapist that it happened when she was moving boxes of nuts and bolts; once she said that she injured herself picking up a 2 X 4; another time she stated that she did it while moving, carrying, and stacking 50 pound boxes of nails.

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[1] In her statement to the insurer, claimant reported that co-worker Dickinson actually witnessed the injurious work incident. (Ex. 16-22). At hearing, Dickinson testified that he first learned of the alleged incident one week later. (Tr. 40).

Claimant's reported symptoms have been consistently described as exaggerated. She testified that her left elbow was visibly swollen, but the emergency room physician who examined her on June 8, 1995 expressly stated that there was no swelling. (Exs. 1, 2). Although claimant testified graphically regarding the immediate onset of symptoms at work ("it felt like someone was sticking nails into my elbow all the way down into my fingertips"), the emergency room examiner more contemporaneously reported claimant's history that her arm was not too painful until the next morning when she developed "sharp pain." Dr. Noall felt that his entire examination was "unreliable due to inconsistencies and nonphysiological responses." (Ex. 12-4). Dr. Gambee concurred with Dr. Noall's report and Dr. Thomas (treating physician) agreed "with the majority of" Dr. Noall's findings. (Exs. 14, 15). Even claimant's physical therapist recorded claimant's recounting of "uncontrollable movement or 'spasms' in the whole [left] arm" and noted that claimant had exaggerated response to strength testing throughout the upper extremity." (Ex. 6; see Ex. 7-1 "exaggerated response of pain").

Claimant testified, apparently describing Dr. Gambee's EMG testing, that "the second shot almost sent me through the window." (Tr. 13). In contrast, Dr. Gambee summarized his view of claimant's condition: "This patient has a rather vague and diffuse pain complaints involving her left upper extremity. . . Her vague history and functional presentation makes [sic] it difficult to clarify the overall picture here." (Ex. 10-1).

My doubts about this claim are further compounded because the only expert evidence supporting the claim is expressly based on claimant's history regarding her injury. I fail to see how such evidence could be persuasive when claimant has told so many stories and no one corroborates any of them. Considering the abject inconsistencies in claimant's reporting, the utter lack of corroboration of any sort, and the "coincidences" among claimant's personal circumstances and her left arm problems, I would find that claimant is not a reliable historian and the medical evidence based on her reporting is not persuasive. Under these circumstances, I must respectfully dissent.

In the Matter of the Compensation of
ROGER HAGEN, Claimant
WCB Case No. 95-09523
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Biehl, Christian and Moller.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) found claimant's low back claim was not prematurely closed; (2) found that claimant did not properly raise the issue of permanent total disability; and (3) affirmed the Order on Reconsideration award of 25 percent (80 degrees) unscheduled permanent disability for a low back condition. On review, the issues are premature closure, extent of unscheduled permanent disability and permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We change the fifth full paragraph on page 2 to reflect that claimant's claim was closed as of October 14, 1994, rather than November 14, 1994. (Ex. 89). We also change the last sentence in the first paragraph on page 3 to read: "The order awarded claimant 25 percent unscheduled disability and 14 percent (21 degrees) scheduled disability for loss of function of the left leg." (Ex. 100). We do not adopt the last four paragraphs of the findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on February 27, 1992. Claimant had surgery to correct a disc protrusion at L5-S1. (Ex. 22). The claim was initially closed in January 1993 with an award of 25 percent unscheduled permanent disability. (Ex. 47). On April 27, 1994, Dr. Wayson operated to correct a recurrent herniation at L5-S1. (Ex. 64). The claim was closed by a Determination

Order issued December 14, 1994, which found claimant medically stationary as of October 14, 1994. (Ex. 89). Claimant was awarded 28 percent unscheduled permanent disability.

Claimant requested reconsideration, challenging the medically stationary date and requesting an increase in permanent partial disability. (Ex. 96A). An Order on Reconsideration issued July 7, 1995, awarding 25 percent (80 degrees) unscheduled disability and 14 percent (21 degrees) scheduled disability for loss of function of the left leg. (Ex. 100).

The ALJ affirmed the July 7, 1995 Order on Reconsideration, which found that claimant's condition was medically stationary as of October 14, 1994.[1] Claimant contends that the claim was prematurely closed because the attending physician had not declared claimant to be medically stationary on October 14, 1994.

"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, 54 Or App 624 (1981).[2]

After the April 27, 1994 surgery, claimant initially did quite well and had good resolution of leg pain. (Ex. 66). Claimant began physical therapy on June 9, 1994. (Ex. 68). In June 1994, Dr. Wayson projected that claimant would be able to participate in light duty work by August 1, 1994. (Ex. 69). On June 27, 1994, claimant's physical therapist reported that claimant had experienced minimal relief from therapy. It was suggested that claimant might benefit from 4 to 6 sessions of lumbar traction. (Ex. 71). On July 21, 1994, Dr. Wayson reported that claimant was continuing to have pain and could be a candidate for an epidural steroid injection. (Ex. 74). Dr. Wayson deferred completion of a job analysis for claimant.

On August 1, 1994, Dr. Wayson reported that claimant continued to have back and leg pain and claimant was not ready to return to light duty. (Ex. 76). On the same date, Dr. Wayson reported that claimant had not responded well to surgery. (Ex. 75). Although claimant initially had a good resolution of his leg and back symptoms, Dr. Wayson reported that claimant had "actually suffered a reversal and is having increasing back and leg pain." (Id.) Dr. Wayson could not find evidence of a recurrent disc and was at a loss to explain his symptoms. Dr. Wayson referred claimant to Dr. Andersen, physiatrist, to see if he had "any further suggestion as far as therapies." (Id.)

On August 25, 1994, Dr. Andersen placed claimant on the "subacute back protocol" in outpatient physical therapy because he did not believe claimant would tolerate the work hardening program. (Ex. 77). According to a September 14, 1994 physical capacity evaluation, claimant did not demonstrate the ability to perform either the "initial grinder set up operator" job or the "factory clerk" position. (Ex. 78). On September 16, 1994, Dr. Andersen reported that claimant had experienced a worsening of symptoms in physical therapy. (Ex. 80). Dr. Andersen commented that claimant's physical capacity evaluation was in the "[l]ight-medium physical demand range" and the inclinometer range of motion measurement appeared nonvalid to the examining therapist. (Id.) Dr. Andersen referred the claim for a disability evaluation.

On October 10, 1994, Dr. Wayson reported:

> "Based on the physical capacity evaluation of 9-14-94 it would appear that [claimant] is not capable of performing either of the two job tasks described. I believe we ought to await Dr. Lorish's evaluation before proceeding further for some recommendation for retraining. It is very possible that in the interim he will have improved enough that Dr. Lorish will feel that he will be able to return to his previous level of employment. I am sorry to be so vague at this point but I would really defer to Dr. Andersen and Dr. Lorish's evaluation of physical capabilities." (Ex. 82; emphasis added).

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[1] Although the ALJ's conclusions referred to the closure date as October 14, 1995, it is clear from the record that the correct date was October 14, 1994. (Exs. 89, 99, 100).

[2] Although claimant refers to new rules adopted by the Department that restrict the "medically stationary" status determination to the attending physician, or with the attending physician's concurrence, those rules were not effective until January 1, 1995. See OAR 436-30-020(2) and 436-30-035(5) (WCD Admin Order 94-059).

On October 14, 1994, Dr. Lorish examined claimant "solely for the purpose of a closing examination." (Ex. 83). Dr. Lorish commented that it was his "understanding that Dr. Andersen and Dr. Wayson believe him to be medically stationary at this point." (Id.) In his "recommendation," Dr. Lorish said "given that Drs. Wayson and Andersen feel the patient to be medically stationary, the patient's claim should be closed using the above ranges of motion." (Id.) The claim was closed by a Determination Order issued December 14, 1994, which found claimant medically stationary as of October 14, 1994. (Ex. 89).

The July 7, 1995 Order on Reconsideration affirmed the medically stationary date. The worksheet attached to the July 7, 1995 Order on Reconsideration indicated that Dr. Lorish had stated that Dr. Wayson and Dr. Andersen had determined that claimant was medically stationary and the claim should be closed. (Ex. 99). The insurer asserts that Dr. Lorish did, in fact, declare claimant medically stationary. We disagree.

Although "magic words" are not necessary, Austin v. SAIF, 48 Or App 7, 12 (1980), the record must be sufficient to conclude that the preponderance of the medical opinion finds claimant 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). The medical reports in this case do not satisfy that standard.

Dr. Lorish's report stated that he examined claimant "solely for the purpose of a closing examination." (Ex. 83). There is no indication that Dr. Lorish examined claimant to determine whether he was medically stationary. Although Dr. Lorish said that he understood that Dr. Andersen and Dr. Wayson believed claimant was medically stationary as of October 14, 1994, there are no reports from Dr. Andersen or Dr. Wayson to establish that fact. To the contrary, we conclude that the reports from Drs. Wayson and Andersen establish that claimant was not medically stationary on October 14, 1994.

On October 10, 1994, four days before the alleged "medically stationary" date, Dr. Wayson reported that he planned to await Dr. Lorish's evaluation before recommending any retraining and he said "[i]t is very possible that in the interim [claimant] will have improved enough that Dr. Lorish will feel that he will be able to return to his previous level of employment." (Ex. 82). Although claimant's strength level at his job at injury was "medium," (Ex. 30), Dr. Andersen's September 16, 1994 report indicated that claimant's physical capacity evaluation was in the "[l]ight-medium physical demand range." (Ex. 80). Thus, Dr. Wayson's comment that it was "very possible" claimant could improve and return to his "previous level of employment" indicates that further material improvement could be expected. Although the insurer argues that Dr. Wayson deferred to the opinions of other physicians, Dr. Wayson said that he deferred to the opinions of Drs. Andersen and Lorish concerning "evaluation of physical capabilities." (Ex. 82). There is no indication from Dr. Wayson that he deferred to the opinions of other physicians as to whether claimant was medically stationary.

Based on Dr. Wayson's October 10, 1994 report, we conclude that he anticipated that either further treatment or the passage of time was expected to materially improve claimant's condition and, therefore, claimant's low back condition was not medically stationary. Our conclusion is supported by Dr. Andersen's comment on September 16, 1994 that claimant's symptoms had worsened in physical therapy. (Ex. 80). Accordingly, the Determination Order and the Order on Reconsideration are set aside as premature.[3]

We have found that claimant's claim was prematurely closed. Inasmuch as our finding may result in increased temporary benefits, we conclude that claimant's counsel is entitled to an attorney fee payable from this increased compensation. ORS 656.386(2); OAR 438-015-0055. Consequently, claimant's counsel is entitled to 25 percent of the increased temporary disability benefits resulting from this order, not to exceed $3,800, payable directly to claimant's counsel.

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[3] Our decision on the premature closure issue renders moot claimant's arguments regarding permanent total disability and, alternatively, the rate of scheduled permanent disability and the extent of unscheduled permanent disability.

ORDER

The ALJ's order dated January 16, 1996 is reversed. The December 14, 1994 Determination Order and July 7, 1995 Order on Reconsideration are set aside as prematurely issued. The claim is remanded to the insurer for processing according to law. Claimant's counsel is awarded 25 percent of the increased compensation resulting from this order, not to exceed $3,800, payable directly to claimant's counsel.

Board Member Moller dissenting.

The majority concludes that, based on Dr. Wayson's October 10, 1994 report, claimant's low back condition was not medically stationary on October 14, 1994. Because I believe that the majority's reasoning improperly places the burden of proof on the employer to establish that claimant was indeed medically stationary, I dissent.

The only evidence that could support the majority's conclusion that claimant was not medically stationary is Dr. Wayson's October 10, 1994 statement that it was "very possible that in the interim [prior to seeing Dr. Lorish for a disability evaluation] he will have improved enough that Dr. Lorish will feel that he will be able to return to his previous level of employment. I am sorry to be so vague at this point but I would really defer to Dr. Andersen and Dr. Lorish's evaluation of physical capabilities." (Ex. 82). Dr. Wayson's statement is cast in such uncertain terms that it is difficult to even consider it in support of the majority's conclusion.

In any event, the interim period of possible improvement of which Dr. Wayson spoke turned out to be four days. Further, when claimant was evaluated by Dr. Lorish four days later, it was for purposes of a closing disability evaluation. There was no indication in Dr. Lorish's evaluation of either actual improvement during the four-day interval or of a reasonable expectation of future improvement. In addition, neither Dr. Lorish, nor Dr. Wayson four days earlier, recommended any further medical treatment.

The majority makes much of the fact that Dr. Lorish mistakenly understood that claimant had been found to be medically stationary by Drs. Wayson and Andersen. However, as the majority acknowledges, it is claimant's burden to establish that he was not medically stationary on October 14, 1994; it is not the employer's burden to establish that he was, in fact, medically stationary. Although mistaken, Dr. Lorish's belief that Drs. Wayson and Andersen had found claimant to be medically stationary does not support a conclusion that claimant was not medically stationary.

The majority also finds support for its conclusion in Dr. Andersen's September 16, 1994 notation that claimant's symptoms had worsened in physical therapy. That notation does not support a nonmedically stationary finding. To the contrary, the fact that claimant's condition worsened, rather than improved, with prescribed treatment suggests, if anything, that claimant was medically stationary. Moreover, when Dr. Andersen next examined claimant less than one month after closure, he reported "there is little to recommend in terms of medication, therefore, [claimant] may have to simply live with his symptoms. I do not feel that physical therapy or any other treatment will produce much in the way of lasting relief." The record contains no indication of any change in claimant's condition between October 14, 1994 and Dr. Andersen's subsequent examination less than one month later. See Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987) (it is appropriate to consider post-closure medical reports if there is no post-closure change in claimant's condition and the only question is whether claimant was medically stationary at the time of closure). Therefore, contrary to the majority's conclusion, Dr. Andersen's opinion actually supports the October 14, 1994 medically stationary date.

Under ORS 656.005(17), an injured worker is considered medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. Here, claimant has not met his burden of proving there was a reasonable expectation of further material improvement. Therefore, I would affirm the ALJ's decision that claimant is medically stationary and proceed to address the extent of claimant's disability.

In the Matter of the Compensation of
MARGARET HOKE, Claimant
WCB Case No. C602921
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Gatti, et al, Claimant Attorneys
Liberty NW Ins. Corp., Insurance Carrier

Reviewed by Board Member Moller and Hall.

On October 23, 1996, the Board received the parties' claim disposition agreement (CDA). Pursuant to that agreement, in consideration 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.

The CDA indicates that the claim is in open status and that claimant is releasing her rights to permanent disability benefits. However, the agreement further provides:

> "The total amount of permanent disability benefits awarded on the claim is 0 percent permanent partial disability. The parties acknowledge that this claim has been submitted to the Department for closure. However, the consideration contained in this agreement was based upon claimant receiving no award of permanent partial disability. The parties therefore agree that should an award of permanent partial disability issue before the effective date of this agreement, that the agreement shall be void and subject to withdrawal by either party."

Based on its language, the CDA will be void if the Department issues a Determination Order (DO) awarding permanent disability prior to approval of the CDA by the Board. Ordinarily, we would disapprove a CDA, such as this one, which is subject to the occurrence of a future uncertain event. See Lynda J. Thomas, 45 Van Natta 894, 895 (1993); James J. Treml, 42 Van Natta 2594 (1990). Moreover, since the uncertain even which could result in the "withdrawal" of the CDA could conceivably occur more than 30 days from the date of submission of the CDA to the Board, such a provision could potentially conflict with ORS 656.236(1)(a)(C) (which authorizes Board disapproval of a CDA if a party seeks disapproval within 30 days of the CDA's submission).

Here, although the CDA is contingent on a future event, we find that it is not possible for the event, (issuance of a DO while approval of the CDA is pending), to occur. Thus, we find the points and authorities cited above to be distinguishable. We reach this conclusion because under ORS 656.236(1) "all other proceedings and payment obligations, except for medical services" on the claim are stayed by submission of the CDA. Thus, although the parties have submitted the claim to the Department for closure, the submission of the CDA has stayed the determination of claimant's permanent disability in this claim by the Department.[1] Under such circumstances, we consider the language in the CDA, which renders it contingent on the non-occurrence of a future event, to be harmless and ineffective.

Finally, we may only disapprove a CDA if it is unreasonable as a matter of law, if it is the result of an intentional misrepresentation, or if a party requests disapproval within 30 days of its submission. ORS 656.236(1)(a)(A),(B) and (C). There is no evidence of an intentional misrepresentation and no party has requested disapproval. Moreover, we do not find the CDA, in which claimant receives $5,500 for releasing her rights to workers' compensation benefits, to be unreasonable as a matter of law. Thus, we find no statutory basis for disapproving the CDA. Accordingly, because the parties' CDA is in accordance with the terms and conditions prescribed by the Board, we approve the disposition.

IT IS SO ORDERED.

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[1] We note that, on October 29, 1996, the Department wrote the parties explaining that processing of the request for claim determination was stayed under ORS 656.236(1) pending final disposition of the CDA.

In the Matter of the Compensation of
JOSEPH C. HUNT, Claimant
WCB Case No. 96-02117
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Black's order that awarded a penalty based on its allegedly unreasonable failure to pay scheduled permanent disability awarded by a reconsideration order. On review, the issue is penalties. We reverse.

FINDINGS OF FACT

SAIF closed claimant's left knee injury claim with a November 9, 1995 Notice of Closure which awarded 11 percent scheduled permanent disability (worth $5,733.92) for loss of use or function of the left knee. Claimant requested reconsideration.

A February 27, 1996 reconsideration order awarded claimant 15 percent scheduled permanent disability for claimant's right knee (worth $7,818.98) and stated: "This amount is in addition to that awarded by Notice of Closure dated Nov. 9, 1995." The order also provided: "Deduction of overpaid temporary disability and/or previously paid permanent disability from any unpaid permanent disability is approved in accordance with the law."

Claimant requested a hearing on February 29, 1996.

On March 1, 1996, the Department issued an amended order indicating that "the new total scheduled [award] is 15 percent for the left knee/leg."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the Department's March 1, 1996 amended order was ineffective because jurisdiction over this matter passed to the Hearings Division when claimant requested a hearing on February 29, 1996. The ALJ further found that SAIF's failure to request a hearing concerning the substance of the order was unreasonable. Finally, the ALJ assessed a penalty in the amount of 25 percent of claimant's 15 percent permanent disability award.

SAIF argues that, even if its conduct was otherwise unreasonable, claimant's compensation was timely paid. We agree and reverse the ALJ's penalty assessment.

Claimant does not contend that SAIF failed to timely pay the 11 percent scheduled permanent disability awarded by the Notice of Closure. Nor does he dispute SAIF's assertion that the additional 4 percent (for a total of 15 percent) scheduled permanent disability awarded on reconsideration was timely paid. (See Ex. 15). Under these circumstances, we find no delay or refusal to pay compensation. See ORS 656.262(11)(a). We further find no "amounts then due" upon which a penalty might be based.[1]

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[1] We note the following errors in the reconsideration order. First, the order directed SAIF to pay an award for claimant's uninjured right knee, rather than his injured left knee. Second, although the order acknowledged that claimant's total scheduled award to date was 15 percent, it also directed SAIF to pay $7,818.98 "in addition to that awarded by Notice of Closure dated November 9, 1995."

At least two aspects of the order are irreconcilable: (1) that the "total award to date" is 15 percent; and (2) the directive to pay $7,818.98 in addition to that awarded by the Notice of Closure. On one hand, payment of $7,818,98 would raise claimant's total award to 26 percent, rather than 15 percent. On the other hand, payment of only 4 percent, for a total paid of 15 percent, would not amount to $7,818.98. Considering these inconsistencies, we are not persuaded by claimant's apparent contention that the amount due under the order was $7,818.98.

We further note that the order expressly provided for offset of previously paid permanent disability, which, in this case was $5,733.92 (paid pursuant to the Notice of Closure). When this previously paid permanent disability was subtracted from the total award to date (15 percent), as authorized, the amount due under the order was 4 percent (worth $2,085.06). SAIF timely paid this additional permanent disability compensation after the order on reconsideration. (Ex. 15). Consequently, we find no "amounts then due" under this claim.

See id.; Gene G. Martin, on recon, 45 Van Natta 2446 (1993); Jeffrey D. Dennis, 43 Van Natta 857 (1991). Accordingly, the ALJ's penalty assessment is reversed.

ORDER

The ALJ's order dated June 20, 1996 is reversed in part and affirmed in part. That portion of the order that directed the SAIF Corporation to pay a penalty is reversed. The remainder of the order is affirmed.

November 6, 1996 Cite as 48 Van Natta 2248 (1996)

In the Matter of the Compensation of
EARNEST E. LASLEY, Claimant
WCB Case No. 94-03312
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to admit evidence which was not submitted at the Department's reconsideration proceeding; (2) declined to grant permanent total disability benefits; and (3) awarded 33 percent (49.5 degrees) scheduled permanent disability for the loss of use or function of the left leg. On review, the issues are the ALJ's evidentiary ruling, permanent total disability, and extent of scheduled permanent disability.

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

On review, claimant contends that the ALJ erred in refusing to admit evidence at hearing that was not submitted on reconsideration pursuant to amended ORS 656.283(7). Claimant argues that retroactive application of amended ORS 656.283(7) to this case would: (1) produce an absurd or unjust result; (2) deny him due process guaranteed by Article I, section 10 of the Oregon Constitution and the Fourteenth Amendment of the United States Constitution; and (3) violate his statutory right under ORS 656.287(1) to present vocational evidence regarding his loss of earning capacity. We do not need to address claimant's challenge to the ALJ's evidentiary ruling because we conclude that admission and consideration of the excluded evidence would not change the result in this case.

Permanent Total Disability

The ALJ declined to grant claimant permanent total disability, finding that he did not carry his burden of proving he is willing to seek employment or that he has made reasonable efforts to obtain employment. See ORS 656.206(3). Claimant argues on review that it would have been futile for him to look for work. We disagree.

In 1989, despite attending physician Dr. Dahlin's opinion that claimant was physically capable of light to sedentary employment, claimant did not cooperate in the development of a return-to-work plan. At that time, claimant's vocational rehabilitation consultant was attempting to identify suitable employment within claimant's physical capabilities. However, because of claimant's non-cooperation, his eligibility for vocational assistance was terminated in June 1989. (Exs. 70-75). The termination of vocational assistance was ultimately affirmed on appeal. (Exs. 83, 87, 102).

In July 1991, claimant was examined by Drs. Smith and Logan at the SAIF Corporation's request. They opined that he was 80 percent disabled in terms of employment capabilities but that he was capable of sedentary work. (Ex. 110-6). Dr. Dahlin concurred with their opinion. (Ex. 112). Notwithstanding medical opinion that claimant was capable of performing sedentary work, there is no evidence that claimant made any efforts to obtain employment or that he otherwise demonstrated a willingness to find work.

Claimant relies on the opinion of Dr. Carroll, his current family physician, who stated in February 1995 that claimant will never be able to perform gainful employment due to his physical pain and related depression. (Ex. 148). Dr. Dahlin subsequently concurred with Dr. Carroll's assessment. (Ex. 149). In addition, claimant relies on his own testimony and the testimonies of his wife and vocational expert, Mr. Hughes, who opined that claimant is unable to engage in gainful employment due to his physical limitations and psychological difficulties. (Tr. 77-78). Mr. Hughes also opined that claimant was not employable in 1993. (Tr. 78).

Notwithstanding the medical opinions declaring claimant unemployable in 1995 (and in 1993), we find that claimant was not medically incapacitated from obtaining and performing work in 1989 and 1991. We base our finding on the contemporaneous opinions of Dr. Dahlin, who reported that claimant was capable of light to sedentary employment in 1989 and capable of sedentary employment in 1991. (Exs. 70, 112). Yet, claimant did not cooperate with the development of a return-to-work plan in 1989, resulting in termination of vocational assistance and potential retraining, and there is no evidence that he has made any further efforts to obtain employment.

For these reasons, even if we considered the evidence excluded by the ALJ, we would still find that claimant has not carried his burden of proving that he is willing to seek employment and that he has made reasonable efforts to obtain employment. Accordingly, we agree with the ALJ that claimant is not entitled to permanent total disability benefits.

Scheduled Permanent Partial Disability

Claimant requests an additional scheduled permanent disability award for the loss of use or function of the left leg, in addition to the 33 percent awarded by the Department and the ALJ.[1] He argues that the November 24, 1992 report by Drs. Rich and Donahoo, with which Dr. Dahlin concurred, (Exs. 127-7, 131), sets forth objective evidence of motor weakness in the left leg conforming to chronic L5 and S1 radiculopathy. He therefore requests 37 percent and 20 percent awards for losses of strength involving the L5 and S1 nerve roots, respectively. See former OAR 436-35-230(8).

The additional awards sought by claimant would reflect a total loss of muscle strength involving the L5 and S1 nerve roots. See id. However, we find no medical evidence to prove that claimant has suffered such permanent, total losses of strength. Drs. Rich and Donahoo found partial losses of muscle strength in the left leg, (Ex. 127-7), but we find no objective medical evidence that those partial losses amounted to more than 90 percent loss of strength involving the L5 nerve root.[2] Therefore, we conclude claimant has not carried his burden of proving his entitlement to an additional award for loss of strength in the left leg.

Finally, claimant argues that he is entitled to a 5 percent scheduled permanent disability award because the compensable injury rendered him unable to repetitively use the left leg due to a chronic and permanent medical condition. See former OAR 436-35-010(6). The "chronic condition" rule requires medical evidence of at least a partial loss of ability to repetitively use the injured body part. Donald E. Lowry, 45 Van Natta 1452 (1993). Here, we find insufficient medical evidence to prove a partial loss of ability to repetitively use the left leg. Therefore, claimant has not carried his burden of proof.

ORDER

The ALJ's order dated March 11, 1996 is affirmed.

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[1] The Department and ALJ awarded 33 percent scheduled permanent disability based on strength loss in the left leg, (1/5 (or 90 percent) weakness involving the L5 nerve root). (Ex.133-2). See former OAR 436-35-007(14)(a), 436-35-230(8) (WCD Admin. Order 6-1992, as amended by WCD Admin. Order 17-1992).

[2] Although there is objective medical evidence of sensory loss involving the L5 and S1 nerve roots, (Ex. 127-7), such findings are not ratable because they do not affect the plantar aspects of the feet. See former OAR 436-35-230(1).

In the Matter of the Compensation of
DAVID R. LUCAS, Claimant
WCB Case No. 95-01737
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall, Christian and Moller.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact except that we modify the ALJ's first paragraph on page 2 of the order. Instead, we find that the product that fell from the pallet consisted at least partially, if not entirely, of canned goods.

CONCLUSIONS OF LAW AND OPINION

On February 13, 1994, while unloading freight, some product fell from a pallet against claimant, pushing him forward and pinning him against another pallet of product. The employer accepted a claim for left knee contusion.

In December 1994, claimant made a claim for his low back on the basis that his condition also was caused by the February 1994 industrial accident. Eventually, claimant underwent surgery for a disc herniation.

The ALJ concluded that the medical evidence supporting causation was sufficiently persuasive to carry claimant's burden of proof. The employer challenges this conclusion, contending that claimant did not prove compensability.

Dr. Collison, claimant's treating chiropractor, indicated that the February 1994 pallet incident was the major contributing cause of claimant's herniated disc. (Exs. 59, 60-45). Dr. Collison found the event to be the most likely cause because it was the most proximal event that could have caused trauma to claimant's low back. (Ex. 60-5). Although acknowledging that he had treated claimant's low back before February 1994, Dr. Collison found that such pain was not evidence of a disc herniation because he had treated an area of the low back that was not related to a disc. (Id. at 49, 58).

Dr. Manley, claimant's family physician, treated claimant's left knee injury. Although Dr. Manley initially indicated that the February 1994 incident did not cause claimant's low back condition (Ex. 57), during a deposition, Dr. Manley stated that the event was the major contributing cause of the herniated disc, (Ex. 61-16). Dr. Manley agreed with Dr. Collison that the low back treatment before February 1994 likely was unrelated to a herniated disc. (Id. at 18). Dr. Manley considered the February 1994 event to be a "significant incident" because it involved an amount of weight that fell on claimant's legs and low back. (Id. at 31, 33). Because the only other significant event involving claimant's low back was too remote in time, Dr. Manley found that the pallet accident caused the low back condition. (Id. at 35, 37).

The remaining opinion is from examining orthopedic surgeon, Dr. Farris.[1] Based on claimant's medical records, Dr. Farris found that claimant "has a long history of low back complaints that go back to at least 1989." (Ex. 55-2). Dr. Farris reported that the "major contributing cause of [claimant's] low back condition and possible need for treatment is his preexisting condition and not the industrial injury[.]" (Id.)

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[1] Dr. Brett, the neurosurgeon who performed claimant's surgery, also reported that claimant's herniated disc was in major part caused by the "work injury." (Exs. 44, 45, 50). However, because Dr. Brett dated the injury as of December 1994, we conclude that he had an inaccurate understanding of the accident and, therefore, his opinion is not persuasive.

Because of the conclusory nature of Dr. Farris' opinion, we find it entitled to little weight. Somers v. SAIF, 77 Or App 259 (1986). We find the lack of explanation supporting the opinion especially fatal in view of Drs. Collison and Manley's opinions that the prior low back treatment was not related to a disc and, thus, was not proof of a herniated disc before February 1994.

Furthermore, we agree with the ALJ that the opinions of Drs. Collison and Manley carry claimant's burden of proof. Dr. Manley, in particular, demonstrated an understanding of the pallet incident that was consistent with testimony at hearing from claimant and a witness to the event. The physicians also explained the basis for their opinions. Thus, because the opinions are based on an accurate history and well-reasoned, we conclude that they are sufficiently persuasive to prove compensability. Somers v. SAIF, supra. Consequently, whether under the material or major contributing cause standard, we find that claimant carried his burden of proof.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,100, 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 his counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 9, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,100, to be paid by the self-insured employer.

Board Member Moller dissenting.

I disagree with the majority that claimant has proven compensability. An understanding of the facts is important to this case. Claimant first received treatment for his low back from Dr. Collison in 1989, when claimant was still attending high school. (Ex. 2-2). Dr. Collison again treated claimant's low back in May 1992 (after football practice), July 1993 (after a pallet fell on claimant at work), August 1993 (after a slip and fall), September 1993 (after claimant chased and caught a thief), October 1993 (after claimant fell asleep on the floor), and January 1994 (after claimant performed extensive stocking at work). (Id. at 2, 11-14, 16). In nearly all cases, claimant sought treatment within a day of the onset of pain. (Id.) This evidence shows that, prior to the alleged February 1994 work incident, claimant's low back was extensively treated, he did not delay in seeking treatment, and he sought treatment following relatively minor incidents.

The record also shows that, although he went to Dr. Manley for other problems, claimant saw only Dr. Collison for his low back. During a deposition, Dr. Manley conceded that claimant had not sought treatment from him for low back pain. (Ex. 61-30). Further, claimant testified that he considered Dr. Collison his "back doctor" and did not see Dr. Manley for back pain. (Tr. 22).

Especially in the context of claimant's prior low back treatment, claimant's behavior following February 13, 1994 simply is not consistent with having sustained a low back injury. On the Form 801, which claimant filed on February 21, 1994, claimant indicated only a left knee injury and that the "freight on the pallet fell against my legs." (Ex. 14). Claimant first went to see Dr. Manley, also on February 21, 1994, telling him that "one of the pallets somehow fell on his legs," hitting him from behind and pushing him forward. (Ex. 9-1).

Claimant did not see Dr. Collison for low back pain until March 9, 1994, when claimant also indicated that "pallets fell over onto his knee." (Ex. 2-16). Claimant did not return for further treatment until May 1994, and then he saw Dr. Collison numerous times in June and August and once in October. (Id. at 17-20). During this time, claimant also went snowboarding.

Claimant did not file his claim for the low back until December 27, 1994, following an incident at home on December 23, 1994, when claimant reached down to pick up a garden hose and experienced sudden and extreme low back pain. Within a half hour of the incident, claimant went to Dr. Collison, needing to be carried into the office because of pain. Claimant subsequently was diagnosed with a herniated disc.

I cannot agree with the majority that the herniated disc was caused by the February 13, 1994 incident. Claimant testified that the "stock from the pallet" fell on his back, with the immediate onset of pain in his left knee and back. (Tr. 20-22). This was the history that was "assumed" by Dr. Manley when he agreed that the major contributing cause of the disc herniation was the February 13, 1994 event. (Ex. 61-1, 61-16). The record amply shows, however, the inaccuracy of this history. Claimant initially told Dr. Manley and Dr. Collison that the pallet hit him only on the legs. The 801 form itself referred only to the knee.[1] Claimant waited over three weeks until he sought treatment for his low back. In view of claimant's prior practice to immediately seek treatment after the onset of back pain, I consider the delay in claimant's treatment after February to be strong evidence that he had only left knee symptoms at that time. Furthermore, claimant's treatment between March and October is entirely in keeping with his chronic and ongoing back pain before February.

Dr. Manley's opinion also lacks persuasiveness because he never treated claimant's back. Finally, Dr. Manley changed his opinion after agreeing with Dr. Farris that claimant's preexisting low back condition was the major contributing cause of his need for treatment. Dr. Manley stated in his deposition that he changed his opinion based on claimant's attorney's "different scenario" of the February incident which indicated to him that the event was significant. (Ex. 61-28). This explanation simply is not persuasive. Dr. Farris' report stated that "the pallet suddenly collapsed and fell on top of him," knocking him to the ground. This description (which also differs from claimant's testimony at hearing) is at least, if not more, "significant" than that used by claimant's attorney at the deposition, which did not include claimant being actually knocked to the ground.

I also find Dr. Collison's opinion unpersuasive. As a chiropractor, he lacks expertise to decide the cause of a disc herniation. Moreover, his opinion is conclusory. In short, his opinion is inadequate to rebut Dr. Farris' opinion that claimant's preexisting condition is the major contributing cause.

For these reasons, I would conclude that claimant did not prove compensability.

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[1] Claimant testified that he did not include the back on his first 801 because he was told by a manager that it would have a bad effect on claimant's opportunities for promotion. (Tr. at 27). Such an explanation simply is not persuasive in light of the fact that claimant has filed a claim for his left knee.

In the Matter of the Compensation of
RICK G. LUNDSTROM, Claimant
WCB Case No. 94-06455
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order which dismissed his request for hearing for lack of jurisdiction. On review, the issues are jurisdiction and penalties.

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

The ALJ dismissed claimant's hearing request regarding imposition of a penalty for the insurer's allegedly unreasonable delay in providing vocational assistance. The ALJ cited Danell L. Sweisberger, 48 Van Natta 441 (1996) (Board lacks jurisdiction to award penalties or attorney fees arising from vocational assistance matters), and Donald D. Paul, 47 Van Natta 1946 (1995) (same).

On review, claimant contends that the Hearings Division retained jurisdiction to assess a penalty because his substantive entitlement to vocational assistance was not resolved by a contested case hearing. See ORS 656.385(1)-(4). We disagree.

In Ana J. Calles, on remand 48 Van Natta 1001 (1996), we rejected the claimant's contention that the Director had not acquired jurisdiction over penalty issues arising under ORS 656.340 because there had not been a final contested case order by the Director. We reasoned that, under ORS 656.385(5), neither the Hearings Division nor the Board may award penalties or attorney fees in regard to matters arising under the review jurisdiction of the Director. Since the sole issue before the ALJ was penalties and attorney fees arising out of a vocational assistance dispute, and since review of the vocational assistance "matter" arose under the review jurisdiction of the Director, the Director likewise had exclusive jurisdiction over related penalties and attorney fees for such "matters."

The sole issue at hearing in this case involved the assessment of a penalty for the insurer's allegedly unreasonable delay in providing vocational assistance. As in Calles, no contested case hearing occurred. Therefore, as we held in Calles, the Director has exclusive jurisdiction over the penalty issue. See ORS 656.385(5).[1]

ORDER

The ALJ's order dated July 29, 1996 is affirmed.

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[1] Moreover, even if we had jurisdiction to consider a penalty issue arising out of a vocational assistance dispute such as this, these proceedings would concern solely the assessment and payment of the "additional amount." See ORS 656.262(11). Therefore, the Director would have exclusive jurisdiction over the penalty issue.

In the Matter of the Compensation of
LAVENA D. RICE, Claimant
WCB Case No. 95-01246
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for irritable bowel syndrome; (2) upheld SAIF's denial of claimant's occupational disease claim for a mental disorder; and (3) rejected claimant's constitutional and Americans With Disability Act (ADA) challenges to the amended statutes. Claimant also requests that this case be heard on oral argument, and SAIF has opposed that request. On review, the issues are constitutionality of the statutory amendments and compensability.

We adopt and affirm the ALJ's order with the following supplementation concerning claimant's ADA challenge.

As a preliminary matter, we address claimant's request for oral argument. Ordinarily, we do not entertain oral argument. OAR 438-011-0015(2). We may, however, allow oral argument where the case presents an issue of first impression which could have a substantial impact on the workers' compensation system. See OAR 438-011-0031(2); Raymond L. Mackey, 47 Van Natta 1 (1995); Jeffrey B. Trevitts, 46 Van Natta 1767 (1994). Discretion to grant such argument rests solely with the Board. OAR 438-011-0031(3).

In this case, through the evidence and argument presented at hearing and the briefs submitted on review, the parties have fully addressed the issues presented, including claimant's ADA challenge to the amended statutes. Because the parties' positions have been so thoroughly defined and briefed, we are not persuaded that oral argument would assist us in reaching our decision. Accordingly, we decline to grant the request for oral argument. See OAR 438-011-0031(3); Michael L. Wofford, 48 Van Natta 1087 (1996).

At hearing, claimant asserted that amended ORS 656.802(3) violates the ADA, because it imposes additional criteria and a higher standard of proof on a mental disorder claim than required of an accidental physical injury claim. The ALJ concluded that the Board was not the proper forum for such a challenge and that, in any event, claimant had not established standing under the Act.

On review, claimant asks that we disavow our prior orders holding that we lack jurisdiction to consider an ADA challenge. See, e.g., Sandra J. Way, 45 Van Natta 876 (1993), aff'd on other grounds, Way v. Fred Meyer, Inc., 126 Or App 343 (1994); Gary W. Benson, 48 Van Natta 1161 (1996). Claimant also argues that, contrary to the ALJ's finding, she is an individual with a disability under the terms of the ADA and therefore has standing to bring her challenge.

We adhere to our determination that the Board is not the proper forum for a claimant's ADA challenge to the workers' compensation statutes. The regulations promulgated under the ADA provide for the investigation and resolution of such complaints by designated *federal* agencies, such as the Department of Labor, or for a private court action. See 28 C.F.R. § 35.170 et seq. The Act does not, however, contemplate investigation or enforcement of the federal statute by a state administrative agency charged with carrying out workers' compensation laws.[1] Therefore, we continue to find that claimant's ADA challenge falls outside our subject matter jurisdiction.

Furthermore, even if we assumed jurisdiction, we agree with the ALJ that claimant has not established that she is "an individual with a disability" for purposes of the ADA.[2] For example, although claimant asserts that her IBS and psychological conditions substantially limit her major life activity of working, we find insufficient evidence to support this contention. Claimant has not shown that, as a result of her conditions, she is "significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person with comparable training, skills and abilities." See 29 C.F.R. 1630.2(j)(3)(i); Gary W. Benson, supra.

Finally, we note that the ADA applies only to discrimination against disabled persons as compared to non-disabled persons. See Cramer v. Florida, 885 F.Supp. 1545, 1551 (M.D.Fla. 1995). The Act does not require that all disabled persons receive equal eligibility to workers' compensation benefits regardless of the difference in each person's disability and the effect that disability may or may not have on their ability to work. Harding v. Winn-Dixie Stores, Inc., 907 F.Supp. 386 (M.D.Fla. 1995). Thus, contrary to claimant's contention, the ADA provides no remedy to claimant's charge that ORS Chapter 656 discriminates between disabled persons by favoring those with accidental physical injuries over those with occupational mental disorders.

ORDER

The ALJ's order dated May 29, 1996 is affirmed.

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[1] The Board's authority is prescribed by ORS Chapter 656. As set forth in ORS 656.726(2), we have jurisdiction over "controversies concerning a claim arising under this chapter."

[2] To establish a violation of Title II of the ADA (discrimination by a public entity), a complainant must show: (1) that he or she is a qualified individual with a disability; (2) that he or she was either excluded from participation or denied benefits of some public agency's service, programs, activities or was otherwise discriminated against by a public entity; and (3) that such exclusion, denial of benefits or discrimination was by reason of the disability. See, e.g., Tyler v. City of Manhattan, 857 F. Supp. 800 (D.Kan. 1994).

In the Matter of the Compensation of
AHMED AL-SHAMMARY, Claimant
WCB Case No. 96-02230
ORDER ON REVIEW
Michael C. Baxter, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Christian and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's current back, neck, headaches, radicular complaints, and groin condition. On review, the issue is compensability. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

On October 12, 1995, while moving large rolls of material at work, claimant experienced low back and right groin pain. On October 16, 1995, claimant sought treatment and was diagnosed with a back strain. (Ex. 2).

On October 20, 1995, claimant was examined by Dr. Pierson, M.D., who assessed right groin and back strains. (Ex. 5-1). Dr. Pierson noted intermittent radiation of pain and numbness into his legs. (Id.) Dr. Pierson found tenderness in the right groin and the low back. (Id.)

Claimant returned to Dr. Pierson on October 27, 1995. Dr. Pierson noted improvement with the low back pain, that groin pain was "minimal," and there was no radiation of pain or numbness into the extremities. (Ex. 8). When examining claimant, Dr. Pierson found that the low back continued to be tender. (Id.) Dr. Pierson assessed improving right groin and back strains. (Id.)

On November 9, 1995, claimant again returned to Dr. Pierson, who noted that claimant still had "pain, more of a soreness, in his low back when it is cold out or when he is lying down and then getting up for any period of time," along with "minor discomfort in the right groin with movement." (Ex. 10). Otherwise, Dr. Pierson noted "no other symptoms." (Id.) Dr. Pierson's examination found "some minor tenderness in the suprapubic region on the right[.]" (Id.) Dr. Pierson assessed resolving right groin and back strains and indicated that claimant should be able to return to full work status in two weeks. (Id.)

Claimant did not return for his scheduled November 28, 1995 appointment with Dr. Pierson because he had moved to Montana. After staying in Montana for several weeks, claimant went to New Jersey to live with his brother. About a month later, claimant moved to Texas and continues to reside there.

On January 9, 1996, the insurer accepted a lumbar strain condition. On February 13, 1996, claimant saw Dr. Shah, M.D., complaining of low back pain radiating into both legs, right groin pain, mid-back pain, neck pain and headaches. (Exs. 14, 18A). Dr. Shah found that neck movements caused pain and that the thoracic spine was tender. (Ex. 18A-1). Dr. Shah also found tenderness in the low back. (Id. at 2).

On February 27, 1996, the insurer issued a Notice of Closure awarding only temporary disability. On the same date, the insurer issued a denial of claimant's "current condition." In requesting a hearing, claimant challenged only the denial.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's testimony and Dr. Shah's opinion were sufficient to carry claimant's burden of proving compensability concerning his headaches and back, neck, groin, and radicular pain. The insurer asserts that Dr. Shah's opinion is not persuasive because it relies on an inaccurate history and is conclusory.

Dr. Shah reported that, as of April 25, 1996, claimant continued to have pain in the low back, mid-back, neck and right groin, as well as headaches. (Ex. 19A-1). Dr. Shah further stated that he "had these all the time." (Id.) Dr. Shah also reported that "all [of claimant's] symptoms are due to his October 12, 1995 injury" because claimant had not sustained any other injury before or after that date.

Claimant testified that his current symptoms were the same as of the date of his injury. (Tr. 12). Claimant also testified that he reported all these symptoms to Dr. Pierson. (Id. at 13).

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. Weiland v. SAIF, 64 Or App 810 (1983). We find several reasons not to defer to Dr. Shah's opinion with regard to part of claimant's condition. First, he appears to rely on an understanding that claimant's symptoms were the same from the date of injury. On October 28, 1995, Dr. Pierson expressly found no radicular symptoms. On November 9, 1995, Dr. Pierson's chartnote shows that claimant had soreness at certain times in his low back and mild pain in his right groin; otherwise, claimant had "no other symptoms." Given this evidence, we do not accept claimant's testimony that he told Dr. Pierson that he had headache's and additional pain in his neck and mid-back, as well as radicular pain and numbness into his legs. Thus, we find Dr. Shah's understanding concerning the history of claimant's symptoms in his neck, mid-back, head, and legs, as well as the headaches, to be inaccurate.

Furthermore, Dr. Shah's opinion is conclusory because he provided no explanation as to how the October 1995 injury continued to be the cause of such symptoms in April 1996. Finally, Dr. Shah did not examine claimant until February 1996, about four months after the injury. Consequently, lacking persuasive medical evidence of a causal relationship between the October 1995 injury and claimant's current mid-back, neck, legs, and headaches condition, we conclude that claimant failed to prove compensability. ORS 656.005(7)(a).

We come to a different conclusion, however, concerning claimant's current low back and groin condition. At his examination with Dr. Pierson, claimant continued to experience low back and groin pain. Thus, Dr. Shah accurately understood that the onset and continuation of such symptoms was from the date of the industrial injury. Consequently, we conclude that claimant proved compensability concerning his low back and groin. ORS 656.005(7)(a).

Because we find that claimant only partially prevailed against the denial, we modify the ALJ's attorney fee award. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the low back and groin condition issues is $1,400, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by 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 June 13, 1996 is reversed in part, modified in part and affirmed in part. The insurer's denial is reinstated and upheld with regard to claimant's current mid-back, neck, radicular leg symptoms, and headaches condition. The ALJ's attorney fee award is modified to $1,400, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOHN S. BYNUM, Claimant
WCB Case Nos. 95-07593 & 95-05420
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Ronald Atwood & Associates, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld the SAIF Corporation's denial, on behalf of The Donut Factory, of claimant's current low back condition; and (2) upheld SAIF's denial, on behalf of Gem Fuel Company, of the same condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant sustained an off-work low back injury in February 1987, for which he underwent surgery in February 1988. In September 1988, claimant underwent a second low back surgery. Claimant filed a low back injury claim while working for The Donut Factory. In November 1988, SAIF/The Donut Factory denied claimant's "current low back condition."

After a hearing in 1989, a prior ALJ found that the work injury had "worsened" claimant's preexisting lumbar condition. The prior ALJ set aside SAIF/The Donut Factory's denial in "its entirety" and remanded the claim to SAIF for processing. SAIF/The Donut Factory did not appeal that order to the Board.

In March 1990, SAIF/The Donut Factory issued a Notice of Closure that awarded 22 percent unscheduled permanent partial disability. By subsequent stipulation, SAIF awarded claimant an additional 8 percent permanent disability.

In May 1991, while working for Gem Fuel, claimant filed another claim for a back strain. SAIF/Gem Fuel accepted a lumbar strain "only." The claim was closed by Determination Order in July 1992. The Order on Reconsideration awarded 5 percent unscheduled permanent disability. That order was not appealed.

In January 1995, claimant sought treatment for increasing low back pain with left leg pain and numbness. SAIF/Gem Fuel denied that its accepted condition contributed to claimant's current condition and need for treatment. SAIF/The Donut Factory denied that its accepted condition was the major contributing cause of claimant's current condition. The ALJ concluded that neither the 1988 nor the 1991 injury was the major contributing cause of claimant's current "combined" low back condition and upheld both denials.

CONCLUSIONS OF LAW AND OPINION

Relying on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), claimant first asserts that SAIF/The Donut Factory "accepted" claimant's entire back condition and, thus, is precluded from denying compensability. In Messmer, the court held that the enactment of ORS 656.262(10)[1] did not effectively overrule its prior decision that claim preclusion barred the employer from contesting compensability of a condition because it failed to appeal a determination order which awarded permanent disability in part based on the effects of surgery for that condition. Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995).

Here, as explained above, in 1989, the prior ALJ found that, "[a]s a result of the falls claimant took [at work] in March and July of 1988, his preexisting low back condition worsened to the extent that he required medical treatment, time loss and additional surgery." The Notice of Closure award of

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[1] This statute provides in part: "Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted."

unscheduled permanent disability was for "injury to the Low Back." (Ex. 25-1). The accompanying impairment evaluation worksheet shows that spine impairment was, in part, based on claimant's two previous low back surgeries. (Ex. 24I-2). Thus, we agree with claimant that, because SAIF/The Donut Factory did not appeal the 1989 order, it is now precluded from challenging the compensability of any condition resulting from the prior surgeries. Deluxe Cabinet Works v. Messmer, supra.

Turning to the cause of claimant's current condition, we first agree with the ALJ that evaluating claimant's condition is greatly complicated by the strong evidence in the record of narcotic-seeking and narcotic-dependent behavior. The record contains numerous instances when claimant sought treatment from different physicians, at times misrepresenting his pain medication in order to obtain additional prescriptions for narcotics. (Exs. 107-1, 112, 124, 125, 128, 129).[2] Claimant has been diagnosed with polysubstance abuse and apparently he received treatment for an addiction to narcotics. (Ex. 125). As a result of such evidence, the ALJ found claimant's testimony not credible and that he was not a reliable historian.

The record contains several opinions concerning the cause of claimant's current low back condition. Examining physicians Dr. Lynch, neurosurgeon, and Dr. Powell, orthopedic surgeon, found that claimant's current condition "is a combination of perception of his level of disability and the natural progression of the pre-existing changes in his lumbar spine." (Ex. 134-9, 10).

Examining physicians Dr. Zivin and Dr. Thompson reported that claimant's "chronic recurrent low back pain" was secondary to his two previous surgeries. (Ex. 141-8). In particular, the panel found that "the previously accepted claims and resulting surgeries are the major contributing factors in his present symptomatology." (Id. at 10). The panel further noted "numerous inconsistencies in the physical examination which would suggest that there is significant psychological or psychosomatic interference with the examination." (Id. at 11).

Examining neurosurgeon Dr. Smith concluded that the cause of claimant's "current complaints are a combination of his original [1988 off-work] accident and surgery, complicated by his second surgery and actual perineural scarring." (Ex. 144-6). Dr. Smith also found that a "strong factor" was claimant's "perceived degree of impairment and his perceived risk for harm." (Id.)

Treating physician Dr. Sternfeld concurred with Dr. Smith's report. (Ex. 146). Dr. Sternfeld subsequently agreed with a "check-the-box" report stating that he was "unable to state the cause of [claimant's] low back problem." (Ex. 152-2).

We are most persuaded by Dr. Sternfeld's opinion. The panels of examining physicians did not indicate they reviewed claimant's complete medical history as of the date he began again seeking treatment in January 1995. For instance, the report from Drs. Lynch and Powell note that the "records then pick up in February 1995[]." (Ex. 134-4). Drs. Thompson and Zivin stated that there "apparently were no medical records available between 1992 and March of 1995." (Ex. 141-10). None of the reports refer to Dr. Sternfeld's diagnosis of polysubstance abuse or his chartnotes outlining claimant's narcotic-seeking behavior.

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[2] Claimant saw Dr. Petterson on February 1, 1995, and was prescribed medication; claimant was to return in two weeks. (Ex. 106). On February 9, claimant went to the emergency room of a hospital, stating that he was out of medication and requesting prescriptions for narcotics. (Ex. 107-1). Claimant also stated that he had last seen Dr. Petterson on January 19; the attending physician refused claimant's request for more medication after calling Dr. Petterson's office. (Id.)

On February 14, claimant saw consulting neurologist Dr. Issacs and asked for a refill of medication; Dr. Issacs provided a limited prescription. (Ex. 108-4). On February 15, claimant went to a different emergency room, again requesting more medication. (Ex. 112). The attending physician refused after contacting Dr. Issacs' office. (Id.)

On February 16 and 23, Dr. Petterson prescribed more medication. (Exs. 106, 116). On March 14, claimant saw Dr. Sternfeld, who also prescribed medication. (Ex. 121-1). On March 20, claimant saw Dr. Sternfeld's associate, Dr. Graham, who refused claimant's request for more narcotics. (Ex. 124). On March 21, claimant saw Dr. Sternfeld, who gave him a limited amount of medication. (Ex. 125-1).

On March 24, claimant made separate visits to consulting physician Dr. Freeman and yet another emergency room. (Exs. 128, 129). Claimant was prescribed medication at both places. (Id.) On March 29, claimant told Dr. Sternfeld that he was in "detox" for treatment of narcotic abuse. (Ex. 125).

Thus, we conclude that Dr. Sternfeld had the more complete and accurate understanding of claimant's condition. As explained above, he could not provide an opinion concerning the cause of claimant's current condition. In the absence of persuasive evidence concerning the cause of claimant's current condition, we are unable to decide that it is the same condition which SAIF/The Donut Factory is precluded from denying. Furthermore, given the lack of evidence relating claimant's current condition to his 1989 claim, we conclude that claimant failed to prove compensability.

Claimant also contends that Messmer should apply to SAIF/Gem Fuel's denial because, according to claimant, the Order on Reconsideration awarded compensation in part based on the prior surgeries. We disagree. The Order on Reconsideration awarded 5 percent unscheduled permanent disability for a chronic condition. (Ex. 100-3). That award was based on the medical arbiter's report, which specifically stated that such impairment was not related to claimant's "previous problems." (Ex. 99-3). Thus, we find no basis for concluding that the Order on Reconsideration award was related to the previous surgeries.

Furthermore, we agree with the ALJ that the preponderance of medical evidence shows that the 1991 injury is not a factor in causing claimant's current symptoms. (Exs. 134-9, 151, 152). Consequently, claimant's current low back condition is not compensably related to the 1991 injury.

ORDER

The ALJ's order dated March 29, 1996 is affirmed.

November 7, 1996 Cite as 48 Van Natta 2259 (1996)

In the Matter of the Compensation of
ATHER FRAZIER, Claimant
Own Motion No. 95-0612M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Farmers Insurance Group, Insurance Carrier

Claimant, pro se, requests review of the insurer's April 8, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from September 28, 1995 through March 19, 1996. The insurer declared claimant medically stationary as of March 19, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. Claimant further requests permanent "total disability" in this claim.

FINDINGS OF FACT

Claimant sustained a compensable left knee injury on October 4, 1979. Claimant's aggravation rights expired on April 25, 1985.

On January 24, 1996, the Board authorized the reopening of claimant's claim for the payment of temporary disability benefits, commencing the date claimant underwent surgery.

On April 8, 1996, the insurer closed claimant's claim. On October 7, 1996, the Board received claimant's request that the Board review the insurer's April 8, 1996 Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Pursuant to OAR 438-012-0060(1), claimant had 60 days from the mailing date of the insurer's Notice of Closure in which to file a request for review, or 180 days from that mailing date if he could establish "good cause" for failure to file the request within 60 days. Therefore, if claimant filed a request for review more than 60 days after the claim closure, but within 180 days, the Board would consider claimant's request if claimant could establish that he had a valid reason for not requesting review within 60 days. Further, pursuant to OAR 438-012-0055, the "notice" advising a claimant of procedures and timelines for appeals must be set forth within the insurer's Notice of Closure (form 2066).

Here, the 60th day after the mailing date of the insurer's April 8, 1996 Notice of Closure was June 7, 1996. Because claimant's request for review of his claim closure was not received by the Board

by June 7, 1996, it was filed more than 60 days after the mailing date of his Notice of Closure. Claimant's request was received on October 7, 1996, and thus, within 180 days after the insurer closed his claim. Here, claimant offers no "good cause" explanation as to why he did not request a review of the carrier's closure of his claim within 60 days. Finally, because the "Notice to Worker" is set forth in boldfaced print in the insurer's April 8, 1996 Notice of Closure in compliance with OAR 438-012-0055, we conclude that claimant was advised of the procedure for requesting a review of the insurer's closure, as well as the time limits for filing such a request for review.

Accordingly, we conclude that claimant's request for review of the insurer's April 8, 1996 Notice of Closure was untimely filed. OAR 438-012-0060.

Assuming *arguendo* that claimant's request for review was timely, we would conclude that claimant has not established that he was not medically stationary at claim closure.

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant has the burden of proof on this issue.

In a March 19, 1996 letter, Dr. Strudwick, claimant's treating physician, opined that:

> "[Claimant] has been considered permanent and stationary for his left knee injury quite some time ago. I would reiterate at this point that I do believe he is permanent and stationary. I would consider him eligible for a light duty position which would prohibit him from repetitive walking, standing, lifting, bending, squatting or stair climbing. Basically, I feel that in all medical probability he could do a sedentary job at this time. I do not anticipate that his condition will improve.
>
> "At some time in the future, as discussed in various numerous reports, [claimant] will need a total knee replacement in his left knee."

Here, Dr. Strudwick opined that claimant was medically stationary on March 19, 1996. Furthermore, Dr. Strudwick did not recommend surgery at claim closure nor did he anticipate improvement in claimant's condition. Dr. Strudwick released claimant to light duty work, and opined that claimant would require a total knee replacement in the future.

In a June 28, 1996 letter, Dr. Strudwick reiterated his opinion that claimant was "permanent and stationary." Furthermore, Dr. Strudwick again noted that he had released claimant to light duty. Finally, Dr. Strudwick opined that "[a]s I stated before, a total knee replacement is [claimant's] most viable option at this time."

Dr. Strudwick's opinion that claimant was medically stationary at claim closure is unrebutted. Dr. Strudwick did not withdraw that opinion on June 28, 1996, but, rather, opined that surgery would be a "viable option" at that point. Thus, claimant has not established that he was not medically stationary at claim closure.

Finally, claimant contends that he is entitled to "total disability" in his 1979 injury claim. We disagree. Because claimant's aggravation rights have expired, his only entitlement to future disability compensation is restricted to time loss benefits (temporary disability) under limited circumstances. ORS 656.278(1)(a). Effective January 1, 1988, the Board no longer has own motion authority to award permanent disability benefits. Independent Paper Stock v. Wincer, 100 Or App 625 (1990).

In conclusion, because claimant's request for review of the insurer's April 8, 1996 Notice of Closure was untimely filed, we do not have the authority to grant claimant's request to "review" the insurer's closure of his claim. We further lack jurisdiction to grant claimant's request for permanent disability benefits in his 1979 injury claim.

IT IS SO ORDERED.

In the Matter of the Compensation of
LEE J. JOHNSON, Claimant
WCB Case No. 93-04238
ORDER ON REMAND
Robert G. Dolton, Claimant Attorney
Cobb & Woodworth, Defense Attorneys

This case is before the Board on remand from the Court of Appeals. Reynolds Metals v. Johnson, 141 Or App 134 (1996). The court has reversed our order which reversed the Administrative Law Judge's (ALJ's) order which upheld the insurer's denial of claimant's surgery claim for his right shoulder condition. Lee J. Johnson, 47 Van Natta 763 (1995). In our prior order, we found that: (1) the insurer's prior acceptance encompassed claimant's current right shoulder condition; and (2) claimant's right shoulder surgery was reasonable and necessary. Citing Volk v. America West Airlines, 135 Or App 565 (1995), the court has remanded for reconsideration in light of the 1995 statutory amendments. Having received and considered the parties' supplemental briefs, we now proceed with our reconsideration.

FINDINGS OF FACT

We continue to adopt the ALJ's findings of fact with the one exception noted in our prior order.

CONCLUSIONS OF LAW AND OPINION

We begin by briefly summarizing the factual and procedural background of the claim. Claimant sustained a compensable injury on May 1, 1989, complaining of right hand, right shoulder, right arm and neck pain. The insurer indicated acceptance of the claim in August 1989 on the form 801, but never specified what condition(s) it had accepted.

Although Dr. Mandiberg initially provided claimant's medical treatment, claimant eventually came under the care of Dr. Ordonez, who suspected a disc protrusion at C6-7. Diagnostic studies revealed severe spondylitic changes at C5-6 and C6-7. Dr. Ordonez performed surgery to the cervical spine in November 1989. Dr. Ordonez considered additional surgery in 1990, but referred claimant instead to an orthopedic surgeon to determine whether claimant's symptoms might be due to a frozen right shoulder or tennis elbow.

The orthopedic surgeon, Dr. Harris, examined claimant on June 8, 1990. At the time, x-rays revealed severe osteoarthritis of the acromioclavicular (AC) joint with protruding osteophytes. Dr. Mandiberg reexamined claimant and later reported that claimant's symptoms were not normal for a shoulder problem. After claimant received no benefit from shoulder injections, Dr. Mandiberg concluded that there was nothing that he could do for claimant and that claimant's pain was not due to a shoulder problem.

Claimant returned to Dr. Ordonez, who recommended an anterior cervical discectomy and three-level fusion to treat cervical spondylosis at C4-5, C5-6 and C6-7. In September 1990, claimant underwent a discectomy and fusion at C5-6 and C6-7. Claimant's pain complaints persisted. Claimant underwent additional diagnostic studies and evaluations by Drs. Anderson, Harris, Puziss and Takacs. An MRI scan of the right shoulder revealed a small osteophyte impinging on the right rotator cuff tendon.

In August 1991, claimant moved to Arkansas and came under the care of Dr. Abraham. On Dr. Abraham's referral, Dr. Bowen became claimant's attending physician in December 1992. Dr. Bowen interpreted x-rays as revealing severe AC arthritis. On January 22, 1993, Dr. Bowen performed right shoulder arthroscopy, right rotator cuff debridement, an arthroscopic acromioplasty and AC joint resection. After claimant continued to report persistent symptoms in the right shoulder, Dr. Bowen opined that further shoulder surgery would not be helpful.

On April 6, 1993, the insurer denied the compensability of claimant's current right shoulder condition and January 1993 surgery. Claimant requested a hearing, contesting the denial.

Dr. Bowen reported in May 1993 that claimant had chronic pain as a result of a myofascial pain syndrome brought on by the compensable injury. Dr. Rutherford, who examined claimant on referral from Dr. Bowen in July 1993, concluded that claimant's symptoms were the result of psychological and socio-economic factors, as evidenced by his pursuit of social security disability. In a November 1993 report, Dr. Rutherford opined that claimant's complaints bore little relationship to the May 1989 injury.

Rejecting claimant's argument that his current right shoulder condition was part of his accepted claim, the ALJ upheld the denial of claimant's surgery and current right shoulder condition. The ALJ found that claimant's right shoulder symptoms were not related to his compensable injury and that his January 1993 surgery was not reasonable and necessary. Claimant requested review.

We reversed the ALJ's order. Lee J. Johnson, supra. As a factual matter, we determined that the insurer had accepted all the conditions that caused claimant's shoulder symptoms and need for treatment following the compensable 1989 injury. Based on our review of the record, we further found that claimant's current right shoulder condition was the same condition as claimant had at the time of the insurer's August 1989 acceptance. We, therefore, concluded that the insurer's April 6, 1993 denial constituted a prohibited "back-up" denial of compensability because it was issued more than two years after claim acceptance. Former ORS 656.262(6)(a). Finally, we found that claimant's shoulder surgery was reasonable and necessary treatment.

The court, however, has now remanded for reconsideration in light of the amendments to Oregon workers' compensation law contained in Senate Bill 369. Volk, supra. Having summarized the factual and procedural background of this case, we proceed with our analysis.

Subsequent to the ALJ's and our orders, the legislature amended ORS 656.327(1) and added ORS 656.245(6), each of which requires review of medical services disputes by the Director, unless a claim for medical services is denied on the basis that the underlying claim is not compensable. Or Laws 1995, ch 332, § § 41, 25. In Walter L. Keeney, 47 Van Natta 1387, 1389, recon den 47 Van Natta 1525 (1995), we concluded that these statutes apply retroactively to pending cases and that the Director now has exclusive jurisdiction over such medical services disputes. See also Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, supra.

Accordingly, we no longer have jurisdiction to decide the issue of the propriety of claimant's surgery. However, inasmuch as the insurer denied the compensability of the underlying right shoulder claim, we retain jurisdiction over the causation dispute concerning claimant's current right shoulder condition. Warren N. Bowen, 48 Van Natta 833 (1996); Richard L. Wheeler, 47 Van Natta 2011 (1995).

In our previous order, we found, as a factual matter, that claimant's current right shoulder condition is the same condition he had at the time of the insurer's 1989 acceptance.[1] Having made that determination, we concluded that the portion of the insurer's denial that denied those conditions constituted a "back-up" denial of compensability.

The 1995 legislature did not change the standard for "back-up" denials in ORS 656.262(6)(a). A carrier still has two years after the date of the initial acceptance to issue a "back-up" denial in cases, such as this, that do not involve fraud, misrepresentation or other illegal activity by the worker.

However, under amended ORS 656.245(1)(a), for "consequential and combined conditions described in ORS 656.005(7)," the insurer is required to provide only those medical services caused in major part by the compensable injury. Moreover, pursuant to amended ORS 656.262(6)(c), a carrier 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).

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[1] On further consideration of this issue, we continue to conclude that, as a factual matter, claimant's current right shoulder condition is the same condition he had when the claim was first accepted in 1989.

By its terms, ORS 656.245(1)(a) and 656.262(6)(c) apply only to situations involving a "combined or consequential condition." See James M. King, 47 Van Natta 1563(1995) (since the claimant's coronary artery disease did not combine with any other preexisting condition or disease, ORS 656.262(6)(c) did not apply); Ronald L. Ledbetter, 47 Van Natta 1461 (1995) (same with regard to the claimant's osteomyelitis condition). Under ORS 656.005(7)(a)(B), a "combined condition" exists when a compensable injury combines with a preexisting condition to cause or prolong disability or a need for treatment. A "combined condition" is compensable only if, so long as and to the extent that the otherwise compensable injury remains the major contributing cause of the disability or need for treatment of the combined condition. Under ORS 656.005(7)(a)(A), a "consequential condition" exists when an injury or disease is a consequence of a compensable injury.

The issue then becomes whether the insurer's denial was based on a "combined" or "consequential" condition. The insurer contends that claimant's current condition is the "combined and consequential result" of his original, accepted shoulder injury and degenerative changes in the shoulder and cervical spine, functional overlay and psychological factors. However, the insurer's denial was not based on either a "combined" or "consequential" condition, nor do we conclude based on our de novo review of the record that there is sufficient medical evidence of a "combined" or "consequential" condition in the record.

Claimant has been diagnosed with severe osteoarthritis in the AC joint. Dr. Takacs opined that 51 percent of claimant's shoulder problem was the underlying degenerative joint disease that was asymptomatic until claimant's compensable 1989 injury. (Ex. 83-2). Based on this evidence, we conclude that the osteoarthritis in claimant's right AC joint preexisted the compensable injury.

However, we concluded in our previous order that the insurer accepted all the conditions that caused claimant's shoulder symptoms and need for treatment after the compensable 1989 injury. This would necessarily include the preexisting osteoarthritic condition. Since claimant's osteoarthritis condition, which preexisted the compensable 1989 injury, is itself a compensable condition, it does not constitute a preexisting condition for the purposes of ORS 656.005(7)(a)(B). Ronald L. Ledbetter, supra, 47 Van Natta at 1462. Inasmuch as there is no "combined condition" for the purposes of 656.005(7)(a)(B), it follows that ORS 656.262(6)(c) and ORS 656.245(1)(a) are inapplicable.

Inasmuch as the insurer has denied a previously accepted right shoulder condition more than two years after claim acceptance, and because there was no allegation that the acceptance was induced by fraud, misrepresentation or other illegality, we again conclude that the portion of the insurer's April 1993 denial that denied the compensability of claimant's current right shoulder condition constitutes a prohibited "back-up" denial. ORS 656.262(6)(a). Thus, we continue to set aside that portion of the insurer's denial.

We now turn to the issue of claimant's attorney fee. In a case in which a claimant finally prevails in respect to any claim or award for compensation after remand from the Supreme Court, Court of Appeals or Board, the ALJ, Board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1).

Here, claimant has finally prevailed after remand on the compensability issue. After considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable attorney fee for claimant's counsel's services before the ALJ, the Board, the court and the Board on remand concerning the compensability issue is $4,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.[2]

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[2] We note that, in our prior order, we awarded claimant a $4,000 attorney fee based in part on services rendered at hearing and on review regarding the propriety of claimant's surgery. Inasmuch as that portion of the ALJ's order that addressed the reasonableness and necessity of claimant's surgery has been vacated, we have not considered claimant's counsel's services rendered at hearing or on Board/court review regarding that issue in determining the amount of claimant's attorney fee.

Accordingly, on reconsideration, the ALJ's order dated September 4, 1992 is affirmed in part, reversed in part and vacated in part. That portion which upheld the insurer's denial of claimant's surgery claim as not reasonable or necessary is vacated for lack of jurisdiction. That portion of the insurer's denial related to the current right shoulder condition is set aside and the claim is remanded to the insurer for processing in accordance with law. The remainder of the ALJ's order is affirmed. Finally, in lieu of all prior attorney fee awards, for services before prior forums and on remand from the court, claimant's attorney is awarded an attorney of $4,500, payable by the insurer.

IT IS SO ORDERED.

November 7, 1996 Cite as 48 Van Natta 2264 (1996)

In the Matter of the Compensation of
DONALD G. LASLEY, Claimant
WCB Case No. 95-13818
ORDER ON RECONSIDERATION
Bogardus & Nichols, Claimant Attorneys
Wallace & Klor, Defense Attorneys

The insurer requests reconsideration of our October 15, 1996 Order on Review which reversed an Administrative Law Judge's order upholding the insurer's partial denial of claimant's injury claim for a torn left rotator cuff. Specifically, the insurer argues that Dr. Casey's opinion is unpersuasive because it is based on an inaccurate history resulting from claimant's inconsistent reporting.

The insurer contends that claimant's original post-injury history of symptoms and treatment is inconsistent with his post-November 1995 diagnosis and "revised" history as reported to Dr. Casey and described at hearing. The insurer also asserts that the "eight month" delay between the March 16, 1995 work injury and claimant's right shoulder symptoms and treatment "seems an unconscionable gap if one were to claim his problems were traumatic in nature." (Motion for Reconsideration, p. 2). We disagree, because neither the facts nor the persuasive medical evidence support the insurer's contentions.

As we explained in our Order on Review, claimant first described periodic left shoulder pain in a pain diagram annotated for examining physicians on April 21, 1995, one month (not eight months) after the March 16, 1995 injury. (During that month, claimant's left arm was immobilized in a sling prescribed for his fractured elbow.) When claimant returned to work on April 24, 1995 (after reporting left shoulder pain on April 21), his left elbow condition improved, but his preexisting left finger and hand numbness and tingling resurfaced and increased and his left shoulder pain progressively worsened until the rotator cuff condition was diagnosed in November. We note that claimant also has a degenerative cervical (not shoulder) condition and left ulnar neuropathy symptoms. Considering these circumstances, we continue to find claimant's slightly delayed left shoulder symptoms and much delayed left shoulder diagnosis reasonably explained. Therefore, we conclude that the purported inconsistencies in this record do not reflect against the claim.

The insurer also objects to our statement that it is undisputed that the mechanism of claimant's injury is consistent with a traumatic rotator cuff tear. In this regard, the insurer relies on the opinions of Drs. Mertens and Staver. Dr. Mertens opined that claimant's rotator cuff tear is degenerative based on his experience that degeneration could cause it and because he found no indication of a traumatic tear in claimant's medical history. (Ex. 24). However, the possibility of a degenerative tear does not mean that claimant's traumatic injury is inconsistent with an injury-related tear. On the contrary, we again note that claimant's injury was traumatic enough to cause an elbow fracture and he did dangle, albeit momentarily, with all his body weight hanging from his shoulder. Moreover, as we have stated, the delay in claimant's right shoulder diagnosis is persuasively explained by the particular circumstances of this case. Thus, in our view, Dr. Martens' opinion does not support a conclusion that the mechanism of claimant's injury was inconsistent with a torn rotator cuff.

In addition, although Dr. Staver checked a box indicating concurrence with a statement that the tear was not traumatic (because shoulder symptoms were not recorded within 6 weeks), he expressly qualified that conclusion by noting that elbow examinations would not disclose shoulder problems. (Ex. 23). Dr. Staver's opinion is not particularly persuasive because it is neither internally consistent nor based on an accurate history.

Under these circumstances, we remain persuaded that the mechanism of claimant's injury was consistent with his torn left rotator cuff and we continue to find Dr. Casey's opinion persuasive, because it is well-reasoned and based on an accurate history. Consequently, based on Dr. Casey's opinion, we also continue to conclude that claimant has carried his burden of proving the compensability of his claim under ORS 656.005(7)(a).

Accordingly, our October 15, 1996 Order on Review is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 15, 1996 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 7, 1996 Cite as 48 Van Natta 2265 (1996)

In the Matter of the Compensation of
SANDRA M. MAYEA, Claimant
WCB Case No. 95-12634
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The self-insured employer requests review of Administrative Law Judge (ALJ) Baker's order which: (1) concluded that the parties' "Stipulation and Order" rescinding the employer's prior denial of claimant's low back condition barred the employer from denying responsibility for treatment of her current low back condition; and (2) set aside the employer's partial denial of claimant's current low back condition. Should we conclude that the stipulation is ambiguous, the employer requests remand to the ALJ for receipt of additional extrinsic evidence regarding the parties' intent. On review, the issue is the preclusive effect of a prior stipulation, and remand.

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

On review, the employer argues that the parties' stipulation, which was approved by a prior ALJ in October 1995, is ambiguous, and that this case should be remanded to the ALJ for receipt of additional evidence regarding the parties' intent. We disagree.

We begin with a brief summary of the facts. Claimant compensably injured her low back in 1982 while working as a grocery checker for a previous employer. She was ultimately awarded 34 percent unscheduled permanent disability for that injury. Diagnostic studies showed degenerative disc disease in the lumbar spine, particularly at L4-5. In 1991 she was reassigned to more sedentary work duties. She continued to have chronic back pain and sought conservative treatment.

In late 1994 claimant was assigned to a management position which required extensive grocery checking. She developed increasing low back pain and sought treatment. She was released from checking duties. A MRI scan in March 1995 showed moderate degenerative changes in the lumbar spine with a moderate protrusion at L4-5, resulting in mild impingement of the left L5 nerve root. Claimant's then-attending physician, Dr. Newby, elected to treat conservatively but indicated that surgery might be possible if she did not improve with the passage of time. (Ex. 40). At that time, claimant had low back pain with radiation into both hips and knees, worse on the left. (Ex. 40A). Dr. Newby opined that the early 1995 onset of low back symptoms constituted a new injury. (Ex. 40). On June 30, 1995, the current employer issued the following denial letter to claimant:

> "You filed a claim for an occupational disease, described as degenerative lumbar disc disease, which allegedly arose out of your employment...on or about January 27, 1995.
>
> "We have reviewed the information in your file and find that your employment...is not the major contributing cause in the development or worsening of your degenerative lumbar disc disease. Therefore, we must deny your claim." (Ex. 40B).

Claimant continued to have low back pain with occasional radiation into the right thigh.

In September 1995, the parties entered into a "Disputed Claim Settlement, Stipulation and Order of Approval" which was approved by an ALJ on October 3, 1995. In that document, the parties stipulated, in relevant part:

> "[The employer] shall and does hereby rescind its denial letter of June 30, 1995. Claimant's current low back condition is accepted as a compensable bulging disc at L4-5, causally related to claimant's work activities with and for [the employer] in January, 1995. [The employer] shall accept further responsibility for the processing of claimant's low back claim, through closure in accordance with the Workers' Compensation Act." (Ex. 43-3).

Subsequently, by letter dated October 20, 1995, the employer notified claimant that it was accepting her claim for a disabling disc bulge at L4-5. (Ex. 45). Meanwhile, claimant continued to have low back pain with radiation into the right buttock. (Ex. 44-3). Dr. Newby recommended surgery for lumbar fusion and stabilization at L4-5. (Ex. 47). Based on medical reports attributing claimant's low back symptoms to preexisting degenerative disc disease, the employer issued a letter on November 7, 1995, denying authorization for surgery, explaining, in part, that "the current need for surgery is related to [claimant's] pre-existing degenerative disk disease and not related to the on the job injury of 1/27/95." (Ex. 48). The November 7, 1995 denial letter is the subject of the current proceeding.

We agree with the ALJ that the parties' stipulation, which was approved on October 3, 1995, clearly and unambiguously rescinded the employer's June 30, 1995 denial letter and accepted claimant's "current low back condition" as causally related to work activities for the employer. Although, as the employer asserts, the stipulation stated the employer was accepting the low back condition for the diagnosis of "bulging disc at L4-5," we find that the clear intent of the stipulation was to accept the "current low back condition" in its entirety. We base our finding on the language of the employer's June 30, 1995 denial letter, which denied claimant's then-current low back condition (degenerative lumbar disc disease) and on the language of the stipulation specifically rescinding the "denial letter of June 30, 1995." At that time, claimant was experiencing low back pain with radiation into the right thigh, the same low back symptoms for which Dr. Newby later requested surgical authorization in October 1995 and for which the employer issued its denial letter on November 7, 1995. (See Exs. 46B, 48).

By stipulating to rescission of the June 30, 1995 denial, the parties essentially stipulated to an acceptance of the then-current low back condition, the same condition which the employer later denied in November 1995. Although the employer now argues that it stipulated to acceptance of the "L4-5 disc bulge" diagnosis only, we note that the parties' stipulation did not divide claimant's low back condition into compensable and noncompensable components, nor did it purport to uphold any portion of the employer's denial of claimant's then-current low back condition. Based on our conclusion that the stipulation is not ambiguous, we deny the employer's motion for remand.

Because claimant's current low back condition which required surgery is the same low back condition which was at issue at the time of the parties' stipulation, we agree with the ALJ that the employer is now precluded from denying responsibility for the current condition and resultant need for treatment.

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

ORDER

The ALJ's order dated March 4, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, payable by the self-insured employer.

In the Matter of the Compensation of
BRADLEY N. WANAMAKER, Claimant
WCB Case No. 95-12023
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) McKean's order that set aside its denial of claimant's psychological condition claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In June 1994, claimant began treating with Dr. Henderson, psychiatrist. Dr. Henderson diagnosed adjustment disorder with depressed mood and indicated that psychotherapy would first focus on the "toxic dynamics" between claimant and his supervisor at work. (Ex. B-3). In particular, Dr. Henderson found that a "personality clash" between claimant and his supervisor had caused claimant's "defense mechanisms" to begin unraveling. (Id.)

On July 14, 1994, claimant was involved in a work-related motor vehicle accident. The insurer eventually accepted cervical, thoracic and lumbosacral strains; post concussive syndrome; head contusion; right ankle sprain; and post traumatic imbalance, positional vertigo, and headaches.

During the treatment for his compensable injuries, claimant continued to treat with Dr. Henderson for depression. In January 1996, Dr. Henderson informed the insurer that he had revised his diagnosis to "Mood Disorder Due to Post Concussion Syndrome with Major Depressive-Like Episode, DSM 293.83." (Ex. 32-2). Dr. Henderson reported that this revised diagnosis reflected the "pathological worsening" of claimant's psychiatric condition resulting from claimant's head injury. (Ex. 33-3).

Relying on Dr. Henderson's opinion, the ALJ first found that claimant's current psychiatric condition had not combined with the preexisting depression and that it constituted a "new" mental disorder. Applying ORS 656.802(3), the ALJ further concluded that claimant had proved compensability. The insurer challenges the ALJ's order, asserting that claimant's current condition is a continuation of the one for which he sought treatment in June 1994 and that claimant did not prove that the major contributing cause of his condition is the compensable injury or employment conditions.

We first hold that ORS 656.802(3) is not the applicable statute for deciding compensability. Although Dr. Henderson revised his diagnosis following claimant's industrial accident, he has consistently explained that claimant's psychological condition worsened following his head injury in that the depression became a more severe form, warranting a different diagnosis. (Exs. 17A-2, 22C-1, 32, 33-3, 34-52, 34-67). The remaining medical opinions also indicate that claimant's current psychiatric condition is a continuation of the depression that was diagnosed before the industrial injury. (Exs. 16-11, 29-7). Thus, because the medical evidence shows that claimant's psychological condition is preexisting, and he asserts that his compensable injury caused it to worsen,[1] we conclude that the most appropriate statute for determining compensability is ORS 656.005(7)(a)(B).[2]

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[1] At hearing and on review, claimant litigated his case on the theory that he proved the psychological condition to be a compensable consequential condition under ORS 656.005(7)(a)(A). Although we decide that ORS 656.005(7)(a)(B) applies in this case, because both statutes require claimant to prove that the compensable injury is the major contributing cause, claimant's burden essentially is the same under either statute.

[2] ORS 656.005(7)(a)(B) provides that, if a compensable injury combines with a preexisting condition, the combined condition is compensable only if the compensable injury is the major contributing cause of the combined condition.

In September 1995, Dr. Henderson wrote to claimant's attorney that the "closed head injury and resulting period of post concussion syndrome has certainly aggravated and made worse [claimant's] depression." (Ex. 22C-1). Dr. Henderson further explained that claimant's "ability to cope" with the initial work issues "deteriorated" after the head injury; moreover, the "additional stress of reduced work efficiency when he was already under the gun of adversarial supervisory pressure to work faster further aggravated [claimant's] depression." (Id.)

In January 1996, Dr. Henderson similarly reported to the insurer that, in June 1994, claimant was "significantly depressed" but "was still functioning and managing his daily life and work." (Ex. 32-1). Following the compensable injury, claimant showed symptoms of major depression, including the "inability to function at employment and his marginal ability to handle his general personal affairs." (Id. at 2).

During a deposition, Dr. Henderson explained that the onset of claimant's major depression was in April 1995, when claimant first returned to work following the industrial injury. (Ex. 34-17, 34-55). Dr. Henderson further indicated that, although claimant's neurological condition at that time had improved, his psychological condition had worsened; this worsening was "fueled" by the pressures at work, which included an increasing "friction" between claimant and his supervisor and claimant's increasing inability to effectively manage this issue. (Id. at 17-18, 19-20, 26, 30-31, 52-53). Specifically, in response to the insurer's attorney's question as to why claimant was neurologically improving but psychologically worsening, Dr. Henderson stated:

> "Now, in other words, you can't put this in an all or nothing, black or white setting. And to add further confusion to it, let's assume that he continues to improve neurologically. Meanwhile, he gets thrown into a severe depression earlier because of his head injury. And then after awhile, the major depression takes on a life of its own. * * * The causalities become such a quagmire of overlaps[.]" (Id. at 52).

Dr. Henderson additionally explained:

> "[Claimant] wasn't able to function cognitively, but there was a gradual improvement in his cognitive functioning, but it wasn't back up to baseline, but it was getting better, but it wasn't completely better. Meanwhile, [claimant] is getting worse as he's beginning to experience a compounding of pressures at work. Time moves on. There's a dynamic there. He's built up a history at that point of what [his supervisors have] done to him and is in more jeopardy. And, meanwhile, the bosses seem to be putting on--pushing more buttons. As so you have an overflow of other events there." (Id. at 53).

The remaining opinion is from examining psychiatrist Dr. Turco, who found that claimant had a chronic depression predating his industrial injury. (Ex. 29-7). Dr. Turco further found that the compensable motor vehicle accident "may have temporarily exacerbated some of his symptoms" but that the "underlying condition has not worsened as a result of the accident." (Id.)

As discussed above, in order to prevail, claimant must show that his compensable injury is the major contributing cause of his combined condition. Although Dr. Henderson provided a substantial amount of evidence, including letters to claimant's attorney and treating physicians, as well as a deposition, we find that his opinion lacks some clarity with regard to the major contributing cause of claimant's current psychological condition. Clearly, however, Dr. Henderson attributed claimant's major depression to employment conditions, which included the conflicts between claimant and his supervisor. With regard to claimant's compensable injury, we understand Dr. Henderson as indicating that the head injury decreased claimant's ability to cope with the stresses he was experiencing at work, especially upon claimant's return to work following the industrial accident.

Because Dr. Henderson extensively emphasized the work issues as a factor in claimant's depression, we find that his opinion is insufficient to prove that the compensable injury was the major contributing cause of the major depression. Because the remaining opinion does not support causation, we conclude that claimant failed to prove compensability.

ORDER

The ALJ's order dated June 7, 1996 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

November 7, 1996 Cite as 48 Van Natta 2269 (1996)

In the Matter of the Compensation of
MICHAEL W. WEBER, Claimant
WCB Case No. 95-13978
ORDER ON REVIEW
James L. Francesconi, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Otto's order that reduced his unscheduled permanent disability for a lumbar strain condition from 39 percent (124.8 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is extent of unscheduled permanent disability.

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

Claimant has an accepted lumbar strain. He also has a multilevel degenerative condition in his low back. On May 25, 1995, Dr. Steinhauer, claimant's treating physician, performed a closing examination. A June 10, 1995 Determination Order awarded 39 percent unscheduled permanent disability for claimant's low back condition. The self-insured employer requested reconsideration and an arbiter panel examination. Drs. Watson, Woolpert and Laycoe performed an arbiter panel examination. Relying on the panel examination, the ALJ reversed the Order on Reconsideration (which had affirmed the Determination Order's 39 percent unscheduled permanent disability award), finding claimant entitled to no unscheduled permanent disability.[1]

Claimant contends that the persuasive medical evidence establishes that his impairment is injury-related and that, therefore, he is entitled to permanent disability. The employer contends that claimant's impairment findings are either invalid or due to a long-standing degenerative condition. We conclude that claimant is not entitled to unscheduled permanent disability for the following reasons.

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).[2]

Neither Dr. Steinhauer nor the arbiter panel attributed claimant's impairment to his degenerative condition. We therefore conclude that impairment findings in claimant's low back, if any, are due to his compensable injury. Kim E. Danboise, 47 Van Natta 2163 (1995).

The ALJ found the opinion of Drs. Watson, Woolpert and Laycoe, medical arbiters, more persuasive than that of Dr. Steinhauer, claimant's attending physician, who measured reduced lumbar

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[1] At hearing, the self-insured employer was the only party contesting the reconsideration order. Because the employer was the dissatisfied party, it had the burden of establishing that the standards had been incorrectly applied ORS 656.283(7); Roberto Rodriguez, 46 Van Natta 1722, on recon 46 Van Natta 2233 (1994).

[2] However, impairment findings from a physician other than the attending physician may be used if those findings are ratified by the attending physician. Tektronix, Inc. v. Watson, 132 Or App 483 (1995). In this case, there are no such ratified findings.

ranges of motion. However, because Dr. Steinhauer did not state whether the range of motion findings were valid, the ALJ applied the validity test pursuant to Director's Bulletin 242 and concluded that Dr. Steinhauer's findings were invalid.

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 436-35-007(4). The Director has prescribed by bulletin the straight leg raising (SLR) method for testing the validity of lumbar flexion. Bulletin 242 (Rev.), effective February 1, 1995, 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. See 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, Dr. Steinhauer, claimant's attending physician, did not note any measurements as being invalid. Under such circumstances, we find the reported measurements to be valid. See e.g., Michael D. Walker, supra (ALJ erred in excluding lumbar flexion measurement made by medical arbiter where medical arbiter did not indicate lumbar flexion measurement was invalid).

Nevertheless, we find the opinion of the medical arbiters more persuasive than that of Dr. Steinhauer. (See Ex. 49). Not only did the arbiters find the range of motion findings to be invalid, they also noted that claimant had marked guarding and subjective limitation during that portion of their examination. The arbiters also noted functional interference and give-way, which invalidated muscle testing. Finally, the arbiters noted that functional interference and subjective limitations on the part of claimant prevented them from defining any objective limitations that would restrict claimant's residual functional capacity. (Ex. 49). Like the ALJ, we find additional support for the arbiters' findings of invalidity in an August 1994 note by Dr. Steinhauer in which he speculated that claimant was avoiding getting better because he "wanted to remain indefinitely on the slow-paced 'rewinder' job." (Ex. 34).

Given these circumstances, we find the arbiter panel's findings of invalidity more persuasive than the prior findings of Dr. Steinhauer. Accordingly, because claimant has failed to establish any impairment, claimant's unscheduled permanent disability is zero. Former OAR 436-35-270(2).

ORDER

The ALJ's order dated May 17, 1996 is affirmed.

In the Matter of the Compensation of
RONALD C. BALLARD, Claimant
WCB Case No. 95-13774
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Christian and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that upheld the insurer's partial denial of his injury claim for a low back condition. On review, the issue is compensability.

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

The ALJ found that the nature and causes of claimant's low back condition are complex medical questions which must be resolved on the basis of expert medical evidence. On review, claimant contends that the causation issue in this case is not medically complex. Before proceeding to that argument, we note that the ALJ did not reject claimant's claim due to an absence of medical evidence regarding causation. To the contrary, the ALJ found conflicting medical evidence regarding causation and concluded that the medical evidence opposing compensability was most persuasive. We agree with that assessment. Nevertheless, we address claimant's legal argument.

The courts have enumerated the following factors for determining whether expert medical evidence of causation is required: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker previously was free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. Uris v. Compensation Dept., 247 Or 420, 427 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993).

Applying the Uris factors to this case, we do not find that claimant's low back symptoms appeared immediately after the May 30, 1995 incident when he fell to the ground at work. Claimant had immediate left ankle pain only, which was diagnosed as an ankle sprain. He was subsequently prescribed pain medication and bed rest for the ankle injury. The first onset of low back pain was on or about June 13, 1995, approximately two weeks after the May 30 incident. The two-week delay in onset distinguishes this case from Uris and Barnett. The claimants in Uris and Barnett felt immediate onset of pain and reported the pain within moments after onset.

Claimant argues that the two-week delay in onset of low back pain should be treated as an "immediate" onset because the pain was "masked" by the effects of the ankle injury and the pain medication and bed rest he was receiving for that injury. We conclude, however, that the masking effect, if any, of the ankle injury and resultant inactivity and medication for the injury is a matter for science and must be determined by skilled, professional persons, not by lay persons. In other words, we find that the question of whether claimant had low back pain which was masked by the effects of his treatment for the ankle injury, is medically complex and must be resolved by expert medical opinion. Here, none of the doctors indicated there was any masking of low back pain. In the absence of an expert medical opinion to support claimant's "masking" theory, we decline to adopt that explanation for the two-week delay in onset of low back pain.

Moreover, Dr. Kitchel, orthopedist, relied on the delay in onset of low back pain to opine, by check-the-box response, that the low back condition was most likely not related to the May 30, 1995 work incident. (Ex. 54). Dr. Kitchel subsequently wrote: "I do not believe that I can say with any medical probability what the major contributing cause to his back problem and need for treatment are. That is based upon the fact that [claimant] did not complain of any low back or leg pain in the first twenty-four to seventy-two hours after his injury." (Ex. 55). Thus, the delayed onset of claimant's low back pain was an important factor in Dr. Kitchel's expert medical opinion. Based on this record, therefore, we find that the causation of claimant's low back condition presented a complex medical question which must be resolved on the basis of expert medical evidence. Uris v. Compensation Dept., supra; Barnett v. SAIF, supra. We agree with and adopt the ALJ's opinion and conclusion that Dr. Kitchel rendered the most persuasive medical opinion. Accordingly, claimant has not met his burden of proof by a preponderance of the evidence.

ORDER

The ALJ's order dated May 22, 1996 is affirmed.

November 13, 1996 Cite as 48 Van Natta 2272 (1996)

In the Matter of the Compensation of
LINDA L. CRAIG, Claimant
WCB Case No. 94-04340
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Johnstone's order that upheld the insurer's denial of claimant's mental disorder claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a store manager for Plaid Pantry. Reza Boroumand was her supervisor. In February 1993, claimant began treating with Dr. Johnson, psychiatrist, who diagnosed multiple personality disorder (MPD).

In November 1993, claimant was promoted to a manager position at a larger store. Around that time, claimant told Mr. Boroumand that she wanted a pay increase. Mr. Boroumand offered to increase claimant's monthly pay by $100 to $1,450 per month.

Claimant testified that, during this conversation, she told Mr. Boroumand that she wanted $9 per hour. (Tr. 30 (Day 1)). She further testified that Mr. Boroumand performed some calculations and told her that she would receive an hourly rate of over $9. (Id. at 31). Mr. Boroumand, however, denied that they spoke of an hourly rate and stated that, instead, claimant indicated that she wanted $1,500 per month. (Id. at 129-30). Mr. Boroumand also testified that claimant was unhappy about receiving a lesser amount and he told her that she had the opportunity to receive raises in the future. (Id.)

On December 1, 1993, after claimant had worked for a month in the larger store, Mr. Boroumand delivered pay checks. Claimant became angry when she saw that her pay check reflected an hourly rate of about $8. (Id. at 31). She approached Mr. Boroumand and told him that her pay check was insufficient because it did not reflect a rate of $9 per hour.[1] Claimant and Mr. Boroumand spoke about the matter but could not resolve it; Mr. Boroumand then left the store.

The next day, claimant and Mr. Boroumand sat at claimant's desk (located in the store) and continued to talk about the pay dispute. Eventually, they went to the back room. According to claimant, throughout the meeting, Mr. Boroumand insisted in a loud voice that claimant admit she lied in accusing Mr. Boroumand of having promised a higher pay rate than $1,450 per month and claimant refused to do so. (Id. at 34-35). Mr. Boroumand denied such actions and testified that claimant was shouting and told him to "shut up and listen to her." (Id. at 143). Both agree that Mr. Boroumand suspended claimant from her job, telling her to get her things and leave the store. (Id. at 36, 143). Both claimant and Mr. Boroumand returned to the store area.

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[1] Mr. Boroumand's testimony is consistent with this portion of claimant's testimony except that he stated that claimant was unhappy because the pay check did not reflect a rate of $1,500 per month. (Tr. 133).

Claimant further testified that, after one of her "alters" emerged, she insisted that Mr. Boroumand talk to her and they returned to the back room. (Id. at 37). According to claimant, she then told Mr. Boroumand that he had been condescending and rude, whereupon Mr. Boroumand raised his arm and pushed claimant against a sink. (Id. at 37-38). Claimant then left the store. A few days later, she was informed that she was terminated from her job.

The ALJ first found that claimant suffered from a diagnosable mental disorder, including MPD. The ALJ further found it "impossible" to make credibility findings for claimant and Mr. Boroumand. Consequently, the ALJ concluded that he was "unable to choose one version over another" with regard to the pay dispute and that claimant failed to prove legal causation. Claimant asserts that she proved legal and medical causation, along with establishing the remaining factors for a mental disorder claim.

In order to prove a claim for mental disorder, claimant must show that employment conditions producing the mental disorder exist in a real and objective sense and are conditions not generally inherent in every working situation or reasonable disciplinary or corrective actions by the employer; a diagnosis of a mental or emotional disorder which is generally recognized in the medical community; and clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

According to Dr. Johnson, claimant has preexisting MPD and depressive disorder and, following the December 1993 events, suffered from panic disorder with agoraphobia. (Ex. 26-1). Dr. Johnson initially stated that the preexisting conditions were "severely aggravated" by the December 1993 events and the panic disorder with agoraphobia directly arose from such incidents. (Id. at 2; Ex. 31-12, 31-44). When deposed, however, Dr. Johnson stated that the major contributing cause was the "sum total of the work experience," including Mr. Boroumand's supervision of claimant, the December 1993 events, and the termination. (Ex. 31-49, 31-118). According to Dr. Johnson, in determining causation, he had not "separated out how those different events worked" but looked at the "sum total." (Ex. 31-118).

Based on such evidence, we consider the mental disorder claim to be based on more than the December 1993 events and included Mr. Boroumand's supervision of claimant prior to this date and the termination. In this regard, we first note that cessation of employment is not a condition that can serve as a basis for a compensable mental disorder. ORS 656.802(3)(b); Elwood v. SAIF, 298 Or 429, 433 (1985). Thus, claimant's termination cannot be included as an "employment condition."

Evidence concerning Mr. Boroumand's supervision of claimant is sketchy. Other than the December 1993 incidents, claimant's testimony provides no details concerning this issue. Dr. Johnson stated only that claimant "was aware that Reza was not accepting of her and had experiences with him where he was critical of her and she couldn't please him and she couldn't wear the right shoes, et cetera, et cetera." (Ex. 31-49). Claimant also told Dr. Matarazzo, examining psychologist, that she and Mr. Boroumand had a good relationship until January 1993, when she began to feel that Mr. Boroumand was "picking" on her and "playing with her mind." (Ex. 28-4). In particular, claimant stated that she began documenting Mr. Boroumand's statements because he would later deny them. (Id.) Claimant also related to Dr. Matarazzo an incident when Mr. Boroumand criticized her shoes; after claimant bought new pairs of shoes, Mr. Boroumand saw them and asked her whether she ever wore athletic shoes. (Id. at 5).

We find such evidence insufficient to prove that Mr. Boroumand's supervision constituted employment conditions not generally inherent in every working situation. In particular, we find that the conduct attributed to claimant's supervisor is the kind of conditions generally inherent in every working situation.

Thus, two of the factors cited by Dr. Johnson (termination and Mr. Boroumand's supervision) making up the "sum total of the work experience" do not qualify as "employment conditions" under ORS 656.802(3). Thus, because Dr. Johnson did not indicate that the remaining factor, the December 1993 events, by itself was the major contributing cause, we conclude that claimant failed to carry her burden of proof.[2] We reach this conclusion even if we accepted only claimant's version of the December 1993 incidents and they qualified as "employment conditions."

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[2] We further note that the only other opinion concerning causation is from Dr. Matarazzo, who does not support a causal relationship between claimant's condition and her employment. (Ex. 18).

ORDER

The ALJ's order dated May 30, 1996 is affirmed.

November 13, 1996 Cite as 48 Van Natta 2274 (1996)

In the Matter of the Compensation of
GREGORY S. DAVIS, Claimant
WCB Case No. 92-00736
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Christian and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mills' that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a license investigator for the Oregon Liquor Control Commission (OLCC). In July 1990, claimant was diagnosed with depression by his family physician, Dr. Brandt. At that time, claimant was under investigation at work concerning claimant's use of sick leave. In November 1990, claimant was disciplined and demoted. Claimant refused the demoted position and eventually was terminated.

In November 1990, claimant began treating with psychiatrist Dr. Dillon for depression. He also participated in counseling with a psychologist.

Claimant contends that his depression is a compensable psychological condition. In order to prove his claim, claimant must show that employment conditions were the major contributing cause of his condition or its worsening. ORS 656.802(2)(a), (b). Furthermore, claimant must establish that employment conditions producing the mental disorder exist in a real and objective sense and are other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer; there is a diagnosis of a mental or emotional disorder; and there is clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3).

The medical evidence supporting a causal relationship between claimant's depression and employment conditions implicate the investigation and resulting demotion as the primary cause. (Exs. A20, A23-5, -13). Claimant disputes the ALJ's conclusion that such actions constitute reasonable discipline by the employer. Specifically, claimant contends that the disciplinary proceeding was unreasonable because it was initiated for an improper purpose, it was conducted in an unreasonable manner, and the decision to discipline was based on erroneous conclusions and contrived evidence.

In October 1989, the Washington State Liquor Control Board (WLCB) approved a liquor license for the Jade Tree Restaurant and Lounge, located in Richland, Washington. A memorandum accompanying the license explained that the application was by Washington Investment Company, of which claimant was the sole corporate officer and stockholder. The document further stated that Woon Lee would manage the business and that Mr. Lee's two previous applications for liquor licenses had been rejected. Finally, the application provided that "applicant for this license freely admits that he will operate the business only to give Woon Lee the time to clear his name with creditors and the WLCB" and the "goal is to get Woon Lee to be the licensee at some point of [sic] time." (Ex. B24-5).

The WLCB first denied Mr. Lee's application for managership of the restaurant. (Ex. B25). Claimant's mother was then substituted for the position, which was authorized by the WLCB. (Ex. B26-1). Mr. Lee, however, actually acted as the on-site manager.

In January 1990, the WLCB served an administrative notice violation against claimant's corporation for serving minors alcohol; the WLCB proposed to suspend the liquor license with an option for monetary penalty. In February 1990, the WLCB levied sanctions against claimant's corporation following the arrest by police of minors who reported they were served alcohol at the restaurant. By April 1990, the restaurant was closed.

During the time the restaurant was in operation, claimant used the following sick leave: 44 hours in October 1989, 120 hours in November 1989, 32 hours in December 1989, 11.75 hours in January 1990, 21.25 hours in February 1990, 83 hours in March 1990, and 84 hours in April 1990.

On July 26, 1990, Dick Evans, OLCC's Director of Field Services, informed claimant that he was under investigation for "possible misuse of sick leave." (Exs. B40, B41, B44-3). The investigation began because a newspaper reporter sought information from Steve Brinkhoff, a regional manager, concerning claimant's ownership in the Washington restaurant. (Ex. B44-2). The investigation was to determine whether claimant used sick leave while operating the business. (Id.) When the investigation revealed that claimant had called the restaurant regularly from work, the investigation enlarged to whether claimant abused the state's long distance telephone service and used work time to make the phone calls. (Id.) As part of the investigation, Dick Evans and Steve Brinkhoff interviewed claimant on two occasions.

On October 10, 1990, the OLCC issued a "Notice of Pre-Dismissal Proceedings" outlining the three bases for the OLCC's action. In the first instance, the OLCC charged that claimant abused state long distance telephone equipment, asserting that, between October 1989 and April 1990, claimant had made a total of 231 long distance phone calls at work to Mr. Lee, the Jade Tree Restaurant, the WLCB, Robert Keene (accountant for the restaurant), Mack Huston (the restaurant's landlord), and claimant's mother. (Ex. B59-2). The notice provided that OLCC policy allowed for occasional short personal calls which, if long distance, must be charged to a personal credit card. (Id.) The document stated that the "quantity of calls made by you are neither occasional, nor were they billed to your personal credit card or home phone" and such conduct "demonstrates your willful and conscious intent to violate state and OLCC phone policies." (Id.)

The second basis for the notice was abuse of sick leave. Citing to statements from restaurant employees that claimant was at the restaurant during work hours and the lack of proof of medical appointments for most periods of sick leave, the notice found that "over a period of several months you established a pattern of conducting your personal business and operating the Jade Tree Restaurant while claiming official sick leave from the State of Oregon." (Id. at 3-4).

The third basis was misuse of state work time. The notice alleged that claimant made his personal long distance phone calls during work time, when he should have been performing his official duties. (Id. at 4). The notice stated that claimant could be dismissed for his conduct and provided him with the opportunity to appear before the agency administrator, Chris Lyons.

Following the hearing, on November 1, 1990, Mr. Lyons notified claimant that claimant was demoted to the position of administrative specialist. The notification stated that the discipline resulted from the three bases discussed in the first notice. (Ex. B62). Additionally, this notice found that claimant had violated Washington liquor statutes because claimant's corporation was twice cited by the WLCB for serving alcohol to minors. (Id. at 3-4). Furthermore, the notice found that claimant "violated WLCB directives, statutes and regulations" by employing Mr. Lee as the manager following the WLBC's disapproval of Mr. Lee in such a position and claimant's subsequent substitution of his mother for the job. (Id. at 4).

As previously stated, claimant contends that the investigation and demotion do not qualify as reasonable disciplinary actions. In this regard, claimant first asserts that the investigation actually was initiated in retaliation for claimant providing information concerning illegal conduct by a coworker and, thus, was undertaken for an improper purpose. We adopt that portion of the ALJ's order rejecting this argument.

Claimant next contends that the investigation was unreasonably conducted because Steve Brinkhoff himself prepared statements from restaurant employees placing claimant at the restaurant during OLCC work hours. Mr. Brinkhoff, and the OLCC, relied upon such statements in concluding that claimant had conducted personal business while claiming sick leave, thus misusing his sick leave. According to claimant, testimony at hearing by two restaurant employees was inconsistent with their statements, thus showing that Mr. Brinkhoff manufactured the employees' statements.

Mr. Brinkhoff obtained statements from six restaurant employees. According to his testimony, Mr. Brinkhoff himself wrote each statement according to what the witness told him; the statement was then reviewed and signed by the witness. (Tr. 15-16 (Day 3)). Kym Kennel, who spoke with Mr. Brinkhoff, at hearing reviewed the statement she signed and confirmed it was her own. (Tr. 6 (Day 6)). Her testimony concerning claimant's presence at the restaurant during weekdays is consistent with the statement. (Id. at 9-10). Jon Richards also provided a statement to Mr. Brinkhoff and testified at hearing. Mr. Richards indicated that the statement accurately reflected his remarks to Mr. Brinkhoff. (Tr. 58 (Day 7)). His testimony about claimant's visits to the restaurant also is consistent with his statement. (Id. at 62-63).

We find no merit to claimant's allegations concerning Mr. Brinkhoff's method in procuring the witness statements. Each statement was signed by the witness. Furthermore, two of the statements were confirmed with testimony at hearing. Thus, we reject claimant's argument that the investigation was improperly conducted.

Claimant also contends that Mr. Brinkhoff had little foundation for deciding that claimant had misused sick leave. According to claimant, nearly half of his sick leave was authorized by Dr. Brandt. Furthermore, claimant contends that he also had medical appointments for the remaining months.

The record does not support claimant's assertions. A December 15, 1989 chartnote by Dr. Brandt indicates that claimant was "given an excuse as to why he was absent from work between Nov. 7 and Dec. 5." (Ex. A1-1). The record, however, contains no evidence that any "excuse" was provided to the employer. On the contrary, claimant's supervisor asked claimant on December 4, 1989, for verification from his physician of illness. (Ex. B27). Furthermore, the record shows that claimant had three appointments each in October and November 1989, four appointments in December 1989, one appointment each in January and February 1990, two appointments in March 1990, and five appointments in April 1990. (Ex. B44-10). When those appointments are compared to the amount of sick leave taken by claimant, we find that the OLCC was reasonable in deciding that not all of claimant's sick leave was due to medical appointments.

Finally, claimant contends that personal long distance phone calls by employees was a "tolerated practice" at his office, a factor which should have been considered in determining whether his own personal long distance calls were improper. We adopt the ALJ's discussion concerning this issue.

We agree with the ALJ that the investigation and demotion constitute reasonable disciplinary actions. First, there is little dispute that claimant made many personal long distance phone calls at state expense. The ALJ's findings of fact, which we have adopted, discusses the evidence in the record clearly showing that such conduct is prohibited. Thus, we find the OLCC was reasonable in concluding that claimant misused the state telephone service.

In view of claimant's extensive sick leave between October 1989 and April 1990, we find that the employer was reasonable in investigating the matter when it learned that claimant had a restaurant business during the same period, especially since the sick leave taken was much greater than that claimed before and after that time period. We further find that the employer was reasonable in disciplining claimant for misuse of sick leave in view of the amount of time claimed, the lack of medical authorization for all the claimed leave, and the evidence from employees showing that claimant was present at the restaurant during work hours.

Furthermore, based on the evidence that claimant made the personal long distance phone calls during the noon hour, when the office was empty, and took a later lunch, we find the employer reasonable in disciplining claimant for misusing work time.

Finally, we consider whether discipline was reasonable based on claimant's conduct with the restaurant. Claimant contends that his employer had no basis for determining that he acted illegally with the WLCB because claimant informed the WLCB concerning his motives for obtaining the liquor license for the restaurant and his relationship with Mr. Lee.

Claimant ignores the fact that his corporation twice was cited for serving alcohol to minors. In this regard, OLCC was not unreasonable in concluding that claimant, as sole shareholder and president, violated Washington law. Furthermore, in demoting claimant, the OLCC found that claimant's activity with the restaurant was directly relevant to his job, which required the reporting of violations, applying licensing criteria, and instructing applicants and licensees concerning the relevant laws and rules. (Ex. B62-4). We find such reasoning reasonable, whether or not the WLCB was aware that Mr. Lee would actually manage the restaurant rather than his mother.

Inasmuch as the medical evidence implicates the investigation and demotion[1] as the only employment conditions causing or worsening claimant's psychological condition, and we find such actions constituted reasonable disciplinary action, we conclude that claimant failed to prove his claim is compensable. ORS 656.802(2), 656.802(3)(b).

ORDER

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

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[1] As discussed above, we have found that the employer was reasonable in investigating and demoting claimant concerning the sick leave matter. Even if such conduct was not reasonable, however, we would continue to conclude that, because the remaining bases for investigating and demoting claimant constitute reasonable disciplinary action, and the medical evidence does not delineate between the various actions for which the employer investigated and demoted claimant, claimant did not carry his burden of proof.

In the Matter of the Compensation of
JULIO FILIPPI, Claimant
WCB Case Nos. 96-00397, 96-00383, 95-04502 & 95-07470
ORDER OF ABATEMENT
Maureen McCormmach, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney
David O. Horne, Defense Attorney

On October 11, 1996, we issued an Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside Wausau Insurance Company's denial of claimant's aggravation claim for an L4-5 disc condition; (2) upheld the SAIF Corporation's denial on behalf of Oregon Parks and Recreation (SAIF/Parks) of claimant's medical services claim for the same condition; and (3) upheld SAIF's denial of claimant's "new injury/occupational disease" claim for the same condition on behalf of Circle C Farms (SAIF/Circle C). Claimant moves for reconsideration of our order, asserting that we erroneously neglected to award an insurer-paid attorney fee under ORS 656.382(2) for her counsel's services on Board review.

In order to further consider claimant's motion, we withdraw our October 11, 1996 order.[1] The remaining parties are granted an opportunity to respond. To be considered, those responses must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

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[1] We note that Wausau has already petitioned the court for judicial review of our October 11, 1996 order. Notwithstanding that appeal, since we are taking this action within 30 days of our October 11, 1996 order, we retain authority under ORS 656.295(8) to withdraw our prior order and to reconsider that decision. See SAIF v. Fisher, 100 Or App 288 (1990); Elmer F. Knauss, recon den 47 Van Natta 1064 (1995).

In the Matter of the Compensation of
VANESSA K. GALINDO, Claimant
WCB Case No. 96-00191
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's partial denial of claimant's preexisting degenerative spine condition and current low back condition. On review, the issue is compensability.

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

After the second sentence in the first paragraph on page 2, we add: "During a March 13, 1995 visit to the emergency medical clinic at the Oregon Health Sciences University, the examining physician remarked that claimant was 'morbidly obese' (Ex 7)." We delete the third sentence from the same paragraph. After the first sentence in the second paragraph on page 2, we add: "The examining physicians observed that claimant was 'massively obese.' They anticipated healing from the muscle strain in 8 to 10 weeks, and recommended further evaluation if not healed within that time." We delete the second sentence from the same paragraph.

We also change the fourth paragraph on page 2 to read: "On April 24, 1995, claimant began treating with Scott A. Fields, M.D.. He estimated that claimant would be medically stationary from the strain in one month. After three missed appointments, claimant next sought treatment for persistent low back pain on August 7, 1995. Given the duration of her symptoms, Dr. Fields ordered an MRI of claimant's lumbar spine (Ex 20). The August 23, 1995 MRI revealed diffuse degenerative disc disease, with disc desiccation at L3-4 and L4-5 (Ex 21). Dr. Fields believed claimant's obesity played a major role in her ongoing low back symptoms and recommended weight reduction (Ex 22)."

Relying upon the opinions of attending physician Fields and examining physicians Gambee and Zivin, the ALJ found that claimant's compensable strain had resolved, and that her ongoing symptoms were due instead to morbid obesity and preexisting degenerative disc disease (not worsened by the compensable injury). The ALJ therefore concluded that claimant's current low back condition and preexisting degenerative disc disease are not compensable. In reaching his conclusion, the ALJ noted: "According to the Metropolitan Insurance Scales, [claimant] is 124 pounds overweight. She is morbidly obese (Ex 23)."

As a preliminary matter, claimant argues that the ALJ conducted an improper investigation outside of the record by consulting an insurance company's weight tables. We find no evidence of impropriety. Rather, our review of the record reveals that it was Drs. Gambee and Zivin, not the ALJ, who, upon consulting the metropolitan insurance weight tables, labeled claimant "morbidly obese" and determined that she was "124 pounds overweight." (See Ex. 23).

Primarily, claimant argues that we should find the opinion of one-time medical consultant Keenen more persuasive than those of attending physician Fields and examining physicians Gambee and Zivin. In support of her argument, claimant contends that Dr. Fields supported her claim until he reviewed the December 1995 IME report indicating that claimant was dissatisfied with her care with him. For that reason, claimant argues, Dr. Fields' January 1996 report, in which he agreed with Drs. Gambee and Zivin's assessment of claimant's current condition, represents a "change" of opinion that is the result of his "bias" and "vindictiveness." We do not agree.

As early as August 1995, Dr. Fields was concerned with the duration of claimant's low back symptoms and ordered an MRI to further evaluate her lumbar spine. After reviewing the August 1995 MRI which revealed diffuse degenerative disc disease, Dr. Fields opined that claimant's obesity played "a major role" in her ongoing low back symptoms, and recommended weight reduction. Thus, Dr. Fields' agreement with Drs. Gambee and Zivin's opinion cannot be said to represent a "change" of opinion.

Moreover, we agree with the ALJ that Drs. Fields, Gambee and Zivin's opinions are more persuasive than that of Dr. Keenen. We too find that the opinions of Drs. Fields, Gambee and Zivin were based on an accurate history[1] and were well-reasoned. We further agree that there is no persuasive reason not to defer to the opinion of attending physician Fields.

ORDER

The ALJ's order dated April 4, 1996 is affirmed.

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[1] Exhibit 9, admitted into evidence without objection, is an April 1995 MRI report pertaining to another individual. Accordingly, we have not considered that evidence in our deliberations. Inasmuch as neither Drs. Fields, Gambee or Zivin relied on that evidence in rendering their opinions, we find that their opinions are based on an accurate medical history.

In the Matter of the Compensation of
STEVEN T. KUNZ, Claimant
WCB Case No. C6-03030
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Peterson & Peterson, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

On November 4, 1996, the Board received the parties' claim disposition agreement (CDA). Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The CDA provides:

> "Pursuant to ORS 656.236, in consideration of the payment of $20,000 by the insurer/employer and the waiver of the right to recover an overpayment in the amount of $5,437.13 by the insurer/employer, claimant releases his rights to the following workers' compensation benefits * * *."

We have previously held that, where an overpayment apparently has been made pursuant to prior claims processing obligations, that overpayment cannot qualify as "proceeds" of the parties' CDA. See Ronald Smith, 47 Van Natta 38 (1995); Timothy W. Moore, 44 Van Natta 2060 (1992). Furthermore, a carrier's contractual forbearance of its right to pursue an offset cannot serve as consideration for a claimant's release of rights to workers' compensation benefits. Id. Consequently, the carrier's release of the $5,437.13 overpayment in this case cannot be consideration for the CDA.[1] Nevertheless, such a provision does not automatically result in the disapproval of the proposed disposition.

In Roy D. Welty, 47 Van Natta 1544 (1995), we considered a CDA which provided, as consideration for the disposition, the release of the carrier's claims to an overpayment, as well as a lump sum payment. After noting that a carrier's contractual relinquishment of the right to pursue an overpayment could not serve as consideration for a CDA, we interpreted the CDA's total consideration as consisting of the lump sum payment, excluding the overpayment.

Similarly, in Margie L. Brame, 48 Van Natta 204 (1996), we considered a CDA which provided for the payment of a lump sum of $8,000, and indicated that "part of the consideration" included the carrier's agreement to waive an overpayment. Relying on Welty, we construed the consideration underlying the CDA as being limited to the $8,000 lump sum and approved the proposed CDA.

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[1] Although the overpayment cannot be consideration for the CDA, the agreement nonetheless memorializes the parties' agreement that the carrier will not seek recovery of the overpayment from claimant.

Here, as we did in Welty and Brame, we interpret the consideration underlying the CDA to include only the $20,000 lump sum, and not to include the carrier's waiver of the overpayment. Based on such an interpretation, we do not consider the consideration for the release of claimant's "non-medical service" benefits to be unreasonable as a matter of law. See ORS 656.236(1)(a)(A).

Accordingly, as interpreted, the CDA is in accordance with the terms and conditions prescribed by the Board. Therefore, the parties' CDA is approved. The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035(1).

IT IS SO ORDERED.

November 13, 1996 Cite as 48 Van Natta 2280 (1996)

In the Matter of the Compensation of
BRIAN D. SHIPLEY, Claimant
WCB Case No. 95-04202
ORDER ON RECONSIDERATION
Nancy F.A. Chapman, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

On May 15, 1996, we abated our May 9, 1996 order that affirmed the Administrative Law Judge's (ALJ's) order which: (1) held that the Hearings Division lacked jurisdiction over the SAIF Corporation's "de facto" denial of claimant's cervical condition and the parties' vocational assistance dispute; (2) affirmed an Order on Reconsideration which held that claimant's lumbar injury claim was not prematurely closed and awarded claimant temporary disability compensation and 7 percent (22.4 degrees) unscheduled permanent disability; and (3) declined to assess a penalty for SAIF's allegedly unreasonable claims processing. In reaching our decision regarding one of the jurisdictional issues, we determined that claimant had not filed a "new medical condition" claim as required by amended ORS 656.262(7)(a). In making this determination, we rejected claimant's argument that the amended statute was not retroactively applicable.

On our own motion, we withdrew our May 9, 1996 order for further consideration. In particular, we intended to examine the question of whether it would be "absurd and unjust" for claimant to comply with the procedural requirements for a "new medical condition" claim when such requirements did not exist when the claim was initially advanced. See Rick A. Webb, 47 Van Natta 1550 (1995). To assist us in conducting our reconsideration, the parties were granted an opportunity to submit supplemental briefs. Having received the parties' responses, we proceed with our reconsideration.

On reconsideration, claimant does not advance an argument about whether retroactive application of ORS 656.262(7)(a) would be "absurd and unjust" under the circumstances presented in this claim. Instead, claimant reiterates his contention that retroactive application of the statute results in an alteration of a procedural time limitation and, thus, that the statute cannot be applied retroactively. Upon further consideration of claimant's arguments, we continue to reject claimant's procedural-time-limitation argument concerning the application of this statute.

The provisions of Senate Bill 369 apply to matters for which the time to appeal has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 115 Or App 565, 572-3 (1995); see also SAIF v. Newell, 136 Or App 280, 282 (1995) (1995 amendments to Workers' Compensation Law applied to case pending before court on effective date of legislation). An exception to this general rule is that changes in procedural time limits do not apply retroactively. Or Laws 1995, ch 332, § 66(6) (SB 369, § 66(6)); see Motel 6 v. McMasters, 135 Or App 583, 587 (1995). For that exception to apply here, ORS 656.262(7)(a) itself must have altered some procedural time limit that applied to claimant's claim. As we explained in our previous order, ORS 656.262(7)(a) has altered no time limitation. Both before and after the enactment of Senate Bill 369, carriers had 90 days within which to accept or deny claims, claimants were free to initiate new claims at any time, and carriers were entitled to some notice of claims before being obligated to process them. What has changed is the nature of the event that triggers a carrier's obligation to process a claim.

Under the old law, a request for compensation did not have to take any particular form; for example, a physician's report requesting medical services for a specified condition was enough. Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992). Under the new law, after claim acceptance, a claimant must now formally request written acceptance of claims for aggravation or new medical conditions. ORS 656.262(7)(a). That change does not alter any time limits; rather, it formalizes the event that triggers the running of the 90-day period in which a carrier has to accept or deny a claim. ORS 656.262(7)(a) did not, however, alter the 90-day period itself. Therefore, we once again decline to apply the time limitation exception to this case. Because the time to appeal this matter has not expired and it has not been finally resolved on appeal, ORS 656.262(7)(a) applies to this case. Volk v. America West Airlines, supra, 115 Or App at 572-3.

In our prior order, we determined on the merits that claimant had not satisfied the requirements of ORS 656.262(7)(a). We reasoned that there was no evidence that claimant requested in writing formal written acceptance of his cervical condition. We specifically noted that his hearing requests noted "compensability" among the contested issues. However, we declined to construe claimant's hearing requests as satisfying the requirements of the statute since claimant had not "clearly requested" formal written acceptance of his cervical condition in those documents.

In discussing the jurisdictional issue, we cited Guillermo Rivera, 47 Van Natta 1734 (1995). In Rivera, we found that the claimant's hearing requests alleging a "de facto" denial of a specific condition constituted "communication in writing" to the employer of the claimant's objections to the notice of acceptance pursuant to ORS 656.262(6)(d).

We have since disavowed our decision in Guillermo Rivera. See Shannon E. Jenkins, 48 Van Natta 1482 (1996). In Jenkins, we reasoned that the text and context of ORS 656.262(6)(d) strongly suggested that the statutory requirement for a 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. In other words, we found that the legislature intended for the worker's "communication in writing" under ORS 656.262(6)(d) to precede the worker's request for hearing. Therefore, we concluded that the claimant's mere filing of a request for hearing alleging a "de facto" denial did not satisfy the amended statute and that the claimant was precluded from proceeding to hearing on the issue of "de facto" denial. Jenkins, supra.

Since this case pertains to ORS 656.262(7)(a) (whereas Jenkins involved the "pre-hearing" written communication requirement of ORS 656.262(6)(d)), Jenkins is not controlling. However, we need not address the issue of whether the Jenkins rationale should be extended to ORS 656.262(7)(a). That is, even if a hearing request could constitute a "new medical condition" claim under ORS 656.262(7)(a), for the reasons expressed in our prior order, the hearing request in this case does not satisfy the requirements of that statute.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our May 9, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 14, 1996 Cite as 48 Van Natta 2281 (1996)

In the Matter of the Compensation of
ABDRAHMAN GAMUDI, Claimant
WCB Case No. 94-12788
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its denial of claimant's mental disorder claim; (2) assessed a penalty for the employer's allegedly unreasonable denial; (3) assessed a penalty for the employer's allegedly unreasonable failure to

provide timely discovery; and (4) awarded an assessed attorney fee of $15,000. Claimant cross-requests review, arguing that: (1) the employer should be ordered to accept the specific mental disorder of major depression; and (2) the attorney fee at hearing should be increased. On review, the issues are compensability, penalties and attorney fees.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the first full paragraph on page 8 (under "Employment Relationship"), we delete the first sentence. We change the fifth sentence in the last paragraph on page 8 to read: "The evidence establishes otherwise."

Compensability

The employer contends that claimant was not credible and the opinions of claimant's treating physicians were based on an inaccurate and incomplete history. We disagree.

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's analysis and conclusions. We conclude that claimant is a credible witness and we reject the employer's assertion that the medical opinions from claimant's treating physicians are unreliable because they are based on claimant's history.

Next, the employer argues that claimant had a preexisting stress condition which was not taken into account by the ALJ or the treating doctors. We disagree.

The ALJ relied on claimant's testimony that he felt stressed by interactions with his supervisor while he was a temporary employee in early 1990 and thereafter, but he did not become depressed until after the late May 1993 incidents. The ALJ found there was no evidence that claimant had any stress symptoms prior to commencing employment for employer and there was no evidence of depression before late February 1994. We agree with the ALJ's conclusion that claimant's pre-May 1993 stress symptoms appeared to be part of the work-related continuum of the stress claimant experienced with his supervisor and did not constitute a "preexisting stress condition."

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

The employer concedes that there is a diagnosis of a mental disorder generally recognized in the medical community. ORS 656.802(3)(c). However, the employer disputes the other factors and contends that claimant failed to establish, by medical evidence supported by objective findings, that his employment conditions were the major contributing cause of his mental disorder. The employer asserts that claimant's treating doctors failed to differentiate between compensable and non-compensable factors and failed to factor out those actions falling within the exceptions set forth in ORS 656.802(3)(b). We disagree.

Dr. Hall, psychologist, began treating claimant on March 23, 1994 for symptoms of depression and anxiety resulting from stress experienced on the job. (Ex. 47). Claimant reported problems with sleep and appetite and had lost considerable weight. Claimant had problems with concentration and increased generalized anxiety while at work. Dr. Hall reported that the cause of claimant's stress was his relationship with his immediate supervisor. (Id.) The lack of resolution and continued contact with claimant's supervisor increased his stress. (Id.) On April 22, 1994, Dr. Hall recommended that claimant be off work for six weeks. Dr. Hall believed that claimant's anxiety, depression and sleep and appetite disturbance were the result of job stress and/or discrimination, rather than marital problems. (Ex. 67-4). Dr. Hall reviewed the civil rights complaint claimant had filed with the Bureau of Labor and Industries and she reported that the allegations in the complaint were consistent with what claimant told her. (Ex. 67-3).

Dr. Bennington-Davis, psychiatrist, reported that claimant's chief stressor was his work environment, particularly the conflict with his supervisor. (Ex. 50). Dr. Bennington-Davis diagnosed claimant with major depression, single episode, panic attacks without agoraphobia and gastritis. (Id.) In a later report, Dr. Bennington-Davis said that the claimant's conflict with his supervisor was the major contributor to his depressive symptoms, although she was unable to comment on the specifics of their relationship. (Ex. 66). Claimant was off work for a period of time and reported dramatic improvement in his symptoms. (Id.) When Dr. Bennington-Davis treated claimant on September 15, 1994, he had relapsed back into a major depression and was again working directly with his supervisor. (Id.)

On July 27, 1994, Dr. Turco, psychiatrist, examined claimant on behalf of the employer. Dr. Turco diagnosed an adjustment disorder with mixed emotional features, including depression. (Ex. 62). On August 16, 1994, Dr. Turco reported that he had reviewed reports from Drs. Hall and Bennington-Davis and did not change his earlier opinion. (Ex. 63). Dr. Turco found those records consistent with the diagnosis and the precipitating factors of claimant's difficulties. (Id.) On January 16, 1995, Dr. Turco reported that he had reviewed personnel records and interviewed two people from the employer's staff. (Ex. 65). As a result of the new information, Dr. Turco changed his opinion. Although Dr. Turco believed that claimant's mental disorder arose out of and in the course of employment, he felt that claimant's employment conditions were generally inherent in every working situation (Ex. 69-19), and the disciplinary actions were reasonable. (Ex. 69-20, -21).

The employer argues that all of claimant's allegations arise from either reasonable disciplinary actions or are generally inherent in every job. We disagree. Because we find, as did the ALJ, that the employer's actions were unreasonable, those actions were not excluded under ORS 656.802(3)(b) and may be considered in the analysis of the compensability of the claim. We agree with the ALJ that claimant's employment conditions were 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. ORS 656.802(3)(b).

We disagree with the employer that the medical evidence failed to differentiate between compensable and non-compensable factors. The only non-work-related stress factor was claimant's failed marriage. Claimant testified that his wife moved out at the end of August 1994 and it came as a complete surprise to him. (Tr. III-36, -37). The medical opinions established that claimant's marital problems were not a major factor in causing claimant's mental disorder. Dr. Hall reported that information from claimant and his wife indicated that the problems in their marriage occurred after the major work events. (Ex. 64B-3). As we mentioned earlier, Dr. Hall believed that claimant's symptoms resulted from job stress and/or discrimination, rather than marital problems. (Ex. 67-4). Dr. Bennington-Davis reported that claimant's marriage failed after he developed the mental disorder. (Ex. 66-2). Dr. Turco testified that the marital stress was not the major part of claimant's stress. (Exs. 69-18, 69-22).

Based on the opinions of Drs. Hall and Bennington-Davis, we conclude that claimant's employment conditions were the major contributing cause of his mental disorder. ORS 656.802(2)(a). We agree with the ALJ that Dr. Turco's change of opinion is not persuasive because he relied on inaccurate information. Moreover, we agree with the ALJ that there was clear and convincing evidence that the medical disorder arose out of and in the course of employment. ORS 656.802(3)(d). We also agree that the employment conditions producing the mental disorder existed in a real and objective sense. ORS 656.802(3)(a). We therefore affirm the ALJ's order setting aside the employer's denial.

Acceptance of Specific Diagnosis

Claimant cross-requests review, arguing that the employer should be ordered to accept the specific mental disorder of major depression. The employer contends that the claim was not made for a specific diagnosis. The employer argues that, if the claim is held compensable, it will have to process the claim and issue a specific acceptance. If claimant does not agree with the accepted condition, claimant has a statutory remedy under ORS 656.262(6)(d).

As we mentioned earlier, the employer conceded that claimant had established a generally recognized mental or emotional disorder diagnosis. ORS 656.802(3)(c). Nevertheless, the employer did not refer to a specific diagnosis nor did the parties litigate the compensability of a specifically identified mental disorder. Under these circumstances, we agree with the employer that it is inappropriate to order the employer to accept a specific mental disorder at this time.

Penalties

We adopt and affirm the ALJ's reasoning and conclusion that a penalty should be assessed for the employer's unreasonable denial and the employer's unreasonable failure to provide timely discovery.

Attorney Fees

Claimant requested an attorney fee of $28,826 for services at hearing. The ALJ awarded $15,000. The employer contends that an appropriate fee at hearing should be between $5,000 and $6,000. Claimant cross-appeals, arguing that the attorney fee at hearing should be increased to $28,826.

On de novo review, we consider the amount of claimant's counsel's attorney fee for services at the hearings level by applying the factors set forth in OAR 438-015-0010(4). Those factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party: (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Based on the application of the previously enumerated factors, we agree with the ALJ that a reasonable fee for claimant's attorney's services at hearing regarding the compensability issue is $15,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's counsel's affidavit) and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(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 $6,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services and the employer's objections thereto), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the unsuccessful cross-request for a specific diagnosis or the penalty and attorney fee issues. 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 January 29, 1996 is affirmed. For services on review, claimant's attorney is awarded $6,000, payable by the self-insured employer.

November 14, 1996 Cite as 48 Van Natta 2284 (1996)

In the Matter of the Compensation of
LINDA J. MILLER, Claimant
WCB Case No. 95-03284 & 94-14286
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Health Future, on behalf of Rogue Valley Medical Center, requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denials of claimant's "current condition"/aggravation claim for a right shoulder condition; and (2) upheld the responsibility denial of Grocer's Insurance, on behalf of Foodland, of claimant's "new injury" for the same condition. On review, the issues are compensability, aggravation and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured her right shoulder in October 1988 while working for Rogue Valley Medical Center. On March 21, 1989, Dr. Peterson performed an anterior acromionectomy on claimant's right shoulder to repair her subacromial impingement. Five months post-surgery, in August 1989, claimant returned for a follow-up examination complaining of pain in the right shoulder, and the base of the neck along with tingling in her right arm. Dr. Peterson found diffuse tenderness about the shoulder and noted possible thoracic outlet compression.

Claimant was declared medically stationary on January 2, 1990, with permanent limitations and future waxing and waning of symptoms anticipated. The claim was closed by Determination Order issued February 15, 1990, awarding 15 percent unscheduled permanent disability. Claimant's unscheduled permanent disability award was later increased to 20 percent by stipulation.

Claimant sought no treatment for her right shoulder between January 1990 and October 1994, although her symptoms waxed and waned depending on the usage of her right arm. She started working for Foodland in July 1992, first as a checker, then in the meat department and deli.

On October 2, 1994, claimant returned to Dr. Peterson complaining of pain and numbness in her right upper extremity and right hand. She reported no specific injury. On the day she decided to seek treatment, she had been wrapping meat in the meat department. Dr. Peterson diagnosed a shoulder girdle strain with low grade thoracic outlet compression.

On October 27, 1994, Health Future, on behalf of Rogue Valley Medical Center, issued a denial of compensability and responsibility for claimant's "current right shoulder symptoms," noting that "the worsening of your right shoulder is related to your current employment at Foodland." On February 22, 1995, Grocer's Insurance (on behalf of employer Foodland) issued a compensability and responsibility denial. Then, on July 25, 1995, Health Future issued an "amended compensability denial," denying an aggravation of claimant's compensable condition.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that the condition for which claimant sought treatment in October 1994 involved the same condition accepted by Health Future in 1988, and that Health Future remained responsible for medical treatment for claimant's right shoulder condition under ORS 656.308(1). On review, Health Future asserts that the ALJ erred in characterizing its compensability denial as a "current condition" denial rather than an aggravation denial. Alternatively, Health Future argues that claimant suffered a new injury or occupational disease as a result of her employment at Foodland and therefore it was no longer responsible for claimant's right shoulder condition.

Compensability /Aggravation

Whether or not we resolve the issue under a "current condition" or aggravation theory, the bottom line is that Health Future is contesting the compensability of claimant's current condition.[1] To establish a compensable aggravation, claimant must prove two specific elements: (1) a "compensable condition"; and (2) an "actual worsening" of the compensable condition. See Gloria T. Olson, 47 Van Natta 2348 (1995). Further, if claimant's current right shoulder condition is a "combined condition" under ORS 656.005(7)(a)(B), claimant must prove that her compensable injury is the major contributing cause of her current condition. Id.

After reviewing the medical record, we are persuaded that the right shoulder symptoms for which claimant sought treatment in 1994 were caused in major part by her 1988 accepted injury.[2]

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[1] Despite Health Future's contention, we agree with the ALJ that claimant's "current condition" was at issue. Health Future's October 27, 1994 denial expressly denied the compensability of claimant's "current shoulder symptoms." While Health Future's subsequent "amended compensability denial" specifically denied the compensability of an aggravation, its initial denial was not so limited. Further, there is nothing in the text of the July 25, 1995 aggravation/worsening denial to indicate that Health Future intended to rescind its prior "current condition" denial.

[2] Because claimant has satisfied the "major contributing cause" standard in any event, we need not address whether her current shoulder condition is a "combined condition" under ORS 656.005(7)(a)(B).

Claimant reported that, since the injury and the resultant 1989 surgery, her right shoulder has remained symptomatic, depending on her activity. (See, e.g., Exs. 38, 39-22, 43-1) In his deposition, Dr. Peterson opined that, assuming claimant had experienced such ongoing symptoms, her need for treatment in October 1994 related to her accepted injury rather than any new industrial injury.[3] (Ex. 45-33). Dr. Weinman, who examined claimant on behalf of Grocers' Insurance, similarly concluded that claimant's right shoulder symptoms in October 1994 were caused in major part by her 1988 injury. (Exs. 43, 44a). Although he only examined claimant on one occasion, Dr. Weinman's opinion is complete, well-reasoned and based on an accurate history. Consequently, like the ALJ, we conclude that claimant has established the compensability of her current condition.

We nevertheless agree with Health Future that claimant has not proven an aggravation claim because there is insufficient evidence of an "actual worsening" of her compensable condition supported by objective findings. ORS 656.273(1). Because claimant has previously been awarded permanent disability for her right shoulder condition, she must establish that her current condition is worse than the waxing and waning of the symptoms contemplated by the previous award. ORS 656.273(8); Paul Bilecki, 48 Van Natta 97 (1996). Yet, there is no persuasive medical evidence indicating that claimant's current (1994) right shoulder symptoms exceeded the waxing and waning contemplated by her prior 20 percent unscheduled permanent disability award. Indeed, both Dr. Weinman and Dr. Peterson agreed that claimant's symptoms were expected and that she experienced no additional right shoulder impairment. Therefore, we conclude that Health Future's aggravation denial should be upheld.

Responsibility

We adopt and affirm that portion of the ALJ's order finding that Health Future remains responsible for medical services for claimant's right shoulder condition under ORS 656.308(1). There is no persuasive evidence that claimant sustained a new injury or occupational disease involving her right shoulder as a result of her employment activities at Foodland.[4]

Attorney Fee

The ALJ's order set aside both of Health Future's denials and awarded an assessed attorney fee for prevailing over "the denial of medical treatment." Although we reverse the ALJ's order insofar as it implicitly set aside Health Future's aggravation denial, we uphold the ALJ's decision to set aside Health Future's "current condition" and responsibility denials. Therefore, we have not disallowed or reduced the compensation awarded claimant by the ALJ's order insofar as the compensation pertaining to claimant's current condition, and claimant's attorney is entitled to an assessed fee on review pursuant to ORS 656.382(2) for services related to that issue. See, e.g., Rodney V. Boqua, 48 Van Natta 357 (1996) (when conditions are considered separately for purposes of rating permanent disability and the carrier appeals the compensation awarded for every condition, claimant is entitled to an assessed fee for successfully defending against the carrier's challenge if the compensation for at least one condition is not reduced).

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 of claimant's current condition and need for treatment is $1,500, payable by Health Future. 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.[5]

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[3] Dr. Peterson's opinion that claimant sustained an acute shoulder strain while working for Grocers' insured was based on an (inaccurate) understanding that claimant's right shoulder was asymptomatic following claim closure and that the symptoms for which she sought treatment had recently developed at work. (See Ex. 44, pp. 32-33).

[4] As noted above, Dr. Peterson's opinion is unpersuasive because it is based on an inaccurate history of claimant's symptoms. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

[5] We note that the ALJ awarded a separate attorney fee of $1,000 pursuant to ORS 656.308(2)(d) for claimant's counsel's meaningful participation in overturning the responsibility denial. In the absence of extraordinary circumstances, this statutory maximum of $1,000 is cumulative for all levels of litigation. Tammy Locke, 48 Van Natta 250 (1996). Claimant did not argue, nor do we find, that this case presents extraordinary circumstances. Therefore, claimant's counsel is not entitled to an additional attorney fee for services on review concerning the responsibility issue.

ORDER

The ALJ's order dated May 7, 1996 is affirmed in part and reversed in part. That part of the order that set aside Health Future's July 25, 1995 aggravation denial is reversed, and Health Future's aggravation denial is reinstated and upheld. The remainder of the ALJ's order is affirmed. For services on review with regard to the compensability of claimant's current right shoulder condition and need for treatment, claimant's counsel is awarded $1,500, payable by Health Future.

November 14, 1996 Cite as 48 Van Natta 2287 (1996)

In the Matter of the Compensation of
ROBERT W. STEPHENSON, Claimant
WCB Case No. 95-06940
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order which: (1) set aside its denial of claimant's current respiratory condition as premature; and (2) awarded an assessed fee pursuant to ORS 656.386(1). On review, the issues are premature denial and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a farm worker, filed a claim for exposure to pesticides in 1992, which the insurer accepted as "spray exposure, nondisabling." An order of a prior ALJ later changed the classification of the claim to "disabling." Claimant eventually received an award of 28 percent unscheduled permanent disability in a March 14, 1995 Determination Order.

The insurer requested reconsideration, which resulted in a medical arbiter's examination conducted by Dr. Lewis, who diagnosed mild obstructive airways disease related to a long-standing history of reactive airways disease with intermittent exposure to potentially irritating fumes from noxious chemicals. Dr. Lewis further opined that claimant's degree of airways obstruction was entirely consistent with his underlying condition and did not represent a permanent injury related to the compensable inhalation exposure in 1992. (Ex. 16-4).

In a follow-up report to the Department, Dr. Lewis reiterated that claimant had no permanent impairment from the accepted condition and that the mild airways obstruction was not related to the compensable injury. (Ex. 17). Based on these reports, a June 6, 1995 Order on Reconsideration reduced claimant's award of permanent disability to zero. (Ex. 19).

On July 31, 1995, the insurer denied claimant's current condition, and any permanent impairment associated with it, on the ground that claimant had no permanent impairment related to his compensable spray exposure in June 1992. (Ex. 20). Claimant requested hearings both with regard to the Order on Reconsideration and the insurer's denial. However, at the hearing, claimant withdrew his hearing request with respect to the reconsideration order. Claimant's sole contention was that the insurer's denial was premature.

The ALJ agreed with claimant that the insurer's denial was premature and set aside the denial of claimant's current respiratory condition.[1] On review, the insurer contends that its denial was not prematurely issued because it was issued in response to a "claim for compensation." We disagree.

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[1] The ALJ wrote that amended ORS 656.262(10) overruled Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994). However, the court in Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) held that amended ORS 656.262(10) did not overrule Messmer.

Where no "claim" for compensation has been made by the claimant or someone on the claimant's behalf pursuant to ORS 656.005(6), the issuance of a denial is generally considered to be premature. See Dorothy M. Jackson-Duncan, 42 Van Natta 1122 (1990). Here, the medical arbiter, Dr. Lewis, diagnosed mild airways obstruction related to claimant's underlying reactive airways disease. Dr. Lewis opined that claimant had no permanent impairment related to his compensable spray exposure. Inasmuch as his role as a medical arbiter was to rate permanent impairment, if any, due to claimant's compensable condition, Dr. Lewis did not contemplate or recommend any treatment for claimant. Under these circumstances, we do not construe Dr. Lewis' medical arbiter's report as a "claim" for mild airways obstruction. See Loreta C. Sherwood, 48 Van Natta 992 (1996) (where physician neither recommended nor provided treatment, medical report did not constitute claim).[2] Accordingly, we conclude that the insurer's denial based on Dr. Lewis' report was "premature."

The insurer further asserts, that claimant's request for hearing from the reconsideration order was a "claim" that justified its denial of claimant's current respiratory condition. The insurer reasons that, inasmuch as claimant was requesting permanent disability for the compensable condition by filing his hearing request, such request triggered its duty to issue a denial of claimant's current condition. We disagree.

Even assuming that a hearing request can be a "claim" under ORS 656.262(7)(a), see Shannon E. Jenkins, 48 Van Natta 1482 (1996) (Guillermo Rivera, 47 Van Natta 1723 (1995) disavowed; request for hearing does not satisfy requirements of ORS 656.262(6)(d)), the hearing request in the instant case was insufficient to constitute a "new medical condition" claim under that statute. That is, inasmuch as there was not a clear request for formal written acceptance of a "new medical condition," we decline to construe the hearing request in this case as a "claim." We, therefore, agree with the ALJ that the insurer's denial in this case was prematurely issued. It follows that the ALJ correctly set it aside.

Finally, the ALJ awarded an assessed attorney fee of $2,800 pursuant to ORS 656.386(1) for claimant's counsel's services in setting aside the insurer's "premature" denial. We disagree with the ALJ's attorney fee award.

Inasmuch as we have determined that claimant has made no "claim," he will receive no benefits as a result of our holding that the insurer's denial was premature and a nullity. Thus, we conclude that claimant has not "prevailed" over a denied claim and is, therefore, not entitled to an assessed attorney fee under ORS 656.386(1). Cf. Jacquelyne M. Schulte, 48 Van Natta 1649, on recon 48 Van Natta 1873 (1996) (since carrier's denial of withdrawn claim was a nullity, the claimant did not "prevail" over a denied claim and, therefore, was not entitled to attorney fee under ORS 656.386(1)); William C. Becker, 47 Van Natta 1993 (1995) (same).[3]

ORDER

The ALJ's order dated January 2, 1996 is reversed in part and affirmed in part. That portion that awarded an assessed attorney fee for claimant's counsel pursuant to ORS 656.386(1) is reversed. The remainder of the ALJ's order is affirmed.

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[2] We note that ORS 656.262(7)(a) allows a "worker" to file a claim for a "new medical condition" after claim acceptance. However, even assuming that Dr. Lewis could file such a claim on claimant's behalf, there was no "clear request" for formal written acceptance of any new medical condition. Therefore, the requirements of ORS 656.262(7)(a) were not satisfied by Dr. Lewis' report.

[3] Although bound by stare decisis to follow Becker and Schulte, Board Chair Hall directs the reader to his dissent in Becker.

In the Matter of the Compensation of
EDWARD W. JORDAN, Claimant
WCB Case Nos. 96-05512, 96-03693 & 96-02508
ORDER DENYING MOTION TO DISMISS
Ransom & Gilbertson, Claimant Attorneys
Ronald W. Atwood & Associates, Defense Attorneys
Michael Fetrow (Saif), Defense Attorney

The SAIF Corporation/Alberts Construction has requested Board review of Administrative Law Judge (ALJ) Davis' September 26, 1996 order. Contending that SAIF's/Alberts' motion was untimely filed, claimant has moved the Board for an order dismissing the request for review. We deny the motion.

FINDINGS OF FACT

On September 26, 1996, the ALJ issued an Opinion and Order that: (1) set aside SAIF's/Alberts' denial of claimant's "new injury" claim for a left-sided disc herniation at L5-S1; (2) upheld SAIF's/Fallon Logging, Inc.'s denial of claimant's aggravation claim for the same condition; and (3) assessed penalties for allegedly unreasonable claim processing.

On Tuesday, October 29, 1996, the Board received SAIF's/Alberts' October 28, 1996 request for Board review of the ALJ's September 26, 1996 order. The request, which was mailed by certified mail, included a Certificate of Service from SAIF's/Alberts' attorney certifying that, on October 28, 1996, the request had been mailed to the Board with copies either mailed or hand-delivered to all parties and their representatives that same day.

A computer-generated acknowledgment of SAIF's/Alberts' request for review was mailed by the Board on October 31, 1996.

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). 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 (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). 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.

Claimant contends that we lack jurisdiction to consider SAIF's/Alberts' appeal because it "did not file [its] appeal within thirty (30) days as required by ORS 656.289(3)." We disagree that SAIF's/Alberts' request for review is defective.

The 30th day after the ALJ's September 26, 1996 order was October 26, 1996, a Saturday. Therefore, the final day to perfect a timely appeal was Monday, October 28, 1996, the first business day following the expiration of the 30-day period. See Anita L. Clifton, 43 Van Natta 1921 (1991). Inasmuch as SAIF's/Alberts' request for review was mailed, by certified mail, to the Board on October 28, 1996, it was timely filed. See ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(a); Harold E. Smith, 47 Van Natta 703 (1995).

We apply similar reasoning to conclude that notice of SAIF's/Alberts' appeal was timely provided to all parties to the ALJ's order. SAIF's/Alberts' counsel's Certificate of Service states that, on October 28, 1996, a copy of its request was mailed or hand-delivered to all parties to the proceeding, as well as to the parties' respective attorneys. That certification is uncontested. Therefore, we conclude that SAIF/Alberts provided timely notice of its appeal to the other parties to the proceeding prior to the expiration of the aforementioned 30-day appeal period from the September 26, 1996 order. See Harold E. Smith, supra. Consequently, we retain appellate jurisdiction to consider SAIF's/Alberts' appeal. See ORS 656.295(2).

Accordingly, claimant'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 implemented. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

November 15, 1996 Cite as 48 Van Natta 2290 (1996)

In the Matter of the Compensation of
BRUCE D. LOCKETT, Claimant
WCB Case Nos. 96-02379 & 95-12649
ORDER OF DISMISSAL
Emmons, Kropp, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Safeco Legal, Defense Attorney

Liberty Northwest Insurance Corporation (Liberty) requested review of that portion of Administrative Law Judge (ALJ) Galton's order that set aside its denial of claimant's bilateral arm condition. Safeco Insurance Company (Safeco) moves to dismiss the request for review on the grounds that Liberty has formally accepted claimant's claim. We grant Safeco's motion to dismiss.

FINDINGS OF FACT

On August 16, 1996, the ALJ issued an Opinion and Order setting aside Liberty's responsibility denial of claimant's bilateral posterior tibial tendinitis condition. On August 20, 1996, Liberty accepted claimant's claim by a Notice of Claim Acceptance. The notice informed claimant that Liberty was accepting bilateral posterior tibial tendinitis as a disabling occupational disease "Per Opinion & Order." Also, on August 20, 1996, Liberty requested Board review of the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Safeco asserts that, in view of Liberty's unqualified acceptance of claimant bilateral arm condition, Liberty is barred from appealing the ALJ's decision. We agree.

In SAIF v. Mize, 129 Or App 636 (1994), before it petitioned for judicial review of a Board order, the carrier accepted the claimant's claim by a clear and unqualified Notice of Acceptance. The court held that the carrier's acceptance rendered moot any controversy over the compensability of the claimant's claim and dismissed the carrier's petition for judicial review. Id. at 640. In so concluding, the court emphasized that once a carrier officially notifies a claimant that it has accepted a claim, it may not subsequently deny compensability with complying without ORS 656.262(6). Id.

In Gerald J. Dahl, 47 Van Natta 1055 (1995), we extended the Mize rationale to apply to cases involving denials of responsibility. In Dahl, the carrier found responsible by the ALJ's order accepted the claimant's claim by formal Notice of Acceptance. Thereafter, it appealed the ALJ's order which had set aside its denial of responsibility. Under those circumstances, we held that the carrier's clear and unqualified acceptance rendered moot any controversy regarding the responsibility for the claimant's claim. Id.

Here, as in Dahl, Liberty's Notice of Acceptance did not indicate that it was contingent upon its appeal of the ALJ's order or that the acceptance was otherwise qualified. Under these circumstances, we conclude that Liberty issued a clear and unqualified acceptance that rendered moot any controversy between the parties regarding the compensability of or the responsibility for the claim.

In reaching this conclusion, we distinguish Janice M. Hunt, 46 Van Natta 1145 (1994). In Hunt, the carrier issued a "Notice of Acceptance" accepting claimant's claim as disabling while the ALJ's order directing that reclassification was on review. Simultaneously, in a "1502" form, the carrier notified claimant of its intent to challenge the classification issue. We declined to dismiss the carrier's request for review, reasoning that since the issue on review was reclassification, as opposed to compensability, Mize and its progeny were distinguishable. In addition, we noted that, because the carrier simultaneously notified claimant of its intent to challenge the classification issue, its acceptance was not inconsistent with its assertion that claimant's claim was nondisabling. Id. at 1146.

Here, unlike Hunt, the dispute does not involve the classification of claimant's compensable condition, but rather it concerns which carrier is responsible for claimant's condition. On that basis alone, Hunt is distinguishable. Moreover, although Liberty did appeal the ALJ's order on the same day it issued the Notice of Acceptance and 1502 form, neither the notice nor 1502 form indicate that Liberty's acceptance was contingent upon its appeal of the ALJ's order. The mere fact that Liberty appealed the ALJ's order on the same day of its acceptance is not sufficient to infer that the acceptance was qualified or contingent upon the outcome of the appeal.[1]

This conclusion is further supported by our decision in Scott C. Clark, 47 Van Natta 133 (1995). In Clark, the carrier had requested review of an ALJ's order which set aside its denial of the claimant's injury claim. Subsequent to its request for review, the carrier sent the claimant a letter indicating that it was accepting the claim. Based on the carrier's unqualified acceptance, we held that the controversy regarding the compensability of the claimant's claim had been rendered moot and, therefore, we dismissed the carrier's request for review. Id. at 134.

For these reasons, we dismiss Liberty's request for Board review.

IT IS SO ORDERED.

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[1] We note that the court's decision in Mize was not premised on the timing of the carrier's acceptance. Rather, it was based on the carrier's clear and unqualified acceptance of the claimant's claim. Mize, supra at 639. Consistent with that rationale, we hold that Liberty's unqualified acceptance renders its appeal of the ALJ's order moot.

November 15, 1996 Cite as 48 Van Natta 2291 (1996)

In the Matter of the Compensation of
BRIAN W. ANDREWS, Claimant
WCB Case Nos. 93-08329 & 93-05174
ORDER OF ABATEMENT
Peter O. Hansen, Claimant Attorney
Stoel Rives, Defense Attorneys
James Thwing (Saif), Defense Attorney

Claimant moves for abatement and reconsideration of our October 16, 1996 Order on Remand which reinstated and upheld the SAIF Corporation's denial of claimant's low back and left leg injury claim

In order to allow us sufficient time to consider the motion, we withdraw our October 16, 1996 order. SAIF is requested to submit a response to claimant's motion. In order to be considered, SAIF'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
EDWARD C. STEELE, Claimant
WCB Case Nos. C6-02786 & C6-02787
ORDER DENYING RECONSIDERATION
S. David Eves, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

On October 10, 1996, the Board approved the parties' claims disposition agreements (CDAs) in the above captioned matters. Pursuant to those agreements, in consideration of the payment of a stated sum, claimant, who is represented by an attorney, released his rights to future workers' compensation benefits, except for medical services, for his compensable injuries.

On November 8, 1996, we received claimant's letter requesting "review" of the CDA. We interpret claimant's letter as a motion for reconsideration of the CDA.

In order to be considered, a motion for reconsideration of the CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Here, the CDA was approved in final order and mailed on October 10, 1996. We received claimant's letter requesting reconsideration of the CDA on November 8, 1996, 29 days after the CDA was approved in final order. Inasmuch as the motion for reconsideration was untimely, we cannot consider it. Paul J. LaFrance, 48 Van Natta 306 (1996); Carl E. Worley, 47 Van Natta 1636 (1995).

Moreover, we approved the CDA in a final order pursuant to ORS 656.236. The approved CDA is final and is not subject to review. ORS 656.236(2). Consequently, we are without statutory authority to alter the previously approved CDA.[1]

IT IS SO ORDERED.

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[1] Claimant continues to seek our response to several questions regarding the processing of his claim and the CDAs. As stated above, we are not authorized to reconsider our prior decision. Nonetheless, even if we could consider claimant's recent submission, we are without statutory authority to address the claim processing issues/questions posed in his request. Those issues were presented pursuant to claimant's hearing request in WCB Case Nos. 89-10606 and 96-02279 for consideration by an Administrative Law Judge (ALJ) at the hearings level and, as a result of our approval of the CDA, the hearing requests were dismissed. We note that claimant has also requested Board review of the ALJ's dismissal order. Therefore, following the expiration of the briefing schedule regarding that appeal, the Board will have an opportunity to consider claimant's argument regarding the propriety of the ALJ's dismissal order and, if found inappropriate, address the substantive questions raised regarding the processing of this claim as raised by claimant's current request. However, in this particular case, our authority is confined to a review of the parties' proposed CDA and a determination whether the proposed disposition is "unreasonable as a matter of law." See ORS 656.236(1)(a)(A). Since we did not find the agreement to be unreasonable as a matter of law, the CDA received our approval. That is the extent that we are authorized to comment on any CDA. Consequently, if claimant considers these comments to be in inadequate, it is again recommended that he direct his questions to his attorney. In the event that he is no longer represented by counsel, he may wish to seek assistance from the Workers' Compensation Ombudsman, Labor and Industries Building, Salem Oregon 97310, (503) 378-3351.

In the Matter of the Compensation of
GARY W. YEAGER, SR., Claimant
Own Motion No. 96-0541M
OWN MOTION ORDER DENYING CONSENT TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Malagon, et al, Claimant Attorneys
Liberty Northwest, Insurance Carrier

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1986 injury claim with Liberty Northwest expired on May 6, 1993. Thus, the claim is subject to ORS 656.278.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if 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, 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. Id.

We find no medical documentation in the record which might establish that claimant's current condition requires outpatient surgery or inpatient hospitalization. Thus, the record fails to establish that there has been a worsening of the compensable injury which requires inpatient or outpatient surgery or other treatment requiring hospitalization. Consequently, based on this record, the Board may not authorize the payment of temporary disability compensation on its own motion.

Accordingly, the Board is without authority to consent to an order designating a paying agent for the purposes of temporary disability compensation. However, since responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. See OAR 436-060-0180(13).

IT IS SO ORDERED.

In the Matter of the Compensation of
JUAN J. BASILIO, Claimant
WCB Case No. 96-02371
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's denial of his current right arm condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant began to experience right shoulder and arm pain in Fall 1994. He first sought medical treatment for his right arm symptoms on February 9, 1995. Claimant was initially diagnosed with chronic right deltoid pain and chronic right elbow pain. (Ex. 6). Claimant was subsequently diagnosed with different conditions. On May 5, 1995, the employer accepted the claim as disabling "Right Arm Pain." (Ex. 52).

After the employer's acceptance, claimant continued to receive treatment for his right arm complaints. Claimant also reported pain in the left arm and shoulder, right back, buttocks, knees and lateral hips. (Ex. 80).

On February 5, 1996, the employer issued a partial denial of claimant's current condition on the basis that it was not compensably related to his employment. (Ex. 115). Claimant requested a hearing, arguing that the employer accepted whatever condition caused his right arm pain.

The ALJ concluded that, based on Dr. Stringham's reports, claimant's accepted right arm condition was a "combined condition," i.e., claimant's work injury merged with a preexisting inflammatory process to produce a "combined condition." The ALJ found that by accepting claimant's claim initially, the employer conceded that claimant's otherwise compensable injury was the major contributing cause of his condition in February 1995. Nevertheless, the ALJ found that ORS 656.262(7)(b) authorized the employer to deny a previously accepted combined condition when the otherwise compensable injury is no longer the major contributing cause. Based on Dr. Stringham's reports that claimant's work activities were not the major contributing cause of his ongoing symptoms or his underlying disease (Exs. 110, 116), the ALJ concluded that claimant failed to prove that his "current condition" was compensably related to his accepted injury.

Claimant argues that, by accepting "right arm pain," the employer accepted his underlying inflammatory disease, which was the cause of his right arm pain, disability and need for treatment in February 1995 and which continues to be the cause of his disability and need for medical treatment.

Even if we assume, without deciding, that the employer's acceptance of "right arm pain" encompassed possible underlying inflammatory disease, we conclude that the employer has established by the preponderance of the evidence that claimant's current condition is not compensable.

Under ORS 656.262(6)(a), if a carrier accepts a claim in good faith and "later obtains evidence" that the claim is not compensable or the carrier is not responsible, it may revoke its acceptance of a claim and issue a denial as long as the denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on the "back-up" denial, the carrier has the burden of proving by a preponderance of the evidence that the claim is not compensable or that it is not responsible for the claim. The requirement of "later obtained evidence" in ORS 656.262(6)(a) refers to new material, i.e., something other than the evidence that the carrier had at the time of the claim

acceptance. CNA Ins. Co. v. Magnuson, 119 Or App 282, 286 (1993). A reevaluation of known evidence, for whatever reason, is not "later obtained evidence" under ORS 656.262(6)(a). Id.[1]

When the employer accepted claimant's claim on May 5, 1995 for "right arm pain" (Ex. 52), Dr. Stringham had issued a report on April 18, 1995, which stated: "It is possible patient has some underlying inflammatory arthritis that is causing a problem that has not been identified as opposed to his work activities." (Ex. 42). Dr. Stringham acknowledged that claimant had repetitive motion in his work activities but he said it was important to rule out any underlying metabolic disease. (Id.)

Although Dr. Stringham's April 18, 1995 report mentioned the possibility that claimant's condition was caused by an underlying inflammatory condition, the copy of that report in the record is date stamped "May 12, 1995" by "GAB," which indicates that Dr. Stringham's report was received by the employer after the acceptance of the claim on May 5, 1995. Under these circumstances, we conclude that the employer did not have a copy of Dr. Stringham's April 18, 1995 report in its possession when it accepted the claim.

We find no evidence in the record to indicate that the employer knew or should have known, at the time of acceptance, that claimant's symptoms could be caused by an underlying inflammatory disease. After acceptance, the employer received reports from Dr. Stringham indicating that claimant's right arm pain since February 1995 was the result of an underlying inflammatory condition, which was not caused by claimant's work activities. (Ex. 120). Dr. Stringham's reports indicated that claimant's work activities were not the major contributing cause of his ongoing symptoms or his underlying inflammatory condition. (Exs. 110, 116). Since Dr. Stringham's later reports were not available to the employer at the time of the May 5, 1995 acceptance, those reports constituted "later obtained evidence" within the meaning of ORS 656.262(6)(a). See CNA Ins. Co. v. Magnuson, supra. Furthermore, since the employer's "back-up" denial was issued within two years from the date of its May 5, 1995 acceptance, we conclude that its "back-up" denial was issued in accordance with the terms of ORS 656.262(6)(a).

In order to sustain its "back-up" denial, the employer must prove, by the preponderance of the evidence, that the claim is not compensable or that the employer is not responsible for the claim. Here, we find that the employer has satisfied that statutory requirement.

When a compensable injury combines with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if the compensable injury is the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B). We agree with the ALJ that Dr. Stringham's opinion established that claimant's work injury combined with a preexisting inflammatory process to produce a "combined condition." On May 24, 1996, Dr. Stringham agreed that claimant's underlying inflammatory condition was not caused by his work activities, although it first became symptomatic as a result of those work activities in February 1995. (Ex. 120). In the May 24, 1996 report, Dr. Stringham agreed with the following:

> "You are of the opinion that [claimant] has an inflammatory process that was in place, but not symptomatic prior to the work injury or exposure of February 1995. It is your opinion that the right arm pain which [claimant] complained of and has been receiving treatment for since February 1995 is the result of this underlying inflammatory condition. It is further your opinion that this condition, while not caused by [claimant's] work activities, first became symptomatic as a result of those work activities in February 1995. Finally, it is your opinion that [claimant's] current condition is the same condition that you saw and have been treating since February 1995, except that this condition has progressed such that he is not experiencing symptoms in other parts of his body." (Id.)

Based on Dr. Stringham's opinion, we conclude that claimant's work injury combined with a preexisting inflammatory process to produce a "combined condition."

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[1] In Michael J. Joseph, 47 Van Natta 2043, 2045 n.3 (1995), we noted that the 1995 amendments to ORS 656.262(6)(a) included the same "later obtained evidence" language that existed in the former version of the statute. Therefore, we concluded that the Magnuson holding was equally applicable under amended ORS 656.262(6)(a).

Turning to the question of whether claimant's work injury was the major contributing cause of the combined condition, we conclude that the employer has established that the injury was not the major contributing cause. Dr. Stringham's December 30, 1995 and February 25, 1996 reports indicated that claimant's work activities were not the major contributing cause of his ongoing symptoms or his underlying condition. (Exs. 110, 116).

There are no other medical reports that establish that claimant's work injury was the major contributing cause of the disability or need for treatment of the combined condition. Dr. Dordevich opined that claimant had no identifiable medical condition and concluded that claimant's complaints were entirely subjective. (Ex. 96-8). Dr. Dordevich also opined that claimant's work activities had no relationship to his complaints. (Ex. 96-10). Dr. Krohn diagnosed claimant with polyarticular inflammatory arthritis, but he opined that claimant's "work environment was not the major contributing cause of his polyarticular arthritis." (Ex. 113-2). Although Dr. Gandler diagnosed fibromyalgia (Ex. 80), we agree with the ALJ that his opinion was not persuasive in light of claimant's improvement following massage therapy and the later opinions of Drs. Krohn, Dordevich and Stringham.

In conclusion, we hold that the employer has established, by the preponderance of the evidence, that the claim is not compensable. ORS 656.262(6)(a). Therefore, we affirm the ALJ's ultimate conclusion that upheld the employer's partial denial of claimant's current condition.[2]

ORDER

The ALJ's order dated June 19, 1996 is affirmed.

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[2] In light of our conclusion, we do not address the employer's argument that claimant failed to establish his condition by medical evidence supported by objective findings.

November 18, 1996 Cite as 48 Van Natta 2296 (1996)

In the Matter of the Compensation of
CYNTHIA I. COBB, Claimant
WCB Case No. 95-13219
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of her mental disorder claim. On review, the issue is compensability.

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

Claimant, age 44 at the time of hearing, worked as a health information analyst for the employer hospital in Klamath Falls, Oregon. Her job duties included pulling medical charts, answering phones, greeting physicians and the public at the front desk of the medical records department, monitoring and ordering supplies, purging files of documentation and sending letters of delinquent medical records to physicians and emergency medical technicians.

In the spring of 1995, claimant moved from Klamath Falls to a rural area outside of Keno, Oregon. Claimant was then required to commute to Klamath Falls for work, a 30 to 40 minute drive, depending on traffic and weather conditions. On April 6, 1995, a Thursday, claimant sought treatment from Dr. Beggs complaining of a severe knotting sensation in her stomach which she attributed to work-related stress. Dr. Beggs took her off work for the remainder of the week. On her return to work, claimant advised her supervisor that she intended to quit, and gave two and a half months' notice.

On May 18 and 19, 1995, claimant experienced lightheadedness, tingling in her hands and a "detached" sensation in her right leg as she drove to and from work. On May 20, a Saturday, she experienced the same sensations as she sat at home before leaving for an appointment in town. She was taken to the emergency room and treated. A few days later, claimant saw Dr. Hartman, who diagnosed a series of mild panic attacks. Dr. Hartman recorded a history of claimant having been under stress at work and anticipating quitting her job within a short period of time. He took claimant off work and advised her to quit immediately.

Claimant quit work on May 24, 1995. On July 12, 1995, claimant filed an 801 form for an anxiety attack brought on by prolonged job stress. In September 1995, claimant sought treatment from Dr. Nagy for depression. The insurer denied the claim based on insufficient evidence on October 13, 1995.

The ALJ found that claimant failed to establish by clear and convincing evidence that her employment conditions were the major contributing cause of her condition, diagnosed by Dr. Nagy as depression, panic disorder and agoraphobia. See ORS 656.802(3)(d). Specifically, the ALJ determined that the only medical opinion which described claimant's work as the major cause of her condition was unpersuasive because it was based on an inaccurate history, i.e., that claimant's job involved ever-increasing work demands. The ALJ concluded that a preponderance of the evidence did not establish any significant increase in claimant's duties over the course of her employment.

On review, claimant contends that the ALJ erred in finding that her workload remained stable over time. In addition, claimant urges us to rely on Dr. Nagy's opinion that her work environment is at least 51 percent of the cause of her diagnosed condition, and give little weight to the contrary opinions of Drs. Sasser and Hartman, who found no reason to link claimant's job to her panic disorder and depression.

After reviewing the record, particularly the testimony of claimant, co-worker Michelle Lybbert and claimant's supervisor, Esther Allred, we are not persuaded that claimant experienced ever-increasing demands at work. At hearing, claimant testified about the stressful elements of her job: anticipating a large stack of charts on her desk every Monday morning, dealing with upset doctors or members of the public, and being interrupted from one task, such as pulling charts, to perform another, such as answering the phone. (Tr. 20-21). Claimant did not, however, contend that her duties and responsibilities had changed or that her workload had significantly increased in the months preceding her anxiety attacks.[1] Further, both Michelle Lybbert and Esther Allred testified that claimant's job duties remained essentially the same over the years. (Tr. 54, 67). Therefore, we agree with the ALJ's conclusion that Dr. Nagy's opinion is based on an inaccurate history,[2] and therefore unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

Second, we are not persuaded that the employment conditions which allegedly caused her condition are conditions other than those "generally inherent in every working situation." See ORS 656.802(3)(b). Conditions "generally inherent in every working situation" are those common to all employment, not merely the specific occupation involved. Housing Authority of Portland v. Zimmerly, 108 Or App 596, 599 (1991). We are authorized to determine what conditions are common to all employment on a case-by-case basis. SAIF v. Campbell, 113 Or App 93, 96 (1992).

Claimant contends that her employment conditions, consisting of a large volume of charts and records to process (especially on Mondays), frequent interruptions and responsibility for a variety of tasks and events, including arranging for donuts on Wednesdays and planning a luncheon to entice staff physicians to complete their medical charts, are not generally inherent in every working situation. We disagree.

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[1] Indeed, claimant testified that the additional responsibility of preparing the expiration list, which she had undertaken in the last few years, involved only about one extra hour each month (Tr. 33).

[2] Dr. Nagy explained that because he did not see claimant until September 1995, nearly four months after she quit her job, he had no way of independently validating her report that her work flow had increased and she was not afforded any additional help to complete her work. (Ex. 11).

We find the conditions claimant describes, which boil down to a large volume of work to process on Mondays and, to a lesser extent, Wednesdays, and responsibility for a variety of tasks and duties in a busy office environment, to be conditions generally inherent to every working situation. Indeed, we have held in similar contexts that under-staffing, performance of double duty and lack of time off were conditions generally inherent in every working situation. See, e.g. Tamara L. Oates, 47 Van Natta 1714 (1995) (frequent reassignment of positions due to under-staffing, performance of double shifts, and lack of time off, are conditions generally inherent in every working situation); see also Karen M. Colerick, 46 Van Natta 930 (1994) (changes in procedures, turnover in personnel, under-staffing and altered job duties constituted conditions generally encountered in every working situation). Thus, even if we accepted claimant's contention that she faced ever increasing demands and responsibilities at work, we would conclude that the demands and responsibilities cited by claimant constituted conditions generally inherent in every workplace.

For the above stated reasons, we conclude that claimant has not established the compensability of her mental disorder under ORS 656.802.

ORDER

The ALJ's order dated May 22, 1996 is affirmed.

November 18, 1996 Cite as 48 Van Natta 2298 (1996)

In the Matter of the Compensation of
LOUIS P. HANSET, Claimant
WCB Case No. 95-02469
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

We adopt and affirm the ALJ's order with the following changes and supplementation. We change the date in the first sentence of the second paragraph of the findings of fact to "April 1993." We change the last sentence in that paragraph to read: "The chart notes from Dr. Larson, neurologist, show some degree of treatment into the summer of 1994 for that injury."

We change the fourth full paragraph on page 2 to read:

> "Claimant saw Mr. Johnson again on October 5. He then saw Dr. Larson on October 6, 1994, giving a history of the incident. Dr. Larson reported that claimant appeared to have a modest stretching injury, muscle stretching and ligamentous strains. (Ex. 16)."

We delete the second sentence of the fifth full paragraph on page 2.

The insurer argues that claimant is not credible. Although the ALJ found claimant's testimony credible, he made no express credibility findings based upon claimant's demeanor. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

After our de novo review of the record, we agree with the ALJ's analysis and conclusions. We agree with the ALJ that, although there were inconsistencies between claimant's testimony and the testimony of other witnesses, those inconsistencies do not detract from claimant's testimony or the evidence regarding the occurrence of his injury, the prompt reporting of the injury and his receipt of medical services soon after the injury. Inconsistent statements related to collateral matters are not sufficient to defeat claimant's claim where, as here, the record as a whole supports his testimony. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985).

The insurer contends that claimant failed to establish "objective findings" of an injury. We disagree.

Although acknowledging that there was "not a great deal of objective medical findings" to support compensability, the ALJ found that the reports from Dr. Tollerton and Dr. Puziss provided objective medical evidence of an injury.

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."

In Jairo J. Garcia, 48 Van Natta 235 (1996), we reviewed the legislative history behind the amendments to ORS 656.005(19). We held that the attending physician's report of the claimant's "pain," without findings that were "reproducible, measurable or observable," was insufficient to satisfy the "objective findings" requirement of ORS 656.005(7)(a) and ORS 656.005(19).

Although ORS 656.005(19) has created a more stringent standard for "objective findings," we find this record contains sufficient evidence of "objective findings" to satisfy that standard.

On October 12, 1994, Dr. Tollerton reported the following right upper extremity findings:

> "Sharp vs. dull sensation is greatly diminished, to the point of almost being nonexistent on the palmar surface of the tips of his fingers & along the entire palmar surface of rt. thumb. He is able to squeeze my hand tightly bilat., however, it causes severe pain in his upper medial forearm. He is able to pull me to him 5+/5+ symmetrically although I can detect some decrease in strength on the flexors of rt. upper arm. The extensors of rt. upper arm are considerably weaker than lt., although again still 5+/5+." (Ex. 17).

Dr. Tollerton diagnosed claimant with low back pain and "nerve contusion vs. nerve begin stretched in RUE [right upper extremity]." (Id.)

The "827" form signed by Dr. Tollerton listed "objective findings," in part, as

> "Decreased sharp vs. dull R. finger tips & thumb, equal grip strength but R hand gripping leads to pain in proximal flexors - Decreased strength R. arm in flexing and extending." (Ex. 19).

Dr. Tollerton diagnosed "RUE nerve abrasion/stretching." (Id.) Dr. Tollerton noted that claimant was "[u]nable to lift and maneuver RUE adequately to perform job as farm hand." (Id.)

On December 28, 1994, Dr. Tollerton reported that claimant's pain had continued. (Ex. 26). Dr. Tollerton reported that he did not find any objective findings "except for a very minimal amt. of generalized weakness on the LUE compared to the rt." (Id.) Claimant had "good grip, flexing and extending, although he is mildly stronger on the lt. than rt." (Id.)

Under ORS 656.005(19), "objective findings" are "verifiable indications of injury" that may include decreased muscle strength. Based on Dr. Tollerton's October 12, 1994 reports, we conclude that claimant's right arm injury was established by objective findings under ORS 656.005(19). Dr. Tollerton reported that, although claimant's strength in his right arm was "5+/5+," he could detect some decrease in strength on the flexors of the right upper arm and the extensors of that arm were considerably weaker than the left arm. (Ex. 17). The "827" form signed by Dr. Tollerton on October 12, 1994 listed similar findings. (Ex. 19). The fact that Dr. Tollerton did not find objective findings over two months later does not negate his earlier findings.

Furthermore, we agree with the ALJ that Dr. Puziss reported "objective findings" of an injury. On March 10, 1995, Dr. Puziss reported several findings, including moderately limited extension of the

cervical spine (causing right trapezius and neck pain to the shoulder); mild tenderness of right trapezius, cervical region, levator, lateral pectoral region; slight limitation of shoulder passive abduction due to stiffness and trapezius pain; positive Tinel's sign on the right; and decreased pin prick sensation right ulnar hand and ring and little finger pads. (Ex. 29). On April 14, 1995, Dr. Puziss reported "2+ local Tinel sign right cubital tunnel, negative left. 4/5 strength of right thenars, normal other intrinsic. Decreased pin prick right ring and little finger pads." (Ex. 31).

In a deposition, Dr. Puziss discussed the following objective signs from his April 24, 1996 examination:[1]

> "[T]he Tinel's is positive, the tingling to the ring and little fingers; negative on the other side. There was decreased pin prick sensation on the right ulnar volar palm, ring and little fingers. There was tenderness of the cubital tunnel a little over the medial epicondyle and these are objective findings unless the patient is faking it and would have to look in an anatomy book and make it up." (Ex. 35-13, -14).

Dr. Puziss also testified that the distribution of numbness was an objective finding. (Ex. 35-17).

We agree with the ALJ that the reports from Dr. Puziss establish that claimant's injury was supported by objective findings. Dr. Puziss reported that claimant had moderately limited extension of the cervical spine, slight limitation of shoulder passive abduction and "4/5 strength of right thenars." (Exs. 29, 31). Under ORS 656.005(19), "objective findings" may include decreased muscle strength and limited range of motion.

Finally, the insurer contends that claimant's ulnar nerve distribution problems preexisted the October 1994 injury and he must prove that the injury was the major contributing cause of a worsening of the preexisting condition pursuant to ORS 656.802(2)(b). We disagree.

Claimant argues that his right arm condition resulted from an on-the-job injury on October 3, 1994. Claimant had worked for the employer about 10 days before the October 3, 1994 incident. The medical evidence relates claimant's right arm condition to the October 3, 1994 injury, rather than to ongoing work activities. Thus, we agree with the ALJ that this case is properly analyzed as an injury claim. Consequently, ORS 656.802(2)(b), which applies in occupational disease claims, does not apply here.

We agree with the ALJ's reasoning and conclusions that claimant has met his burden of proving the compensability of the right arm injury, whether that burden is identified as material or major contributing cause. We rely on Dr. Puziss' reports that claimant's October 3, 1994 work injury was the major contributing cause of his ulnar nerve irritation and probable right cubital tunnel syndrome. (Exs. 32, 34).

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 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 July 15, 1996 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the insurer.

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[1] On April 24, 1996, Dr. Puziss reported:

> "3+ Tinel's sign right cubital tunnel with tingling to ulnar distribution in hand and digits. Negative left. Negative Tinel's sign right carpal and Guyon's tunnels, and left. Decreased pin prick right ulnar volar palm and ring and little fingers. Cubital tunnel 2-3+ tender. Medial epicondyle trace. No ulnar nerve subluxation. Intrinsic muscle testing is normal." (Ex. 34).

In the Matter of the Compensation of
JANICE Y. RUTHERFORD, Claimant
WCB Case No. 96-01998
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order which upheld the SAIF Corporation'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.

The ALJ upheld SAIF's denial of claimant's low back injury claim, finding the medical opinion of an examining physician, Dr. Fuller, more persuasive than that of claimant's attending physician, Dr. Madnick. On review, claimant contends that the medical opinion of Dr. Madnick is persuasive and supports a finding that her work activity on November 1, 1995 was the major contributing cause of a low back strain. We disagree.

It is claimant's burden to prove the compensability of her 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, Dr. Fuller, the only physician to address the issue, opined that claimant's work activities combined with a preexisting pelvic obliquity/ hyperlordosis/scoliosis to cause back pain that ultimately resulted in claimant's need for treatment. (Ex. 7-5). Under such circumstances, we agree with SAIF that this case is governed by ORS 656.005(7)(a)(B).

Dr. Madnick opined that claimant's work activity was the major contributing cause of her "symptoms," noting a history that claimant had an acute onset of symptoms at work and that claimant had no prior history of low back pain. (Ex. 10). Ordinarily, we defer to the opinion of the attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find persuasive reasons not to defer to Dr. Madnick's opinion.

Specifically, we agree with the ALJ that the record does not support Dr. Madnick's history that claimant had an acute onset of low back symptoms on November 1, 1995. Although claimant testified at times that her low back symptoms developed as a result of a specific incident of injury, claimant also testified that there was no specific lifting incident. (compare Trs. 25, 32 with Tr. 31). Given the discrepancy in claimant's testimony, we look to the contemporary records in order to determine the nature of the onset of claimant's symptoms. Cf. Steve L. Nelson, 43 Van Natta 1053, 1054 (1991) (claimant's testimony given little weight when inconsistent with the contemporaneous medical documentation).

Based on our review of the contemporaneous claim and medical records, we find that they do not support the history of an acute onset of low back pain on which Dr. Madnick relies. (Exs. 2, 3, 3A, 5). Instead, the record is more supportive of Dr. Fuller's history that claimant experienced a gradual onset of symptoms in early November 1995 without a discrete precipitating event, went on a previously scheduled vacation from November 7, 1995 to November 15, 1995, and then experienced renewed back pain after returning to work on November 16, 1995. (Ex. 7-2). According to Dr. Fuller, the fact that claimant's symptoms developed gradually without a specific incident of injury was typical of low back pain related to underlying anatomic discrepancies. (Ex. 9-2). Thus, Dr. Fuller concluded that claimant's preexisting, underlying conditions were the major contributing cause of claimant's need for treatment in November 1995, even though claimant's work activities may have precipitated her symptoms. Id.

Because we find that Dr. Fuller's history is more accurate than Dr. Madnick's, we agree with the ALJ that Dr. Fuller's opinion is more persuasive. Somers v. SAIF, 77 Or App 259, 263 (1986). Therefore, we affirm the ALJ's decision to uphold SAIF's denial.

ORDER

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

November 19, 1996 Cite as 48 Van Natta 2302 (1996)

In the Matter of the Compensation of
PATRICIA J. HOFSTETTER, Claimant
WCB Case Nos. 96-01165 & 95-10561
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denial of her claim for a left shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that there were no "objective findings" supporting compensability of claimant's left shoulder condition. In reaching his conclusions, the ALJ relied on the opinion of claimant's physician, Dr. Davis.

After reviewing the legal definition of "objective findings," Dr. Davis indicated that there were no objective findings supporting a left shoulder injury. Based on the following analysis, we conclude that the record contains "objective findings" of a left shoulder injury.

"Objective findings in support of medical evidence" are defined as "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. ORS 656.005(19).

We have held that "objective findings" is a legal term, not a medical term, and that a physician's opinion that examination findings do not constitute objective findings is irrelevant if those findings otherwise satisfy ORS 656.005(19). Catherine Gross, 48 Van Natta 99 (1996); Scott Petty, 46 Van Natta 1051 (1994); Craig H. Ayer, 43 Van Natta 2619 (1991).

Here, in spite of his statement that there were no "objective findings" supporting a left shoulder injury, Dr. Davis reported that claimant had "decreased muscle spasm in both shoulders and upper trapezius musculature bilaterally." Based on Dr. Davis' undisputed statement that claimant had "decreased" muscle spasm in both shoulders and upper trapezius musculature bilaterally, we find that claimant had muscle spasm in her left shoulder and left trapezius musculature. Such a finding satisfies the legal definition of an "objective finding." ORS 656.005(19); see also Naomi Whitman, 48 Van Natta 605, on recon 48 Van Natta 891(1996). Under such circumstances, we find that claimant has established objective findings of a left shoulder injury.[1] Catherine Gross, supra.

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[1] In its respondent's brief, the employer asserts that claimant has not established medical causation. However, the employer denied the left shoulder claim solely on the basis of a lack of objective findings. The denial does not assert that medical causation was not established. Moreover, there was no attempt to amend the denial at hearing. Under such circumstances, it would be fundamentally unfair to decide this dispute based on a theory different than that litigated at hearing. See Terry Hickman, 48 Van Natta 1073 (1996); Greg S. Meier, 45 Van Natta 922, on recon 45 Van Natta 1015 (1993). Thus, the employer may not assert that medical causation was not established.

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 attorney's statement of services), 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 May 8, 1996 is reversed in part. That portion which upholds the self-insured employer's denial is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,000, payable by the employer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JUDITH R. KING, Claimant
Own Motion No. 96-0195M
OWN MOTION ORDER
Reeves, Kahn & Eder, Claimant Attorneys
SAIF Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for her compensable left upper extremity lateral epicondylitis and bilateral carpal tunnel syndrome injury. Claimant's aggravation rights on that claim expired on February 21, 1994. Claimant requested temporary disability compensation for her current carpal tunnel syndrome with neurodermatitis involving the right hand condition and ensuing surgery.

On May 9, 1996, SAIF issued a denial of claimant's current cervical strain and bilateral shoulder bursitis/tendinitis condition. In addition, SAIF opposed reopening claimant's 1988 injury claim on the following grounds: (1) surgery or hospitalization is not reasonable and necessary for the compensable injury; (2) SAIF is not responsible for claimant's current condition; and (3) claimant was not in the work force at the time of disability. Claimant requested a hearing to appeal SAIF's denial. (WCB Case No. 96-05051). The Board consolidated the own motion matter with the hearing pending resolution of that litigation. In our order consolidating, we requested that the Administrative Law Judge (ALJ) make findings of fact and a recommendation regarding whether claimant was in the work force at the time of disability.

By Opinion and Order dated September 5, 1996, ALJ Menashe determined that SAIF's May 9, 1996 denial of cervical strain and bilateral shoulder bursitis/tendinitis was premature. The matter of the carpal tunnel syndrome with neurodermatitis of the right hand was not litigated since SAIF had not denied the compensability of that condition. Finally, ALJ Menashe issued a separate, unappealable recommendation in which he found that claimant was not in the work force at the time of disability.

On October 10, 1996, we requested the parties' positions regarding whether surgery had been recommended or requested, and whether claimant was in the work force at the time of disability. SAIF responded, without argument or supporting evidence, that: (1) no surgery or hospitalization is requested as medically necessary; and (2) claimant is not a member of the work force. Claimant submitted evidence that surgery is recommended for the compensable injury, and argued that she was in the work force at the time of disability.

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

We need not resolve this question because, even if claimant required surgery for a worsening of her compensable condition, the record does not establish that she was in the work force when she became disabled.

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). Here, claimant must prove that she was in the work force when her condition worsened requiring surgery. 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, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Relying on the medical record, ALJ Menashe concluded that claimant's compensable condition was not "severe" enough to render her unable to work for sixteen months, from September 1994 until early 1996. The record supports that conclusion. On September 9, 1994, Dr. Puziss released claimant to light or medium work. In a February 19, 1996 "aggravation" report, Dr. Takacs authorized time loss, noting that claimant was restricted to utilizing "extremely light upper [body] extremity use only."

Citing Dr. Takacs' March 19, 1996 medical report, the ALJ noted that Dr. Takacs had opined that claimant was unable to work due to her compensable injury after her condition had worsened. On that basis, the ALJ concluded that Dr. Takacs' opinion did not address claimant's compensable condition at the time of disability. However, although claimant had complained of worsening symptoms in January 1996, Dr. Takacs did not recommend surgery as a possibility until March 1996.[1] Consequently, Dr. Takacs' surgery recommendation coincided with his opinion that claimant was unable to work due to her "worsened" condition. Therefore, we are persuaded that claimant was unable to work due to the compensable condition between January and March 1996, when her condition worsened requiring surgery.

However, in order to satisfy the third Dawkins criterion, claimant must establish, in addition to the "futility" standard, that she has been willing to work. The Board has previously found that, even though a physician might opine that a claimant is unable to work due to a work injury, if the claimant has demonstrated that he / she is unwilling to work, he or she is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. See Arthur R. Morris, 42 Van Natta 2820 (1990); Stephen v. Oregon Shipyards, 115 Or App 521 (1992); Martin L. Moynahan, 48 Van Natta 103 (1996); Marlene J. Andre, 48 Van Natta 404 (1996).

Here, we are not persuaded that claimant has satisfied the "willingness" test set forth in Dawkins, supra. Dr. Puziss released claimant to light or medium work in September 1994. Dr. Takacs opined that claimant's compensable condition worsened in early 1996. The record indicates that claimant has not worked nor has she sought work since she was released to return to work in 1994. Claimant submitted a May 16, 1996 affidavit, in which she stated that she has been unable to work due to the compensable injury since her wrist operations in 1994. Claimant further stated that "I want to work but I cannot." However, as noted above, the record does not support claimant's contention that it was futile for her to seek work from September 1994 until she became "disabled" from work in early 1996. Claimant also attested that she could not find any work that she could perform "in my current condition." However, the record does not establish that she sought any work at all.

Because we are not persuaded that it was futile for claimant to work from September 1994 until her condition worsened, nor that she sought "anything that I can do in my current condition" during that time, we are likewise not persuaded by claimant's sworn statement that she was willing to work at the time of disability. Claimant's actions (or the lack thereof) in seeking work from September 1994 until March of 1996 suggest that she was unwilling to attempt the work to which she had been released. See Martin L. Moynahan, supra; Marlene J. Andre, supra. Therefore, we agree with the ALJ's recommendation that claimant has not established that she was in the work force at the time of disability.

Accordingly, we deny claimant's request for own motion relief.

IT IS SO ORDERED.

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[1] Claimant's claim is in own motion status. Therefore, the degree of severity of the worsened medical conditions for which a claimant is eligible for time loss is different than the degree of severity allowing for time loss in an "aggravation" claim. In order to qualify for temporary disability compensation in an own motion claim, a claimant's compensable condition must have "worsened" to the extent that it requires outpatient surgery or inpatient hospitalization. ORS 656.278(1).

In the Matter of the Compensation of
RICKY W. KRIEGER, Claimant
WCB Case No. 96-01585
ORDER ON REVIEW
Hollander, 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) Menashe's order that set aside its denial of claimant's occupational disease claim for a left foot condition. On review, the issue is compensability.

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

Relying on the medical opinion of claimant's podiatrist, Dr. Rutan, the ALJ found that claimant had established compensability of his left foot condition as an occupational disease. For the reasons given in the ALJ's order, we agree that Dr. Rutan's opinion is more persuasive than that of Dr. Peterson, orthopedic surgeon, who examined claimant and rendered an opinion on behalf of the insurer.

On review, the insurer argues that claimant's claim is based on the worsening of a preexisting condition which combined with his work activities. On the basis of this argument, the insurer contends that claimant must prove that his work activities were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

Dr. Rutan indicates that claimant had a preexisting, but asymptomatic, os peroneum. An os peroneum is a sesamoid bone sometimes formed in the tendon of the peroneus longus muscle. Dorland's Illustrated Medical Dictionary (25th ed. 1974).

Dr. Rutan believed that the major contributing cause of claimant's left foot condition was most likely claimant's work activities. Dr. Rutan explained that the repeated overuse of the peroneal muscles can cause a tendonitis to develop at its insertion. Dr. Rutan explained that the presence of the os peroneum alters the attachment of the tendon and increases strain. In addition, Dr. Rutan indicated that claimant's preexisting condition was worsened temporarily by the work activities.

ORS 656.802(2)(b) provides that if the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. See Dan D. Cone, 47 Van Natta 2220 (1995).

Here, the "combined condition" is the tendonitis in claimant's left foot. Even assuming that claimant's preexisting os peroneum combined with his work activities to cause the tendinitis, Dr. Rutan has opined that the major contributing cause of the tendonitis (the "combined condition") was claimant's work activities. Furthermore, Dr. Rutan indicated that the preexisting condition was worsened by the work activities. (Ex. 7-1). Although Dr. Rutan indicates that the worsening is only temporary, a temporary pathological worsening of a preexisting condition is sufficient to establish compensability of an occupational disease. Weller v. Union Carbide, 288 Or 27, 36-37 (1980); Daniel L. Kibbee, 46 Van Natta 2309, n. 1 (1994); Michael J. Swirbul, 43 Van Natta 2413, 2414 (1991). Accordingly, even if ORS 656.802(2)(b) applies, we find that the statutory requirements to establish compensability have been met.

The insurer next contends that claimant failed to establish his claim is supported by "objective findings." See ORS 656.005(19); 656.802(2)(d). The record does not establish that the "objective findings" argument was raised at hearing. Moreover, the insurer's denial denies claimant's claim on the basis that claimant's employment was not the "major/material contributing cause of your current condition and current need for treatment." Thus, it appears that the insurer is raising the "objective findings" argument for the first time on Board review.

We acknowledge that the "objective findings" defense could be interpreted as merely another basis for sustaining the insurer's denial. However, fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue. See Robert L. Tegge, 47 Van Natta 1973 (1995); Gunther H. Jacobi, 41 Van Natta 1031 (1989).

Here, there is no indication prior to the insurer's arguments on Board review that the claim was being contested on the basis of a lack of "objective findings." Because we find that it would be fundamentally unfair to address this late-raised defense for the first time on Board review, we decline to do so. See Terry Hickman, 48 Van Natta 1073 (1996) (where defense of lack of objective findings was not raised or litigated at hearing, carrier could not raise "objective findings" defense for first time on review).

Accordingly, we agree with the ALJ that claimant has established compensability of his condition under ORS 656.802.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, payable by the 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 15, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the insurer.

November 19, 1996 Cite as 48 Van Natta 2306 (1996)

In the Matter of the Compensation of
MARTIN T. LYTLE, Claimant
WCB Case No. 96-02172
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed the Order on Reconsideration award of 5 percent (16 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following changes and supplementation. We delete the second, third and fourth paragraphs on page 3 and replace them with the following:

Dr. Neumann, medical arbiter, referred to the "invalidity of the straight leg raising validity test" and reported that claimant's findings of motion were within the normal range for his age, body build and physical condition. (Ex. 16-5). Moreover, in the closing examination on July 14, 1995, Dr. Peterson, claimant's attending physician, reported that claimant's range of motion was consistent with the physiological range of motion for his age group and the accepted injury had not resulted in a significant loss of lumbar range of motion. (Ex. 11-2). We conclude that claimant is not entitled to an award for lost range of motion.

ORDER

The ALJ's order dated June 5, 1996 is affirmed.

In the Matter of the Compensation of
GREGORY K. WALLACE, Claimant
WCB Case No. 95-08606
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order directing it to pay claimant's scheduled permanent partial disability (PPD) award at the rate of $347.51 per degree. On review, the issue is rate of scheduled PPD. We reverse.

FINDINGS OF FACT

Claimant has an accepted claim with the insurer for a 1988 left knee injury. A November 21, 1991 Determination Order awarded a total of 38 percent (57 degrees) scheduled PPD for the left knee payable at the $145 per degree rate in effect at that time. Former ORS 656.214(2). The November 1991 Determination Order was not appealed and became final as a matter of law.

The claim was subsequently reopened pursuant to ORS 656.273 and reclosed by a November 3, 1994 Determination Order that increased claimant's total scheduled PPD award to 42 percent (63 degrees). Both claimant and the insurer requested reconsideration of that award. A July 24, 1995 Order on Reconsideration reduced the award to 38 percent (57 degrees), as previously awarded under the 1991 Determination Order. Claimant requested a hearing on the July 24, 1995 reconsideration order, raising as the only issue the rate at which the reconsideration award should be paid.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the insurer must pay the July 1995 reconsideration award at the current scheduled PPD rate of $347.51 per degree provided under amended ORS 656.214(2) (effective June 7, 1995). On review, the insurer argues that the July 1995 reconsideration order merely reinstated the November 1991 award of 38 percent (57 degrees) scheduled PPD, payable at the $145 per degree rate in effect at that time. Thus, the insurer argues that there is no new award payable at the current rate.

We conclude that the insurer's position is consistent with the following operative "Order" language in the July 1995 reconsideration order:

> "THE DEPARTMENT ORDERS THAT THE AWARD OF PERMANENT PARTIAL DISABILITY BE REDUCED.
>
> "THE TOTAL SCHEDULED AWARD TO DATE FOR THE FOLLOWING BODY PART(S) IS:
>
> "38 PERCENT EQUAL TO 57 DEGREES FOR LEFT LEG (KNEE)
>
> "THE INSURER IS ORDERED TO PAY THE WORKER AN AWARD OF $8,265.00. THIS IS IN LIEU OF ALL PREVIOUS AWARDS IN THIS CLAIM. THE DEDUCTION FROM THIS AMOUNT OF ANY OVERPAID TEMPORARY DISABILITY BENEFITS OR PREVIOUSLY PAID PERMANENT PARTIAL DISABILITY BENEFITS, IS AUTHORIZED. . . ." (Emphasis added).

The ALJ found that a new award of scheduled PPD was created by the above-referenced language "[t]his is in lieu of all previous awards in this claim." Thus, the ALJ concluded that the insurer must pay the reconsideration award at the current $347.51 per degree rate.[1] The ALJ's conclusion assumes that the "in lieu of" provision in the reconsideration order references the award of

[1] We have previously concluded that, except for claims with injury dates from January 1, 1992 through December 31, 1995, all new awards of scheduled PPD must be paid at the higher $347.51 per degree rate provided under amended ORS 656.214(2). See Sharon L. Hand, 48 Van Natta 1798 (1996); Randy L. Dare, 48 Van Natta 1230 (1996).

"38 percent equal to 57 degrees for left leg (knee)." In fact, the "in lieu of " provision appears immediately after language ordering the insurer "to pay the worker an award of $8,265.00." Given this placement, we find that the specific amount of $8,265.00 is the award made in lieu of all prior awards. This specific amount equates to payment of the award of scheduled PPD at the $145 per degree rate applicable to the 1991 Determination Order, i.e., 57 degrees at the rate of $145 per degree equals $8,265.00. Thus, we conclude that the reconsideration order did not create a new award of PPD payable at the current $347.51 per degree rate.

Former OAR 436-30-135(7)(a) provides further support for our conclusion. Under this rule, where a party requests reconsideration of an award of PPD under a Notice of Closure or Determination Order, "compensation reduced in a reconsideration order shall be 'in lieu of' any compensation awarded by the Notice of Closure or Determination Order." It appears that the "in lieu of" provision at issue in the present case is language included in this reconsideration order in compliance with former OAR 436-30-135(7)(a). Thus, this language was included in the July 1995 reconsideration order to clarify that the reconsideration award was made in lieu of, and not in addition to, the PPD awarded under the November 1994 Determination Order on which reconsideration was requested. The limited purpose of this language does not support the ALJ's conclusion that the "in lieu of" language created a new award of PPD that superseded the final award made under the unappealed November 1991 Determination Order.

For these reasons, we conclude that the July 1995 reconsideration order did not create a new award of PPD that must be paid at the current rate. We further conclude that prior Board decisions cited by the ALJ and claimant do not support a different result. The ALJ and claimant both rely on the Board's decision in Donald F. Spears, 37 Van Natta 1650 (1985). Claimant also relies on Keith W. Miles, Jr., 46 Van Natta 1524 (1994), and Debbie A. Monrean (Kahn), 38 Van Natta 97 (1986).

In each of these cases, the Board construed PPD awards made "in lieu of" prior awards. However, these decisions do not address the particular issue before us on review, which is the rate of payment of a scheduled PPD award made "in lieu of" prior awards.[2] In addition, our conclusion in the present case is based on our reading of the relevant "in lieu of" language in the context of the reconsideration order as a whole, which includes language which is unique to this case. Furthermore, the present case is distinguishable from Miles and Spears because the awards in those cases were made in lieu of the award being appealed, which had not become final. Here, claimant seeks to substitute the current scheduled PPD award for a prior award that has become final as a matter of law. Substituting

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[2] In Miles, the issue before the Board was the correct percentage/degrees of claimant's total scheduled PPD award. An initial Determination Order (DO) awarded 18 percent scheduled PPD. A second DO awarded 30 percent scheduled PPD "in lieu of" the prior award of 18 percent. A third DO set aside the second DO, awarded 30 percent scheduled PPD and 26 percent unscheduled PPD, and provided that "[t]his is the value allowed by this order only and does not include payments previously ordered." A fourth DO clarified that the third DO was issued "in lieu of" the second DO. Claimant requested a hearing on the second and third determination orders before they became final. The Board found that the third order superseded the second order based in part on the "in lieu of" language provided in the fourth order. The Board further found that the first order remained valid because the second order had been superseded, and the award made in the third order did not include payments previously ordered. Thus, the Board ultimately concluded that claimant's total award was 48 percent scheduled PPD and 26 percent unscheduled PPD.

In Monrean, the Board authorized the insurer to offset unscheduled PPD paid under a 1981 determination order against a subsequent lower award of unscheduled PPD made "in lieu of, and not in addition to, all previous awards made in this claim." Based on this "in lieu of" language, the Board concluded that the more recent award was substituted for the prior award, and that payments under the prior award were prematurely made. Thus, the Board authorized an offset of payments made under the prior award against the amounts due under the more recent award and future awards of PPD.

In Spears, the Board concluded that an insurer acted reasonably in paying an additional amount of PPD in periodic payments rather than a lump sum. Resolution of this issue turned on the number of degrees of PPD awarded at hearing. See former ORS 656.230(2). The claimant had requested a hearing from a determination order awarding 64 degrees unscheduled PPD, and the Referee awarded 112 degrees unscheduled PPD "in lieu of" the determination order award. The Board concluded that the Referee's award was 112 degrees, rather than the 48 degree differential between the Referee's award and the determination order award.

the current award for the prior final award would effectively circumvent § 66 (5)(a) of SB 369 (Or Laws, ch 332, § 66(5)(a)). Pursuant to that provision, the higher $347.51 scheduled PPD rate does not apply to any matter for which an order or decision has become final on or before June 7, 1995. Finally, while the Board in Monrean did substitute a more current award of PPD for a prior final award, the "in lieu of" language in that case was not included in compliance with former OAR 436-30-135(7)(a). As discussed above, we interpret the "in lieu of" language in the present case within the context of that rule.

Accordingly, consistent with the above discussion, we conclude that the July 1995 reconsideration order did not make a new award of scheduled PPD. We, instead, conclude that the reconsideration order merely reinstated the prior, final award of scheduled PPD under the 1991 Determination Order, and that it did so "in lieu of" the award under the November 1994 Determination Order. As the 1991 award has already been paid in full, claimant is not entitled to any additional compensation as a result of the July 1995 reconsideration order.[3]

ORDER

The ALJ's order dated May 1, 1996 is reversed. The rate of compensation per degree of scheduled permanent disability under the July 24, 1995 Order on Reconsideration shall be $145 per degree. The ALJ's "Out-of-Compensation" attorney fee is reversed.

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[3] In light of our decision, we need not address the insurer's alternative argument that any new award made by the reconsideration order was improper because claimant has not established a permanent worsening of his condition since the last closure. Similarly, we need not address claimant's counter argument that the insurer cannot request modification of the "new award" under the reconsideration order because it did not request a hearing from that order.

If we were to address these arguments, we would reach the same ultimate conclusion. Claimant does not challenge the insurer's contention that he has not established a permanent worsening of his condition, and the record does not establish such a permanent worsening. When there has been no permanent worsening of a condition, impairment values shall continue to be the same impairment values that were established at the time of the last arrangement of compensation. Former OAR 436-35-007(5); Stepp v. SAIF, 304 Or 3 (1987); Calvin L. Williams, 47 Van Natta 444 (1995). As claimant has not established a permanent worsening of his condition on this record, we would reinstate the prior award of scheduled PPD made under the 1991 Determination Order. Id. In so doing, we would reject claimant's contention that the insurer is barred from challenging the reconsideration order. The insurer had no reason to request a hearing from the July 1995 Order on Reconsideration given its position that the order did nothing more than reinstate the November 1991 award of 38 percent (57 degrees) scheduled PPD, payable at the rate of $145 per degree. That interpretation was both reasonable and correct. When the ALJ subsequently reached the opposite conclusion and ordered the insurer to pay the reconsideration award at the current $347.51 per degree rate, the insurer filed a timely request for Board review of the ALJ's order. The insurer's action was sufficient to preserve its right to challenge the reconsideration order on Board review.

November 20, 1996 Cite as 48 Van Natta 2309 (1996)

In the Matter of the Compensation of
JANICE B. BOWEN, Claimant
WCB Case No. 96-00358
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order which upheld the insurer's denial of her occupational disease claim for cervical, thoracic, lumbosacral and myofascial pain conditions. On review, the issues are whether claim preclusion bars claimant's current occupational disease claim and, if not, compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has been a waitress for 36 years and had worked for the last employer since 1990. Claimant sustained a compensable injury on November 4, 1991. A neurosurgeon, Dr. Brett, provided claimant's treatment and diagnosed a T-8 compression fracture and bilateral C6 nerve root impingement from spondylitic disease at C5-6. Dr. Brett recommended an anterior cervical discectomy and fusion at C5-6. However, Dr. Brett opined that the need for surgery and claimant's osteoarthritis and cervical disc disease were not related to work activities. (Ex. 9). On the other hand, Dr. Brett stated that claimant's compensable injury was the major factor in the thoracic compression fracture. Id.

Dr. Brett performed the recommended cervical surgery on November 27, 1991. The insurer then accepted the T-8 compression fracture on January 23, 1992. On April 13, 1992, claimant requested a hearing alleging that the insurer's acceptance should be expanded to include the cervical condition. Claimant withdrew the hearing request on June 4, 1992, resulting in a June 18, 1992 Order of Dismissal. (Ex. 32).

On January 13, 1993, a Determination Order issued, closing the accepted compression fracture claim. After issuance of an Order on Reconsideration, and after claimant filed a hearing request challenging the reconsideration order, the parties executed a stipulation on September 3, 1993. (Ex. 40). The stipulation awarded claimant 8 percent unscheduled permanent disability and dismissed claimant's request for hearing and "all issues raised or raisable." Id.

Claimant underwent another cervical discectomy and fusion at C6-7 in August 1994. No claim was made for that surgery, also performed by Dr. Brett. Claimant sought no further treatment until July 1995, when she consulted Dr. Hoggard for complaints of mid-back pain.

Dr. Hoggard referred claimant to Dr. Bell, a neurologist, who opined that claimant had signs of cervical radiculopathy. On August 6, 1995, claimant stopped working when her employer ceased operations for remodeling.

On August 23, 1995, claimant filed a claim for her "back." The insurer denied the claim on December 27, 1995, after which claimant filed a hearing request.

At hearing, claimant clarified the conditions for which she was filing a claim. Claimant alleged that her compensable conditions consisted of cervical and thoracic degenerative disc disease, cervical and lumbosacral strain, and myofascial pain. (Tr. 2).

The insurer contended that either the 1992 dismissal order or the September 1993 stipulation barred any claim for the above conditions. The ALJ rejected the insurer's argument that the dismissal order barred claimant's claim, reasoning that a dismissal without prejudice is not a final judgment for claim preclusion purposes. See Gary Goodeagle, 47 Van Natta 628 (1995). However, the ALJ determined that the compensability of the claim for cervical degenerative disc disease could not be considered, because, since the condition had been diagnosed prior to the September 1993 stipulation, the compensability of the condition could have been negotiated before approval of the settlement. See Good Samaritan Hospital v. Stoddard, 126 Or App 69, rev den 319 Or 572 (1994); Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993).

Nevertheless, the ALJ determined that no preclusive effect applied to the other conditions for which claimant had asserted a claim. However, the ALJ concluded that these conditions were not compensable on the merits.

On review, claimant contends that the ALJ incorrectly found that the September 1993 stipulation barred her claim for degenerative cervical disc disease. Moreover, claimant asserts that Dr. Bell's medical opinion establishes that her work activities were the major contributing cause of the disputed back conditions. We agree with claimant's contentions.

A party may not relitigate any issue resolved by a stipulation, since a party is bound to the terms of the agreement. E.g., Safeway Stores, Inc. v. Seney, supra. 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 raised before the date of the agreement. Good

Samaritan Hospital v. Stoddard, supra, 126 Or App at 73. In Stoddard, the court relied on the Board's findings that the disputed condition was related to the work injury, that it had been diagnosed, and that medical treatment had been requested prior to the settlement in concluding that the condition at issue could have been raised before the date of the agreement. Thus, the claimant was barred from asserting a claim for the compensability of the disputed condition. Id.

In this case, like Stoddard, claimant's degenerative cervical disc disease had been diagnosed prior to the September 1993 stipulation. (Ex. 9). However, unlike the disputed condition in Stoddard, no physician had related the degenerative condition in this case to claimant's employment. To the contrary, Dr. Brett had specifically opined that this condition was not work related in the context of the November 1991 injury claim. Id. Moreover, Dr. Brett did not seek reimbursement for medical services from the insurer with respect to claimant's cervical surgery. Under these circumstances, we conclude that Stoddard is distinguishable and that the compensability of claimant's degenerative cervical condition could not have been negotiated prior to the stipulation in September 1993.[1] Therefore, we find that the stipulation did not bar the subsequent claim in 1995 for cervical degenerative disc disease.[2]

We now proceed to the question of whether claimant's back conditions are compensable on the merits. For the following reasons, we conclude that they are.

Citing the last injurious exposure rule (LIER),[3] claimant contends that her 36 years of waitressing are the major contributing cause of her disputed conditions and that her last employer is responsible for her conditions because it could have contributed to her back conditions. Claimant is correct that she may rely on her entire employment history to establish the compensability of her occupational disease. Silveira v. Larch Enterprises, 133 Or App 292 (1995); Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994; Kristin Montgomery, 47 Van Natta 961 (1995) (employment conditions of an insured who has not been joined in a case may be considered to prove compensability). Therefore, to establish the compensability of the disputed conditions as an occupational disease, claimant must establish that her employment activities over 36 years were the major contributing cause of those conditions. ORS 656.802(2)(a). There are two medical opinions that address the causation issue: those of Dr. Bell and Dr. Gambee.

Dr. Bell, claimant's current attending physician, initially expressed difficulty in determining the contribution of the accepted 1991 thoracic compression fracture and subsequent cervical surgeries to claimant's current conditions. (Exs. 58, 59). However, Dr. Bell later agreed that claimant's work activities over the past 36 years as a waitress were the major contributing cause of her cervical and thoracic degenerative disc disease, cervical and thoracic strain, and myofascial pain condition, and that her work activities in the last five years had contributed to those conditions. (Ex. 61-2). Dr. Bell further agreed that claimant's work involved heavy lifting with outstretched arms while twisting and bending. According to Dr. Bell, this caused a significant amount of wear and tear on her intervertebral discs and was the major contributing cause of her degenerative disc disease. Id.

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810(1983). Claimant credibly testified that she described her work activities to Dr. Bell and that Dr. Bell's history was accurate. (Trs.

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[1] We emphasize that claimant's current claim is for an occupational disease based on her 36 years of employment. This claim is not based on her November 1991 injury. Because the current occupational disease claim arises out of a different factual transaction than the November 1991 injury claim, we agree with claimant that she did not previously have the opportunity to litigate the compensability of the degenerative cervical condition as an occupational disease. Drews v. EBI Companies, 310 Or 134, 142-43 (1990).

[2] 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. 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.

[3] Claimant specifically invoked LIER at the hearing in order to prove compensability. (Tr. 2). Accordingly, we apply LIER to resolve the compensability issue. Cf. Manuel Garibay, 48 Van Natta 1476, 1478 (1996) (Because LIER was not raised, cited, or referenced at any time during proceeding, rule not applied).

31, 32, 33). Under these circumstances, we agree with claimant that Dr. Bell's opinion is well-reasoned and based on complete and accurate information. Somers v. SAIF, 77 Or App 259, 263 (1986). Thus, we find no persuasive reason not to defer to Dr. Bell's opinion. In addition, we find Dr. Bell's opinion more persuasive than that of Dr. Gambee.

Dr. Gambee attributed claimant's medical problems to the aging process and long-term tobacco use. (Ex. 60-7, 62). However, Dr. Gambee's opinion is not persuasive because he took only a cursory history from claimant regarding the nature of her work activities. (Ex. 60-4). Moreover, Dr. Gambee's opinion is not sufficiently explained. For that reason as well, we do not find it persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

In summary, we find that the most persuasive medical evidence establishes that claimant's work activities as a waitress over 36 years were the major contributing cause of her cervical, thoracic, lumbosacral and myofascial pain conditions. Thus, we conclude that they are compensable.

We now determine responsibility under LIER. Claimant first sought medical treatment for the above conditions while the insurer was on the risk. There has been no subsequent employment after claimant left work on August 6, 1995. The insurer is responsible for claimant's cervical, thoracic, lumbosacral and myofascial conditions unless it was impossible for employment conditions while it was on the risk to have caused claimant's conditions or unless earlier employment was the sole cause of claimant's conditions. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985).

Because the most persuasive medical evidence establishes that claimant's last employment contributed to the disputed conditions, we find that the insurer has not satisfied the impossibility/sole cause standard and is responsible for those conditions. Therefore, we reverse the ALJ's decision upholding the insurer's denial.

Inasmuch as claimant has prevailed with respect to 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 is $4,400 payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, counsel's statement of services 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 26, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,400, to be paid by the insurer.

November 20, 1996 Cite as 48 Van Natta 2312 (1996)

In the Matter of the Compensation of
LOIS BRIMBLECOM, Claimant
Own Motion No. 90-0218M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Emmons, et al, Claimant Attorneys
Grocers Insurance Co., Insurance Carrier

Claimant requests review of the insurer's August 27, 1996 Notice of Closure which closed her claim with an award of temporary disability compensation from April 14, 1988 through June 11, 1996. The insurer declared claimant medically stationary as of June 11, 1996. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

FINDINGS OF FACT

On May 19, 1982, claimant sustained an industrial injury to her back and shoulder. On August 24, 1983, the insurer's denial of claimant's "psychological problems" was upheld. Claimant's aggravation rights expired on December 16, 1987. Claimant underwent right knee surgery in 1988. The insurer accepted claimant's right knee condition in 1989.

On August 31, 1990, the Board authorized the reopening of claimant's claim for the payment of temporary disability compensation for claimant's compensable right knee condition. Claimant underwent right knee arthroplasty in 1991. In 1992, claimant entered into an injury management program. On January 11, 1996, Dr. Hoff performed claimant's revisional right knee arthroplasty. On August 27, 1996, the insurer closed claimant's claim, declaring her medically stationary on June 11, 1996, and notifying claimant that she was eligible for time loss payments from April 14, 1988 through June 11, 1996.

CONCLUSIONS OF LAW AND OPINION

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that 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 August 27, 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); Paul E. Voellar, on recon 42 Van Natta 1962 (1990). Even though medical opinion establishes that a claimant requires 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). 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).

Relying on Dr. Hoff's June 11, 1996 opinion that claimant was incapable of returning to work and that she should be "considered permanently and totally disabled," the insurer contends that because claimant's right knee condition had not improved nor would it likely improve with further treatment, claimant was medically stationary at claim closure.

Contrarily, claimant relies on Dr. Hoff's post-closure opinion that physical therapy "may still be [of] some benefit" in providing right knee strength, and that a psychiatric evaluation was necessary "to see if there is anything that can be done in the way of behavior modification to assist with [claimant's] pain." Claimant contends that Dr. Hoff's September 10, 1996 opinion clearly establishes that she meets the requirement under ORS 656.005(17) that, at claim closure, her compensable condition would improve with further treatment.

As noted previously, claimant's "psychological condition" was denied by the insurer in 1983. There is no evidence in the record that any psychological or chronic pain condition has been accepted by the insurer as compensable since that time. Therefore, unless claimant can establish that her psychological or pain condition is an accepted component of an injury claim, she must establish that she was not medically stationary with respect to her compensable right knee condition when the insurer closed her claim. Rogers v. Tri-Met, supra. Further, although Dr. Hoff recommended that there may "still be some benefit obtained from physical therapy in providing [right knee] strength," claimant must demonstrate that there was a reasonable expectation that further or ongoing medical treatment would "materially improve" her compensable condition(s) at claim closure. Maarefi v. SAIF, supra.

In his June 4, 1996 chart note, Dr. Hoff opined that "[claimant] is not showing significant improvement in the knee." Dr. Hoff further opined that "I do not think at this time that there is anything further in the way of a work up that should be considered." In his June 11, 1996 letter, Dr. Hoff opined that "I do not see in the future that [claimant] is going to be capable of returning to gainful employment and think at this time that she can be considered permanently and totally disabled." In his September 10, 1996 letter, Dr. Hoff expressed "hope for some medical improvement." However, in his chart note of the same date, Dr. Hoff noted that "[claimant] has not noted any significant improvement in the right knee." He further noted that claimant was nonambulatory, having presented on that date in a wheelchair. His examination of claimant's knee, however, revealed no effusion, and he charted that she had full, active knee extension.

Here, the record does not establish that claimant was not medically stationary at claim closure, nor that Dr. Hoff withdrew his June 11, 1996 opinion that claimant was permanently and totally disabled, e.g., her compensable right knee condition would not improve in the future. On September 10, 1996, Dr. Hoff opined that there was hope for medical improvement, but that opinion was not directed to claimant's compensable knee condition. Moreover, although Dr. Hoff opined that further physical therapy may provide some knee strength, he counters by adding that he was uncertain whether the physical therapy would relieve claimant's pain. Finally, Dr. Hoff asserted that at no time had he stated that "there is nothing more that can be done to assist [claimant]." However, the provision of physical therapy or pain management to assist claimant would not necessarily establish that claimant was not medically stationary at claim closure, or that her compensable condition would materially improve. Dr. Hoff opined that he had nothing further to offer claimant surgically.

Because Dr. Hoff does not recommend any treatment which will materially improve claimant's compensable condition, and because medical documentation has established that claimant did not improve with respect to her knee condition between June 4, 1996 and September 10, 1996, we are not persuaded that any further material improvement would have been expected at claim closure. Therefore, we conclude that, contrary to claimant's assertions, Dr. Hoff's September 10, 1996 opinion confirms his June 11, 1996 diagnosis, and claimant's compensable condition will not materially improve with further treatment or the passage of time. ORS 656.005(17); Scheuning v. J.R. Simplot & Co., supra.

On this record, we are not persuaded that claimant has met her burden of proving that she was not medically stationary on the date her claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's August 27, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

November 20, 1996 Cite as 48 Van Natta 2314 (1996)

In the Matter of the Compensation of
NEVAY K. FRYMIRE, Claimant
WCB Case No. 96-02796
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Christian and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's claim for spousal benefits. In her brief, claimant contests those portions of the ALJ's order which: (1) declined to assess a penalty for an allegedly unreasonable denial; and (2) awarded a $2,800 assessed attorney fee for prevailing over the insurer's denial. On review, the issues are spousal benefits, penalties, and attorney fees. We affirm.

FINDINGS OF FACT

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

On April 13, 1987, a Determination Order issued which stated, *inter alia*, "THE DEPARTMENT ORDERS THE INSURER TO PAY, TO THE BENEFICIARIES, BENEFITS FOR FATAL INJURY." The insurer did not appeal the April 13, 1987 Determination Order.

FINDINGS OF ULTIMATE FACT

At the time of its February 29, 1996 denial and thereafter, the insurer possessed a legitimate doubt regarding its liability for the payment of spousal benefits to claimant.

CONCLUSIONS OF LAW AND OPINION

Spousal Benefits

Based on the 801 form, a 1502 form, a 1503 form and the insurer's payment of spousal benefits, the ALJ concluded that the insurer had accepted claimant's claim for widow benefits and was therefore precluded from denying spousal benefits. We agree that the insurer's denial is precluded, but do so based on the following reasoning.

Whether an acceptance occurs is an issue of fact. SAIF v. Tull, 113 Or App 449, 454 (1992). Acceptance is an act through which the insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law. Gene C. Dalton, 43 Van Natta 1191 (1991). Merely paying or providing compensation is not considered acceptance of a claim. ORS 656.262(10).

To begin, we do not agree that the 801 form, the 1502 form, or the 1503 form establish the insurer's acceptance of claimant's claim for spousal benefits. Rather, those documents indicate that the insurer was accepting the deceased worker's fatality as a compensable workers' compensation claim. (Exs. 3, 3A, 3B). Moreover, the fact that the insurer paid spousal benefits for nine years does not equate with acceptance of claimant's claim. ORS 656.262(10). Therefore, the insurer did not accept claimant's claim for spousal benefits on this basis.

However, on April 13, 1987, a Determination Order issued which specifically directed the insurer to pay spousal benefits to claimant. The insurer did not appeal this order from the Department. Based on the insurer's failure to appeal the April 13, 1987 order, we conclude that it is precluded from denying claimant's claim for spousal benefits.

In Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995) (hereinafter "Messmer I"), an employer failed to appeal a Determination Order has 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.

Following the court's decision, the legislature amended ORS 656.210. In Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (hereinafter "Messmer II"), the court concluded that the amended statute did not require a change in result of the case. 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 the payment of permanent disability benefits does not preclude an employer from subsequently contesting compensability.

Here, the preclusive effect of the Determination Order is even more clear than in Messmer. That is, the Determination Order did not award benefits for a noncompensable condition. Rather, the Determination Order expressly awarded the identical type of benefits (widow benefits) that the insurer now attempts to deny. Thus, the insurer's failure to appeal the April 13, 1987 Determination Order precludes it from now contesting the merits of claimant's claim for spousal benefits. Accordingly, we agree with the ALJ that the insurer's denial must be set aside.

Penalties

We adopt the conclusions and reasoning concerning the penalty issue as set forth in the "Unreasonable Denial" portion of the ALJ's order.

Attorney Fees/Hearing

The ALJ awarded claimant's counsel an assessed attorney fee of $2,800 for prevailing over the insurer's denial. Claimant asserts that she is entitled to a greater attorney fee. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we agree with the ALJ that $2,800 is an appropriate attorney fee for claimant's counsel's services at hearing. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record).

Attorney Fees/Board 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 regarding the compensation 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. Claimant is not entitled to an attorney fee for her counsel's unsuccessful efforts regarding the penalty and attorney fee issues.

ORDER

The ALJ's order dated July 12, 1996, as amended July 16, 1996, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

November 20, 1996 Cite as 48 Van Natta 2316 (1996)

In the Matter of the Compensation of
MARIA JOLLEY, Claimant
WCB Case No. 96-01633
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed an Order on Reconsideration which: (1) awarded 29 percent (43.5 degrees) scheduled permanent disability for loss of use or function of the left forearm (wrist) and 28 percent (42 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist); and (2) assessed a penalty pursuant to ORS 656.268(4)(g). On review, the issues are extent of scheduled permanent disability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

On review, the employer continues to disagree with our decision in Roberto Rodriguez, 46 Van Natta 1722 (1994). In Rodriguez, relying on Harris v. SAIF, 292 Or 683 (1982), we concluded that, where a carrier is seeking reduction of an award of permanent disability, the burden of proof is on the carrier. Although the employer argues that Rodriguez was wrongly decided, we decline to revisit the case, and we rely on the case as precedent, as did the ALJ.

The employer also argues, and claimant agrees, that the ALJ incorrectly cited to OAR 436-035-0007(18), (19), WCD Admin. Order 96-051. Because claimant's claim was closed prior to the February 17, 1996 effective date of the rule, we agree that the aforementioned rule does not apply to the case. OAR 436-035-0003(1).

We adopt the remainder of the ALJ's Conclusions, as set forth in the "Merits" section of the Opinion and Order with the following supplementation.

In affirming the ALJ's award of scheduled permanent disability, we distinguish Corrine M. Esperanza, 47 Van Natta 1914 (1995). In Esperanza, we held that the claimant had not established entitlement to scheduled permanent impairment under former OAR 436-35-007(14), where the medical evidence indicated that the claimant suffered from "possible" left carpal tunnel syndrome and did not establish that the claimant had suffered an injury to the left medial nerve.

Here, unlike Esperanza, there is no dispute that claimant does have bilateral carpal tunnel syndrome and in fact, has undergone release surgery on both wrists. (Exs. 6, 8). Moreover, the insurer has specifically accepted median nerve neuropathy. (Ex. 5). Finally, the attending physician concurred with impairment findings registering sensory loss which was attributed to mild post-traumatic neuropraxia resulting from the surgery. Under these circumstances, the record establishes that claimant suffered an injury to her median nerves. Therefore, an award for loss of grip strength under former OAR 436-35-007(14) is appropriate.

Claimant's counsel is entitled to an assessed attorney 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 assessed attorney fee for claimant's counsel's services on review regarding the permanent disability issue is $1,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. In reaching this conclusion, we have not considered claimant's counsel's services regarding the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated April 23, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, to be paid by the self-insured employer.

November 20, 1996 Cite as 48 Van Natta 2317 (1996)

In the Matter of the Compensation of
BARBARA M. LAPIES, Claimant
WCB Case No. 96-02514
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that set aside its denial of claimant's left foot injury claim. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. Claimant's employer is a temporary agency. At the time claimant was injured, she worked at a copy and duplicating business.

CONCLUSIONS OF LAW AND OPINION

The employer paid its employees by giving them the option of physically picking up a paycheck at its office or mailing the paycheck. Each employee was required to first provide a time card to the employer before the paycheck was made available.

On December 22, 1995, claimant delivered her time card and picked up her paycheck from the employer's office. While exiting the employer's office building, claimant slipped and fell, fracturing her left ankle.

The ALJ found that claimant's injury arose out of and occurred in the course of employment. The insurer challenges this conclusion, asserting that claimant's activity at the time of injury is outside the course and scope of her employment.

In order to be compensable, an injury must arise out of and occur in the course of employment. ORS 656.005(7)(a). The first element examines the causal connection between the employment and injury, while the latter requirement concerns the time, place and circumstances of the injury. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). Although both elements are evaluated, neither is dispositive. Id. As the Court has stated, the ultimate test is whether, considering all the pertinent circumstances, the temporal, spatial, circumstantial, and causal connections between the claimant's

injury and employment were sufficient to justify compensation. Andrews v. Tektronix, Inc., 323 Or 154, 162 (1996).

In applying this test, we consider the following factors. Claimant was not paid for her time to deliver her time card and pick up her paycheck. More specifically, this activity was not performed during her scheduled work time with the copy and duplicating business and apparently, did not constitute a work duty for this business. The employer's office also was in another location from the copy and duplicating company. Thus, we find that claimant's activity when she was injured was independent from claimant's work with the copy and duplicating business.

Furthermore, even if we assumed that claimant's injury was "in the course" of her employment with the temporary agency, we find no evidence that the conditions of claimant's employment put her in a position to be injured. The record shows only that claimant was injured between the entrance to the employer's office and the parking lot, when she slipped on some fallen leaves. (Tr. 4). There is no evidence that the employer controlled the area where claimant fell and was responsible for cleaning debris, including fallen leaves. In the absence of such proof, claimant failed to show a causal connection between the injury and the normal conditions of her employment with the temporary agency. SAIF v. Marin, 139 Or App 518, 524-25 (1996); Henderson v. S. D. Deacon Corp., 127 Or App 333, 338-39 (1994).

Consequently, we conclude that claimant's injury is not compensable. ORS 656.005(7)(a).

ORDER

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

Board Chair Hall dissenting.

I agree with the ALJ that claimant proved her injury was in the course and scope of employment. In analyzing whether an injury arises out of and is in the course of employment, all pertinent factors, including temporal, spatial, circumstantial, and causal connections, are considered. Andrews v. Tektronix, Inc., 323 Or 154, 162 (1996). Thus, the test is broad and depends on the general connection between an injury and work.

Claimant was injured after delivering her time card and picking up her pay check. This method was approved by the employer. I agree with the ALJ that, because claimant was performing one of the designated methods for submitting her time card and receiving her paycheck from the employer, her injury was in the course and scope of employment.

Because I disagree with the majority's conclusion, I dissent.

November 20, 1996 Cite as 48 Van Natta 2318 (1996)

In the Matter of the Compensation of
JANICE A. TALEVICH, Claimant
WCB Case No. 96-00684
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order which: (1) upheld the SAIF Corporation's denial of her occupational disease claim for left wrist, left elbow and left shoulder conditions; (2) declined to award penalties and attorney fees for SAIF's allegedly unreasonable denial; and (3) declined to award penalties and attorney fees for an alleged discovery violation. In her brief, claimant contends that the claim should be remanded for further proceedings to address the issue of a "back-up" denial. On review, the issues are compensability, penalties, attorney fees, remand, and "back-up" denial. We deny the motion for remand, reverse in part and affirm in part.

FINDINGS OF FACT

In October 1986, claimant, a case manager for the employer, Adult and Family Services, developed left elbow pain after painting a bathroom at home. Claimant did not seek treatment until September 1988, when she sought care from Dr. Martens, who diagnosed chronic recurrent epicondylitis, lateral tennis elbow. (Ex. A). Claimant filed a workers' compensation claim form 801 on September 19, 1988, alleging that her left arm condition was aggravated by her work activities. (Ex. C). SAIF denied the claim on October 11, 1988. The denial was not appealed.

Claimant subsequently sought medical treatment from Dr. Boyd in 1989 and 1990 for left elbow, left wrist and left shoulder pain. Although Dr. Boyd related claimant's conditions to her employment, no claim was filed at the time. Claimant sought no further treatment after October 1, 1990 until seeking care from Dr. Ushman in September 1995.

Claimant reported increasing pain involving the left elbow, left wrist and left trapezius to Dr. Ushman, who diagnosed left epicondylitis, left wrist strain and left trapezius strain. (Ex. 2-1). Dr. Ushman opined that these conditions were probably work related. Id. After SAIF erroneously informed Dr. Ushman that it had accepted claimant's 1986 claim, Dr. Ushman opined that claimant's symptoms were a continuation of that claim. (Ex. 7).

On December 15, 1995, SAIF denied a new occupational disease claim for left epicondylitis, left trapezius strain and left wrist strain and informed claimant that the claim would be processed under the "accepted" 1986 claim. (Ex. 8). On December 18, 1995, SAIF issued an amended denial, reiterating its denial of a new occupational disease claim and advising claimant that it would not process her medical treatment under the denied 1986 claim. (Ex. 9).

Claimant appealed the December 18, 1995 amended denial. Claimant's attorney initially requested discovery on January 15, 1996. On February 5, 1996, claimant's attorney requested records regarding the 1986 claim. SAIF's counsel provided discovery on March 21, 1996.

CONCLUSIONS OF LAW AND OPINION

"Back-up Denial"

Claimant initially contends that SAIF's December 18, 1995 denial constitutes a "back-up" denial and that the case should be remanded to the ALJ for further proceedings to address this issue. We disagree.

As SAIF points out, claimant did not raise the issue of a "back-up" denial at hearing. (Tr. 1, 2). Therefore, we do not address this issue on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Julio Filippi, 48 Van Natta 2138 (1996), abated on other ground 48 Van Natta 2277 (1996). It follows that there is no "compelling" basis to remand. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). We, thus, decline claimant's motion for remand.

Compensability

The ALJ upheld SAIF's denial of claimant's occupational disease claim for left wrist strain, left elbow epicondylitis, and left trapezius strain, concluding that her claim was based on the worsening of preexisting conditions, and that claimant had failed to prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. See ORS 656.802(2)(b); Dan D. Cone, 47 Van Natta 2220 (1995). In reaching this conclusion, the ALJ reasoned that, since claimant had failed to appeal a 1988 denial of her left epicondylitis condition, and since she did not file a claim for treatment of her left wrist and left trapezius conditions in 1989 and 1990, he could only consider claimant's work activities after her last medical treatment on October 1, 1990 in determining compensability. Finding the medical opinion of Dr. Ushman, the only physician to address the causation issue with respect to her most recent claim, to be unpersuasive, the ALJ determined that claimant had failed to sustain her burden of proof.

On review, claimant alleges that the ALJ improperly concluded that he could only consider her work activities after October 1, 1990 in determining compensability. Claimant contends that the ALJ should have considered the causal impact of her 18 years of employment in determining compensability,

and that the ALJ mistakenly analyzed the claim for left wrist strain and left trapezius strain as an occupational disease based on the worsening of a preexisting condition. Claimant argues that only her epicondylitis condition would be considered a preexisting condition because of her failure to appeal the 1988 denial. Finally, claimant asserts that Dr. Ushman's opinion satisfies her burden of proving that her left wrist and left trapezius conditions are compensable. We agree.

As previously noted, the ALJ determined that claimant's left wrist strain and left trapezius strain were "preexisting" conditions and that, therefore, claimant was required to prove that her work activities were the major contributing cause of the combined condition and a pathological worsening of the disease. We concur with claimant, however, that her failure to appeal the 1988 denial of her left elbow condition did not render the left wrist and left trapezius strains "preexisting" conditions.

Claimant was not diagnosed with left wrist and left trapezius strains prior to the 1988 denial. (Exs. J, 1). Thus, we find that claimant could not have litigated the conditions in 1988 when the conditions had not even been diagnosed. Moreover, SAIF's denial was specifically limited to "chronic recurrent epicondylitis" and "lateral tennis elbow syndrome." Inasmuch as the denial framed the issues that could have been litigated, we conclude that the unappealed denial had no preclusive effect on the claim for left wrist and left trapezius strain. See King v. Building Supply Discount, 133 Or App 179, 182 (1995); see also Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993) (carriers are bound by the express language of their denials).[1]

We also conclude that claimant's failure to file a claim for her left wrist and left trapezius as a result of her medical treatment in 1989 and 1990 does not prevent consideration of the causal effect of her work activities prior to October 1990. SAIF does not argue that claimant did not timely file her occupational disease claim.

Accordingly, we disagree with the ALJ's determination that claimant must prove a pathological worsening of her left wrist and left trapezius conditions and that he could only consider the causal effect of claimant's work activities after October 1990. Instead, we find that to prove compensability of her left wrist and left shoulder conditions, claimant must prove that her 18 years of employment are the major contributing cause of her left wrist and left trapezius conditions. We conclude that claimant has sustained her burden of proof.

This claim presents a complex question of medical causation because of the gap in medical treatment from 1990 to 1995. We, therefore, require expert medical evidence for its resolution. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Uris v. Compensation Department, 247 Or 420, 424 (1967).

Dr. Ushman provided the only medical evidence regarding causation. In several documents Dr. Ushman stated that claimant's conditions were or probably were work related. (Exs. 2-2, 2a, 5b, 6a). On April 2, 1996, Dr. Ushman agreed that, based on claimant's history of work activities, the type and onset of symptoms and objective findings, claimant's work activities were the major contributing cause of the left trapezius strain and left wrist strains. (Ex. 14). There is no contrary medical evidence. Based on Dr. Ushman's persuasive and uncontradicted medical opinion, we conclude that claimant has sustained her burden of proving that her left wrist and left trapezius conditions are compensable as occupational diseases. Accordingly, SAIF's denial is set aside to the extent that it denied the compensability of those conditions. Inasmuch as Dr. Ushman opined that there had been no pathological worsening of the preexisting left epicondylitis condition (Ex. 14), SAIF's denial is upheld with respect to that condition. Dan D. Cone, supra.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability of her left wrist and left trapezius conditions. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for

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[1] Citing Margaret R. Jones, 45 Van Natta 1249 (1993), SAIF contends that claimant's current left wrist and left shoulder conditions are the same as her condition prior to the 1988 denial, asserting that only the terminology used to describe her condition has changed. We disagree. Our review of the medical evidence does not establish that, before and after the 1988 denial, claimant has been seeking treatment for the same problem in the left wrist and left shoulder. Instead, we find that claimant's "post-denial" left wrist strain and left trapezius strains are distinct and separate conditions from the left elbow condition diagnosed prior to the 1988 denial. Accordingly, we do not find Jones controlling in this case.

claimant's attorney's services at hearing and on review regarding the compensability of those conditions 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 issues, the value of the interest involved, and the risk that counsel may go uncompensated.

Penalties and Attorney Fees

Claimant contends that she is entitled to penalties and attorney fees because SAIF's denial was unreasonable and because SAIF failed to timely provide discovery. For the following reasons, we conclude that, while claimant is not entitled to penalties, an award of attorney fees for SAIF's discovery violation is appropriate.

We first address the issue of unreasonable denial. 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).

Here, we do not find SAIF's denial to have been unreasonably issued. Given claimant's failure to appeal the 1988 denial and to file a claim for her left wrist and left shoulder conditions when she received treatment in 1989 and 1990, we conclude that SAIF had "legitimate doubt" regarding its liability for claimant's left wrist and left trapezius conditions. Accordingly, we decline to award a penalty for unreasonable denial.

The ALJ declined to award penalties or attorney fees for SAIF's alleged discovery violation, reasoning that there was no evidence of "amounts then due" upon which a penalty may be assessed under ORS 656.262(11). Given this finding, the ALJ determined that it was unnecessary to determine whether SAIF's late disclosure of documents was unreasonable.

Inasmuch as SAIF's December 18, 1995 denial preceded the alleged discovery violation, there was no compensation due at the time of the alleged discovery violation. Therefore, there were no "amounts then due" at the time of the allegedly unreasonable conduct on which to base a penalty under ORS 656.262(11)(a). See Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989) (penalty for discovery violation based on compensation due at the time of the violation); Betty V. West, 46 Van Natta 1469 (1994) (no penalty authorized under former ORS 656.262(10)(a) when claim was in denied status at the time of discovery violation).

The ALJ also stated that there was no authority for an attorney fee award under ORS 656.382(1) for a discovery violation. Based on our compensability decision regarding the left wrist and trapezius conditions, we disagree. See Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991); Boehr v. Mid-Willamette Valley Food, 109 Or App 292, 295 (1991) (failure to comply with discovery requirements may result in attorney fee award under ORS 656.382(1) provided underlying claim is compensable). Attorney fees under ORS 656.382(1) do not depend on "amounts then due"; such fees may be assessed for an unreasonable resistance to the payment of compensation. See Eastmoreland Hospital v. Reeves, supra.

We conclude based on our review of the record that SAIF's failure to provide claimant records regarding the 1986 claim until March 21, 1996 was unreasonable. Inasmuch as the records pertaining to the 1986 claim were important to the claim preclusion and compensability issues, we also conclude that SAIF unreasonably resisted the payment of compensation after issuance of its December 18, 1995 denial (as a result of our order setting aside the denial) insofar as it pertained to the left wrist and trapezius conditions. Accordingly, we assess an attorney fee under ORS 656.382(1). Betty v. West, 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 SAIF's discovery violation is $750, 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, and the value of the interest involved.

ORDER

The ALJ's order dated May 10, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the part of SAIF's denial pertaining to claimant's left wrist and left trapezius conditions is reversed. That portion of SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. That portion of the ALJ's order that declined to award an attorney fee for SAIF's discovery violation is also reversed. Claimant is awarded an assessed attorney fee of $750, to be paid by SAIF. For services at hearing and on review regarding the compensability issue, claimant's counsel is awarded an assessed fee of $4,000, to be paid by SAIF. The remainder of the ALJ's order is affirmed.

November 21, 1996 Cite as 48 Van Natta 2322 (1996)

In the Matter of the Compensation of
FERRAL C. CROWDER, Claimant
WCB Case No. 94-12846
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that directed it to pay claimant's unscheduled and scheduled permanent disability awards, as granted by a Determination Order and Order on Reconsideration, at the rates set forth in amended ORS 656.214. Claimant cross-requests review of those portions of the ALJ's order that: (1) upheld the insurer's partial denial of his psychological condition; (2) found that claimant's low back injury claim was not prematurely closed; (3) declined to grant permanent total disability; and (4) dismissed claimant's hearing request from a Director's vocational assistance order. On review, the issues are jurisdiction, rate of permanent disability, compensability, premature closure, and permanent total disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction - Vocational Assistance

The ALJ dismissed, for lack of jurisdiction, claimant's request for hearing regarding the Director's October 11, 1994 order which concluded that claimant is not eligible for vocational assistance. On review, claimant contends that the ALJ properly had jurisdiction to review the Director's order. We disagree and affirm the ALJ's order on this issue.

ORS 656.283(2) was amended by the 1995 Legislature and now provides that when the Director issues an order regarding vocational assistance after administrative review of the matter, "the order shall be subject to review only by the director." (Emphasis supplied.) We held in Ross M. Enyart, 47 Van Natta 1540 (1995), that the legislature expressly intended that this provision apply retroactively and that the Director now has exclusive jurisdiction over all vocational assistance disputes.

Claimant contends that the language in amended ORS 656.283(2)(c) creates an exception to retroactive application of the statute when it states: "When the director issues an order after review under paragraph (b) of this subsection, the order shall be subject to review only by the director." Claimant argues that, because the Director's jurisdiction extends only to orders issued "under paragraph (b)" of amended ORS 656.283(2), a paragraph that did not exist prior to enactment of the 1995 amendments, the legislature intended that the Hearings Division and Board retain jurisdiction to resolve vocational assistance disputes litigated under the predecessor statute.

We previously rejected this same argument in Danell L. Sweisberger, 48 Van Natta 441 (1996). Based on the text and context of amended ORS 656.283(2), we concluded that the Director's exclusive jurisdiction over vocational assistance matters extends to review of administrative orders issued under the predecessor statute, as well as orders issued under paragraph (b) of the amended statute. For the reasons discussed in Sweisberger, we continue to construe subsection (2)(c) of the amended statute as divesting the Board and Hearings Division of jurisdiction to review vocational assistance administrative orders issued by the Director in all pending and future cases, without exception.

Rate of Permanent Disability

On review, the insurer argues that claimant was barred from challenging the rate of his permanent partial disability (PPD) award because the rate issue was not previously raised at the Department's reconsideration proceeding. We agree, and partially reverse the ALJ's order on this issue.

Amended ORS 656.283(7) provides, in pertinent part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself." (Emphasis supplied.)

By seeking the increased rate of PPD awarded by the August 22, 1994 Determination Order, we find that claimant was raising a substantive challenge to the order. We base our finding on the following reasoning. The August 22, 1994 Determination Order awarded claimant 50 percent (160 degrees) unscheduled PPD, and stated: "THE INSURER IS NOW ORDERED TO PAY YOU $16,000." Thus, the Determination Order awarded claimant a set dollar amount ($16,000) for his unscheduled PPD award. Based on that set sum award, it is apparent from the order that claimant's unscheduled PPD award was calculated at the rate of $100 per degree, (i.e., $16,000 divided by 160 degrees equals $100 per degree). Because claimant's Determination Order award of PPD was calculated at a certain rate, we conclude that the PPD rate issue arose from the Determination Order, and it was therefore incumbent upon claimant to raise an objection to the PPD rate at the reconsideration proceeding. Because he did not do so, amended ORS 656.283(7) now bars him from raising at hearing the rate of unscheduled PPD awarded by the Determination Order. See William T. Masters, 48 Van Natta 1788 n.1 (1996) (held that the rate of temporary disability is an issue that arose from claim closure; because that issue was not raised at reconsideration, it could not be raised at hearing for the first time).

Claimant argues that the PPD rate issue could not have been raised on reconsideration because the 1995 amendments affecting the PPD rate did not become effective until June 7, 1995, three weeks after the Order on Reconsideration issued on May 12, 1995, which affirmed the Determination Order's award of 50 percent unscheduled PPD. While we agree that the 1995 amendments took effect after the reconsideration order issued in this case, we disagree with his assertion that a challenge to the PPD rate could not have been raised on reconsideration. Moreover, the fact that a change in the law took effect after the reconsideration order does not remove the statutory prohibition against raising claim closure issues at hearing that were not first raised on reconsideration.

There is only one exception to amended ORS 656.283(7)'s prohibition on closure issues that were not first raised on reconsideration. That exception applies to issues that "[arise] out of the reconsideration order itself." Here, because the May 12, 1995 Order on Reconsideration awarded 26 percent (39 degrees) scheduled PPD, whereas there was no scheduled PPD award by the Determination Order, we find that the rate of the scheduled PPD award arose out of the reconsideration order itself. Therefore, amended ORS 656.283(7) did not prohibit claimant from raising the scheduled PPD rate issue at hearing.

To summarize, we conclude that amended ORS 656.283(7) prohibited claimant from challenging the rate of the 50 percent (160 degrees) unscheduled PPD awarded by the Determination Order. However, because the 26 percent scheduled PPD award arose from the reconsideration order itself,

claimant was not prohibited from challenging the rate of that award at hearing.[1] Accordingly, we partially reverse the ALJ's order on this issue.

Compensability

The ALJ concluded that claimant failed to prove his consequential condition claim for a psychological condition. He relied on the opinion of Dr. Turco, psychiatrist, who could not apportion causation between the three factors of claimant's compensable low back injury, his unemployment status, and the estimated loss in capital gains tax liability from the sale of his farm. (Ex. 52A). For the reasons discussed by the ALJ, we agree that Dr. Turco's opinion is most persuasive.

The ALJ also concluded, however, that this case was controlled by Roseburg Forest Products v. Zimbelman, 136 Or App 75 (1995). We disagree. In Zimbelman, we found that claimant's emotional condition was caused in part by the claimant's reaction to the processing of his claim and his belief that the amount of his compensation was incorrect. The court held that a claimant's reaction to the amount of compensation and to claims processing is not caused by the compensable injury, but by the process by which the claimant is compensated for the injury. Id. at 79 n 2. Reasoning that those causes were collateral to the injury, the court concluded they could not be considered as caused by the compensable injury. Id.

In this case, we do not find that claimant's psychological condition is attributable in any way to the amount of compensation for his injury or to claims processing. On that basis, Zimbelman is distinguishable. Based on Dr. Turco's opinion, we find that "a major contributing factor" in claimant's condition was the capital gains tax liability from the sale of his farm, estimated to be $110,000. On review, claimant argues that there is no proof of an actual tax loss from the sale. It is not the actual tax loss which is the stressor, however. Rather, the stressor is claimant's perception that he sustained the loss. At hearing, claimant maintained that his capital gains tax liability was a "big" factor in his psychological condition. (Tr. 38).

Claimant also argues that the sale of claimant's farm, and any financial loss resulting from the sale, directly resulted from his disability due to the compensable injury and that the financial loss should therefore be treated as a compensable consequence of the compensable injury. However, claimant's own testimony does not support a causal connection between the sale of the farm and his psychological condition. At hearing, claimant testified it was not the sale of the farm that upset him; rather, it was the capital gains tax liability and, additionally, his failure to consult with a tax expert prior to the sale. (Tr. 38-39). We conclude that the amount of claimant's tax liability and his failure to consult a tax expert prior to the sale were not caused by the compensable injury and cannot be considered compensable consequences of the injury. Because those factors are significant contributors to claimant's psychological condition, and Dr. Turco cannot say whether the compensable injury is the major contributing cause of his condition, we agree with the ALJ there is a failure of proof.

Premature Closure/PTD

We adopt and affirm the ALJ's order regarding the issues of premature closure and PTD.

ORDER

The ALJ's order dated February 12, 1996 is reversed in part and affirmed in part. The portions of the order that directed the insurer to pay the 50 percent (160 degrees) unscheduled PPD award at the rate pursuant to amended ORS 656.214, and awarded an out-of-compensation attorney fee payable out of the additional compensation created by that directive, are reversed. The remainder of the order is affirmed.

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[1] The dissent suggests that we are holding that the PPD rate arises exclusively out of claim closure. If that is the dissent's interpretation of our decision, such a reading is inaccurate. We are merely holding that, where, as here, the PPD rate did arise from claim closure, it is an issue that could have been raised during the reconsideration proceeding and a party's failure to raise the issue at that time precludes the party from raising the issue at hearing.

Board Chair Hall dissenting in part and concurring in part.

The majority concludes that amended ORS 656.283(7) bars claimant from challenging the rate at which his 50 percent unscheduled permanent partial disability (PPD) award is payable. I disagree and dissent from that portion of the order.

My disagreement is for the same reason previously stated in my dissenting opinion in William T. Masters, 48 Van Natta 1788 (1996). In Masters, the Board also relied on amended ORS 656.283(7) to conclude that the claimant may not raise the issue of the rate of temporary disability at hearing unless the issue was first raised at the reconsideration proceeding. Like the temporary disability rate issue, the issue of PPD rate may arise at any time and is not an issue that arises exclusively out of claim closure. In this case, for example, the rate issue first arose after the Order on Reconsideration issued on May 12, 1995, because the 1995 amendments which affected PPD rates took effect on June 7, 1995. Because the PPD rate issue does not arise from claim closure, amended ORS 656.283(7) does not apply to bar that issue from being raised for the first time at hearing.

Furthermore, because the 1995 amendments to ORS 656.283(7) did not take effect until after the reconsideration order issued in this case, I conclude it would be absurd and unjust to retroactively apply the procedural requirement in amended ORS 656.283(7) that a party first raise an issue on reconsideration. See Rick A. Webb, 47 Van Natta 1550 (1995); Ida M. Walker, 43 Van Natta 1402 (1991). It would have been impossible for claimant to anticipate the preclusive effect of amended ORS 656.283(7) and raise the PPD rate issue on reconsideration, before the amended statute had even taken effect. Therefore, I would not apply amended ORS 656.283(7) retroactively under the facts of this case, and respectfully dissent from that portion of the majority's opinion.

November 21, 1996 Cite as 48 Van Natta 2325 (1996)

In the Matter of the Compensation of
MORRIS B. GROVER, Claimant
Own Motion No. 96-0403M
OWN MOTION ORDER
Malagon, et al, Claimant Attorneys
SAIF Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable low back strain with subsequent L4-5 laminectomy injury. SAIF issued a denial of the compensability of claimant's current multi-level spinal stenosis with L3-4 disc herniation condition. In its denial, SAIF contended that, although claimant's 1980 injury was not the major contributing cause of his recent L2-3 and L3-4 conditions and treatment, it would "continue to provide medical benefits related to [claimant's] accepted low back strain and subsequent L4/5 laminectomy." SAIF further stated that it "agrees to pay that portion of [claimant's] recent medical treatment and hospitalization as it related to [claimant's] accepted claim." In addition, SAIF opposes reopening claimant's 1980 injury claim on the ground that claimant was not in the work force at the time of his current disability.

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

On August 7, 1996, claimant underwent a laminectomy at L2-3 and L3-4, a medial facetectomy and diskectomy, and L4-5 redo laminectomy. Thus, we conclude that claimant's compensable L4-5 condition worsened requiring surgery.[1]

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)

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[1] However, because claimant did not appeal SAIF's August 28, 1996 denial of his current L2-3 and L3-4 conditions and resulting treatment, those conditions remain in denied status. Therefore, we have no authority to authorize temporary disability compensation for claimant's non-compensable conditions and resulting treatment.

not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant was not in the work force at the time of disability because he was currently receiving permanent total disability (PTD) as a result of another injury, unrelated to his 1980 claim. Therefore, SAIF contends that "[claimant] is no longer in the work force nor available to seek work." We disagree.

In Morris B. Grover, 48 Van Natta 486 (1996), the Board authorized the reopening of claimant's 1979 injury claim with the insurer, noting that claimant remained in the work force by virtue of his PTD status in another injury claim.[2] Here, we apply similar reasoning with respect to claimant's entitlement to temporary disability compensation in his 1980 injury claim with SAIF. Claimant contends that he qualifies for temporary disability compensation because "the main reason [claimant] is unable to work is a combination of his compensable industrial injury with the SAIF Corporation as well as his compensable industrial injury with [the insurer]." We need not address claimant's inability to work because of one compensable injury or the other, or whether a combination of the two injuries disabled him from work.

Here, if claimant can establish that he was disabled due to any industrial injury, he has established that he was unable to work because a compensable injury rendered him disabled. William L. Halbrook, 46 Van Natta 79 (1994). Therefore, because claimant is permanently and totally disabled as a result of an industrial injury claim, regardless of whether or not that injury is related to his 1980 injury claim, claimant has established that he was unable to work because of a compensable injury, and, thus, he remained in the work force at the time of disability. Id.

On this record, we conclude that claimant has established that he was in the work force at the time of disability.

As we further reasoned in Morris B. Grover, supra, although a claimant has established that he is entitled to temporary disability benefits in an industrial injury claim, if he is receiving permanent total disability benefits in another injury claim, the claimant is not entitled to receive 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, supra.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning August 7, 1996, the date he was hospitalized for surgery.[3] When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080. This attorney fee award is not subject to any offset. See OAR 438-015-0085(2).

IT IS SO ORDERED.

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[2] The Board subsequently dismissed claimant's request for temporary disability compensation in his 1979 injury claim. The insurer contended that it erred in submitting claimant's request for temporary disability to the Board because it had assumed payment of claimant's permanent total disability benefits (from SAIF) effective April 10, 1987. When notified of the insurer's declaration of responsibility for his PTD payments, claimant withdrew his request, asserting that he was not entitled to both permanent and total disability from the same carrier. Morris B. Grover, 48 Van Natta 729 (1996).

[3] We again note that, because claimant's L2-3 and L3-4 conditions remain in denied status, we retain jurisdiction to authorize the reopening of claimant's claim for the payment of temporary disability compensation with respect to his current accepted L4-5 condition. Therefore, pursuant to this order, SAIF is responsible only for that portion of temporary disability compensation to which claimant is entitled as a result of his compensable L4-5 condition.

In the Matter of the Compensation of
RICHARD R. HILLS, Claimant
WCB Case No. 94-11389
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order which: (1) declined to award interim compensation; and (2) declined to assess penalties for the SAIF Corporation's allegedly unreasonable claims processing. On review, the issues are interim compensation and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the ALJ's "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant began working for the employer in February 1991. In October 1992, claimant violated the employer's drug/alcohol policy and his continued employment was contingent upon meeting the terms of a "last chance agreement." (Exs. 1, 2). Failure to comply with the terms of the agreement subjected claimant to immediate termination. (Ex. 2).

Claimant sustained a compensable injury on July 11, 1994. That day, claimant was seen at a hospital emergency room for a jaw injury. While at the emergency room, claimant was given a urine drug test for which he tested positive for marijuana use. (Ex. 5).

On July 13, 1994, claimant was examined by Dr. Lewis, who diagnosed TMJ strain and soft tissue inflammation. (Ex. 9). On July 22, 1994, Dr. Lewis released claimant to full time modified work. (Ex. 12).

Claimant came to work and accepted the employer's return to work offer on July 25, 1994. (Ex. 12-1). Before claimant could do anything else, however, he was fired for violating his "last chance agreement" because of the positive marijuana use test on July 11, 1994.

Claimant was paid interim compensation prior to his termination on July 25, 1994. SAIF accepted claimant's claim for fracture of the left coronoid process of the mandible on July 27, 1994. (Ex. 13). SAIF did not pay interim compensation between July 25, 1994 and July 27, 1994.

The ALJ found that claimant was not entitled to temporary disability benefits from the date he was fired to the time SAIF accepted his claim. Relying on Viking Industries v. Gilliam, 118 Or App 183, rev den 316 Or 529 (1993), the ALJ reasoned that when claimant chose to violate the employer's alcohol/drug policy, claimant in effect chose to voluntarily terminate his employment. Further, the ALJ determined that, pursuant to OAR 436-60-030(11)(b), claimant was deemed to have failed to begin employment for violating a normal employment standard. See ORS 656.268(3)(c).

Claimant requested review. In our prior order, in light of the 1995 amendments to ORS 656.325(5)(b), we declined to address the propriety of the portion of the ALJ's order that held that claimant "voluntarily quit" his employment. Richard R. Hills, 48 Van Natta 201 (1996). We found that, under amended ORS 656.325(5)(b), SAIF could terminate claimant's temporary total disability (TTD). However, ORS 656.325(5)(b) also states that the carrier is to commence payment of temporary partial disability (TPD) to the worker when the attending physician approves modified work (that would have been offered had claimant remained employed), provided that the employer has a written policy of offering modified work to injured workers. We found that the record contained no evidence of whether "the employer ha[d] a written policy of offering modified work to injured workers." See ORS 656.325(5)(b). As such, we considered the record incompletely and insufficiently developed to determine whether claimant's employer could have commenced payments of temporary partial disability after claimant was terminated for breaching its employment policy. Consequently, we remanded the case to the ALJ for further development of the record.

On remand, the ALJ admitted Exhibit A, which contained selected portions of the employer's employee handbook (in effect at the time of claimant's compensable injury). The ALJ found that the employer had a written policy of offering modified work to employees. (Exs. A-3, -4). The ALJ adhered to and republished the original Opinion and Order.

On review, claimant objects to the ALJ's findings that he voluntarily quit work and that he failed to begin his employment pursuant to former OAR 436-60-030(11)(b).

We first address the ALJ's conclusion that claimant was not entitled to time loss after being fired on July 25, 1994 because he failed to begin his employment pursuant to former OAR 436-60-030(11)(b). The ALJ found that claimant was entitled to temporary partial disability benefits under former OAR 436-60-030(10) and (11) when he accepted the employer's return to work offer. The ALJ reasoned that, pursuant to former OAR 436-60-030(11)(b), claimant was discharged for violation of a normal employment standard, i.e., violation of the employer's alcohol/drug policy and claimant's "last chance agreement." Consequently, the ALJ concluded that claimant was deemed to have failed to begin employment pursuant to ORS 656.268(3)(c) and therefore, the employer could terminate temporary disability benefits.

ORS 656.268(3) provides, in part:

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

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

"* * * * *

"(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment; or

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

Former OAR 436-60-030 (WCD Admin. Order 94-055) provides, in part:

"(10) An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation from the date an injured worker begins any kind of wage earning employment prior to claim determination. * * *

"(11) Temporary partial disability compensation paid under section (10) shall continue until:

"* * * * *

"(b) The job no longer exists, or the job offer is withdrawn by the employer. This includes, but is not limited, to termination of temporary employment, layoff or plant closure. A worker shall be included in this subsection who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim. The worker is entitled to temporary total disability compensation as of the date the job no longer is available. For the purpose of this rule, a worker quitting the job or the employer discharging the worker for violation of normal employment standards is not withdrawal of a job offer, but shall be considered the same as the worker failing to begin employment pursuant to ORS 656.268(3)(c)[.]"

Here, claimant accepted the employer's written offer of modified employment, but he did not have an opportunity to begin modified work. Therefore, ORS 656.268(3)(a) does not apply because claimant did not return to modified employment. Compare Viking Industries v. Gilliam, supra (employer was entitled to terminate temporary disability benefits under ORS 656.268(3)(a) because the claimant returned to modified work).

Nevertheless, we agree with the ALJ that ORS 656.268(3)(c) applies to this case. Dr. Lewis, claimant's attending physician, approved claimant's return to full-time modified work on July 22, 1994. (Ex. 12). That offer of modified work was offered in writing to claimant and he came to work and accepted the employer's return to work offer on July 25, 1994. However, claimant failed to begin such employment because, before he could actually begin work, the employer fired him for violating his "last chance agreement" because of his positive marijuana use test on July 11, 1994.

Under former OAR 436-60-030(11)(b), "the employer discharging the worker for violation of normal employment standards is not withdrawal of a job offer, but shall be considered the same as the worker failing to begin employment pursuant to ORS 656.268(3)(c)[.]" Under that rule, if a worker is discharged by the employer for a violation of a normal employment standard, the worker is deemed to have failed to begin the offered modified employment. We agree with the ALJ that claimant's violation of the "Last Chance Agreement" constituted a violation of "normal employment standards." Therefore, we conclude that SAIF properly terminated claimant's temporary disability benefits pursuant to ORS 656.268(3)(c).[1]

Penalty

Claimant also asserts that he is entitled to a penalty/attorney fee for SAIF's unreasonable unilateral termination of time loss. Because no benefits have gone unpaid, 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).

ORDER

The ALJ's order dated April 4, 1996 is affirmed.

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[1] In light of our disposition, we do not address the ALJ's alternative conclusion that when claimant chose to violate the employer's alcohol/drug policy, claimant in effect chose to voluntarily terminate his employment.

Furthermore, we do not address the dissent's argument that former OAR 436-60-030(11)(b) is invalid because it exceeds statutory authority. Because claimant did not raise this issue at hearing or on review, we do not address it. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Board Chair Hall dissenting.

Applying former OAR 436-60-030(11)(b), the majority reasons that if a worker is discharged by the employer for a violation of a normal employment standard, the worker is deemed to have failed to begin the offered modified employment. For the following reasons, I dissent.

Claimant did not voluntarily quit. Rather, the record shows that claimant accepted the employer's return to work offer, reported to work, started his job and was fired. Claimant did not "fail to begin" the offered modified employment.

Furthermore, former OAR 436-60-030(11)(b) is invalid because it exceeds statutory authority. Although ORS 656.268(3)(c) refers to situations in which "the worker fails to begin such employment," former 436-60-030(11)(b) defines "failing to begin employment" as "the employer discharging the worker for violation of normal employment standards."[1] The statutory reference in ORS 656.268(3)(c) to "failing to begin employment" refers to claimant's failure to begin employment, not the employer's termination of claimant's employment.

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[1] ORS 656.268(3)(c) provides, in part:

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

"* * * * *

"(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment[.]" (Emphasis added).

Here, claimant reported to work and started his job. Therefore, claimant "began employment." Claimant was subsequently terminated for violation of the last chance agreement. Those are two separate events. Former OAR 436-60-030(11)(b) exceeds its statutory authority by defining the "failure to begin employment" to be the same as the employer's termination of the worker.

For these reasons, I respectfully dissent.

Former OAR 436-60-030 (WCD Admin. Order 94-055) provides, in part:

"(11) Temporary partial disability compensation paid under section (10) shall continue until:

"* * * * *

"(b) The job no longer exists, or the job offer is withdrawn by the employer. This includes, but is not limited, to termination of temporary employment, layoff or plant closure. A worker shall be included in this subsection who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim. The worker is entitled to temporary total disability compensation as of the date the job no longer is available. For the purpose of this rule, a worker quitting the job or the employer discharging the worker for violation of normal employment standards is not withdrawal of a job offer, but shall be considered the same as the worker failing to begin employment pursuant to ORS 656.268(3)(c)[.]" (Emphasis added).

In the Matter of the Compensation of
HEATHER M. DAVIDSON, Claimant
WCB Case No. 95-11752
ORDER OF DISMISSAL
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

The insurer requested review of Administrative Law Judge (ALJ) Schultz's order that set aside its denial of claimant's L5-S1 disc herniation and L4-5 central disc bulge condition. The parties have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them, in lieu of the ALJ's order, as well as those issues pending before the Hearings Division in WCB Case No. 96-07471. Those portions of the settlement which pertain to issues pending before the Hearings Division have received ALJ approval.

Pursuant to the settlement, claimant agrees that the insurer's denial, as supplemented in the agreement, "shall forever remain in full force and effect." The parties further stipulate that claimant's hearing request "shall be dismissed with prejudice" and that the insurer's request for Board review is withdrawn.

We have approved those portions of the parties' settlement which pertain to issues pending in this appeal, thereby fully and finally resolving this dispute, in lieu of the ALJ's order.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] In granting this approval, we note that a provision in the settlement states that "[the parties] are not in possession of any medical bills eligible for payment under ORS 656.313." Such a statement conflicts with other portions of the settlement which list the medical service provider billings that are subject to reimbursement under ORS 656.313(4)(c) and (d), as well as claimant's consent to a reimbursement in excess of the statutory "40 percent" limitation. See Charles E. Munger, 46 Van Natta 462 (1994). In light of the aforementioned "list" and "40 percent acknowledgment" provisions, we have interpreted the potentially inconsistent provision as stating that the parties are not in possession of any other medical bills eligible for payment under ORS 656.313.

In the Matter of the Compensation of
LARRY G. NEWTH, Claimant
WCB Case No. 94-04371
ORDER ON REVIEW
Richard P. Noble, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's consequential stroke condition; and (2) awarded a $30,600 attorney fee. Claimant cross-requests review, seeking an increased attorney fee award. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We begin with a summary of the relevant facts.

Claimant suffered a compensable right ankle injury in December 1993. His diagnosis was "right medial malleolar fracture versus ankle sprain." (Ex. 75-2). He treated conservatively, with a stirrup, plaster splint, anti-inflammatory medication, and physical therapy. (Exs. 75-2, 98). In February 1994, when claimant's ankle and foot symptoms did not resolve, Dr. Cook, attending physician, ordered a bone scan to aid diagnosis. On February 10, 1994, at about 8:00 a.m., claimant was given an injection of Technitium 99 MDP (a radioisotope) and told to return to the nuclear medicine department in four hours for the scan procedure.

Within 15 or 20 minutes, claimant felt a warm sensation throughout his body. He and his wife walked about a block to a restaurant. Claimant's wife returned to her work at the hospital, in time for a 9:00 a.m. appointment. While reading his book shortly thereafter at the restaurant, claimant suddenly felt strange and lightheaded, his vision blurred, and he experienced the onset of left-sided facial and arm numbness. He became very uncomfortable, dizzy, and disoriented; his visual disturbance worsened gradually, particularly in the left eye; and he developed a posterior headache, which also worsened gradually. Claimant made his way back to the nuclear medicine unit at the hospital, where his wife met him and observed that he appeared unwell.

The bone scan was performed. Afterward, claimant was examined in the emergency room and admitted to the hospital for evaluation of a suspected transient ischemic attack. His eventual diagnosis was an episode of cerebral vascular insufficiency, or stroke. Claimant was discharged on February 14, 1994. Weeks later, claimant was almost totally blind. His posterior headaches continued for several months.

The employer contends that the claim fails on medical and legal grounds. First, it argues that the medical evidence supporting the claim is unpersuasive because it is based on an inaccurate history that claimant's initial stroke symptoms were gradual in onset, whereas contemporaneous reports described them as abrupt or sudden. Second, even if the radiopharmaceutical injection caused claimant's stroke, the employer contends that the claim is not compensable because only medical treatment (not diagnostic services, such as the bone scan) are deemed compensable causes of indirectly consequential conditions under ORS 656.005(7)(a)(A).

We consider medical causation first. The February 1994 medical reports describe claimant's left side facial numbness, confusion, blurred vision in the left eye, dizziness, posterior headache, and unsteady gait. (Exs. 105, 106, 110, 111, 112, 113, 122). Subsequent reports and claimant's testimony describe essentially the same symptoms, in the same time frame, with somewhat more detail. (Tr. 31-34; Exs. 149, 192, 203, 206, 212). Accordingly, we find that claimant's stroke symptom history has been materially consistent over time. The remaining question is whether claimant's symptoms should be characterized as sudden or gradual for purposes of determining the cause of the stroke.

The medical experts agree that the etiology of claimant's stroke depends largely on the timing of his initial symptoms. If claimant's symptoms were sudden, the stroke was likely embolic and idiopathic; if the symptoms were gradual, the stroke was likely thrombotic and injection-related.

The pivotal phrases, "sudden" and "gradual" are not explicitly defined. However, we are able to glean their meanings from their context in the record. For example, Dr. Wynn (examining neurologist), acknowledged that embolic stroke symptoms are "like someone turned out the lights." (2 Tr. 21). Similarly, Drs. Wynn and Smith (treating neurologist) agreed that embolic stroke symptoms happen "essentially, instantaneously -- within seconds" of the stroke event. (2 Tr. 20, see Tr. 177-79). Considering the critical time association required for embolic stroke symptoms and the "lights out" analogy, this medical evidence supports a conclusion that multiple embolic symptoms happen essentially all at once, while thrombotic stroke symptoms do not.

Drs. Smith, Young, and Clark reviewed claimant's contemporaneous medical records and concluded that claimant's particular symptoms were consistent with a thrombotic, rather than an embolic, stroke based on the nature and timing of the symptoms. We find these opinions well-reasoned and based on an accurate history, and therefore, persuasive.

In reaching this conclusion, we note that claimant's initial symptoms (as recorded contemporaneously) were more gradual than sudden, despite the terminology used by emergency room and admitting physicians.[1] Specifically, we note that claimant's February 10, 1994 stroke symptoms occurred over a 3-4 hour period, not within seconds. Moreover, even the initial medical reports describe the onset of claimant's posterior headache after his dizziness and loss of vision, indicating progression of symptoms rather than instantaneous onset.

Thus, because the medical evidence supporting the claim is well-reasoned and based on (and consistent with) claimant's history, it is persuasive.[2] Accordingly, we adopt the ALJ's opinion that the claim is compensable except for the third paragraph on page four, as supplemented above.

The employer also argues that the claim is not compensable because the compensable right ankle injury did not itself cause claimant's stroke. Moreover, because the bone scan was purely diagnostic, the employer contends that it would not be "treatment" otherwise deemed a compensable cause of claimant's indirectly consequential stroke under ORS 656.005(7)(a)(A). See Barrett Business Services v. Hames, 130 Or App 190, rev den, 320 Or 492 (1994) (Where reasonable and necessary treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A)); compare Robinson v. Nabisco, Inc., 143 Or App 59 (1996) (Where the major contributing cause of the claimant's condition is an injury sustained during an independent medical examination, the original compensable injury is not deemed its major contributing cause under ORS 656.005(7)(a)(A)). We disagree.

As the court explained in Robinson and Hames, supra, a consequential injury incurred during reasonable and necessary medical treatment of a compensable condition is deemed compensable because such an injury flows "directly and inexorably" from the original compensable injury. See 143 Or App at 65; 130 Or App at 193, 196-97. Here, because the stroke injury resulted directly from the attending physician's prescribed[3] injury-related bone scan injection, it flowed no less directly and inexorably from

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[1] We acknowledge that the initial medical reports use the words "sudden" and "abrupt" to describe the onset of claimant's symptoms. However, these reports were written before a stroke was suspected and the time critical relationship between symptoms and diagnosis was therefore not yet implicated. Under these circumstances, we interpret the terms as meaning "unexpected" or "without warning," rather than time oriented.

[2] The employer argues that Dr. Smith's opinion is legally insufficient to carry claimant's burden because it is based solely on the temporal relationship between claimant's symptoms and his stroke. We disagree, because Dr. Smith's opinion is expressly based on the quality and timing of the symptoms, as well as the systematic elimination of other potential contributing causes. (See Exs. 203-7, 210; Tr. 138-142, 151-53, 157, 173-74).

[3] There is no contention that the bone scan was unreasonable or unnecessary.

claimant's compensable ankle injury than did the consequential injury in Hames. See Finch v. Stayton Canning Co., 93 Or App 168, 173 (1988); Priscilla J. Bosley, 43 Van Natta 380, 384 (1991) (A diagnostic service, such as a CT scan, is a compensable medical service so long as it is reasonable, necessary, and related to a compensable condition). Accordingly, Hames controls and the compensable ankle injury is deemed the major contributing cause of claimant's consequential stroke. Compare Robinson v. Nabisco, Inc., supra at 66 (An injury resulting from an independent medical examination "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.").

Attorney Fees

The ALJ awarded a $30,600 attorney fee, based on 153 hours of attorney work time. The employer contends that the fee award is excessive because claimant included 30.5 hours expended on a medical malpractice issue before counsel was retained regarding the workers' compensation matter. Even without considering this time, the employer argues that claimant's attorney's time expenditure was excessive because its attorney spent only half as much time on the case.

Claimant responds that the time spent between September 1994 and February 21, 1995 (five hours) was essential to the workers' compensation case and notes that he requested no fee for time spent preparing his request for attorney fees. He contends that his entire time expenditure was reasonable and necessary because he submitted comprehensive medical reports from eight witnesses and called two to testify at hearing. He also submitted a trial memorandum, presented medical exhibits at hearing, and made use of medical literature during the hearing. Based on such services, as well as the other factors recited in OAR 438-015-0010(4), claimant asks that the ALJ's attorney fee award be increased to $76,500.

On de novo review, we consider the amount of claimant's counsel's attorney fee for services at the hearings level by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's stroke. Approximately 130 exhibits were received into evidence, including at least five medical reports generated by claimant's counsel. The hearing lasted a day and a half (almost 11 1/2 hours) and the transcript consists of 260 pages. Four witnesses, including claimant, testified on his behalf. One witness testified for the employer. Three of the five witnesses were medical experts. Claimant submitted 10 pages of hearing memoranda and an affidavit from his counsel attesting to 153 hours of service.[4]

As compared to typical compensability cases, the issue here was of above average complexity. The claim's value and the benefits secured are of above average proportions, consisting of substantial medical services and probably, permanent disability. The hearing was relatively lengthy (lasting longer than one day) and involved extensive examination of three expert witnesses. Claimant's counsel devoted a significant number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Finally, although there was a decided risk that claimant's counsel's efforts might have gone uncompensated, counsel's skill and time was well spent in reducing that risk through preparation. See Schoch v. Leupold & Stevens, 144 Or App 259 (1996) (The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)).

After considering these factors, we disagree with the employer's contention that $15,000 is a reasonable attorney fee for services rendered at the hearings level regarding the compensability issue. However, we also consider the ALJ's $30,600 award to be excessive. Specifically, after consideration of the aforementioned factors, we conclude that $22,500 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. In particular, we have considered the complexity of the issue, the value of the interest involved, the nature of the proceeding, the skill of the attorneys, the time devoted to the case, and the risk that claimant's counsel might go uncompensated.

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[4] The affidavit describes counsel's time expenditures, including approximately 28 hours of background medical research; 11 hours of legal research; 30 hours of hearing preparation; and 8 hours writing the trial memorandum.

Furthermore, after considering and applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $4,000, 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 and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved. No fee is awarded for services on review related to the ALJ's attorney fee award.

ORDER

The ALJ's order dated June 26, 1996 is modified in part and affirmed in part. In lieu of the ALJ's $30,600 attorney fee award, claimant's counsel is awarded a $22,500 attorney fee, payable by the self-insured employer. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded a $4,000 attorney fee, payable by the employer.

November 22, 1996 Cite as 48 Van Natta 2334 (1996)

In the Matter of the Compensation of
NANCY L. PENDERGAST-LONG, Claimant
WCB Case No. 95-12710
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of claimant's surgery claim for a low back condition. On review, the issues are the effect of a prior Disputed Claim Settlement (DCS) and compensability. We reverse.

FINDINGS OF FACT

In 1986 and 1987, claimant suffered low back strain injuries which SAIF accepted. After the injuries, claimant suffered intermittent flare-ups of back pain. By 1992, her diagnosis was degenerative disc disease at L4-5.

On July 17, 1992, SAIF denied claimant's then-current care and treatment. (Ex. 15).

In December 1992, the parties entered into a DCS which provided, inter alia, that SAIF's denial would remain in full force and effect; that "[c]laimant shall have no further entitlement to compensation or any other legal right related to the denied treatment or condition(s)"; and that "the parties agree that the Requests for Hearing [from SAIF's denial] shall be dismissed with prejudice and that payment shall be accepted in full settlement of all issues raised or raisable." (Ex. 16-4). The DCS also provided: "Claimant retains all rights that my [sic] later arise under ORS 656.245, 565.273 [sic], 656.278, and 656.340, insofar as these rights may be related to either original accepted claim." (Id).

In 1995, a diagnostic discogram disclosed, for the first time, a disc condition at L5-S1. Later that year, Dr. Miller performed fusion surgery from L4-5 to L5-S1.

SAIF denied claimant's surgery claim on the basis that the 1986 injury was not the major contributing cause of her need for treatment.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant's medical services claim precluded by the parties' 1992 DCS. Alternatively, based on the medical evidence, the ALJ concluded that the claim was not compensable. In doing so, the ALJ reasoned that the opinion of Dr. Miller (claimant's treating surgeon) was not persuasive because Dr. Miller conclusorily attributed claimant's 1995 L5-S1 disc derangement to the 1986 compensable low back injury. For the following reasons, we disagree.

Claimant's claim is for fusion surgery at L4-5 and L5-S1. The L5-S1 condition caused the need

for surgery.[1] Thus, in 1995, claimant had a condition at L5-S1 (and a related need for treatment) which had not been diagnosed at the time of the 1992 DCS. The DCS could not resolve a dispute over the compensability of a condition as yet undiagnosed; such an issue was neither raised nor raisable at the time of the DCS. Under these circumstances, the DCS has no preclusive effect on claimant's current claim for treatment for her L5-S1 disc.[2] See Judy A. Tuttle, 45 Van Natta 165 (1993). Accordingly, we proceed to the merits.

Based on the mechanism of the work injuries, the process of degeneration, and claimant's continuing symptoms, Dr. Miller, treating surgeon, opined that the 1986 and 1987 strains involved direct injury to claimant's L5-S1 disc and that the work injuries were the major contributing cause of claimant's recent need for surgery. (Exs. 35-2, 38). The only other evidence concerning causation is provided by Dr. Donahoo, who considered only claimant's L4-5 condition and specifically excluded consideration of the L5-S1 area. (Ex. 34). Dr. Miller's opinion is well-reasoned, based on an accurate history, and uncontroverted. See Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810 (1983). We rely on it and conclude that the current claim for medical services is compensable, because the work injuries were the direct and material cause of the need for treatment. See ORS 656.245(1)(a); ORS 656.005(7)(a)[3]; see e.g., Maureen C. Cole, 45 Van Natta 2145 (1993).

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 $5,000 payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated May 10, 1996 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $5,000 attorney fee, payable by SAIF.

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[1] Dr. Miller included fusion at L4-5 because of the likelihood that the L5-S1 surgery would otherwise provoke a problem at the adjacent significantly degenerated disc. (Exs. 27, 28-2). Thus, in our view, the L5-S1 disc caused the need for the L4-5 disc to be fused. Moreover, to the extent that the L4-5 surgery would otherwise be precluded by the 1992 DCS, we note that claimant's L4-5 condition has progressed since her work injuries. Because it has also progressed since 1992, it is not the "same condition" which was subject to settlement in 1992 and the current claim is not thereby precluded. See Liberty Northwest Insurance Corp. v. Bird, 99 Or App 560 (1989).

[2] SAIF argues that the 1992 DCS extinguished claimant's entitlement to any further compensation for the 1986 injury. We are not persuaded by this argument because it is contrary to the terms of the above-quoted DCS. (Compare Gilkey v. SAIF, 113 Or App 314, rev den 314 Or 573 (1992) (Where the parties agreed that there was no relationship between an injury and a condition, they were bound by that agreement).

[3] To the extent that claimant might be subject to the major contributing cause standard of ORS 656.005(7)(a)(A), we would also find that Dr. Miller's opinion was sufficient to carry that burden. (See Ex. 38). See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

In the Matter of the Compensation of
TREVOR E. SHAW, Claimant
WCB Case No. 95-01654
ORDER OF ABATEMENT
Schneider, Hooton, Claimant Attorneys
Scheminske, et al, Defense Attorneys

The insurer requests abatement and reconsideration of our order dated July 30, 1996, as reconsidered on August 27 and October 24, 1996, that ordered the insurer to pay claimant temporary disability benefits from June 4, 1993 to January 17, 1994, and a 25 percent penalty based on those amounts of compensation.

In order to allow us sufficient time to consider the motion, we withdraw our prior orders. Claimant is granted an opportunity to respond to the motion. 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.

November 22, 1996 Cite as 48 Van Natta 2336 (1996)

In the Matter of the Compensation of
ROGER L. VONARX, Claimant
WCB Case No. 95-11341
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

On review, claimant contends that the ALJ erred in relying on the opinion of his treating physician, Dr. Bowman. Claimant argues that Dr. Bowman's opinion is internally inconsistent because, on the one hand, he opined that the June 1995 work incident was the reason claimant required treatment, but on the other hand, he also opined that the preexisting degenerative back condition was the major contributing cause of the need for treatment. We find no inconsistency in Dr. Bowman's opinion.

Dr. Bowman opined that the June 1995 work incident, in which claimant lifted a garbage bag weighing five pounds, was the precipitating cause of his disability and need for treatment, but that the preexisting condition was the major contributing cause. (Ex. 29-1). As the Court of Appeals has recognized, the "precipitating cause" is not necessarily the "major contributing cause." See Dietz v. Ramuda, 130 Or App 397, 401 (1994). Thus, we find no inconsistency in Dr. Bowman's opinion that the work incident was the precipitating cause, but not the major contributing cause, of claimant's disability and need for treatment.

When the medical evidence is divided, we tend to give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reason not to defer to the opinion of Dr. Bowman. His opinion is supported by that of Dr. Hamby who also attributed claimant's condition in major part to the preexisting condition. (Ex. 28-16). Both doctors' opinions are consistent with claimant's history, which he confirmed at hearing, that he has had chronic low back pain since his back (compression fracture) injury in 1992. (Tr. 6). For these reasons, we defer to Dr. Bowman's opinion and conclude that claimant has not carried his burden of proof.

ORDER

The ALJ's order dated June 20, 1996 is affirmed.

In the Matter of the Compensation of
TIM L. BESHEONE, Claimant
WCB Case No. 95-02103
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board en banc.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that reduced claimant's award of scheduled permanent disability for loss of use or function of the left arm from 33 percent (63.36 degrees), as awarded by an Order on Reconsideration, to 7 percent (10.5 degrees). The insurer cross-requests review, arguing that: (1) the ALJ erred by excluding its impeachment evidence; and (2) the ALJ erred in awarding scheduled permanent disability for loss of range of motion and a chronic condition. On review, the issues are evidence and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. We change the last sentence of the second paragraph from "right arm contusion" to "left arm contusion."

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant compensably injured his left wrist on April 1, 1994. Claimant was diagnosed with a contusion and sprained arm. (Ex. 1B).

On April 14, 1994, Dr. Carpenter diagnosed a stretch injury to the left ulnar nerve. (Ex. 1D). Dr. Carpenter reported on June 3, 1994 that claimant had weakness of the ulnar nerve and radial nerve and he diagnosed a left brachial plexus injury. (Ex. 2). Dr. Carpenter referred claimant to a neurologist for further studies, which were normal. (Exs. 3, 4).

The insurer accepted a "contusion/strain left forearm" on June 16, 1994. (Ex. 4C).

On June 29, 1994, Dr. Bowman reported that a bone scan showed increased uptake in his injured left arm. (Ex. 4E). Claimant's arm was re-placed in a cast.

On July 28, 1994, Dr. Dobbes reported that claimant's left arm contusion was resolved and claimant was released to regular work. (Ex. 8).

An October 28, 1994 Determination Order declared claimant medically stationary as of October 13, 1994 and awarded temporary disability, but no permanent disability. (Ex. 10). Both parties requested reconsideration.

The Order on Reconsideration issued February 2, 1995, awarding 33 percent (63.36 degrees) scheduled permanent disability for claimant's left arm. (Ex. 12). The parties stipulated that the Appellate Reviewer erroneously computed 25 percent impairment for "4/5 radial nerve (extension)" strength loss and that the correct computation was 10 percent, which reduced the total award to 24 percent for claimant's left arm. (Ex. 13; Tr. 1). The insurer requested a hearing.

The ALJ concluded that claimant was entitled to an award of 7 percent (10.5 degrees) for loss of use of the left forearm.

Evidence

At hearing, the insurer sought to introduce Exhibits 14, 15A and Exhibits 16 through 24, as well as testimony of three witnesses for purposes of impeachment.[1] According to the insurer, the

[1] We note that the ALJ also excluded the May 4, 1995 chart note in Exhibit 4E-4. (Tr. 2, 3). Although the insurer does not argue about the admissibility of that chart note on review, we treat the May 4, 1995 chart note in Exhibit 4E-4 the same as the rest of the insurer's impeachment evidence.

We also note that the parties do not dispute that the exhibits admitted by the ALJ were part of the record on reconsideration.

impeachment evidence pertained to the truthfulness and veracity of claimant, including the accuracy of the medical findings which rely on claimant's truthfulness and full effort.

The ALJ excluded the impeachment evidence offered by the insurer, but the ALJ did allow an offer of proof. The ALJ concluded that amended ORS 656.283(7) precluded the introduction of any evidence that was not presented at the reconsideration proceeding. (Tr. 3).

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. Newell v. SAIF, 136 Or App 280, 282 (1995); Volk v. America West Airlines, 115 Or App 565, 572-73 (1995). There are no express exceptions applicable to the amendment of ORS 656.283(7). Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

In Precision Castparts Corp. v. Plummer, supra, the court held that amended ORS 656.283(7) does not apply to evidence previously and properly admitted, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Because the claimant's testimony in Plummer was admissible when it was offered and considered by the ALJ and the Board, the court held that the admission of the testimony was not error.

In Dean J. Evans, 48 Van Natta 102 (1996), we acknowledged that the holding in Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), was overruled by Precision Castparts Corp. v. Plummer, supra, to the extent that it applies to cases where the hearing was held before June 7, 1995. 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. In Evans, we continued to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995.

Here, the hearing was held on October 3, 1995, after the effective date of Senate Bill 369. Therefore, the holding in Precision Castparts Corp. v. Plummer, supra, does not apply. Dean J. Evans, supra. We proceed to decide whether the insurer's impeachment evidence was admissible.

In Joe R. Ray, supra, we held that the 1995 amendments by Senate Bill 369 to ORS 656.283(7) retroactively apply to exclude any evidence (including at-hearing testimony), which was not submitted at the reconsideration proceeding, at a subsequent hearing concerning the extent of permanent disability. Relying on the plain language of amended ORS 656.283(7), as supported by the legislative history, we concluded that the legislature intended to limit evidence concerning issues arising from a Notice of Closure or Determination Order to that evidence submitted at the reconsideration and made a part of the reconsideration record.

In Ray, we referred to testimony in the legislative history that indicated that the amendments to ORS 656.283 were intended to overrule court cases that had allowed the admission of further evidence after reconsideration, including Leslie v. U. S. Bancorp, 129 Or App 1 (1994) (holding that former ORS 656.283(7) did not preclude the claimant from raising an issue for the first time at hearing), and Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993) (holding that former ORS 656.283(7) allowed the ALJ to consider evidence that could not have been submitted on reconsideration). 48 Van Natta at 328.

Here, the issue involves the interplay between the section of ORS 656.283(7) that allows admissibility of impeachment evidence in certain circumstances and the section of the same statute that limits admissibility of "[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." The question is whether impeachment evidence not submitted at reconsideration, and not made a part of the reconsideration record, is admissible at a subsequent hearing concerning the extent of permanent disability. For the following reasons, we conclude that such impeachment evidence is not admissible.

To interpret amended ORS 656.283(7), we must discern legislative intent. ORS 174.020. We begin by examining the text and context of amended ORS 656.283(7). PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The context includes other provisions of the same statute and other related statutes. Id. at 611. In examining context, we consider relevant rules of statutory construction, such as the statutory mandate that, "where there are several provisions or particulars, such construction is, if possible, to be adopted as will give effect to all." ORS 174.010. If those sources do not reveal legislative intent, we resort to legislative history and other extrinsic aids. Id. at 611-12.

As amended, ORS 656.283(7) provides, in 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 the 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. * * * Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself. However,** nothing in this section shall be construed to prevent or limit the right of the worker, insurer or self-insured employer to present [evidence] **the reconsideration record** at hearing [and] to establish by a preponderance of [the] **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." (Added words are in bold face type; deleted words are in brackets).

The insurer argues that, based on the plain language of amended ORS 656.283(7), impeachment evidence can always be withheld and subsequently introduced in a later proceeding. The insurer asserts that the three sentences of ORS 656.283(7) dealing with admissibility of impeachment evidence are inclusory and apply to all cases without any exception noted. According to the insurer, the plain language of those sentences mandates that impeachment evidence can be withheld and later used at hearing and need only be disclosed in certain cases.[2]

Before we address the insurer's arguments, we briefly review the admissibility of impeachment evidence in workers' compensation proceedings before the effective date of Senate Bill 369. Under former OAR 438-07-017[3] (WCB Admin. Order 1-1994) (eff. 1/95), the parties had to disclose all medical and vocational materials before the hearing. Other documents reasonably believed to be relevant and

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[2] The insurer has requested oral argument and claimant has no objection. We will not ordinarily entertain oral argument. OAR 438-011-0015(2). However, we may allow oral argument where the case presents an issue of first impression that could have a substantial impact on the workers' compensation system. See OAR 438-011-0031(2); Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996); Jeffrey B. Trevitts, 46 Van Natta 1767 (1994). The decision to grant such a request is solely within our discretion. OAR 438-011-0031(3).

Here, through their appellate briefs, the parties have adequately addressed the issues before the Board and we are not persuaded that oral argument would assist us in reaching our decision. Accordingly, we decline to grant the request for oral argument. See Raymond L. Mackey, 47 Van Natta 1 (1995).

[3] Former OAR 438-07-017 (WCB Admin. Order 1-1994) (eff. 1/95), provided:

"(1) All medical or vocational material, whether created or existing before, on, or after the date of injury or exposure shall be disclosed under 438-07-015 and is not subject to the impeachment exceptions as set forth in the following sections of this rule.

"(2) Subject to the exception set forth in section (3) of this rule, all audio tapes, video tapes, transcriptions, summaries, and notes of recorded or unrecorded statements given by a claimant to an insurer, self-insured employer, claims administration agency, or employer shall also be disclosed under 438-07-015.

"(3) A video tape or surveillance film of a party may be withheld for solely impeachment purposes, unless the video tape or surveillance film has been reviewed by a medical or vocational expert.

"(4) Subject to the exception set forth in section (3) of this rule, other documents which are not subject to the disclosure requirements of sections (1) and (2) of this rule and are believed relevant and material only for purposes of impeachment of a witness need not be disclosed in advance of hearing and may be offered and admitted solely for impeachment. Documents so offered shall not be considered by the referee as substantive evidence. Upon request, all such documents shall be disclosed prior to the close of the hearing, whether or not offered, at which time the other party may offer the documents as substantive evidence."

material solely for purposes of impeaching a witness did not have to be disclosed before the hearing and could be offered and received solely for the purpose of impeachment. See SAIF v. Cruz, 120 Or App 65 (1993) (interpreting an earlier version of OAR 438-07-017; Board had to determine whether the party withholding the evidence could reasonably have believed the evidence was admissible solely for impeachment purposes). On the request of a party, all documents not otherwise privileged, whether or not offered as evidence, had to be disclosed before the end of the hearing, at which time any other party could offer the documents, if any, as substantive evidence. Under the former rule, noncompliance with the disclosure requirements resulted in exclusion.

In contrast, under amended ORS 656.283(7), a party is allowed to withhold impeachment evidence until the opposing party's case in chief has been presented. Impeachment evidence consisting of medical or vocational reports not used during the hearing must be provided to any opposing party at the conclusion of the presentation of evidence and before closing arguments are presented. However, impeachment evidence other than medical or vocational reports that is not presented as evidence at hearing is not subject to disclosure. Thus, it is clear that, under amended ORS 656.283(7), the legislature intended to change the Board's earlier rules to allow a party to withhold certain types of impeachment evidence.

To determine whether impeachment evidence was admissible in this case, we first examine the portions of amended ORS 656.283(7) that refer to impeachment evidence. Amended ORS 656.283(7) provides, in 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 the 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.**" (Added words are in bold face type; emphasis added).

The first sentence quoted above discusses when impeachment evidence may be admitted. The following two sentences discuss the disclosure of impeachment evidence. Since the issue in this case involves the admissibility of impeachment evidence, and not its disclosure, we focus on interpreting the first sentence.

Claimant does not dispute that the evidence at issue in this case constituted "impeachment evidence" under amended ORS 656.283(7). We note that "impeachment evidence" is not defined in amended ORS 656.283(7) or in chapter 656, nor is it defined in the workers' compensation administrative rules. However, in case law, "impeachment" refers to the "elicitation or presentation of any matter for the purpose of impairing or destroying the credibility of a witness in the estimation of the trier of fact." State v. Johanesen, 319 Or 128, 130 n.2 (1994) (citing Simpson v. Sisters of Charity of Providence, 284 Or 547, 564 (1978)); cf. ORS 40.355 (Rule 609) (discussing impeachment by evidence of conviction of crime "[f]or the purpose of attacking the credibility of a witness"); ORS 40.360 (Rule 609-1) (discussing impeachment for bias or interest by attacking the credibility of a witness).[4]

By its terms, amended ORS 656.283(7) provides that a party may withhold impeachment evidence "until the opposing party's case in chief has been presented, at which time the impeachment evidence may be used." Here, since the insurer seeks to introduce impeachment evidence, the "opposing party" is claimant. The phrase "case in chief" is not defined in amended ORS 656.283(7), or anywhere else in the workers' compensation statutes. In interpreting a statute, however, "words of common usage typically should be given their plain, natural, and ordinary meaning." PGE v. Bureau of Labor and Industries, supra, 317 Or at 611. "Case in chief" commonly means "[t]hat part of a trial in which the party with the initial burden of proof presents his evidence after which he rests." Black's Law Dictionary 196 (5th ed. 1979). Cf. ORCP 58B(2) (order of proceedings on jury trial; "plaintiff then shall introduce the evidence on plaintiff's case in chief, and when plaintiff has concluded, the defendant shall do likewise").

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[4] We further note that Representative Mannix, a sponsor of Senate Bill 369, testified before the Senate Labor and Government Operations Committee that impeachment evidence is "evidence designed to show somebody was non-truthful or filing a fraudulent claim or the like." Tape Recording, Senate Committee on Labor and Government Operations, January 30, 1995, Tape 15B.

As used in amended ORS 656.283(7), then, "case in chief" refers to that part of this hearing in which claimant, the "opposing party," presents evidence.[5] Thus, under amended ORS 656.283(7), the insurer's impeachment evidence may be introduced after claimant's case in chief is presented.

Contrary to the insurer's argument, the plain language of amended ORS 656.283(7) does not provide that impeachment evidence can be introduced at any time in the history of the claim. Rather, by its terms, amended ORS 656.283(7) provides that impeachment evidence may be admitted in specific circumstances. The underlying premise of amended ORS 656.283(7) is that, for the statute concerning impeachment evidence to apply, the record must still be open. No evidence, impeachment or otherwise, can be admitted after the record has been closed, except in specific circumstances involving newly discovered evidence. See former OAR 438-07-025(2).[6]

This case involves a hearing concerning the extent of claimant's permanent disability. As we discussed in Joe R. Ray, supra, amended ORS 656.283(7) applies retroactively to exclude any evidence that was not submitted at reconsideration, and not made a part of the reconsideration record, at a subsequent extent of permanent disability hearing. In an extent of disability case, each party's "case in chief," i.e., the record, is developed at the reconsideration level. The hearing before the ALJ actually constitutes a level of appellate review. Thus, in a hearing concerning the extent of a worker's permanent disability, the record is essentially "frozen" and no new evidence may be introduced by either party.[7] The parties' arguments are limited to the evidence developed on reconsideration. For that reason, it is important that the positions of the parties be clearly presented to the initial tribunal, i.e., at reconsideration.

There is no support in the text or context of amended ORS 656.283(7) for the insurer's argument that impeachment evidence can always be withheld and subsequently introduced in a later proceeding. The admission of impeachment evidence pursuant to amended ORS 656.283(7) is limited to situations in which the record is still open. In a subsequent hearing concerning the extent of a worker's permanent disability, no new evidence may be introduced by either party. Joe R. Ray, supra. Therefore, we conclude that the provision of amended ORS 656.283(7) that allows a party to withhold impeachment evidence "until the opposing party's case in chief has been presented, at which time the impeachment evidence may be used," does not apply in a subsequent hearing concerning the extent of an injured worker's permanent disability.

If we were to adopt the insurer's argument that amended ORS 656.283(7) allows impeachment evidence in all proceedings, the insurer's interpretation would fail to give effect to the provision of amended ORS 656.283(7) that provides 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." The insurer's approach violates a principle of construction to be applied in the first level of statutory analysis: "[W]here there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all." ORS 174.010; PGE v. Bureau of Labor and Industries, supra, 317 Or at 611.

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[5] We note that the insurer requested the hearing and, therefore, had the "initial" burden of proof. Although the definition for "case in chief" in Black's Law Dictionary, supra, refers to the "part of a trial in which the party with the initial burden of proof" presents evidence, amended ORS 656.283(7) refers to the "opposing party's case in chief," which indicates that the legislature intended that both parties would present a "case in chief," not just the party with the initial burden of proof. By its terms, amended ORS 656.283(7) indicates that either party may present impeachment evidence in response to the other party's "case in chief."

[6] Former OAR 438-07-025(1) provides that a referee (now an administrative law judge) may "reopen the record and reconsider his or her decision before a request for review is filed or, if none is filed, before the time for requesting review expires." Former OAR 438-07-025(2) provides:

> "A motion to reconsider shall be served on the opposite parties by the movant and, if based on newly discovered evidence, shall state:
>
> "(a) The nature of the new evidence; and
>
> "(b) An explanation why the evidence could not reasonably have been discovered and produced at the hearing."

[7] We note, however, that ORS 656.268(6)(e) provides that "[a]ny medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding."

The insurer's interpretation of amended ORS 656.283(7) allowing impeachment evidence in all proceedings would also conflict with amended ORS 656.268(7)(g), which now provides that, after reconsideration, no subsequent medical evidence of a worker's impairment is admissible before the Department or on appeal. Furthermore, we disagree with the insurer's interpretation of the eighth sentence of amended ORS 656.283(7), which provides, in part:

> **"Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing * * *."** (Added words are in bold face type).

The insurer argues that the eighth sentence of amended ORS 656.283(7) conclusively establishes that impeachment evidence is admissible. According to the insurer, the exclusion of evidence only applies to evidence required to be submitted at reconsideration by ORS 656.268, as well as circumstances where an issue "arises out of reconsideration" itself. The insurer argues that, based on a detailed reading of amended ORS 656.268(7)(f) and (g),[8] the only evidence required to be submitted at reconsideration is medical evidence and vocational evidence related to the accepted disabling injury and the arbiter's report. Therefore, the insurer asserts that, because the eighth sentence of amended ORS 656.283(7) only limits evidence required by ORS 656.268, i.e., medical and vocational evidence, all other types of evidence are admissible at hearing.

Before we address the insurer's contentions regarding the eighth sentence of amended ORS 656.283(7), we note that in Joe R. Ray, supra, we discussed the statutory changes to the ninth sentence of amended ORS 656.283(7). We concluded that the ninth sentence clearly referred to the reconsideration record as opposed to the evidentiary record developed at hearing. 48 Van Natta at 326-37. The ninth sentence in amended ORS 656.283(7) provides, in part, that:

> "nothing in this section shall be construed to prevent or limit the right of the worker, insurer or self-insured employer to present [evidence] **the reconsideration record** at hearing [and] to establish by a preponderance of [the] **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." (Added words are in bold face type; deleted words are in brackets).

In Ray, we found that eliminating the parties' right to present "evidence" at hearing and replacing it with the right to present "the reconsideration record" at hearing was consistent with the prohibition of post-reconsideration evidence in the eighth sentence of amended ORS 656.283(7). We concluded that replacing "the" with "that" prior to the word "evidence" in the second paragraph referred to the reconsideration record rather than the evidentiary record developed at hearing.[9] 48 Van Natta at 327.

In this case, for the following reasons, we conclude that the eighth sentence in amended ORS 656.283(7) refers to the reconsideration record as opposed to the evidentiary record developed at hearing.

In amended ORS 656.283(7), the phrase "required by ORS 656.268" clearly refers to its immediate antecedent, "reconsideration." Thus, the phrase "required by ORS 656.268" refers to the reconsideration proceeding, not to the type of evidence required at the reconsideration proceeding. The

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[8] Amended ORS 656.268(7) provides, in part:

"(f) The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure. [, and]

"**(g) 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." (Added words are in bold face type; deleted words are in brackets).

[9] In Joe R. Ray, supra, we also rejected the claimant's argument that the word "evidence" in amended ORS 656.283(7) was ambiguous and should be read to mean "medical evidence," the term used in amended ORS 656.268(7)(g). We reasoned that ORS 656.268(7)(g) only addresses evidentiary limitations regarding "findings of impairment" where a medical arbiter has been appointed. 48 Van Natta at 327 n.2.

insurer's argument that the phrase "required by ORS 656.268" refers to the type of evidence required by ORS 656.268 is inconsistent with the grammar of that phrase, in which "required by ORS 656.268" ordinarily would modify its closest noun or noun phrase, "reconsideration." Moreover, if "required by ORS 656.268" were intended to refer to "evidence," the legislature could have more clearly stated its meaning, by stating, for example:

> "Evidence [required by ORS 656.268] on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration * * * is not admissible at hearing * * *." (Portion in brackets added).

Thus, we interpret the phrase "required by ORS 656.268" in the eighth sentence of amended ORS 656.283(7) to refer to reconsideration, not to the type of evidence required at the reconsideration proceeding. Therefore, we reject the insurer's argument that the eighth sentence of amended ORS 656.283(7) only limits evidence required by ORS 656.268, i.e., medical and vocational evidence, and all other types of evidence are admissible at hearing.

In summary, considering the text and context of amended ORS 656.283(7), we conclude that impeachment evidence that was not submitted at reconsideration, and not made a part of the reconsideration record, is statutorily inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. Our construction gives effect to all the provisions of ORS 656.283(7) amended by Senate Bill 369.

Although we need not consider the legislative history to amended ORS 656.283(7), PGE v. Bureau of Labor and Industries, supra, 317 Or at 611-12, the history provides no support for the insurer's argument that the legislature intended to allow impeachment evidence in all proceedings without any exceptions. In Joe R. Ray, supra, 48 Van Natta at 327-29, we discussed the legislative history concerning admissibility of evidence in post-reconsideration proceedings. However, we did not examine the legislative history concerning impeachment evidence.

On January 30, 1995, Representative Mannix, a sponsor of Senate Bill 369, testified before the Senate Committee on Labor and Government Operations:

> "[ORS 656].283, sub (7): Modifies the rules of evidence at the hearing and limits the review of reconsideration orders. The rules for conducting hearings, as they come out now, basically require more than just closure of medical and vocational reports or even certain evidence by the end of a hearing. But if you have some impeachment evidence which may have nothing to do with the medical or vocational condition, you have to disclose it. This says, no, that you are able to withhold impeachment evidence, which is evidence designed to show somebody was non-truthful or filing a fraudulent claim or the like. That if it is medical or vocational evidence, you certainly have to provide that ultimately by the end of the hearings process. But other kinds of evidence can be withheld. For example, what if you have a co-worker who is ready to testify that the injury didn't happen, and you believe the worker believes that, and you want to use that worker to impeach. But at the hearing, it becomes evident that there is other evidence that the co-worker is wrong. Do you have to disclose that the co-worker gave you that statement and create tension between the co-worker and the injured worker? No, you should be able to decide that information doesn't need to be disclosed, because it's negative for the claimant, not positive; it has nothing to do with the medical or vocational condition and all it will do is create bad blood. That's just an example." Tape Recording, Senate Committee on Labor and Government Operations, January 30, 1995, Tape 15B.

On March 6, 1995, Representative Mannix testified before the House Committee on Labor:

> "Section 34 [ORS 656.283] sets standards for review and appeal of vocational disputes. This sets up a system where the Department and the Director can meet the Supreme Court requirements without having to have a whole litigation ground in the Hearings Division. It pretty much limits the standards of review and there is a discussion here of 656.283(7). It modifies Rules of Evidence at hearing and limits review of Reconsideration

> Order and gets back to the issue we talked about before as to not bringing in new stuff at the hearing on reconsideration, but also tells the Board what we think ought to be done on impeachment evidence, since it has gotten harder and harder to hold back any impeachment evidence and, in fact, this does run counter to some of the latest commentaries or directives from the Board about impeachment evidence. It speaks for itself." Tape Recording, House Committee on Labor, March 6, 1995, Tape 45B (emphasis added).

The legislative history to amended ORS 656.283(7) provides no indication that the legislature intended to allow impeachment evidence that was not submitted at reconsideration, and included in the reconsideration record, to be admitted at a subsequent extent of permanent disability hearing. Rather, Representative Mannix's comment that the statute "speaks for itself" provides support for our conclusion that, based on the text and context of amended ORS 656.283(7), the legislature did not intend to allow impeachment evidence to be introduced in post-reconsideration proceedings.

Finally, we address the insurer's argument that the evidence it offered addressed an issue which "arose out of the reconsideration itself." The insurer asserts that the reconsideration order gave rise to the issue of credibility because claimant was awarded permanent disability even though he had allegedly given false findings during the arbiter's exam. The insurer contends that claimant's veracity was not at issue prior to the reconsideration order and only became an issue when the appellate reviewer relied on breakaway weakness to support an award for a strength deficit and used that false strength deficit to support a chronic condition award.

We disagree with the insurer that claimant's veracity only became an issue after the Order on Reconsideration issued. If the insurer believed that claimant had given false findings during the arbiter's exam, the insurer should have raised that issue on reconsideration. The appellate reviewer should have been allowed to consider that information before issuing the Order on Reconsideration. The fact that the appellate reviewer found the medical evidence sufficient to establish entitlement to a permanent disability award does not raise a new issue. If we accepted the insurer's argument that the decision on reconsideration raised a new issue which permitted admission of "post-reconsideration" evidence pursuant to amended ORS 656.268(8), the effect would be to eviscerate the provisions of amended ORS 656.268(8) and amended ORS 656.283(7) that explicitly limit the admissibility of post-reconsideration evidence. See Cecil L. Wilmarth, Jr., 48 Van Natta 1194 (1996) (a "post-medical arbiter/post-reconsideration order" report from the claimant's attending physician did not address a new issue arising out of the reconsideration order). Therefore, because no new issue arose out of the reconsideration order, amended ORS 656.268(8) does not apply to this case.

Furthermore, even if we assume that the insurer's issue arose out of the reconsideration order itself, the statutes do not allow for the introduction of any new evidence, whether for impeachment or otherwise. Amended ORS 656.268(8) provides:

> **"No hearing shall be held on any issue not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing."** (Added words are in bold face type; emphasis added).

Amended ORS 656.283(7) contains a similar provision that was discussed earlier:

> **"Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."** (Added words are in bold face type; emphasis added).

That section of amended ORS 656.283(7) differentiates between evidence that can be admitted at hearing and issues that can be raised at hearing. Although new evidence is not admissible in a post-reconsideration hearing, issues may be raised if the issues "arise[] out of the reconsideration order itself." Similarly, amended ORS 656.268(8) provides that "issues arising out of the reconsideration order may be addressed and resolved at hearing." (Emphasis added).

By their terms, amended ORS 656.283(7) and amended ORS 656.268(8) allow a party to raise new issues that "arise out of the reconsideration order." Even if we assume that the insurer's issue arose out of the reconsideration order itself, the statutes do not allow for the introduction of any new evidence, whether for impeachment or otherwise. Therefore, we conclude that neither amended ORS 656.283(7) nor amended ORS 656.268(8) allow the insurer to present impeachment evidence that was not submitted at reconsideration at a subsequent extent of permanent disability hearing. Thus, even if the evidence offered by the insurer "arose out of the reconsideration order," it is not admissible. See Cathy M. Montgomery, 48 Van Natta 1170 (1996).

Extent of Scheduled Permanent Disability - Loss of Strength

An October 28, 1994 Determination Order declared claimant medically stationary as of October 13, 1994 and awarded temporary disability, but no permanent disability. Both parties requested reconsideration. The Order on Reconsideration issued February 2, 1995, awarding 33 percent left arm scheduled permanent disability. The parties stipulated that the Appellate Reviewer erroneously computed 25 percent impairment for "4/5 radial nerve (extension)" strength loss, and that the correct computation therefore was 10 percent, which reduced the total award to 24 percent for claimant's left arm.

The ALJ concluded that claimant was entitled to an award of 7 percent (10.5 degrees) for loss of use of the left forearm. In reviewing claimant's loss of strength, the ALJ noted that Drs. Carpenter and Bowman and the medical arbiters all found some loss of strength in claimant's left hand. Nevertheless, the ALJ concluded that, even assuming that claimant had loss of muscle strength as a result of the injury, it was not possible to rate it under the standards because there was no evidence to determine the specific nerve supplying the muscle or muscle groups that had reduced strength.

Claimant contends that the ALJ's finding concerning loss of strength is wrong because, under OAR 436-35-110(8)(a), for injuries to muscle or musculo tendonous group, the value shall be determined "as if the nerve were affected."

The extent of claimant's permanent disability is determined by an application of the "standards." Claimant became medically stationary on October 13, 1994 and a Determination Order issued on October 28, 1994. Accordingly, the disability standards contained in Workers' Compensation Department Administrative Orders Nos. 6-1992 and 93-056 apply to claimant's claim. Former OAR 436-35-003(2).

Even if we assume, without deciding, that claimant's loss of strength in the left arm was "due to" the compensable injury, we conclude that claimant is not entitled to a rating under former OAR 436-35-110(8) because there is no evidence that claimant's loss of strength of the left forearm was caused by a peripheral nerve injury, loss of muscle or disruption of the musculo tendonous unit.

Loss of strength is rated when the cause is a peripheral nerve injury. Former OAR 436-35-110(8) (WCD Admin Order 6-1992). The value of impairment is determined based upon the specific nerve affected as described in the table in OAR 436-35-110(8) and as modified pursuant to 436-35-007(14). Id. Loss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued as if the nerve supplying that muscle or muscle group was impaired. Former OAR 436-35-110(8)(a).

On June 3, 1994, Dr. Carpenter commented that claimant had weakness of the ulnar nerve and radial nerve. (Ex. 2). Dr. Carpenter referred claimant to a neurologist for further studies. On June 8, 1994, claimant underwent nerve conduction studies and an electromyography of the left upper extremity. (Exs. 3, 4). The median and ulnar nerve conduction studies were normal and claimant had no evidence of significant ulnar neuropathy or radiculopathy. (Ex. 3). In addition, claimant had a normal left upper extremity electromyography. (Ex. 4).

On June 22, 1994, Dr. Bowman reported that claimant's measurements of grip strength were "[r]ight 140, 120, 140; left 35, 40 and 40." (Ex. 5). Dr. Bowman commented that claimant's "[s]ubjective complaints outweigh and do not match objective findings." (Id.)

The medical arbiters, Drs. Gancher, Thomas and Case, found that claimant had "5/5 strength in deltoids, biceps, and triceps; he had some breakaway testing on testing in the left wrist extensors and left grip, approximately 4/5 strength in these two muscle groups." (Ex. 11). The medical arbiters concluded that claimant had "slight limitation in usage of his left forearm and wrist. The objective findings include 4/5 strength in the left wrist extensors and left grips and slight reduction in supination and extension of his left wrist, presumably due to pulling in the volar compartment of his left forearm." (Id.)

The February 2, 1995 Order on Reconsideration awarded 33 percent (63.36 degrees) scheduled permanent partial disability for loss of use or function of the left arm. (Ex. 12). The worksheet attached to the Order on Reconsideration included the following comments concerning claimant's loss of strength:

> "4/5 Strength left wrist extension - OAR 436-35-110
> 4/5 radial nerve (extension) = .2 x 50% = 25%
> 4/5 median nerve (grip) = .2 x 44% = 8.8 Rd to 9%
> 4/5 ulnar nerve (grip) = .2 x 31% = 6.2 Rd to 6%
> Note: Diagnosis is chronic left forearm strain which is by definition a trauma to a musculotendinous unit. See OAR 436-35-110(a)." (Ex. 12-4) (emphasis in original).[10]

Under former OAR 436-35-110(8)(a), loss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired. Although the medical arbiters reported that claimant had "4/5 strength in the left wrist extensors and left grips and slight reduction in supination and extension of his left wrist, presumably due to pulling in the volar compartment of his left forearm," (Ex. 11), they did not explain the cause of the weakness or whether the loss of strength was due to loss of muscle or disruption of the musculo tendonous unit.

We note that the worksheet attached to the Order on Reconsideration mentioned that the diagnosis was "chronic left forearm strain which is by definition a trauma to a musculotendinous unit. OAR 436-35-110(a)." (Ex. 12-4). We agree with the insurer that former OAR 436-35-110(8)(a) refers only to loss of strength due to loss of muscle or disruption of the musculo tendonous unit. There is no rating for trauma to the musculo tendonous unit. See Brian G. Vogel, 46 Van Natta 83, on recon 46 Van Natta 225 (1994) (diagnosis of tendonitis did not establish a disruption of the musculo tendonous unit); former OAR 436-35-010(2) (permanent loss of use or function of a body part due to an on-the-job injury, as defined and used in the standards, "shall be the sole criteria for the rating of permanent disability in the scheduled body parts under these rules").

Moreover, there is no evidence in the record to establish that claimant's loss of strength was caused by a peripheral nerve injury, loss of muscle or disruption of the musculo tendonous unit. As we mentioned earlier, the worksheet attached to the Order on Reconsideration referred to the radial nerve, the median nerve and the ulnar nerve in connection with rating claimant's loss of strength. However, there is no evidence in the record that indicates that any of claimant's nerves were impaired. Rather, the evidence is to the contrary since the June 1994 nerve conduction studies were normal, as was the electromyography of the left upper extremity. (Exs. 3, 4). Although claimant relies on Dr. Carpenter's report identifying the nerves involved (Ex. 2), that report is entitled to little weight because the subsequent nerve studies were normal. On this record, we conclude that claimant has failed to prove loss of strength attributable to nerve injury, loss of muscle, or disruption of the musculo tendonous unit. Therefore, claimant is not entitled to a value for loss of strength for the left arm under former OAR 436-35-110(8). See Charles S. Grove, 48 Van Natta 829 (1996).

In reaching this conclusion, we distinguish this case from Lawrence K. Donaghy, 47 Van Natta 1031 (1995). In Donaghy, the medical reports assessing the claimant's permanent disability arising from the compensable injury established that his right quadriceps and hamstring strength was 4/5. We found that evidence sufficient to establish that the claimant's loss of strength was due to loss of muscle or disruptions of the musculo tendonous units relating to his right quadriceps and hamstring. Former OAR 436-35-230(10). We concluded that, because the medical reports specifically addressed the claimant's permanent disability, if any, relating to his compensable right knee injury, those reports implicitly supported the conclusion that his weakness in the right quadriceps and hamstring was due to loss of muscle or disruption of the musculo tendonous unit as a result of his compensable injury.

Here, in contrast, claimant's loss of strength award was based on impairment of the radial, median and ulnar nerves, not on loss of muscle or a disruption of the musculo tendonous unit. Yet, there is no medical evidence from claimant's treating physician or the medical arbiters that any of those nerves were impaired. Moreover, as we mentioned earlier, the June 1994 nerve conduction studies were

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10 The parties stipulated that the Appellate Reviewer erroneously computed 25 percent impairment for "4/5 radial nerve (extension)" strength loss, and that the correct computation therefore was 10 percent, which reduced the total award to 24 percent for claimant's left arm. (Ex. 13; Tr. 1).

normal, as was the electromyography of the left upper extremity. (Exs. 3, 4). Under these circumstances, there is no support, implicit or otherwise, for a conclusion that claimant's loss of strength in the left arm was attributable to nerve injury, loss of muscle, or disruption of the musculo tendonous unit.

Finally, we reject claimant's argument that, even if the record is incomplete as to which nerves are involved, he is still entitled to an impairment rating for loss of strength and that the lowest value for loss of strength should be assigned, i.e., the ulnar nerve, below mid forearm at 32 percent. The record does not establish that claimant's loss of strength in the left arm was based on impairment to his ulnar nerve.

Extent of Scheduled Permanent Disability - Repetitive Use and Range of Motion

The insurer argues that the ALJ erred in awarding claimant permanent partial disability for loss of range of motion and a chronic condition. After reviewing the record, we agree with the ALJ's reasoning and conclusion that claimant is entitled to 5 percent scheduled permanent disability for a chronic and permanent condition limiting repetitive use of the left arm, combined with a 2 percent impairment for loss of range of motion, which results in a total award of 7 percent (10.5 degrees) for loss of use of the left forearm.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services on review regarding the insurer's cross-request for 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 the insurer. In reaching this conclusion, we have particularly considered the time devoted to the insurer's cross-request (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 18, 1995 is affirmed. For services on review, claimant's attorney is awarded a fee of $750, payable by the insurer.

Board Chair Hall and Member Biehl concurring in part and dissenting in part.

We agree with the majority that the ALJ properly excluded the insurer's impeachment evidence. We disagree, however, with the majority's conclusion that claimant is not entitled to a value for loss of strength for the left arm. For the following reasons, we dissent from that portion of the majority's opinion.

The ALJ found that Drs. Carpenter and Bowman and the medical arbiters all found some loss of strength in claimant's left hand. Nevertheless, the ALJ concluded that it was not possible to rate claimant's loss of muscle strength under the standards because there was no evidence to determine the specific nerve(s) supplying the muscle or muscle groups that had reduced strength.

Claimant correctly argues that the ALJ's finding concerning loss of strength is wrong because, under former OAR 436-35-110(8)(a), loss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued "as if the nerve supplying that muscle or muscle group were impaired."

The medical arbiters concluded that claimant had "slight limitation in usage of his left forearm and wrist. The objective findings include 4/5 strength in the left wrist extensors and left grips and slight reduction in supination and extension of his left wrist, presumably due to pulling in the volar compartment of his left forearm." (Ex. 11). The worksheet attached to the Order on Reconsideration referred to the radial nerve, the median nerve and the ulnar nerve in connection with rating claimant's loss of strength:

"4/5 Strength left wrist extension - OAR 436-35-110
4/5 radial nerve (extension) = .2 x 50% = 25%
4/5 median nerve (grip) = .2 x 44% = 8.8 Rd to 9%
4/5 ulnar nerve (grip) = .2 x 31% = 6.2 Rd to 6%
Note: Diagnosis is chronic left forearm strain which is by definition a trauma to a musculotendinous unit. See OAR 436-35-110(a)." (Ex. 12-4) (emphasis in original).

The majority misconstrues former OAR 436-35-110(8)(a) and adds a requirement not in the rule. Former OAR 436-35-110(8)(a) provides:

"Loss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired."

This is not a case of nerve impairment. Rather, claimant has suffered a loss of strength due to loss of muscle or disruption of the musculo tendonous unit. Therefore, the lack of evidence of nerve damage is not determinative. Impairment is not based on an actual nerve injury. Rather, the value is determined "as if" the nerves were impaired.

In reaching its conclusion that there is no evidence that claimant's radial nerve, median nerve or ulnar nerve were impaired, the majority interprets the rule to read:

"Loss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued only if there is specific nerve impairment of the nerve(s) supplying that muscle or muscle group."

We are to interpret rules in the same manner as we interpret statutes. That is, we are "simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted * * *." ORS 174.010. Here, the majority erroneously interprets former OAR 436-35-110(8)(a) by substituting its own language.

We also disagree with the majority's conclusion that a "strain" does not constitute an "abnormal separation." In Brian G. Vogel, 46 Van Natta 83, on recon 46 Van Natta 225, aff'd 132 Or App 7 (1994), the Court of Appeals affirmed our conclusion that a "disruption" in former OAR 436-35-110(2)(a) was "an abnormal separation." In that case, we concluded that a diagnosis of tendonitis was merely an inflammation of tendons and did not establish a disruption of the musculotendonous unit.

Here, in contrast, claimant has a left forearm strain rather than tendonitis. As the majority points out, a "strain" is defined, in part, as "an overstretching or overexertion of some part of the musculature." Dorland's Illustrated Medical Dictionary 1478 (25th ed. 1974). An "overstretching" of some part of the musculature is equivalent to an "abnormal separation" or a "disruption." Thus, contrary to the majority's conclusion, there is no distinction between a "strain" and a "disruption."

Under former OAR 436-35-110(8)(a), loss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued "as if the nerve supplying that muscle or muscle group were impaired." Since claimant has suffered a loss of strength due to disruption of the musculo tendonous unit, the Order on Reconsideration should be affirmed.

In the Matter of the Compensation of
KENNETH L. DEVI, Claimant
WCB Case No. 93-10959
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Craig A. Staples, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the self-insured employer's denial of claimant's current low back condition and need for medical treatment. On review, the issue is compensability.

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

As a preliminary matter, the employer questions which exhibits were admitted into the record at hearing, noting that the ALJ's Opinion and Order specifies that Exhibits 1 through 89 and 191 and 111A were admitted into evidence. At hearing, the ALJ admitted Exhibits 1 through 291 and 111A without objection, but with the proviso that the parties would pare the exhibits down to a more manageable number after hearing. There is no evidence that any culling ever took place. Therefore, we conclude that Exhibits 1 through 291 and 111A were admitted into the record.

Turning to the merits, we briefly summarize the relevant facts. In 1976, claimant was treated for low back pain of several months' duration. He was diagnosed with mild degenerative changes at L5-S1. (Exs. 1, 13). In October 1978, claimant compensably injured his neck and back when he was knocked off his feet by a flying board. (Ex. 2).

Claimant first sought treatment seven months later, in May 1979, for upper thoracic, mid thoracic and neck pain. Dr. Goodman diagnosed mechanical back syndrome, rather than a radicular problem. He also noted degenerative changes in claimant's thoracic spine. (Ex. 3). In May 1981, Dr. Hoogeveen became claimant's treating physician. Dr. Hoogeveen noted that the degenerative changes in claimant's low back at L5-S1 had increased since 1976. (Ex. 7). In November 1981, claimant was examined for the employer by Dr. Martens, who diagnosed claimant's condition as "contusion, thoracolumbar spine and strain, cervicothoracic spine." Dr. Martens also diagnosed degenerative arthritic changes in the thoracolumbar spine that preexisted claimant's 1978 injury. (Ex. 13).

The claim was closed by a December 11, 1981 Determination Order that awarded no permanent disability. (Ex. 16). On August 26, 1982, a prior ALJ awarded 10 percent unscheduled permanent disability for claimant's low, mid and upper back. (Ex. 22).

Beginning in May 1981, a number of physicians noted degenerative changes in claimant's back, including the low back, and, in April 1984, Dr. Bert noted severe degenerative disc disease at the lumbosacral level with spondylosis throughout the lumbar spine. (Exs. 7, 13, 21, 30, 42, 44). Over the ensuing years, claimant was treated conservatively for neck and back pain and, in 1988, a prior ALJ awarded a total of 30 percent unscheduled permanent disability. (Exs. 118, 172).

Claimant continued to receive treatment for his back symptoms. In 1989, Dr. Hoogeveen noted that claimant was having episodes of right lower extremity numbness. (Exs. 192, 193). An MRI demonstrated degenerative disk disease (DDD) with spondylosis from the L2-3 through the L5-S1 levels. (Ex. 195).

On January 7, 1993, claimant experienced a motor vehicle accident when his car slid on ice into a barricade. On February 16, 1993, Dr. Weise evaluated claimant's back condition. Tests and further evaluation by Dr. Ray demonstrated severe spinal stenosis from L3 to S1 and an L5-S1 right disk herniation with calcification, for which decompression surgery was recommended. (Exs. 261, 266, 268, 269, 270, 273, 275, 276). Dr. Ruckle became claimant's treating physician after claimant moved to Washington state. Drs. Zivin and Thompson, Dr. Aberle and Dr. Thomas Rosenbaum examined claimant for the employer. (Exs. 280, 283, 284, 285, 286). On July 20, 1993, the employer denied the surgery on the basis that claimant's compensable 1978 injury was not the cause of claimant's current condition. (Ex. 282).

The ALJ concluded that claimant had failed to establish the compensability of his current condition. We agree.

The record clearly establishes that claimant was diagnosed with DDD in 1976. (Ex. 1). Moreover, as noted by the ALJ, a number of claimant's treating and examining physicians indicated that claimant's 1978 injury combined with his preexisting DDD. Thus, claimant must prove that his 1978 injury was the major contributing cause of his current condition and need for treatment. ORS 656.005(7)(a)(B).

Because of the number of possible causes and the passage of time, the causation of claimant's current condition is a complex medical question which must be resolved by persuasive expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Persuasive medical opinions are well-reasoned and based on complete and accurate information. Somers v. SAIF, 77 Or App 259 (1986). 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 such reasons.

After our review of the extensive medical record, we agree with the ALJ's reliance on the opinions of Drs. Zivin and Thompson and Dr. Thomas Rosenbaum. (Exs. 280, 283, 285, 286). We are more persuaded by their complete and well-reasoned opinions that claimant's current condition and need for medical treatment is solely due to his preexisting DDD, and not to his 1978 injury, rather than Dr. Ruckles' conclusory and unexplained opinion to the contrary.[1] Somers v. SAIF, supra; Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Alternatively, claimant contends that the employer is barred by res judicata from raising the issue of the compensability of his degenerative condition and pain syndrome. We decline to address this argument because it is an issue being raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not presented at hearing).

At hearing, claimant raised the issue of the compensability of the condition that made claimant's 1995 back surgery necessary. (Tr. 5). In the colloquy that took place during opening statements, claimant stated: "[W]hat we're asking you [the ALJ] to look at is the opinions of the doctors and the testimony of the claimant to determine whether or not you believe this was a serious accident. And your answer to that question should solve the remaining questions." The employer then stated: "I would concur with the claimant that the question that you [the ALJ] need to address is whether the industrial injury of October 5, 1978 is the major contributing cause of the surgery that was proposed in 1993. * * * This is a medical question." (Tr. 5, 6, 7, 8, 9). Claimant did not argue that prior orders closing the claim precluded the employer from denying claimant's current condition. Moreover, claimant admits that he did not raise this argument until the unrecorded closing arguments. (Claimant's reply brief at 3).

We acknowledge that claimant's position on review could be characterized as merely a different theory in support of compensability, rather than a separate issue. Nevertheless, because claimant did not make his preclusion argument before closing arguments, we conclude that the employer would be prejudiced if we considered this late-raised theory on review. See Clive G. Osbourne, 47 Van Natta 2271 (1995); Gunther H. Jacobi, 41 Van Natta 1031 (1989).

ORDER

The ALJ's order dated March 14, 1996 is affirmed.

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[1] We also agree with the ALJ's discussion of the lack of contribution of the January 1993 MVA to claimant's current condition. See O&O at 6, 8; Exs. 274, 284.

In the Matter of the Compensation of
DIANE S. HILL, Claimant
WCB Case No. 94-08899
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board en banc.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its "de facto" denial of claimant's left trapezius and shoulder condition and awarded an assessed attorney fee; and (2) set aside its partial denial of claimant's depression condition. On review, the issues are whether claimant filed a "new medical condition" claim under ORS 656.262(7)(a), compensability, and attorney fees. We vacate in part and affirm in part.

FINDINGS OF FACT

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

Claimant has a compensable bilateral neuropathy and carpal tunnel syndrome claim, which was accepted by the employer in 1993. In January 1994, claimant developed left shoulder weakness, and subsequently experienced shoulder and left trapezius tenderness.

In May 1994, claimant's treating physician, Dr. Witczak, referred claimant to Dr. Gostnell, Ph.D., for treatment of emotional problems. Dr. Gostnell diagnosed claimant as suffering from depression.

In July 1994, claimant was examined by Dr. Parvaresh, who diagnosed a dysthmic disorder. On July 18, 1994, the employer issued a partial denial of claimant's depression condition.

On July 22, 1994, Dr. Witczak responded to an inquiry from the employer's claims processor. He reported that the major cause of claimant's trapezius and left shoulder pain was an alteration of the biomechanics of her hand use, as well as pain from her median and ulnar nerve neuritis. The claims processor did not respond to Dr. Witczak's report.

Claimant filed a request for hearing on July 26, 1994, which challenged the employer's July 18, 1994 denial. On December 9, 1994, claimant filed a supplemental hearing request which explained that, in addition to the issue of compensability of claimant's depression condition, claimant also would raise the issue of a "de facto" denial of the trapezius and shoulder condition. A hearing was held in this matter on January 18, 1996.

CONCLUSIONS OF LAW AND OPINION

ORS 656.262(7)(a)/"New Medical Condition" Claim

At hearing, the employer argued that claimant had not complied with the requirements of amended ORS 656.262(7)(a) in requesting formal written acceptance of the new left shoulder condition. The ALJ held that Dr. Witczak's July 22, 1994 opinion was sufficient to satisfy the "new medical condition claim" provisions of the statute. Addressing the merits of the claim, the ALJ found claimant's left shoulder condition compensable. We vacate the ALJ's compensability decision because claimant did not file a "new medical condition" claim.

Amended ORS 656.262(7)(a) provides:

> "After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. * * * Notwithstanding any other provision in this chapter, the worker may initiate a new medical condition claim at any time."

We first find that, under Senate Bill 369, the statute retroactively applies. Or Laws 1992, ch 332, § 66; Volk v. America West Airlines, 115 Or App 565 (1995). We next examine what result the legislature intended when it enacted ORS 656.262(7)(a). ORS 174.020. We begin by examining the text and context of ORS 656.262(7)(a). PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). Only if those sources do not reveal the legislature's intent do we resort to legislative history and other extrinsic aids. Id. at 611-12.

On its face, ORS 656.262(7)(a) manifests the legislature's intent that, in cases involving aggravation or new medical condition claims that arise after claim acceptance, the worker must "clearly request formal written acceptance of the [aggravation or new medical] condition" before the carrier has an obligation to issue a written notice accepting or denying that condition. (Emphasis added). The carrier then has 90 days after it "receives written notice of such claim[]" to either accept or deny the claim. (Emphasis added). Taken together, we read that language to require that, in order to file a "new medical condition claim" after claim acceptance, a worker must clearly request in writing the formal written acceptance of the new medical condition claim from the insurer or self-insured employer.

The context of ORS 656.262(7)(a) supports this interpretation. ORS 656.262(6)(d), which was also added to the statute as part of Senate Bill 369, now requires that, for a worker to contest an alleged "de facto" denial at a hearing, the worker must first communicate in writing to the carrier his or her objections to the notice of acceptance. See Shannon E. Jenkins, 48 Van Natta 1482 (1996). Taken together, these subsections support a conclusion that the legislature intended to require a worker who wishes to file an aggravation or new medical condition claim to do so through a formal written request for acceptance of the aggravation or new medical condition claim before requesting a hearing.

Alternatively, even if we considered the statutory text and context to be ambiguous regarding whether a "formal written request" for acceptance must precede a request for hearing or whether a hearing request can also serve as a "new medical condition claim, we would reach the same conclusion. An examination of the legislative history concerning ORS 656.262(7)(a) supports this holding.

ORS 656.262(7)(a) was enacted by Senate Bill 369. Representative Mannix, a co-sponsor of the bill, testified that ORS 656.262(7)(a):

> "...makes it clear that if you're trying to bring up a new medical condition, something that didn't occur in your claim before, there is a process here now that you ask for written acceptance. Write a letter. The reality of free flow is that you want employers and insurers to get the bill and pay the bill and take care of it, but we have created a system where they are so nervous now that if they issue a notice of acceptance and it doesn't cover everything, they have to issue a denial of this, that or the other. We want a free flow of communication where if the worker thinks enough wasn't covered, write a letter. Now, if they aren't going to cover it, they're going to be stuck with denying it, but it's going to require communication. And if something new comes up on the claim later on, write a letter and say I want this included in my claim. But the problem right now is that there may be a bill that comes in with a diagnostic label on it and that's now treated as a new claim. Nobody notices it, and they may even pay the bill, but they didn't issue a notice of acceptance. Well, if somebody wants a notice of acceptance after the claim is accepted, and they think that there's a new condition, they can write a letter. If the bill isn't paid, by the way, without the issuance of a denial, they can still litigate that. Hey, you refused to pay this bill that you got on my claim. But we're trying to reduce litigation here and just smooth the flow of information." Tape Recording, House Committee on Labor, March 6, 1995, Tape 46A (emphasis added).

Although Representative Mannix did not expressly state that a hearing request could not constitute a "new medical condition" claim, he testified that a claimant should write a letter to the carrier if he or she believes that a new condition should be accepted. Representative Mannix's comments demonstrate that the intent of the new legislation was to smooth the flow of information and reduce litigation. To best achieve the legislature's intent, we construe ORS 656.262(7)(a) as requiring that a request for formal written acceptance of new medical condition precede a hearing request. As we observed in Jenkins, such a reading comports with the express legislative objective of the Worker's Compensation Law to provide an administrative system that reduces litigation and eliminates the

adversarial nature of compensation to the greatest extent practicable. See ORS 656.012(2)(b); Shannon E. Jenkins, supra, 48 Van Natta at 1486.[1]

Moreover, the expressed legislative intent as it appears in the statute and the underlying legislative history is consistent with the practicalities of our administrative process. When a request for hearing is filed with the Board, almost immediately this request is acknowledged to all the parties and a hearing date and location are scheduled. The matter is assigned to an Administrative Law Judge. Considerable administrative time and expense is incurred. If the parties subsequently conclude that there is no real dispute between them, the request for hearing must be dismissed. Our interpretation of the legislative intent expressed in both ORS 656.262(6)(d) and (7)(a) avoids this needless expenditure of resources where the matter can be resolved simply through improved communication. We believe this policy to be of considerable importance.

Having determined that a "new medical condition" claim must precede a hearing request, we now apply ORS 656.262(7)(a) to the facts of this claim. Here, we find that claimant did not comply with the statute in making a new medical condition claim for the left trapezius and shoulder pain condition. Although Dr. Witczak's July 22, 1994 response to the carrier supports a causal relationship between the compensable condition and the current trapezius condition, the report does not "clearly request formal written acceptance" of those conditions. Rather, the report is silent on the issue of acceptance. (Ex. 52).

Claimant filed a request for hearing alleging a "de facto" denial. However, claimant did not first request formal written acceptance of her left trapezius and shoulder pain condition before filing a request for hearing. Given our conclusion that a request for formal written acceptance of a new medical condition must precede a hearing request, and since the employer challenged the propriety of proceeding with litigation of the compensability issue[2], we conclude that claimant was precluded from alleging at hearing that the carrier "de facto" denied her left trapezius and shoulder conditions. Moreover, even if claimant's hearing request could constitute a new medical condition claim, we would find on the facts of this case that it did not satisfy the statutory requirements of ORS 656.262(7)(a).

Claimant's attorney's December 9, 1994 letter to ALJ Lipton, which was copied to the employer, stated in pertinent part:

> "The issues presently pending before the Hearings Division involves the compensability of [claimant's] mental condition. The formal denial was issued on July 18, 1994.
>
> "In addition to that issue, claimant will raise an issue pertaining to the de facto denial of [claimant's] trapezius and shoulder condition. Claimant contends that the major contributing cause of [claimant's] trapezious shoulder pain is an alteration of the biomechanics of her hand use, secondary to the residual discomfort in her left upper extremity." (Pleadings file).

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[1] Relying on Guillermo Rivera, 47 Van Natta 1723, 1724 (1995), in which we held that a request for hearing satisfies the requirements of ORS 656.262(6)(d), claimant argues that a request for hearing specifically raising the issue of a "de facto" denial of claimant's left trapezius and shoulder condition should similarly satisfy the requirements of ORS 656.262(7)(a). We disagree.

We disavowed our decision in Guillermo Rivera in Jenkins. In Jenkins, we reasoned that the text and context of ORS 656.262(6)(d) strongly suggested that the statutory requirement for a 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. In other words, we found that the legislature intended for the worker's "communication in writing" under ORS 656.262(6)(d) to precede the worker's request for hearing. Therefore, we concluded that the claimant's mere filing of a request for hearing alleging a "de facto" denial did not satisfy the amended statute and that the claimant was precluded from proceeding to hearing on the issue of "de facto" denial. Jenkins, supra.

Since this case pertains to ORS 656.262(7)(a) (whereas Jenkins involved the "pre-hearing" written communication requirement of ORS 656.262(6)(d)), Jenkins is not controlling. Nevertheless, as a policy matter, we find the Jenkins principle of declining to consider a hearing request as the equivalent of a "claim" to be compelling. Therefore, consistent with the Jenkins rationale, we decline to construe claimant's request for hearing in this case as a "new medical condition" claim.

[2] This decision should not be construed as prohibiting parties in a workers' compensation proceeding from agreeing to litigate issues not properly raised. See EBI Companies v. Thomas, 66 Or App 105 (1983).

Granted, claimant's reference to a "de facto" denial of the left trapezius and shoulder condition provided notice to the carrier that she intended to establish the compensability of the listed conditions. Nevertheless, such a reference does not "clearly request the formal written acceptance" of the new medical conditions as ORS 656.262(7)(a) directs. Inasmuch as neither claimant's hearing request nor Dr. Witczak's July 22, 1994 response (separately or cumulatively) "clearly request formal written acceptance" of claimant's left shoulder conditions, claimant failed to satisfy requirements of ORS 656.262(7)(a), even assuming that a hearing request could constitute a "new medical condition" claim.

Having reached this conclusion, we now summarize the application of ORS 656.262(7)(a) to the facts of this case. The record shows that, following acceptance of the bilateral carpal tunnel syndrome and neuropathy, claimant was diagnosed and treated for left shoulder and trapezius pain. There is no evidence, however, that claimant (or anyone else on her behalf) filed a written request, or any correspondence, with the employer asking it to accept a new medical condition claim for the shoulder and trapezius condition. Thus, on this record, we find that claimant did not satisfy the requirements of ORS 656.262(7)(a) regarding the filing of a "new medical condition" claim.

Consequently, because no "new medical condition" claim was filed, it was premature for the ALJ to address the compensability of claimant's left trapezius and shoulder condition. Accordingly, we vacate the ALJ's compensability decision regarding this condition, as well as the accompanying $2,000 attorney fee award.

Depression/Consequential Condition

We affirm and adopt the ALJ's Conclusions of Law and Opinion on the issue of compensability of claimant's depression condition.

Claimant's attorney is entitled to an assessed fee for defending against the employer's request for review on the issue of compensability of the depression 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 assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (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 23, 1996 is vacated in part and affirmed in part. Those portions of the ALJ's order which addressed the compensability of claimant's left shoulder and trapezius condition, and awarded a $2,000 attorney fee, are vacated. The remainder of the ALJ's order is affirmed. For services on review concerning the depression condition, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the employer.

Board Chair Hall and Board Member Biehl dissenting in part and concurring in part.

We agree with the majority's decision regarding the compensability of claimant's claim for depression. However, we disagree with the majority's interpretation of ORS 656.262(7)(a) and its decision to cite the legislative history behind that statute. We also disagree with its extension of the rationale of Shannon E. Jenkins, 48 Van Natta 1482 (1996) to ORS 656.262(7)(a). For the following reasons, we respectfully dissent.

The majority holds that, for the purposes of ORS 656.262(7)(a), a request for hearing cannot also serve as a "new medical condition" claim. As pointed out in the dissent in Jenkins, the majority in that case erred in finding that a hearing request could not satisfy the written communication requirement of ORS 656.262(6)(d). As compelling as the reasons were in Jenkins for finding that a hearing request may satisfy the requirements of ORS 656.262(6)(d), the case for considering a hearing request as a "new medical condition" claim under ORS 656.262(7)(a) is even stronger.

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."

Unlike ORS 656.262(6)(d), which requires written communication with the carrier regarding a notice of acceptance "before" a worker may allege a "de facto" denial at any hearing, ORS 656.262(7)(a) contains no such "timing" requirement.[1] In fact, the statute specifically states that a new medical condition claim may be initiated at any time. Thus, there is no statutory requirement that a new medical condition claim precede a hearing request. The majority errs by inserting a requirement into ORS 656.262(7)(a) that is not present in the statute. ORS 174.010.

ORS 656.262(7)(a) also contains no form requirement, with the exception that the new medical condition claim is not made by receipt of a "medical claim billing." The statute requires only that such a claim "clearly request" formal written acceptance of the new medical condition claim. There is no authority to prohibit a "request for hearing" from serving as the "clear request" for acceptance of new medical conditions. In the instant case, the statutory requirement was satisfied by claimant's attorney's December 9, 1994 letter to ALJ Lipton, which was copied to the employer, stating in pertinent part:

> "The issues presently pending before the Hearings Division involves the compensability of [claimant's] mental condition. The formal denial was issued on July 18, 1994.
>
> "In addition to that issue, claimant will raise an issue pertaining to the de facto denial of [claimant's] trapezius and shoulder condition. Claimant contends that the major contributing cause of [claimant's] trapezious shoulder pain is an alteration of the biomechanics of her hand use, secondary to the residual discomfort in her left upper extremity." (Pleadings file).

The hearing in this matter was convened on January 18, 1996, more than 90 days after the employer's receipt of the December 9, 1994 letter. Under these circumstances, we are at a loss to explain the majority's conclusion that there was no request for formal written acceptance of the left trapezius and shoulder condition. By raising the issue of a "de facto" denial of the trapezius/shoulder condition, claimant was clearly seeking acceptance of the condition.

Because we believe it is clear that the text of ORS 656.262(7)(a) does not preclude a hearing request from constituting a new medical condition claim, there is no need to examine the legislative history behind that statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 611 (1993). However, to the extent that the majority relies on legislative history to support its interpretation of the statute, we believe that it travels down a dangerous path in relying on the comments of a single legislator to determine the intent of a legislative provision. See Murphy v. Nilson, 19 Or App 292, 296 (1974) (the testimony of individual legislators is not competent for the purpose of determining legislative intent).

More importantly, even if Representative Mannix's comments do accurately reflect the legislature's intent in drafting ORS 656.262(7)(a), the actual language of the statute, which is, after all, the best indication of legislative intent, does not support a conclusion that a new medical condition claim must precede a hearing request. As previously noted, the statutory language contains no timing

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[1] ORS 656.262(7)(a) requires the insurer to accept or deny claims for new medical conditions within 90 days of receiving notice of such claims.

requirement. A new medical condition claim may be made at any time. It is well-settled that we may not insert into a statute what has been allegedly omitted in order to effectuate our interpretation of what the legislature intended. See Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996).[2]

In conclusion, as it did in Jenkins with respect to ORS 656.262(6)(d), the majority once more imposes a jurisdictional requirement not found in the statute by concluding that a request for hearing cannot satisfy the notice requirement of ORS 656.262(7)(a). The error is even greater here than in Jenkins because the latter statute has less stringent limitations on form and timing than the former statute does. Because the majority extends the reasoning of Shannon E. Jenkins, supra, to a statute where it is even less appropriate, we must respectfully dissent.

[2] Alleging that its interpretation of legislative intent is consistent with the "practicalities of our administrative process," the majority asserts that requiring a new medical condition claim to precede a hearing request will save administrative resources. While the majority's decision to, in effect, rewrite ORS 656.262(7)(a) based on policy considerations has some surface appeal, it ignores the fact that the actual language of the statute does not support the majority's decision. If the majority's policy considerations have merit, it is the legislature's, not the Board's, responsibility to rewrite the statute to achieve those goals.

November 26, 1996 Cite as 48 Van Natta 2356 (1996)

In the Matter of the Compensation of
RONALD L. JORDAN, Claimant
WCB Case No. 96-01579
ORDER ON REVIEW
Estell & Smith, Claimant Attorneys
Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Christian and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that increased claimant's unscheduled permanent disability award for a trigeminal nerve injury from 2 percent (6.4 degrees), as awarded by an Order on Reconsideration, to 10 percent (32 degrees). Claimant cross-requests review of that portion of the ALJ's order that reduced his unscheduled permanent disability award for a cervical and thoracic injury from 12 percent (38.4 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is unscheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first sentence of the findings of fact, we change the date to "May 1994." On page 2, we change the last sentence in the first paragraph to read "loss of function of one trigeminal nerve" rather than "loss of sensation in one trigeminal nerve." We do not adopt the second paragraph of the "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured in May 1994. The insurer accepted several conditions, including a concussion, multiple facial fractures, and cervical/thoracic sprains. (Exs. 15, 22). The claim was closed by a September 26, 1995 Notice of Closure, which awarded 3 percent scheduled permanent disability for the left eye, and 15.5 percent scheduled permanent disability for loss of hearing in the left ear. (Ex. 31).

Claimant requested reconsideration. An Order on Reconsideration was issued on February 7, 1996, which reduced claimant's 3 percent scheduled permanent disability for the left eye to zero, affirmed the 15.5 percent scheduled permanent disability for loss of hearing in the left ear and awarded 14 percent unscheduled permanent disability for reduced cervical and thoracic range of motion and loss of function of one trigeminal nerve. (Ex. 35).

Claimant requested a hearing to contest scheduled and unscheduled permanent disability. The insurer cross-requested a hearing, seeking a reduction in claimant's award of permanent disability.

The ALJ initially found that the sole issue in the case was whether claimant's unscheduled permanent disability award for cervical and thoracic range of motion should be reduced. On reconsideration, finding that the issue was the extent of claimant's unscheduled permanent disability, the ALJ concluded that it was proper to address three areas of impairment: cervical range of motion, thoracic range of motion and trigeminal nerve sensation. The ALJ reduced claimant's unscheduled permanent disability award for cervical and thoracic range of motion from 12 percent to zero. In addition, the ALJ awarded claimant 10 percent unscheduled permanent disability for a loss of sensation on one side of the trigeminal distribution.

Trigeminal Nerve

On review, the insurer argues that the ALJ exceeded his authority by increasing claimant's unscheduled permanent disability award for the loss of sensation on one side of the trigeminal distribution in the absence of a request by claimant to increase his permanent disability.

Claimant acknowledges that he did not specifically request an increase in the permanent disability award for the trigeminal distribution, but he argues that fact is of no consequence. We disagree.

An ALJ's scope of review is limited to the issues raised by the parties. Saedeh K. Bashi, 46 Van Natta 2253 (1994). It is well-settled that we will not increase or reduce an award of permanent disability in the absence of a request to do so by one of the parties. E.g., Herbert C. Kaler, 47 Van Natta 1607 (1995); Carlos S. Cobian, 45 Van Natta 1582, 1583 (1993).

Here, claimant initially requested a hearing to contest scheduled and unscheduled permanent disability. At the beginning of his closing argument, claimant referred to the hearing request, stating that "the scheduled and unscheduled disability should be increased." (Claimant's closing argument at 1). However, regarding the injury to his trigeminal nerve, claimant stated:

> "The claimant had moderate to marked hypoesthesia over the distribution of the supra-orbital ridge to the trigeminal occipital nerve border at the top of the head. There are three trigeminal nerves and because the claimant has impairment to one, he is entitled to 2% pursuant to OAR 436-35-390(4)(b). 5% x 33% = 1.65 = 2%.
>
> "There are no chronic conditions and therefore based upon these impairments we combined 8% for the cervical, 4% for the thoracic, and 2% for the nerve damage for a total of 14% unscheduled disability." (Claimant's closing argument at 3).[1]

At the end of his closing argument, claimant said:

> "Therefore the Notice of Closure, which awarded 15.5% loss of hearing in the left ear, as affirmed by the Order on Reconsideration dated February 7, 1996, should be affirmed. The unscheduled disability equal to 14% should be affirmed. Claimant concedes that the reduction of the left eye disability to zero was correct." (Claimant's closing argument at 4).

In claimant's reply brief to closing arguments, he responded to the insurer's arguments regarding the cervical/thoracic award, but did not comment further on the award for the trigeminal nerve damage.

Although claimant argued that the unscheduled disability award of 14 percent should be affirmed, claimant clearly asserted that he was entitled to a 2 percent award for the trigeminal nerve damage. (Claimant's closing argument at 3). Thus, the only issue before the ALJ was the issue raised by the insurer, i.e., whether claimant's unscheduled permanent disability award for cervical and thoracic range of motion should be reduced. We will not increase or reduce an award of permanent disability in the absence of a request to do so by one of the parties. See e.g., Herbert C. Kaler, supra. Consequently, we reinstate and affirm the 2 percent unscheduled permanent disability award granted in the Order on Reconsideration for a trigeminal nerve injury.

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[1] We note that claimant's comments about the trigeminal nerve award are essentially the same comments in the worksheet attached to the Order on Reconsideration. (Ex. 35-6).

Cervical and Thoracic Range of Motion

Claimant cross-requests review, arguing that the ALJ erred by reducing his unscheduled permanent disability award for reduced cervical and thoracic range of motion from 12 percent to zero. We adopt and affirm the ALJ's analysis and conclusion.

ORDER

The ALJ's order dated May 17, 1996, as reconsidered June 18, 1996, is reversed in part and affirmed in part. That portion of the ALJ's order that increased claimant's unscheduled permanent disability award for a trigeminal nerve injury from 2 percent (6.4 degrees) to 10 percent (32 degrees) and awarded an "out-of-compensation" attorney fee is reversed. The February 7, 1996 Order on Reconsideration award of 2 percent (6.4 degrees) for a trigeminal nerve injury is reinstated and affirmed. The remainder of the ALJ's order is affirmed.

November 26, 1996 Cite as 48 Van Natta 2358 (1996)

In the Matter of the Compensation of
PHILLIP G. NUNES, Claimant
WCB Case No. 95-12414
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Review by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the SAIF Corporation's denial of his injury claim for a left shoulder condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction and exception.

The dates in Findings of Fact Nos. 3 and 4 are corrected to read November 4, 1994. The date in Finding of Fact No. 5 is corrected to read June 1995.

In lieu of Finding of Fact No. 11, we substitute the following: We do not find that the November 4, 1994 slipping incident at work was a material contributing cause of claimant's disability or need for treatment related to his left shoulder condition.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the left shoulder injury claimant suffered while wrestling with his son in June 1995 constituted a "preexisting condition" which combined with the slipping incident at work on November 4, 1994 to cause his disability and need for shoulder treatment. Applying ORS 656.005(7)(a)(B), the ALJ concluded that claimant did not carry his burden of proving the November 1994 incident was the major contributing cause of his disability and need for treatment.

On review, claimant contends that the ALJ erred in applying the "major contributing cause" standard of compensability to his claim. Arguing that the June 1995 wrestling injury did not constitute a "preexisting condition" as defined in ORS 656.005(24), claimant contends that the appropriate standard is "material contributing cause." However, we need not resolve that question because, even under the "material contributing cause" standard, we conclude that claimant has not carried his burden of proof.

Claimant concedes that the causation of his shoulder condition presents a complex medical question which must be resolved by expert medical opinion. The only medical opinion offered in this case is by claimant's treating orthopedic surgeon, Dr. Keizer, who opined that the November 1994 incident was the major contributing cause of his shoulder condition and resultant disability and need for treatment, including surgery. However, there is no indication that Dr. Keizer knew about the June 1995

wrestling incident. For the reasons discussed by the ALJ, we conclude that Dr. Keizer's lack of history concerning the off-the-job incident, which preceded claimant's disability and treatment for the shoulder, rendered his causation opinion wholly unreliable. See Miller v. Granite Construction Co., 28 Or App 473 (1977) (Medical opinion based on an inaccurate or incomplete history is not persuasive). Therefore, claimant has not carried the burden of proving his claim under either the major or material contributing cause standard.

ORDER

The ALJ's order dated June 20, 1996 is affirmed.

November 26, 1996 Cite as 48 Van Natta 2359 (1996)

In the Matter of the Compensation of
AMY J. PETERKIN, Claimant
WCB Case No. 95-00998
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the insurer's denial of her occupational disease claim for bilateral carpal tunnel syndrome (CTS); and (2) declined to assess a penalty based on the insurer's alleged discovery violations. On review, the issues are compensability and penalties.

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

Claimant bears the burden of proving that her work activities were the major contributing cause of her bilateral CTS 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 both work-related and nonwork causes probably contribute to claimant's CTS, we find that the causation issue is essentially a medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986).

In this case, the medical evidence is provided by Drs. McWeeney, Grimm, Hill, Long, Weller, Smith, and Watson. The doctors generally agree that claimant performed repetitive hand-intensive work (in the photo file clerk and desk diary clerk positions) which likely contributed to her CTS. They also generally agree that claimant's pregnancy-related fluid retention and swelling contributed to her condition. Thus, the question is whether claimant has established that her work activities contributed more to her CTS than did her pregnancy.

Dr. McWeeney noted that claimant's CTS symptoms came on at work and subsided when she was off work. However, he also found claimant's return to work "reasonable," and predicted that her symptoms would subside "within two months of pregnancy." (Ex. 4). Absent a reasoned specific conclusion concerning causation, we find Dr. McWeeney's opinion equivocal and unhelpful.

We find Dr. Grimm's opinion (that pregnancy and work activities both contributed to claimant's CTS) similarly unhelpful, because it does not compare the relative contributions of these causes. See Dietz v. Ramuda, 130 Or App 397 (1994).

Dr. Long, consulting physician, noted that claimant's CTS symptoms coincided with her work activities and did not resolve after her pregnancy. He acknowledged that fluid balance changes during pregnancy could "cause preexisting nerve lesions to become symptomatic during pregnancy." (Ex. 11-5). Because there is no evidence that claimant had such preexisting lesions and Dr. Long did not otherwise explain why claimant's CTS problems began with her pregnancy, we do not find Dr. Long's opinion (that work was the major cause of claimant's CTS) particularly persuasive.

Dr. Hill's opinion is unpersuasive, because it attributes claimant's CTS to work activities without explanation. (Ex. 10). Because the opinion is conclusory, we decline to rely on it. See Somers v. SAIF, supra.

On the other hand, Dr. Watson, examining physician, explained in detail how claimant's pregnancy (and her related untreated inflammatory condition) contributed to her CTS condition (not just her symptoms). He also considered claimant's work activities and concluded that pregnancy was the major cause of the CTS condition. Because we agree with the ALJ that Dr. Watson's opinion is well-reasoned and based on accurate and complete information, we rely on it and conclude that claimant has not carried her burden.[1] Accordingly, the claim must fail.

Finally, because the claim is not compensable, there are no "amounts then due" which might otherwise support a penalty. See ORS 656.262(11)(a); David R. Zimmerly, 42 Van Natta 2608 (1990).

ORDER

The ALJ's order dated July 5, 1995 is affirmed.

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[1] We are unpersuaded by claimant's contention that Dr. Watson would "never" find a pregnant woman's CTS claim work-related. On the contrary, we find that Dr. Watson explained clearly what factors would impact his causation conclusions in such cases. (See Exs. 12-9-10, 12-19, 12-21, 12-26, 13-1, 16-5). We also note that the opinion of Drs. Smith and Weller support that of Dr. Watson. (See Ex. 7).

In the Matter of the Compensation of
JASON O. ROGERS, Claimant
WCB Case No. 95-12249
ORDER ON REVIEW
Ernest M. Jenks, 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) Mills' order that: (1) declined to award an attorney fee under ORS 656.386(1); and (2) declined to award penalties and attorney fees under ORS 656.262 (11) and 656.382(1) for allegedly unreasonable claim processing. On review, the issue are penalties and attorney fees.

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

Claimant seeks an attorney fee under ORS 656.386(1) for obtaining a pre-hearing rescission of "de facto" denials of fractured sternum and fractured rib conditions. Claimant first contends that the requirement of a "denied claim" under ORS 656.386(1) does not apply to cases, such as this one, which involve ORS 656.262(6)(d).[1] We disagree.

We have previously held that satisfaction of the notice requirements of ORS 656.262(6)(d) does not, by itself, result in entitlement to an attorney fee pursuant to ORS 656.386(1). Kenneth C. Lane, 48 Van Natta 1027 (1996). In order to establish entitlement to an attorney fee, the requirements of ORS 656.386(1) must also be met. Pursuant to 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 in 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 any compensation." (Emphasis added).

In Michael J. Galbraith, 48 Van Natta 351 (1996), we held 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 condition was not compensable.

Here, as in Galbraith, all compensation has been paid. Moreover, there is no evidence in the record that suggests that SAIF questioned the causal relationship between the claimed conditions and the compensable injury. Under such circumstances, we agree with the ALJ's decision that there is no "denied claim."

Claimant next argues that by failing to modify its notice of acceptance within 30 days, as requested, SAIF has expressly denied claimant's claim. We disagree. ORS 656.262(6)(d) gives a claimant the right to request a hearing on a "de facto" denial where the carrier fails to take action within 30 days. However, we have previously held that the right to a hearing does not necessarily equate to a "denied claim" under ORS 656.386(1). See Jerome M. Baldock, 48 Van Natta 355, 356 (1986).

Here, claimant had a right to a hearing since SAIF failed to revise its acceptance notice within 30 days. However, as explained above, the statutory requirements for a "denied claim" have not been established. Accordingly, we disagree with claimant's contention that the carrier's failure to timely amend its notice by itself is sufficient to establish an express denial.

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[1] 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."

Finally, we note that this case is distinguishable from our decision in Emily M. Bowman, 48 Van Natta 1199 (1996). In Bowman, the claimant requested a hearing regarding the carrier's failure to amend its denial to accept low back and right foot plantar fascitis claims. In its response to the claimant's request for hearing, the carrier denied that the claimant had sustained a work-related injury or occupational disease. Subsequently, however, the insurer amended its denial to include the low back and plantar fascitis claims. We found that the carrier's response constituted a denial of the plantar fascitis and low back conditions on the express ground that these conditions were not compensable. Thus, we found that there was a "denied claim" for purposes of awarding a fee under ORS 656.386(1).

Here, in its March 28, 1996 response to claimant's request for hearing, the carrier denied that a condition had been incorrectly omitted from its acceptance and also stated: "No jurisdiction over alleged 'de facto' denial in claimant's 11/6/95 request for hearing. ORS 656.262(7)(a)." We find this language to be distinguishable from that used in Bowman.[2]

In Bowman, the carrier's responsive pleading unequivocally denied that a compensable injury or disease had occurred. Here, by contrast, the language in SAIF's response is not a denial of causation. Rather, this language is similar to that in Timothy E. Knight, Jr., 48 Van Natta 1718, 1719, n. 2 (1996), where, in its response to the claimant's hearing request, the carrier asserted that the "Administrative Law Judge lacks jurisdiction to provide any relief." We found that the carrier's response did not constitute an express refusal to pay compensation on the ground that the claimant's condition was not compensable or otherwise did not give rise to an entitlement to compensation. Thus, we find Bowman distinguishable.[3]

Because all compensation has been paid, there are no amounts then due on which to base a penalty under ORS 656.262(11) and no unreasonable resistance to the payment of compensation to support an award of an attorney fee under ORS 656.382(1).

ORDER

The ALJ's order dated June 5, 1996 is affirmed.

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[2] We find Bowman distinguishable on another basis also. Here, unlike in Bowman, SAIF had already amended its denial to accept the rib and sternum fractures on January 2, 1996, prior to its March 28, 1996 response to claimant's hearing request. Because SAIF had already accepted the disputed conditions prior to its response to the hearing request, we do not interpret its statements in the pleading as an "express denial" of the claims.

[3] The dissent also equates SAIF's responsive pleading in this case to the carrier's contention at hearing in John R. Syron, 48 Van Natta 2091 (1996), that claim preclusion barred modification of the acceptance notice. We disagree. In Syron, the claimant's attorney wrote to SAIF on July 20, 1995 and requested that SAIF amend its Notice of Acceptance to include L5-S1 disc herniation. On August 23, 1995, the claimant requested a hearing raising the issues of "de facto" denial and attorney fees. SAIF did not amend its acceptance prior to hearing. At the hearing, SAIF unsuccessfully argued that claim preclusion barred modification of its acceptance notice. We found that SAIF's claim preclusion argument at hearing amounted to an express denial for purposes of awarding an attorney fee under ORS 656.386(1).

We find Syron distinguishable on a least two bases. First, here, at the time SAIF responded to claimant's hearing request, it had already amended its acceptance to include the disputed conditions. In Syron, by contrast, SAIF did not amend its acceptance prior to the hearing. In addition, unlike the argument in Syron, SAIF's jurisdiction argument in this case was not a defense which would bar compensation for the condition permanently. Rather, it was a contention that the prerequisites for jurisdiction to consider the compensability of the condition had not yet been met. By contrast, the claim preclusion defense in Syron, if successful, would have barred the claimant from receiving compensation for the disputed condition. Thus, we disagree with the dissent's reliance on Syron.

Board Chair Hall dissenting.

In responding to claimant's hearing request, SAIF denied that a condition had been incorrectly omitted from the acceptance notice and also stated: "No jurisdiction over alleged 'de facto' denial in claimant's 11/6/95 request for hearing. ORS 656.262(7)(a)." This language amounts to a refusal 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." See ORS 656.386(1) (Emphasis added); Emily M. Bowman, 48 Van Natta 1199 (1996) (carrier's responsive pleading can constitute an express denial under ORS 656.386(1)).

SAIF's "jurisdiction" argument is similar to its "claim preclusion" argument in John R. Syron, 48 Van Natta 2091 (1996). In Syron, SAIF asserted that claim preclusion barred modification of the acceptance notice. On review, the Board found that an attorney fee was warranted under ORS 656.386(1), because the claim preclusion argument amounted to a refusal to pay on the express ground that the condition was not compensable or otherwise did not give rise to an entitlement to any compensation.

Here, SAIF's response asserted that no condition was omitted from its acceptance and that the ALJ lacked jurisdiction over the hearing request. This appears to be an express denial that the claimed conditions are not compensable or otherwise do not give rise to an entitlement to any compensation.

Because I believe that SAIF's response to the hearing request constituted a "denied claim" within the meaning of ORS 656.386(1), I believe that an attorney fee is warranted. Therefore, I respectfully dissent.

November 26, 1996 Cite as 48 Van Natta 2363 (1996)

In the Matter of the Compensation of
ROBIN W. SPIVEY, Claimant
WCB Case No. 96-00604
ORDER ON REVIEW
Lavis, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by the Board en banc.[1]

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Davis' order that: (1) affirmed an Order on Reconsideration which awarded 6 percent (19.2 degrees) unscheduled permanent disability for a cervical injury; and (2) awarded claimant an assessed attorney fee under ORS 656.382(2). On review, the issues are extent of unscheduled permanent disability and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the ALJ's order with the following correction. The correct date of the Determination Order is July 31, 1995, not July 1, 1995. Finally, we do not adopt the ALJ's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, because the attending physician neither performed a closing examination nor concurred with the findings of Drs. Noall and Smith, the medical arbiter provided the only evidence that could be considered in rating permanent impairment. In addition, the ALJ found that claimant had a combined condition based on claimant's preexisting degenerative disc disease and Dr. Stelson's suggestion that the work injury caused this underlying degenerative disc condition to become symptomatic. However, because SAIF did not issue a pre-closure partial denial pursuant to ORS 656.262(7)(b),[2] the ALJ concluded that SAIF did not consider claimant's condition as a "combined condition." Furthermore, since SAIF did not issue a pre-closure partial denial under ORS 656.262(7)(b), the ALJ concluded that the Order on Reconsideration correctly rated the full loss of motion in the cervical spine as determined by the medical arbiter's report, without adjustment for contribution from any preexisting condition.

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[1] Member Moller has recused himself from participating in the review of this case. OAR 438-011-0023.

[2] ORS 656.262(7)(b) provides that "[o]nce a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

On review, SAIF argues that ORS 656.262(7)(b) does not apply to claimant's claim. Specifically, SAIF argues that the text and context of ORS 656.262(7)(b), when read in conjunction with amended ORS 656.268(1)(a),[3] indicate that ORS 656.262(7)(b) applies only to the closure of non-medically stationary claims. While we do not agree that ORS 656.262(7)(b) is applicable only to the closure on non-medically stationary claims, we agree, based on the following reasoning, that the provision does not apply to this case.

In construing ORS 656.262(7)(b), we have held that a "pre-closure" denial is valid when the denial is based on the combined condition no longer being compensable under ORS 656.005(7)(a)(B). Marianne L. Sheridan, 48 Van Natta 908 (1996); c.f. Elizabeth B. Berntsen, 48 Van Natta 1219 (1996) ("pre-closure" denial of an accepted condition is not valid if not based on a consequential or combined condition). In addition, we have held that, by its terms, ORS 656.262(7)(b) applies only to situations involving a "combined condition." Elizabeth B. Berntsen, supra at 1221. We have not examined, however, whether ORS 656.262(7)(b) requires the carrier, before claim closure, to deny a combined condition that is not first compensable under ORS 656.005(7)(a)(B).

In deciding this question, our first task is to discern what the legislature intended when it enacted ORS 656.262(7)(b). ORS 174.020. We begin by examining the text and context of ORS 656.262(7)(b). ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). Only if those sources do not reveal the legislature's intent do we resort to legislative history and other extrinsic aids. PGE v. Bureau of Labor and Industries, supra, 317 Or at 611-12.

The plain meaning of ORS 656.262(7)(b) provides that the carrier must issue a denial if the accepted injury no longer is the major contributing cause of the combined condition prior to claim closure. The statute is not premised on a worker's medically stationary status. This construction also is consistent with other statutory provisions. See ORS 656.262(6)(c) (providing that a carrier is not precluded from denying an accepted combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition); 656.268(1)(a) (providing that claims may not be closed before the worker is medically stationary unless the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition); 656.268(2)(a), (4)(a) (providing that a carrier may request closure, or itself close a claim, when the worker's accepted injury no longer is the major contributing cause of the worker's combined or consequential condition).

The application of all of the aforementioned statutes is expressly contingent upon the presence of either a combined or consequential condition. Moreover, the triggering language of the all of the provisions, i.e., "no longer is," "ceases to be," implies the existence of an accepted combined or consequential condition as a prerequisite to the applicability of those statutes. Whether a claimant's claim is accepted by a carrier as a combined or consequential condition is a function of claims processing.

The processing of any claim begins with a worker making a claim for an injury or condition. A carrier is then obligated under ORS 656.262 to either accept or deny the worker's claim. If a carrier accepts the worker's claim, it is further obligated to specifically indicate what condition(s) it is accepting. ORS 656.262(6)(b)(A). If an injured worker disagrees with the condition(s) accepted, the carrier must be notified in writing pursuant to ORS 656.262(6)(d). If the worker is not satisfied with the carrier's response, a hearing can be requested to determine, through litigation, what condition(s) are properly a part of the accepted claim. Id. Similarly, if a new medical condition arises after claim acceptance, ORS

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[3] Amended ORS 656.268(1)(a) provides:

"(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:

"(a) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7) and the worker is not enrolled and actively engaged in training. When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated."

656.262(7)(a) provides a mechanism for informal acceptance by a carrier or for subsequent litigation if there is a dispute regarding whether or not a new medical condition should be a part of the accepted claim.

Combined and consequential condition are defined in ORS 656.005(7), which sets forth the standard for determining the compensability of a claimed injury in the first instance. Thus, it follows that any later reference in the statutes to combined or consequential conditions are predicated on those conditions being determined compensable under ORS 656.005(7).

Taken in the statutory context of how a claim is processed, it is clear that ORS 656.262(7)(b) cannot apply unless the accepted condition, whether voluntary or by litigation, is a combined condition.[4] To hold otherwise would transfer the carrier's claims processing obligation to either the Appellate Unit or the Hearings Division even though no claim for a combined condition has been made by the claimant and the carrier has not been requested to process such a claim. If, however, the carrier has accepted a combined or consequential condition, ORS 656.262(7)(b) would apply.

Because we are able to discern the legislature's intent when it enacted ORS 656.262(7)(b) by examining the text and context of that statute, it is not necessary to resort to legislative history. ORS 174.020; PGE v. Bureau of Labor and Industries, supra. However, legislative history supports our interpretation of ORS 656.262(7)(b).

Jerry Keene, a workers' compensation insurance defense attorney and drafter of some of Senate Bill 369's text, testified as follows regarding ORS 656.262(7)(b):

> "[t]his just specifies that if the insurer is going to take advantage of the provision under [ORS 656.]005(7)(a)(B) concerning preexisting conditions and resultant conditions that before they close that claim they have got to issue a denial of what they are denying so the Department knows what is still accepted and can rate it." Tape Recording, Senate Labor and Government Operations Committee, February 17, 1995, Tape 48B. (Emphasis supplied)

Regarding amended ORS 656.268(1), Jerry Keene testified:

> "this in part conforms the criteria for claim closure to the definitions of a compensable injury that we talked about at the beginning with regard to situations where the preexisting condition becomes the major contributing cause of the condition. At that point[,] the condition is no longer compensable. There must be a denial pursuant to that issued -- we talked about that earlier -- so that the worker can contest it, then the Department can go ahead and close the claim and rate what is accepted and everything moves on in a logical order." Tape Recording, Senate Labor and Government Operations Committee, February 17, 1995, Tape 48B. (Emphasis supplied).

In addition, regarding amendments to ORS 656.262, Jerry Keene testified:

> "[s]ubsection 6c overturns Sheridan v. Johnson Creek [Market, 127 Or App 259 (1994),] and United Airlines[, Inc.] v. Brown[, 127 Or App 253 (1994),] and allows for an insurer to issue a denial on open claims involving resultant conditions where the work injury component of the claim is no longer the major contributing cause of the resultant condition. And I would note that the proposed provisions of [ORS] 656.268(1) also give the insurer another option to close the claim at that point. Either way it gets postured for a decision so the worker can challenge it and that compensability decision can be determined." Tape Recording, Senate Labor and Government Operations Committee, February 1, 1995, Tape 19A.

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[4] Whether a condition has been accepted is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). If a carrier accepts the symptoms of a disease, it may also have accepted the disease causing those symptoms. Georgia Pacific v. Piwowar, 305 Or 494, 591 (1988). In order to determine whether ORS 656.262(7)(b) applies, it is first necessary to make a factual decision regarding what condition(s) (combined or otherwise) have been accepted by the carrier.

Finally, Representative Mannix, one of the sponsors of Senate Bill 369, testified as follows regarding Section 28, the section containing the amendments to ORS 656.262:

> "[w]e have the acceptance of a resultant or consequential condition. It doesn't preclude you from later on denying a resultant or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the resultant or consequential condition. That is the same discussion we have had before, but over time the resultant or consequential condition may resolve or may reduce and you can later say, all right, I was accepting this as a resultant condition, but now, say a year later, it's no longer, it doesn't meet the standards any longer to be covered as a resultant condition, so now I'm going to deny it." Tape Recording, House Labor Committee, March 6, 1995, Tape 46A. (Emphasis supplied)

This legislative history supports our interpretation of the legislature's intent in enacting ORS 656.262(7)(b) to require the carrier to issue a denial if the accepted injury no longer is the major contributing cause of the combined condition, in order for the carrier to take advantage of statutory provisions regarding combined and consequential conditions. The first quoted statement above from Jerry Keene is especially illustrative -- if the carrier intends to take advantage of the provisions of ORS 656.005(7), which define compensable combined and consequential conditions, the carrier must issue a denial before closing the claim and if it does so, the "accepted" condition(s) will be rated and "everything moves on in a logical order." Consequently, it is clear that before ORS 656.262(7)(b) applies, a condition must have been accepted under ORS 656.005(7) as a combined condition.[5] To interpret the statute in any other manner effectively requires compensability litigation within the "extent" rating process.[6] Given the evidentiary restrictions of ORS 656.283(7) applicable in "extent" hearings, the record could be extremely limited. Also, this "compensability" litigation could end up being conducted even if claimant has not objected to the carrier's "Notice of Acceptance" or if no claim for a new medical condition as been filed.

Here, Dr. Stelson, who treated claimant immediately following the compensable injury, diagnosed claimant's condition as a cervical strain. (Exs. 4, 7, 10). By letter dated December 22, 1994, SAIF formally accepted a "Cervical Strain." (Ex. 12). Claimant did not request SAIF to accept, nor did SAIF voluntary accept, cervical disc degeneration or a combination of a cervical strain and the degenerative condition. In fact, the first medical evidence which implicated cervical disc degeneration as a cause of claimant's symptoms was a May 8, 1995 insurer-arranged medical examination. (Ex. 47). On this record, we conclude that the accepted condition is a cervical strain, and without a combined or consequential component. Thus, ORS 656.262(7)(b) does not apply to this case and SAIF was not obligated to issue a denial under that provision prior to closing claimant's claim. We now turn to the merits.

Dr. Martens, the medical arbiter, measured some loss of range of motion in claimant's neck, 90 percent of which he opined was caused by preexisting degenerative disc disease and 10 percent "due to" the compensable strain. (Ex. 59). The lost range of motion reported by Dr. Martens is the only basis upon which an award of unscheduled permanent impairment could be awarded on this record.

Relying on former OAR 436-35-007(3)(b), the Order on Reconsideration awarded claimant 6 percent unscheduled permanent disability for loss range of motion in the cervical spine, making no adjustment for any contribution from preexisting degenerative disc disease. (Ex. 60). Former OAR 436-35-007(3)(b) provided that where impairment was due to a compensable injury and noncompensable preexisting condition under ORS 656.007, the entire disability was rated so long as the compensable

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[5] We note that this conclusion does not preclude claimant from a rating for a "combined" or preexisting condition. This closure pertains solely to claimant's accepted condition. If claimant prevails over a denial of a "new medical condition," the carrier will be required to process the claim according to law, including claim closure and rating of the accepted combined condition.

[6] This conclusion should not be interpreted as restricting the parties from litigating the issue of whether permanent disability is due to the compensable injury in a hearing concerning the extent of permanent disability. ORS 656.214 provides for an award of permanent disability so long as the disability is attributable to compensable injury. Rather, our conclusion should be interpreted as precluding litigation regarding whether a non-accepted condition is compensable within the context of a hearing on the extent of permanent disability that is attributable to the accepted injury.

injury remained the major contributing cause of the combined condition. Given our discussion above, we do not believe this rule is applicable to this case. However, former OAR 436-35-007(3)(b), promulgated by WCD Admin. Order 95-060, only applies to those claims closed after August 23, 1996. See former OAR 436-35-003(1). Claimant's claim was closed by a July 31, 1995 Determination Order. Accordingly, the temporary rules promulgated in WCD Admin. Order 95-060 do not apply to this case.

The appropriate "standards" are those set forth in WCD Admin. Order 6-1992. Under those rules, only impairment findings due to the accepted injury or conditions are considered. Former OAR 436-35-007(2). Where permanent impairment is due to the accepted condition and unrelated or noncompensable conditions, the carrier is required to provide medical documentation of the extent of the preexisting impairment. Id.

Dr. Marten's opinion establishes that 10 percent of claimant's lost range of motion is due to the accepted cervical strain. The total impairment value for claimant's lost range of motion is 6 percent. Thus, claimant has an impairment value of .6 as a result of the compensable injury. That is rounded up to the nearest whole number for an award of 1 percent unscheduled permanent disability. Former OAR 436-35-007(11) & (13).

Inasmuch as claimant's compensation has been reduced on review, he is not entitled to an attorney fee pursuant to ORS 656.382(2). Consequently, we reverse the ALJ's award of an assessed attorney fee.

ORDER

The ALJ's order dated April 25, 1996 is modified. In lieu of the Order on Reconsideration's award of 6 percent (19.2 degrees), claimant is awarded 1 percent (3.2) degrees unscheduled permanent disability. The ALJ's attorney fee award is reversed.

November 27, 1996 Cite as 48 Van Natta 2367 (1996)

In the Matter of the Compensation of
IVAN J. CVARAK, Claimant
Own Motion No. 66-0435M
OWN MOTION ORDER
SAIF Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for medical services for his February 26, 1960 industrial injury. SAIF has recommended that the Board deny the provision of the requested medical services, contending that the "injury of 1960 is not the major contributing cause of [claimant's] current low back condition." Because claimant's industrial injury occurred prior to 1966, the Board, under ORS 656.278, has jurisdiction to decide this compensability issue.

FINDINGS OF FACT

Claimant injured his low back on February 26, 1960. Claimant initially responded to conservative treatment, but gradually worsened. On July 27, 1960, a spinal fusion from L4 to S1 was performed. In a June 26, 1961 letter and medical report, Dr. Rankin, claimant's treating physician, noted that claimant had been under his care "since March 11, 1960 for chronic low back strain." Claimant's claim was closed in September 1961, with a permanent partial disability award of 50 percent loss of function of his left leg.

Claimant returned to Dr. Rankin several times during 1961-1963 with complaints of low back pain, more on the left side than on the right, left leg and thigh pain, and foot pain. On July 29, 1963, Dr. Rankin requested that claimant's claim be reopened for conservative treatment of his lower back, which, Dr. Rankin opined, was "the direct result of the original injury." Dr. Rankin further opined that "I believe that [claimant's] present complaints represent a true aggravation over the condition existing at the time that his disability evaluation was performed."

In 1964, claimant was examined by Dr. Kimberly because of recurrent low back and left posterior hip pain. Dr. Kimberly recommended exploration of the fusion and revision of the donor site scar. This procedure was carried out sometime in March 1964. Claimant did not again seek medical attention for his low back until June 1976, when he complained of low back pain and radiation of pain into the posterior and lateral left thigh. Claimant was examined by Dr. Gripekoven, who recommended conservative therapy.

Claimant was admitted to the Workmen's Compensation Board Disability Prevention Center from November 23, 1976 through January 6, 1977. In a medical discharge summary, Dr. Holm, medical examiner, diagnosed claimant with chronic L3-4 sprain, early osteoarthritis at L3-4, neuroma of the left superior cluneal nerve, and neuropathy of the left lateral cutaneous nerve of the thigh. Dr. Holm opined that claimant had a further moderate degree of physical impairment, and recommended a job change to be carried out via a pre-vocational training program.

On March 3, 1977, Drs. Rich, Noall and Post performed claimant's closing examination. In their comments and recommendations, the physicians opined that claimant was medically stationary, and that his claim could be closed. The doctors further opined that "all [of claimant's] low back impairment dates back to his 1960 injury."

There are no medical reports in the record for the entire period between 1977 and 1996. In his early 1996 chart notes, Dr. Chu, claimant's current treating physician, noted that claimant complained of low back pain. Dr. Chu referred claimant to Dr. Buza, neurosurgeon, for surgery consultation. Dr. Buza recommended anti-inflammatories, muscle relaxants, heat massage and ultrasound treatments for chronic low back and left leg pain, and returned claimant to Dr. Chu's care.

Dr. Chu then referred claimant to a rehabilitation center for physical therapy for low back and lateral thigh pain. In an April 23, 1996 initial evaluation summary, Ms. Healy, physical therapist, noted that claimant had chronic low back and left leg pain and that he would undergo physical therapy twice a week for three weeks.

CONCLUSIONS OF LAW AND OPINION

Inasmuch as claimant sustained a compensable injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, the Board may exercise its own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. ORS 656.278(1)(b); Carl M. Price, 46 Van Natta 514 (1994), aff'd mem 132 Or App 376 (1995). No worsening of the pre-1966 injury is required for such authorization. Gerald S. Gaage, 42 Van Natta 2722 (1990); Donald B. Karstetter, 42 Van Natta 156 (1990). In this regard, the Board applies the same standard clarified in Beck v. James River Corp., 124 Or App 484, 498 (1993), regarding the compensability of medical services under ORS 656.245. In that respect, medical services for conditions resulting from a work injury are compensable if the need for treatment bears a material relationship to the compensable condition. Id.

In 1963, Dr. Rankin opined that claimant's then-current condition was "the direct result of the original injury." In 1976, Dr. Gripekoven, re-evaluating physician, opined that claimant had developed a soft tissue sprain which was "superimposed upon [claimant's] longstanding chronic condition." Dr. Gripekoven noted that claimant's condition had remained relatively "quiescent" for the past 10 years, but opined that claimant's then-current condition "is related to a chronic condition from his original [injury] problem, which has once again become symptomatic." In their March 1977 closing examination, Drs. Rich, Noall and Post opined that "all [of claimant's] low back impairment dates back to his 1960 injury."

In an April 8, 1996 report, Dr. Buza opined that claimant had "chronic low back and left leg pain." Dr. Buza opined that claimant's pain "may be secondary to degenerative changes neurologically" (emphasis added).[1] In a May 2, 1996 palliative care request, Dr. Chu responded to SAIF's inquiry of

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[1] In his April 8, 1996 report, Dr. Buza also opined that "I do not believe [claimant] is any worse than the last time he was seen here." However, we have previously found that a claimant does not have to establish a "worsening" in a pre-1966 claim to be entitled to medical services for his current compensable condition. Gerald S. Gaage, supra; Donald B. Karstetter, supra. In any case, the report from that "previous" examination is not in the record.

"how the requested care related to claimant's compensable condition" by opining that claimant had chronic low back pain, left leg pain and history of low back surgery.

In his September 11, 1996 letter responding to SAIF's inquiry regarding claimant's current condition, Dr. Buza opined the following:

> "In my opinion, the major contributing cause of [claimant's] condition began 30 years ago due to his on-the-job injury. However, his condition has waxed and waned. [Claimant] does have degenerative changes.
>
> "Perhaps the major cause of [claimant's] complaint is due to other circumstances as you have suggested, i.e. being on his feet for long hours, and increased degenerative changes due to his age.
>
> "The natural progression of aging and other degenerative processes are all related to [claimant's] increasing symptomatology in addition to the previous injury 30 years ago. Waxing and waning of his symptoms is natural for this condition. At this point, due to his age, the natural progression of aging probably plays a larger role in [claimant's] symptoms than the injury of 1960."

Here, Dr. Buza opined that the major contributing cause of claimant's current condition is his 1960 on-the-job-injury. His opinion that "aging" played a larger role in claimant's current condition does not necessarily contradict his opinion that the injury is the "major contributing cause." Dr. Buza's latter opinion regarding the aging process appears more speculative in that he uses the term "perhaps" to respond to SAIF's "suggestion" that other circumstances may play a larger role in claimant's current condition. Furthermore, Dr. Buza opined that claimant's condition has "waxed and waned" over the years, and that the "natural progression of aging, other degenerative processes" and claimant's 1960 injury "are all related" to claimant's current condition.

Although there are considerable gaps in claimant's medical record, each of claimant's physicians over the 30-year period has related his current condition (at the time) to his original 1960 injury. There is a history of claim reopenings for low back and left leg treatment, as well as several low back surgeries. Dr. Buza is consistent with the majority of the physicians in that he related claimant's current condition to his 1960 industrial accident, even though he also attributed other factors to claimant's current increasing symptomatology. To the extent that his later statement could be interpreted as reaching an opposite conclusion, we do not find the "speculative" nature of that portion of his opinion persuasive.

Therefore, on this record, we conclude that a material contributing cause of claimant's current condition was his 1960 injury.[2] Accordingly, we authorize the reopening of claimant's 1960 industrial injury claim for the payment of medical services which are reasonable and necessary and causally related to the compensable injury. OAR 438-012-0037. Authorization for these services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstance. After those medical services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[2] Here, we find no new condition for which claimant must prove compensability. Therefore, we need not establish a "major contributing cause" standard. (Medical services for conditions resulting from a compensable injury are compensable if the need for treatment bears a material relationship to the compensable condition. Beck v. James River Corp., supra.)

In the Matter of the Compensation of
WILLIAM D. WILDER, Claimant
Own Motion No. 66-0405M
OWN MOTION ORDER
Peter O. Hansen, Claimant Attorney
SAIF Legal Department, Defense Attorney

On March 7, 1995, the SAIF Corporation submitted claimant's request for medical benefits and temporary disability compensation relating to his compensable right wrist injury. SAIF recommended against reopening claimant's claim, contending that: (1) claimant has not sustained a worsening of the compensable injury; (2) claimant's current condition does not require surgery or inpatient hospitalization; and (3) surgery or hospitalization is not reasonable and necessary for the compensable injury. SAIF issued a denial of the compensability of and responsibility for claimant's current left wrist condition on January 6, 1995, on which claimant requested a hearing with the Hearings Division. (WCB Case No. 95-02505). On October 18, 1996, Administrative Law Judge (ALJ) Brazeau issued an Order of Dismissal in claimant's 1961 and 1975 injury claims. Claimant has not appealed that order, and it is now final by operation of law.[1]

Because claimant's industrial injury occurred prior to January 1, 1966, ORS 656.245, which provides lifetime medical services for compensable injuries, does not apply to that injury. William A. Newell, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services and temporary disability compensation for compensable injuries occurring before January 1, 1966. See ORS 656.278(1). We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury which requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a).

Here, there is no evidence in the record to establish that claimant's current left wrist condition is compensably related to his 1961 industrial injury.[2] However, should claimant have evidence that his current left wrist condition is compensably related to his 1961 right wrist injury claim, he may request reconsideration of this order within 30 days after its mailing date. Should claimant also request temporary disability compensation, and have evidence that his left wrist condition requires surgery or inpatient hospitalization, he should submit that evidence to the Board within the same 30-day period.

Accordingly, we deny claimant's request for medical services and temporary disability compensation.

IT IS SO ORDERED.

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[1] We note, however, that the Hearings Division does not have jurisdiction with respect to compensability or temporary disability compensation issues in pre-1966 injury claims. See ORS 656.278(1); Carl M. Price, 46 Van Natta 514 (1994), aff'd. mem 132 Or App 376 (1995). Here, claimant followed the directions listed on SAIF's January 6, 1995 denial, which notified claimant that, in order to protect his rights, he must: (1) request a hearing with the Hearings Division within 60 days after the date of the denial; and (2) within 60 days from the mailing date of the denial, make a written claim with the employers and/or insurers listed on the denial. Because claimant also appealed a responsibility denial issued on a subsequent non-pre-1966 injury claim (over which the Hearings Division does have jurisdiction), we consolidated our record with the hearing pending outcome of that litigation. In our order consolidating, we requested that, at the hearing, the ALJ take evidence on the issue of whether claimant's compensable condition required surgery or hospitalization. We further requested that, at the conclusion of the hearing, the ALJ forward to the Board a recommendation with respect to the own motion matter, as well as a copy of the order issued in WCB Case Nos. 94-09496 and 95-02505. Because neither claimant nor his counsel appeared at hearing, it was dismissed. Therefore, the ALJ did not have an opportunity to take evidence on the own motion issue. We further note, however, that because claimant did not contest the responsibility denial of the non-pre-1966 insurer, that insurer cannot now be held responsible for claimant's current left wrist condition.

[2] Because claimant has not established the compensability of his current left wrist condition to his 1961 injury claim, we need not address whether claimant's current condition requires inpatient or outpatient surgery or other treatment requiring hospitalization at this time. Id.

In the Matter of the Compensation of
LOIS A. BOTEFUR, Claimant
WCB Case No. 95-11363
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order which: (1) declined to consider a medical arbiter's report and claimant's testimony regarding the extent of claimant's permanent disability; (2) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability; (3) upheld the SAIF Corporation's denials of claimant's injury claim for muscle tension headaches and a neck and shoulder myofascial pain condition; and (4) declined to award penalties and attorney fees for SAIF's allegedly unreasonable claim processing. On review, the issues are evidence, unscheduled permanent disability, compensability, penalties and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation regarding the evidentiary/permanent disability issues.

After a March 31, 1995 Notice of Closure closed her compensable forehead laceration claim without an award of permanent disability, claimant requested reconsideration, including appointment of a medical arbiter. (Ex. 66). An examination was scheduled, but claimant was unable to keep the appointment. Thus, the Order on Reconsideration was issued on December 19, 1995 without an arbiter's report. The Order on Reconsideration affirmed the Notice of Closure. The medical arbiter, Dr. Buchholz, did examine claimant after issuance of the reconsideration order.

At the February 27, 1996 hearing, the ALJ declined to consider the arbiter's report, as well as claimant's testimony, regarding the permanent disability issue, citing Joe R. Ray, 48 Van Natta 325 (1996). The ALJ then concluded that claimant was not entitled to an award of unscheduled permanent disability.

Inasmuch as the hearing took place after the effective date of the 1995 legislative amendments (June 7, 1995), the ALJ correctly declined to consider claimant's testimony concerning the permanent disability issue. Dean J. Evans, 48 Van Natta 1092 (1996) (distinguishing Precision Castparts v. Plummer, 140 Or App 227 (1996) and holding that evidentiary limitations of Ray are still applicable to hearings held after June 7, 1995). However, ORS 656.268(6)(e) allows consideration of a "post-reconsideration" medical arbiter's report in a hearing on extent of permanent disability. The ALJ declined to consider the arbiter's report, concluding that the 1995 amendments to ORS 656.283(7) rendered ORS 656.268(6)(e) "moot."

We need not determine whether the ALJ's reasoning was correct, for, even if we considered the arbiter's report, we would still conclude that the ALJ correctly affirmed the Order on Reconsideration's determination that claimant has no permanent impairment due to the compensable injury.

Dr. Patel, claimant's attending physician, declared claimant medically stationary on July 27, 1994 and stated that there was no permanent impairment. (Ex. 11c). Dr. Patel subsequently reaffirmed that claimant had no permanent impairment due to the August 29, 1994 injury. (Ex. 34-2). Dr. Patel again stated that claimant was medically stationary in response to a March 10, 1995 inquiry and wrote "residual headache" when asked to confirm that claimant had no permanent impairment due to the compensable injury. (Ex. 37).

Considering the totality of Dr. Patel's responses to SAIF's inquiries as to claimant's permanent impairment, if any, due to the compensable injury, we conclude that there is insufficient evidence to support an award of permanent disability. Moreover, the medical arbiter concluded that claimant had no "residual deficit" from the compensable injury. (Proposed Exhibit 84-9). Accordingly, even if we considered the medical arbiter's report, we would still find that claimant is not entitled to an award of unscheduled permanent disability. Therefore, we conclude that the ALJ properly affirmed the Order on Reconsideration.

ORDER

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

November 29, 1996 Cite as 48 Van Natta 2372 (1996)

In the Matter of the Compensation of
RODNEY W. CAROTHERS, Claimant
WCB Case No. 96-00472
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) found that claimant was not working at a "temporary [out-of-state] workplace" under ORS 656.126 (5) and (7), and, as such, was not an Oregon subject worker; and (2) upheld the SAIF Corporation's denial of claimant's back injury claim. On review, the issue is whether claimant was an Oregon subject worker under ORS 656.126(1).

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

Claimant began working for an Oregon employer in April 1995 as a carpenter. His first job was in Oregon, but he was subsequently assigned in September 1995 to a job in Vancouver, Washington. Claimant regularly worked at the Washington job site for about three months.

The employer obtained workers' compensation coverage through SAIF effective April 1, 1995. SAIF advised the employer that Oregon workers at a temporary Washington worksite would be covered under its policy. SAIF cautioned, however, that, if work was performed at the Washington location for more than 30 days, Washington workers' compensation coverage would be necessary. Aware that the Washington job would take more than 30 days, the employer obtained Washington workers' compensation coverage for its workers at the Vancouver location.

Claimant was injured in the course and scope of his employment on December 4, 1995 in Vancouver, Washington. Claimant filed a Washington claim that was accepted in that state. Claimant then filed a claim against SAIF that was denied on the ground that he was not an Oregon subject worker. Claimant requested a hearing.

The ALJ determined that, if the "permanent employment relation" test were applied, claimant would be considered an Oregon employee temporarily absent from the state when injured. See ORS 656.126(1); Northwest Greentree, Inc., v. Cervantes-Ochoa, 113 Or App 186 (1992). Therefore, the ALJ reasoned that claimant would have a compensable claim if the test was applicable.

However, the ALJ found that the interstate agreement between Washington and Oregon regarding jurisdiction over out-of-state injuries replaced the employment-relation test. (Ex. 2).[1] Applying the terms of that accord, the ALJ concluded that, because claimant was injured at a Washington location where the employer did work for more than 30 days in a calendar year, claimant was not employed at a temporary Washington workplace and, thus, was not entitled to Oregon workers' compensation coverage under ORS 656.126(1). Id.

In determining that the interstate agreement superseded the "permanent employment relation" test, the ALJ acknowledged the case law holding that the Oregon/Washington interstate agreement was

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[1] The interstate agreement provides, in part, that Oregon workers' compensation law will be extended to provide coverage of any Oregon workers injured in the course of employment in Washington while the employer has a "temporary workplace" in Washington. The agreement defines "temporary workplace" as not including a specific location within the state where the employer's work is performed for more than 30 days in a calendar year.

not intended to change the employment-relation test. E.g., Power Master, Inc. v. National Council on Comp. Ins., 109 Or App 296 (1991). However, the ALJ noted that a different version of the interstate agreement was in effect when Power Master was decided and that the 1989 legislature had added ORS 656.126(7). That statute defines a "temporary workplace" to exclude a worksite where an employer does work for more than 30 days.

Citing ORS 656.126(5) (which allows the Department of Consumer and Business Services to enter into jurisdictional agreements with other states and provides that such agreements determine the rights of injured workers hired in Oregon but injured while temporarily in another state), the ALJ held that the Oregon and Washington accord had binding effect on subjectivity questions concerning Oregon workers injured in Washington. We agree.

ORS 656.126(1) provides:

> "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 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."

Therefore, in order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of state incidental to Oregon employment. In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test," wherein all circumstances are relevant, including the intent of the employer, the understanding of the employee, the location of the employer and its facilities, the circumstances surrounding claimant's work assignment, the state laws and regulations to which the employer is otherwise subject, and the residence of the employees. Northwest Greentree, Inc. v. Cervantes-Ochoa, supra. Under the test, the key inquiry is the extent to which claimant's work outside the state is temporary. Power Master Inc. v. Blanchard, 103 Or App 467, 471 (1990); Hobson v. Oregon Dressing, Inc., 87 Or App 397, 400, rev den 304 Or 437 (1987); Phelan v. H.S.C. Logging, Inc., 84 Or App 632, 635, rev den 303 Or 590 (1987).

Claimant contends that the permanent employment relation test should have been applied here and that, given the ALJ's undisputed finding that the test was satisfied, his claim should have been determined to be compensable under Oregon law. According to claimant, the interstate agreement applies only if a worker is employed in a "temporary work place," i.e., a specific location in another state where the employer's work is performed for less than 30 days. Claimant reasons that, if an Oregon worker working out of state is injured during the 30-day period, the agreement provides that exclusive coverage is provided under Oregon law. If, however, a claimant is injured when he or she leaves the state for more than 30 days, then subjectivity is determined under the "permanent employment relation" test. We disagree.

ORS 656.126(5) specifically allows the Department of Consumer and Business Services to enter into agreements with other states (such as it has with Washington) relating to conflicts in jurisdiction. The statute further provides that such agreements are binding as to the rights of workers hired in Oregon and injured while temporarily in another state. The interstate agreement between Oregon and Washington, executed pursuant to ORS 656.126(5), provides that an Oregon worker injured in the course of employment while working in Washington will be covered under Oregon Law while the employer has a "temporary workplace" in the state of Washington. (Ex.2-2). For the purposes of the agreement, a "temporary workplace" does not include a specific location within the state where the employer's work is performed for more than 30 days.

Here, there is no dispute that the employer's work was performed in Washington for more than 30 days. Thus, claimant was not injured while the employer had a "temporary workplace" within the state of Washington. Under such circumstances, the interstate agreement does not extend Oregon workers' compensation coverage to this injury.

We recognize, as did the ALJ, that the court in Power Master v. National Counsel on Comp. Ins., supra, applied the permanent employment relation test to a subjectivity determination concerning

an injury in Washington However, like the ALJ, we do not find that Power Master controls, inasmuch as it involved a different version of the interstate agreement between Oregon and Washington.[2]

The applicable version of the interstate agreement specifically provides that Oregon coverage will only be extended to those injuries while the Oregon employer has a "temporary workplace" in Washington. Inasmuch as claimant's injury does not qualify for Oregon coverage under the Oregon/Washington interstate agreement, claimant is not considered an Oregon employee temporarily out of the state under ORS 656.126(1).[3] Thus, we agree with the ALJ that claimant is not an Oregon subject worker.[4]

ORDER

The ALJ's order dated April 17, 1996 is affirmed.

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[2] The ALJ and the parties devote considerable attention to the impact of our decision in James Crawley, 47 Van Natta 364 (1995). In Crawley, the claimant was a Washington worker injured while temporarily in Oregon. Therefore, in contrast to this case regarding ORS 656.126(1), Crawley concerned ORS 656.126(2) and those instances in which an out-of-state employer has a "temporary workplace within this state." The precise issue in Crawley was whether the Washington employer's workplace in Oregon was or was not a "temporary workplace" under ORS 656.126(7). We determined that it was not. Accordingly, we held that the Washington employer was required to have Oregon workers' compensation coverage. Despite the factual differences between Crawley and this case, we find Crawley analogous to this case. In both cases, the claimant's injury did not occur at a "temporary workplace." Just as the employer in Crawley was required to have workers' compensation coverage in the state in which the claimant's injury occurred, so, too, was the employer in this case required to have coverage in the "foreign jurisdiction" (as opposed to coverage in its "home" state).

[3] Claimant cites ORS 656.126(6) in support of his argument that the permanent employment relation test applies because that statute acknowledges that a claimant can have compensable claims in more than one state. However, that statute merely addresses crediting compensation paid or awarded under another state's workers' compensation law. It does not preclude our interpretation of the interplay between the interstate agreement and the relevant portions of ORS 656.126.

[4] This decision should not be interpreted as holding that the "permanent employment relation" test is no longer viable. The test remains applicable in "non-interstate agreement" cases. However, in cases involving an interstate agreement executed in compliance with ORS 656.126(5), subjectivity determinations shall be determined in accordance with the terms of the agreement. Therefore, in such situations, an interstate agreement executed pursuant to ORS 656.126(5) "supersedes" the "permanent employment relation" test. Such an interpretation provides stability and predictability for employers who perform work in Washington since they will know with certainty when they must provide out-of-state coverage, i.e., when they perform work in that state for more than 30 days within a calendar year.

Board Chair Hall dissenting.

The majority affirms the ALJ's determination that claimant was not a subject worker under ORS 656.126(1) because it finds that claimant was not injured while the employer had a "temporary workplace" within the state of Washington. In reaching that decision, the majority relies on the interstate agreement between Oregon and Washington rather than the well-established "permanent employment relation" test. See Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or App 186, 189-90 (1992); Jose Gomez, 46 Van Natta 2264 (1994). Because the interstate agreement does not answer the question of whether claimant is an Oregon subject worker, I would instead apply the "permanent employment relation" test and find claimant to be a subject worker entitled to Oregon workers' compensation benefits. For this reason, I must respectfully dissent.

ORS 656.126(1) provides:

> "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 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."

Claimant's injury was sustained while working in Washington. Thus, the issue is whether claimant was injured while temporarily out of state incidental to his Oregon employment. The

interstate agreement between Oregon and Washington provides that the Workers Compensation Division of the Oregon Department of Insurance and Finance (now Department of Consumer and Business Services) "will extend protection for any Oregon employer under its jurisdiction, and benefits to any of the employer's Oregon workers who may be injured in the course of employment in Washington while the employer has a temporary workplace in the state of Washington." (Ex. 2-2, emphasis added). For the purposes of the agreement, a "'temporary workplace' does not include a specific location within the state where the employer's work is performed for more than 30 days in a calendar year." Id.

In this case, there is no dispute that the employer's work in Washington was performed for more than 30 days in a calendar year. Thus, claimant was not injured in a "temporary workplace" as defined by the interstate agreement. Unlike the majority, however, I do not conclude that this necessarily means that claimant was not an Oregon subject worker when injured in Washington. With all due respect to the drafters, the interstate agreement is ambiguous, confusing, and, indeed, appears to contradict itself in terms of what it intends to accomplish.

One stated purpose of the interstate agreement is to enable workers of their respective states to "continue to be entitled to protection and benefits provided by the Workers Compensation laws of their respective home states." (Ex. 2-1). Moreover, the agreement provides that, if an employee is injured while an employer has a "temporary workplace" in Oregon or Washington, the injured worker's exclusive remedy is provided by the home state's workers' compensation law. Thus, if, by definition, the place of injury is not a "temporary workplace," then the agreement does not define the exclusive remedy. Therefore, it must still be determined if claimant was "temporarily" working in Washington. Since the interstate agreement does not provide the answer to this question, the "permanent employment relation" test must be applied. Inasmuch as SAIF does not contest the ALJ's finding that claimant would be an Oregon subject worker under this test, claimant's injury is compensable under Oregon law.

With due respect to the majority's interpretation of the interstate agreement, my analysis is more consistent with the statutory scheme of ORS 656.126. In my view, the interstate agreement is "inclusive," i.e., it gives Oregon workers the benefits of their home state's law, which would be consistent with ORS 656.126(6), which grants Oregon workers the advantage of the benefits under Oregon law when a claim is accepted in both Oregon and Washington.

In conclusion, I believe the majority errs in not applying the "permanent employment relation" test to determine whether claimant is an Oregon subject worker. Although the majority concludes that the interstate agreement between Oregon and Washington has "superseded" this test, such a conclusion finds no support in case law[1] or in the agreement itself. Because the majority fails to apply the appropriate test to determine subjectivity, I must dissent.

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[1] James Crawley, 47 Van Natta 364 (1995) does not hold that the interstate agreement controls subjectivity questions concerning injuries Oregon workers sustain in Washington. As noted by the majority, Crawley concerned a different statutory provision (ORS 656.126(2) rather than ORS 656.126(1)) and a different issue; that is, whether the Washington employer's workplace in Oregon was a "temporary workplace." See ORS 656.126(7). Given the considerable factual differences between Crawley and this case, Crawley is not controlling.

November 29, 1996 Cite as 48 Van Natta 2375 (1996)

In the Matter of the Compensation of
LOIS BRIMBLECOM, Claimant
Own Motion No. 90-0218M
OWN MOTION ORDER OF ABATEMENT
Emmons, et al, Claimant Attorneys
Grocers Ins. Co., Insurance Carrier

Claimant requests reconsideration of our November 20, 1996 Own Motion Order Reviewing Carrier Closure, in which we affirmed the insurer's August 27, 1996 Notice of Closure in this claim. Specifically, claimant contends that: (1) the Board erred in determining that her current pain condition is not a compensable component of her accepted back, shoulder and right knee injury claim; and (2) the Board erred in determining that the claim was not prematurely closed.

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

IT IS SO ORDERED.

November 29, 1996 Cite as 48 Van Natta 2376 (1996)

In the Matter of the Compensation of
CHARLES L. CHITTIM, JR., Claimant
WCB Case No. 95-10919
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The insurer requests review of Administrative Law Judge (ALJ) McKean's order that set aside its denial of claimant's current low back condition. In its brief, the insurer contends that the ALJ lacked authority to address the compensability of claimant's March 1995 disc herniation. On review, the issues are scope of denial and compensability.

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

Claimant had a disc bulge at L3-4 that preexisted his 1995 compensable injury. In June 1994, Dr. Soldevilla performed a decompressive lumbar laminectomy and foraminotomies at L3 through L5. On March 1, 1995, claimant compensably injured his low back after slipping and falling at work. An MRI revealed herniated disks at L3-4, left, and L4-5. The insurer accepted "low back sprain with surgical procedure of diskectomy at L4-5, as described by your doctor." (Ex. 29).

Dr. Soldevilla performed decompression surgery at L3-4 and L4-5, with L4 and L5 foraminotomies, an examination of the L4-5 disk, and an L3-4 diskectomy. Claimant's post-surgical care was managed by Drs. Palmer and Breen. Claimant experienced ongoing left leg pain. Dr. Breen released claimant to work with a 10-pound lifting limit, which was increased to 50 pounds after work hardening. In July 1995, claimant again complained of low back and leg pain, and, on July 31, 1995, claimant's lifting was limited to 20 pounds.

In September 1995, Dr. Soldevilla opined that claimant had experienced a re-herniation of the L3-4 disk and requested further surgery. On September 25, 1995, the insurer issued a partial denial of compensability for "Redo, L3-4 Discectomy," on the basis that "the current request for surgery is not a portion of [its] accepted condition and hence not compensable." (Ex. 50). Claimant requested a hearing on the denial.

The ALJ concluded that claimant had proven that the March 1, 1995 work injury was a material cause of claimant's L3-4 herniated disc.

The insurer asserts that the ALJ improperly addressed the compensability of the March 1995 disc condition, because its denial was limited to a partial denial of claimant's current L3-4 disc condition and was not a denial of claimant's March 1995 L3-4 disc condition. We disagree.

An insurer is bound by the express language of its denial. Tattoo v. Barrett Business Service, 118 Or App 348 (1993). Moreover, an ALJ is limited to addressing only those conditions that have been denied. See Pamela S. Cheney, 44 Van Natta 1137, 1139 (1992). If a condition is not encompassed by the denial, and claimant's appeal is limited to that denial, the ALJ lacks authority to consider the compensability of that condition. Id. Here, because claimant's request for hearing is limited to the denial, he may challenge only those conditions encompassed therein.

In this case, the basis for the insurer's denial was that claimant's current request for surgery ("Redo, L3-4 Discectomy") was not part of its accepted conditions and hence was not compensable. The insurer specified in its denial that its acceptance was for "low back sprain with surgery authorized at L4-

5." From this language, we conclude that the insurer denied that claimant's L3-4 disc was an accepted portion of the 1995 claim (i.e., neither a low back sprain nor an L4-5 disc) and that the insurer intended to deny claimant's L3-4 disc from the outset. Consequently, we conclude that the scope of the denial included claimant's March 1995 L3-4 disc injury. In addition, the issue was framed by the ALJ at hearing as a denial of claimant's L3-4 disc and the parties agreed. (Tr. 2, 3). This indicates that both parties understood that compensability of the L3-4 disc was being contested. The ALJ, therefore, had authority to address compensability of claimant's L3-4 herniated disc.[1] See Jane Mathey, 44 Van Natta 1646 (1992).

The insurer next argues that the persuasive medical evidence shows that claimant does not have a re-herniated L3-4 disc, and, even if claimant does have a re-herniated disc at L3-4, it is not compensable. We disagree.

Medical opinions regarding claimant's current low back condition have been provided by three doctors: Dr. Soldevilla, claimant's treating neurosurgeon; Dr. Strum, who examined claimant for the insurer; and Dr. Silver, neurosurgeon.

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). Here, we find no persuasive reasons not to defer to Dr. Soldevilla's opinion.

Dr. Soldevilla has treated claimant's low back since 1992 and performed claimant's 1995 L3-4 diskectomy. He is familiar with claimant's medical history. On September 7, 1995, Dr. Soldevilla described pain in an L4 distribution and an MRI scan showing a recurrent L3-4 disc on the left. (Ex. 54-2). Dr. Soldevilla opined that claimant suffered a re-herniation of the L3-4 disc and that claimant's current condition and need for treatment were directly related to the March 1, 1995 low back injury as well as claimant's efforts to return to work. (Ex. 52A).

Dr. Breen, who followed claimant subsequent to Dr. Soldevilla's April 1995 surgery, documented claimant's progress.[2] Dr. Breen's chart notes report an increase in claimant's symptoms in conjunction with his attempts to return to work. In May 1995, claimant reported pain into his left leg, which was treated with pain medication. Dr. Breen noted that claimant was showing improvement on the medication and released claimant to work with a ten-pound lifting limit. On June 19, 1995, claimant reported occasional tingling down the left leg that had been decreasing. Dr. Breen increased claimant's weight restriction to 50 pounds. When claimant returned to Dr. Breen on July 10, 1995, Dr. Breen noted that claimant had been experiencing pain in his back and into his legs, which Dr. Breen correlated with heavy lifting. On July 31, 1995, claimant complained of increased pain down his left leg. Dr. Breen noted slightly positive straight leg raising on the left, limited claimant's lifting to 20 pounds, ordered an MRI and deferred to Dr. Soldevilla to assess whether neurosurgical intervention was required. (Exs. 34, 35, 37, 38, 39, 41, 42, 47, 48). As noted above, Dr. Soldevilla's reassessment of claimant's condition took place on September 7, 1995.

Dr. Strum, in contrast, saw claimant on only one occasion. He opined that claimant's current symptoms were related to his preexisting multilevel degenerative disk disease. (Ex. 45). As the ALJ noted, Dr. Strum based his opinion on a history that claimant had resolution of his leg pain and minimal back pain and returned to regular duties for several weeks, which is contrary to the medical record. Moreover, Dr. Strum initially formed his opinion regarding the cause of claimant's current

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[1] The insurer also argues on review that claimant failed to comply with ORS 656.262(7)(a), which requires a worker to file written notice of a claim for a new medical condition. Inasmuch as this argument was not raised at hearing, we are not inclined to address it on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Roger Eli, 47 Van Natta 1938 (1995). Moreover, even if we had considered this argument, we would find that, inasmuch as the insurer denied claimant's L3-4 disc claim and continued to assert its denial at hearing, the insurer waived any procedural defect regarding claimant's alleged failure to comply with ORS 656.262(7)(a). See Thomas v. SAIF, 64 Or App 193 (1983); Lawrence Runninghawk, 47 Van Natta 114, on recon 47 Van Natta 287 (1995).

[2] Subsequent to the 1995 surgery, Dr. Breen of Kaiser Permanente's occupational health clinic, supervised claimant's return-to-work efforts.

condition without the benefit of imaging studies. After he obtained the studies, he read them as showing scar tissue, rather than a recurrent disc herniation, but concluded, in effect, that the scar tissue was not the cause of claimant's current condition, which, he stated, involved the S1, not the S4, dermatome. This finding is not supported by the findings in Dr. Strum's initial examination report, (compare Ex. 45 with Ex. 53), nor with Dr. Soldevilla's findings.

Dr. Silver, who performed a neurosurgical consultation, had some reservations regarding the propriety of further surgery. (Exs. 54, 55). Nevertheless, he thought that claimant may have a recurrent or persisting disc herniation on the left at L3-4. He specifically indicated that, if that assessment was correct, the 1995 injury remained the major cause of claimant's current problem. (Ex. 55).

Based on Dr. Soldevilla's persuasive opinion, which is supported by the medical record, we agree with the ALJ's conclusion that claimant's current condition and need for treatment is directly related to the 1995 on-the-job injury and is, therefore, 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 $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 22, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by the insurer.

November 29, 1996 Cite as 48 Van Natta 2378 (1996)

In the Matter of the Compensation of
JAMES C. ENGLISH, Claimant
WCB Case No. 95-13067
ORDER ON RECONSIDERATION
Ernest M. Jenks, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our October 1, 1996 order that: (1) set aside its partial denial of claimant's somatic dysfunction of the cervical, dorsal/thoracic and lumbar areas of the spine; and (2) awarded an insurer-paid attorney fee of $3,000 under ORS 656.386(1). Contending that we misconstrued its denial and erroneously granted an attorney fee award, SAIF asks that we reinstate its denial in its entirety and rescind our attorney fee award. In order to consider SAIF's contentions, we abated our prior order. Having received claimant's response, we proceed with our reconsideration.

Claimant's November 28, 1995 request for hearing raised issues regarding "de facto" denials of "cervical, cervicodorsal, lumbar strains, and somatic dysfunction." On January 18, 1996, SAIF issued a partial denial of claimant's "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas" on the grounds that the July 9, 1993 injury was not the major contributing cause of the condition and there were insufficient objective findings which supported medical evidence of a diagnosable condition. (Ex. 41). On January 25, 1996, SAIF amended its acceptance to include an acceptance of a cervical strain. (Ex. 42). SAIF noted that its January 18, 1996 partial denial remained in effect. (Id.)

The ALJ found that the evidence did not establish that "somatic dysfunction" meant something different than a strain. The ALJ upheld SAIF's January 18, 1996 partial denial as to "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas" to the extent that terminology meant something other than the cervical, dorsal/thoracic and lumbar strains which had already been accepted.

Based on our review of the medical evidence, we concluded that, although different diagnoses had been used to describe his conditions, claimant's "somatic dysfunction" of the cervical, dorsal/thoracic, and lumbar areas of the spine were the same conditions accepted by SAIF. See Leslie C. Muto, 46 Van Natta 1685 (1994), aff'd mem 133 Or App 770 (1995). Consequently, we set aside SAIF's partial denial of claimant's "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas." We also awarded an attorney fee of $3,000 under ORS 656.386(1).

On reconsideration, SAIF contends that we misconstrued its denial and erroneously granted an attorney fee award. SAIF asserts that its partial denial of "somatic dysfunction" could not reasonably be construed as an attempt to deny the accepted conditions. According to SAIF, claimant did not prevail against a "denied claim" within the meaning of ORS 656.386(1). We disagree.

Under ORS 656.386(1), a claimant's attorney is entitled to an attorney fee "in cases involving denied claims" where claimant "prevails finally" in a hearing or on review or where the attorney "is instrumental in obtaining a rescission of the denial." A "denied claim" is defined in 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 any compensation."

In Michael J. Galbraith, 48 Van Natta 351 (1996), we held 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 condition was not compensable. We find this case distinguishable from Michael J. Galbraith, supra.

In its January 18, 1996 letter, SAIF partially denied claimant's "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas" on the grounds that the July 9, 1993 injury was not the major contributing cause of the condition and there were insufficient objective findings which supported medical evidence of a diagnosable condition. (Ex. 41). In an amended acceptance on January 25, 1996, SAIF noted that its January 18, 1996 partial denial remained in effect. (Ex. 42). In another letter dated January 25, 1996, SAIF explained that acceptance of somatic dysfunction "may include additional physical and psychological conditions which may not be related to [claimant's] original industrial injury." (Ex. 43). Citing ORS 656.262(7)(a),[1] SAIF stated that "acceptance of somatic dysfunction of the areas of the back to include cervical, cervical/dorsal and lumbar areas is not statutorily required." (Id.)

In the January 18, 1996 and January 25, 1996 letters, SAIF refused to pay for claimant's "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas" on the express ground that those conditions were not compensable and did not give rise to an entitlement to any compensation. If successful, SAIF's arguments would have prevented claimant from receiving benefits for the "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas." See John R. Syron, 48 Van Natta 2091 (1996) (attorney fee awarded under ORS 656.386(1) because the carrier's "claim preclusion" defense, if successful, would have prevented the claimant from receiving compensation for his disc herniation). SAIF's January 18, 1996 and January 25, 1996 letters meant that claimant's "somatic dysfunction of cervical, dorsal/thoracic and lumbar areas" were "denied" within the meaning of ORS 656.386(1).

Claimant "prevailed finally" against the denials on Board review. Therefore, claimant's attorney is entitled to an attorney fee under ORS 656.386(1). After considering SAIF's motion for reconsideration, claimant's response, and the factors recited in OAR 438-015-0010(4),[2] we continue to find that $3,000 is a reasonable attorney fee for claimant's counsel's services at hearing and on review.

Claimant's attorney requests an additional assessed attorney fee of $300 for time spent responding to SAIF's reconsideration request. 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 on reconsideration regarding the compensability issue is $300, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's response to the reconsideration request), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[1] ORS 656.262(7)(a) provides, in part: "The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions."

[2] SAIF argues that the "value of the interest involved" factor under OAR 438-015-0010(4) is effectively "zero." Even if we assume that the "value of the interest involved" is nominal, that is only one of the factors taken into consideration. We also have particularly considered the time devoted to the issue, the complexity of the issue, and the risk that claimant's counsel may go uncompensated.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our October 1, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 29, 1996 Cite as 48 Van Natta 2380 (1996)

In the Matter of the Compensation of
ATHER FRAZIER, Claimant
Own Motion No. 95-0612M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Farmers Ins. Group, Insurance Carrier

Claimant, *pro se*, requests reconsideration of our November 7, 1996 Own Motion Order Reviewing Carrier Closure which found that: (1) claimant's request for review of the insurer's April 8, 1996 Notice of Closure of his claim was untimely; and (2) assuming *arguendo* that claimant's request was timely, affirmed the insurer's April 8, 1996 closure on the merits. With his request, claimant submits a November 14, 1996 statement in which he contends that he had "good cause" for not filing his request for review timely.[1] On reconsideration, we adhere to the conclusion reached in our November 7, 1996 order. We base this decision on the following reasoning.

In his November 14, 1996 statement, claimant attested that his treating physician had left the city, apparently leaving claimant without an attending physician. Claimant further stated that his rehabilitation nurse "found me a doctor [who] is a knee specialist and by the time she found this doctor (Dr. Coward in Sacramento, Ca.) it took darn near 3 months."

Pursuant to OAR 438-012-0060(1), claimant had 60 days from the mailing date of the insurer's Notice of Closure in which to file a request for review, or 180 days from that mailing date if he could establish "good cause" for failure to file the request within 60 days. Claimant's request was not filed within 60 days of the mailing date of the insurer's Notice of Closure, but was filed within 180 days of that notice. Therefore, it is incumbent upon claimant to establish "good cause" for his failure to file within 60 days.

Here, claimant contends that his physician left town, and he was unable to find a new treating physician for three months. On this record, as stated in our previous order, we need not resolve whether claimant has demonstrated "good cause" for his failure to file a request for review of the insurer's closure of his claim within 60 days after that notice was mailed.

We reach this conclusion because, as stated in our November 7, 1996 order, even if we assumed that claimant's request for review was timely, claimant has not established that he was not medically stationary at claim closure. Further, claimant submitted no new evidence with his request for reconsideration which would establish that he was not medically stationary. Therefore, Dr. Strudwick's opinion that claimant was medically stationary at claim closure remains unrebutted. In light of such circumstances, we remain unable to find that claimant has carried his burden of proving that he was not medically stationary in April 1996 when the insurer closed his claim.

Accordingly, we abate and withdraw our November 7, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our November 7, 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.

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[1] Because it is unclear whether claimant sent a copy of his November 14, 1996 letter to the insurer, we enclose a copy of that letter with our order copy to the insurer.

In the Matter of the Compensation
WCB Case No. 95-00692
JULIE A. GOULD, Claimant
ORDER ON RECONSIDERATION (REMANDING)
Olson Law Firm, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

On June 14, 1996, we abated our May 16, 1996 order in which we affirmed the Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of claimant's mental disorder claim. We took this action to consider SAIF's motion for reconsideration. Having received and considered claimant's response to the motion and SAIF's reply, we now proceed with our reconsideration.

The ALJ found that claimant, a corrections officer, had met her burden of proving that she sustained a compensable mental disorder under ORS 656.802(3). In reaching this conclusion, the ALJ relied on the medical opinion of a clinical psychologist, Dr. deCampos, who opined that claimant's employment was the major contributing cause of her mental disorder, diagnosed as major depression. We agreed with the ALJ that Dr. de Campos' opinion was persuasive. We, therefore, concurred with the ALJ that claimant had sustained her burden of proof.

SAIF now offers "newly discovered evidence" that allegedly demonstrates that claimant misled the ALJ in regard to an alleged extramarital relationship between claimant and an inmate at the time of the August 9, 1995 hearing. In support of its motion, SAIF notes claimant's testimony that her relationship with her husband was very open and honest and that they were best friends. (Tr. 148). SAIF also refers to medical records in which claimant denied marital problems. (e.g. Ex. 15-3). SAIF contends that we should remand the claim to the ALJ because claimant failed to disclose at hearing or to her medical providers the existence of this alleged non-work related emotional stressor.

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). Specifically, a compelling reason must be shown to merit remand. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable with due diligence at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Here, we conclude that a compelling reason has been shown for remanding. First, the evidence clearly concerns disability since it concerns claimant's disabling psychological condition. Next, considering the history claimant gave to the physicians involved in the case and her hearing testimony in which she did not disclose the alleged extramarital relationship, we find that the evidence was not previously obtainable. Although claimant argues that SAIF could have obtained the same evidence with further questioning at hearing, we do not agree.

Claimant told medical examiners that her marriage was good. At the hearing, claimant was asked about her marriage (Tr. 148), but she testified that she had a good relationship with her husband and did not disclose her relationship with the inmate. There is no evidence that claimant's husband, who testified at hearing, was aware of claimant's and the inmate's relationship. Under these circumstances, we are satisfied that SAIF could not reasonably have obtained evidence of the existence of this alleged non-work-related stressor with due diligence at or before the hearing. Cf. Iose L. Cervantes, 41 Van Natta 2419 (1989) (where the claimant admitted that, during his testimony in a prior hearing, he had lied about being involved in a fight which resulted in injury, carrier not required to have adduced enough evidence in the first hearing to force the claimant to admit he lied).

Having concluded that the submitted evidence was not obtainable with due diligence, we now address the issue of whether it is likely to affect the outcome of the hearing.

SAIF has offered new medical reports from Dr. deCampos and Dr. Neuberg, claimant's attending physician. Dr. Neuberg met with SAIF's counsel and reviewed the information regarding claimant's alleged relationship with the inmate. Based on this additional information, Dr. Neuberg agreed with the statement in a concurrence letter that claimant's employment in November 1994 was not

the major contributing cause of her psychiatric condition. (Ex. W-2). However, we found in our original order that Dr. Neuberg's opinion was not persuasive due to inconsistencies in her prior opinions. Given these prior inconsistencies, and the fact that Dr. Neuberg had previously opined that claimant's mental disorder was not work related, we do not find that her current opinion would likely affect the outcome of the case.

SAIF's counsel also met with Dr. deCampos and showed her letters exchanged between claimant and the inmate. SAIF sent Dr. deCampos a proposed concurrence letter in which she was asked whether the need to keep secret the development of a personal relationship with an inmate in violation of the policy of Department of Corrections would be an emotional stressor. Dr. deCampos was also asked whether her assessment of claimant's candor and motives was the same, whether she still felt comfortable in relying on information provided by claimant in concluding that work exposure was the major contributing cause of claimant's depression and need for treatment, and whether claimant had either consciously or subconsciously manipulated and enlarged work events. (Ex. V).

Dr. deCampos declined to sign the concurrence letter. However, she did submit a separate narrative report to SAIF in which she opined that she was unable to answer the questions as posed, but that, assuming the veracity of SAIF's information, "the basis of my previous opinion on this patient would be very different." (Ex. V-4, emphasis added). Considering Dr. deCampos' response to SAIF's inquiry, we are persuaded that it would likely affect the outcome of the case.[1]

Having found that SAIF has established a compelling reason to remand for the admission of the additional evidence, we grant SAIF's motion. On remand, 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 November 1, 995 is vacated. This matter is remanded to ALJ Myzak for further proceedings consistent with this order.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we note our recent decision in Tricia C. Wagner, 48 Van Natta 2175 (1996). In Wagner, we remanded a claim for admission of additional evidence consisting of the claimant's testimony in a deposition taken in a separate civil proceeding. The claimant's testimony (the substance of which we also determined was not obtainable with due diligence prior to hearing) established that she had not provided an accurate or complete history to an examining physician whose opinion we found was the most persuasive regarding the causation of the claimant's psychological condition. Based on the "newly discovered evidence," the physician opined that, if true, the evidence would undermine the claimant's credibility and that it was probable that an off-the-job stressor was the major contributing cause of the claimant's psychiatric symptoms.

Here, Dr. deCampos did not explicitly opine that claimant's alleged extramarital relationship was the major contributing factor in her mental disorder. However, Dr. deCampos stated that the "basis" for her previous opinion would be very different. In light of Dr. deCampos' response to SAIF's inquiry, we are persuaded, as we were in Wagner, that a remand for the admission of the additional evidence would likely affect the outcome of this case.

Board Member Haynes specially concurring.

I concur with the lead opinion's conclusion that, considering the Board's earlier compensability decision, it is appropriate to remand this case for further development of the record. However, in reaching this conclusion, I wish to emphasize that my opinion should not be interpreted as an agreement with the Board's initial compensability decision. Rather, for the reasons stated in the lead opinion on reconsideration, I agree that this case should be remanded to the ALJ for the admission of the evidence SAIF has submitted. Thus, I specially concur with our Order on Reconsideration (Remanding).

Board Chair Hall dissenting.

I disagree with the majority's decision, on reconsideration, to remand this case for admission of additional evidence. To merit remand for additional evidence, such evidence must not have been obtainable at the time of the hearing and must be likely to affect the outcome of the hearing. Compton v. Weyerhaueuser Co., 301 Or 641 (1986). Here, there has been no showing that the evidence that SAIF seeks to introduce was not obtainable with due diligence at the time of the hearing, nor has there been a showing that it would likely affect the outcome of the case.

First, SAIF could have, with more thorough pre-hearing investigation, obtained evidence of claimant's alleged relationship with the inmate prior to hearing. Moreover, I do not agree with the majority that SAIF's questioning of claimant at hearing was sufficiently rigorous to satisfy the due diligence requirement.

Second, when given the opportunity to retract her opinion or to explicitly state that it would be different, Dr. deCampos did not do so. I, therefore, find insufficient evidence that Dr. deCampos has changed her opinion. Thus, I would also find that the evidence that SAIF has obtained is unlikely to affect the outcome of the case.

Under these circumstances, I would deny the motion for remand. For this reason, I must dissent.

November 29, 1996 Cite as 48 Van Natta 2383 (1996)

In the Matter of the Compensation of
GENE R. HARRISON, Claimant
WCB Case Nos. 95-09719 & 94-10661
ORDER ON REVIEW
Susak, Dean & Powell, Claimant Attorneys
Roberts, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's aggravation claim for a cervical condition; and (2) upheld Houston General Insurance's (HGI) denial of claimant's "new injury" claim for the same condition. HGI cross-requests review of those portions of the order that: (1) assessed a penalty for an allegedly unreasonable denial; and (2) awarded an attorney fee against it rather than SAIF. On review, the issues are responsibility, penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" and "Ultimate Findings of Facts."

CONCLUSIONS OF LAW AND OPINION

Responsibility

We adopt the ALJ's "Conclusions of Law and Opinion" on this issue, with the following modification and supplementation.

SAIF argues that the ALJ erred in relying on the opinion of Dr. Camp, treating physician, to conclude that SAIF remains responsible for claimant's cervical condition. We agree with SAIF that Dr. Camp was ultimately unable to quantify the relative contributions of factors contributing to claimant's current cervical condition (and we modify the ALJ's opinion accordingly). (See Ex. 57-40). However, Dr. Camp's uncertainty in this regard does not carry SAIF's burden of proving that claimant suffered a new injury subsequent to its coverage.

SAIF argues that we should rely on Dr. White's opinion that the 1994 work incident caused the 1994 need for treatment. (See Ex. 52). Even assuming that Dr. White's opinion would be sufficient to establish a "new injury" in 1994, we decline to rely on it.

Dr. White never had the opportunity to examine claimant or to evaluate his condition over time. Dr. Camp, on the other hand, has been claimant's longtime treating physician. He examined claimant many times before and after the 1994 injury. Under these circumstances, we find Dr. Camp's inability to ascribe "major cause" significance to the 1994 injury more persuasive than Dr. White's less informed conclusion. See Weiland v. SAIF, 64 or App 810 (1983).

In sum, we agree with the ALJ that SAIF has not carried its burden of proving that claimant's 1994 work injury (during HGI's coverage) is the major contributing cause of claimant's current cervical condition. Accordingly, SAIF remains responsible under ORS 656.308(1).

Penalties and Attorney Fees

We adopt the ALJ's reasoning and conclusion regarding the penalty issue.[1]

The ALJ directed SAIF to pay a $1,000 attorney fee for services related to SAIF's aggravation and responsibility denials. In addition, the ALJ directed HGI to pay a $3,500 attorney fee for services related to HGI's denial of compensability.

HGI argues that SAIF should be responsible for the entire attorney fee for services at hearing, because SAIF denied compensability as well as responsibility. We agree.

SAIF argues that it is not responsible for claimant's attorney fee under ORS 656.386(1), because it did not deny compensability. However, SAIF's aggravation denial had the effect of denying that claimant was entitled to compensation. See Vicki M. Emerson, 48 Van Natta 821 (1996). Moreover, SAIF argued at hearing that claimant's cervical condition is not work related. (Tr. 8). Under these circumstances, and because SAIF is responsible for claimant's current condition, it is also liable for an assessed fee under ORS 656.386(1) for claimant's attorney's efforts in establishing compensability. See Western Pacific Construction v. Bacon, 82 Or App 135 (1986) (Where multiple carriers, including the carrier ultimately found responsible, denied both compensability and responsibility, the carrier responsible for the claim was liable for the attorney fee at hearing under former ORS 656.386(1)); Charles R. Morgan, 48 Van Natta 841, on recon, 48 Van Natta 960 (1996).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services related to the compensability issue at hearing 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), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Finally, we note that the ALJ awarded a $1,000 attorney fee for services related to prevailing over SAIF's responsibility and aggravation denials. (O&O p.6). We modify.

Claimant is also entitled to an attorney fee under ORS 656.308(2)(d) for prevailing against SAIF's responsibility denial. Based on claimant's attorney's appearance and active and meaningful participation in this regard, and considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services related to the responsibility issue at hearing[2] is $1,000, payable by SAIF. See ORS 656.308(2)(d).

ORDER

The ALJ's order dated May 1, 1996, as reconsidered June 11, 1996, is modified in part and affirmed in part. That portion of the order that directed the SAIF Corporation to pay claimant a $1,000

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[1] HGI argues that no penalty should be assessed against it, because it had a legitimate doubt regarding its liability for the claim. However, HGI's responsibility defense does not make its denial of compensability reasonable. In the absence of evidence raising a legitimate doubt regarding compensability, we agree with the ALJ that HGI's compensability denial was unreasonable and a penalty was appropriate.

[2] ORS 656.308(2)(d) authorizes a $1,000 maximum cumulative fee for services at hearing and on review. See Tammy Locke, 48 Van Natta 250 (1996). In this case, the fee is awarded for services at the hearings level only, because claimant submitted no brief on review.

attorney fee for prevailing against SAIF's responsibility and aggravation denials is modified so that the fee is awarded for services at hearing related to prevailing against SAIF's responsibility denial only. That portion of the order that directed Houston General Insurance to pay claimant a $3,500 attorney fee is modified. SAIF, rather than HGI, is directed to pay claimant a $3,500 attorney fee for services at hearing regarding the compensability issue. The remainder of the order is affirmed.

November 29, 1996 Cite as 48 Van Natta 2385 (1996)

In the Matter of the Compensation of
EVA M. LOPEZ, Claimant
WCB Case No. 95-12076
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) Livesley's order that: (1) set aside its denial of claimant's current condition; (2) set aside its denial of claimant's aggravation claim for a right arm condition; (3) assessed a penalty for an allegedly unreasonable denial; and (4) assessed an attorney fee of $3,500 for services at hearing. On review, the issues are compensability, aggravation, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except we replace "regime" with "regimen."

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted nondisabling claim for right arm contusion/sprain as a result of a November 11, 1993 industrial accident. In October 1995, the insurer denied claimant's current condition and aggravation claim.[1] The ALJ found that, to prevail over both denials, claimant need only show that her condition was materially related to her compensable injury. Further finding sufficient medical evidence establishing causation, the ALJ concluded that claimant proved her current condition and aggravation claim compensable.

On December 28, 1993, claimant's former treating physician, Dr. Humphry, found claimant medically stationary and released her for regular work. (Exs. 12, 13). On March 30, 1994, claimant saw Dr. Korpa, who diagnosed a thoracic strain and prescribed physical therapy, but continued to release claimant for regular work. (Ex. 14). On June 10, 1994, Dr. Korpa informed claimant that he "could do no more for her" and could not determine the cause of her continuing shoulder pain. (Ex. 28). Dr. Korpa also found claimant medically stationary with no ratable impairment. (Id.)

On August 2, 1994, claimant saw Dr. Soriano, who diagnosed a chronic shoulder strain and restricted claimant to light work. (Ex. 31). On October 7, 1994, Dr. Wylie examined claimant. He found "nonspecific right shoulder tenderness," released her to regular work, and found her medically stationary with no anticipation of permanent impairment. (Ex. 34).

On September 12, 1995, claimant again saw Dr. Soriano, and was diagnosed with "myofascial pain of right shoulder girdle and arm status post crush and pull injury." (Ex. 39-1). Dr. Soriano requested that the insurer reopen the claim for worsened symptoms and "objective findings" of "decreased range of motion of the right shoulder, decreased grip strength on the right and decreased sensation to light touch, pin prick and 2 point discrimination." (Ex. 40). On referral from Dr. Soriano, Dr. Grant examined claimant and diagnosed "chronic posttraumatic myofascial right neck, shoulder, periscapular, and upper extremity pain syndrome, secondary to work injury[.]" (Ex. 41-2). Dr. Grant prescribed "myofascial oriented physical therapy." (Id.)

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[1] Claimant actually asserted that her claim had become disabling. Because this contention was made more than a year after the date of injury, it was treated as an aggravation claim under ORS 656.273. See ORS 656.277(2).

On January 12, 1996, claimant saw examining physicians Dr. Arbeene, orthopedic surgeon, and Dr. Barth, neurologist. The physicians diagnosed "multiple right upper extremity symptoms without orthopedic or neurologic findings to confirm a more specific diagnosis." (Ex. 57-7). On a historical basis, the physicians found that claimant's symptoms "appear to be attributable to the November 25, 1993 [sic] injury." (Id.) They could not, however, "identify a major cause for her current complaints of pain," nor "explain the chronicity of her complaints" and "the subjective worsening of her complaints now in comparison with her symptoms immediately after her injury." (Id.)

On the same date, claimant saw examining psychiatrist Dr. Telew, who reported that he viewed claimant "as having a pain disorder associated with psychological factors." (Ex. 52-12). Dr. Telew did not find the November 1993 injury to be the "major causative factor of her pain disorder," instead attributing it to "personality traits." (Id.)

We first note that claimant's current condition of myofascial pain condition was not accepted. Thus, in order to prevail against the current condition denial, claimant must prove compensability of the myofascial pain condition. Claimant must make the same showing to establish a compensable aggravation. See Gloria T. Olson, 47 Van Natta 2348, 2350 (1995) (holding that amended ORS 656.273 requires that a condition serving as the basis of an aggravation claim which is not already compensable must be established as compensable in order to prove "a worsened condition resulting from the original injury").

The only evidence showing a relationship between the myofascial pain condition and claimant's November 1993 injury is Dr. Soriano's chartnote that such condition was "post crush and pull injury" and Dr. Grant's chartnote that the condition was "secondary to work injury." We find that the lack of explanation and reasoning renders such evidence insufficient to meet claimant's burden of proof.

First, there is the report by Drs. Arbeene and Barth indicating that they could not identify the major cause of complaints or symptoms or explain why her symptoms were chronic and worsening. This report is consistent with chartnotes from some of claimant's prior treating physicians, including Dr. Korpa, who also could not identify the cause of claimant's symptoms, and Dr. Wylie, who found "nonspecific right shoulder pain." Furthermore, Dr. Telew found that claimant's condition was in major part caused by psychological factors.

We find that such evidence shows that claimant's condition is complex and not readily apprehensible, especially with regard to causation. Drs. Soriano and Grant, however, provide no explanation or reasoning how the injury caused the myofascial pain syndrome. We find such an absence fatal to the persuasiveness of their reports attributing the condition to the November 1993 injury. See Somers v. SAIF, 77 Or App 259, 263 (1986) (when there is a dispute between medical experts, we rely on those opinions that are in part well-reasoned).

Consequently, we find that the record contains no persuasive medical evidence establishing a causal relationship between the myofascial pain condition and the November 1993 injury. Thus, we conclude that claimant did not prove her current condition compensable or a compensable aggravation. ORS 656.005(7)(a), 656.273(1).

Finally, our order results in a lack of foundation for awarding a penalty or assessing an attorney fee. ORS 656.262(11)(a); 656.386(1). Consequently, since we have found that claimant's condition was not compensable, we likewise reverse those portions of the ALJ's order concerning the penalty and attorney fee issues.

ORDER

The ALJ's order dated March 1, 1996 is reversed. The insurer's denials of claimant's current condition and aggravation claim are reinstated and upheld in their entireties. The ALJ's penalty and attorney fee awards also are reversed.

Board Chair Hall dissenting.

I disagree with the majority that claimant failed to prove compensability. Dr. Soriano, who has treated claimant since August 1994, related claimant's myofascial condition to her compensable injury. Dr. Grant began treating claimant in October 1995 and also indicated that claimant's condition resulted from her compensable injury. Based on their extensive contact with, and treatment of, claimant, Drs. Soriano and Grant are the most familiar with claimant's condition.

Drs. Arbeene and Barth, on the other hand, saw claimant one time and provide no reasoning for their conclusion; in fact, they do not even agree with the diagnosis of myofascial pain condition.

Claimant's treating physicians clearly are in the best position to evaluate claimant's condition. Thus, their opinions are entitled deference. Weiland v. SAIF, 64 Or App 810, 814 (1983). Because Drs. Soriano and Grant both indicate that claimant's myofascial condition resulted from her compensable injury, claimant carried her burden of proof.

In the Matter of the Compensation of
MARCELLA S. LYON, Claimant
WCB Case No. 94-14292
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Employer Defense Counsel, Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of claimant's right thigh, hip, and low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has been a nurse for 15 years. By 1990, she was treating for a fibromyalgia or fibrositis condition which involved intermittent symptoms of general fatigue, knee pain, difficulty walking, upper back and shoulder pain. Claimant's fibromyalgia rarely, if ever, involved low back, hip, or upper leg symptoms.

During the winter of 1989-1990, claimant developed mild low back pain associated with standing for hours at work wearing a 14 pound lead apron. (Ex. 1-1). A February 1990 MRI of claimant's lumbar spine was normal except for a minimal bulge at L5-S1. (Ex. 3). As of an October 1993 physical examination, claimant was not limping and she did not have leg or low back symptoms.

In late May 1994, claimant suffered two work injuries. The first occurred while she was wearing a heavy lead apron and attempting to secure a gurney brake before transferring a comatose patient to an x-ray table. Claimant jumped on the brake and experienced immediate pain, primarily in the right thigh and groin area. The second injury happened three days later, while claimant and a co-worker were transferring a patient to a bed. With her thighs braced against the bed, claimant lifted the patient and reached forward. Again she felt immediate pain primarily in her groin and along the inner side of her right thigh. These symptoms differed from the prior fibromyalgia in their location, sharpness, and persistence. Claimant carried herself differently, walked differently, and limped after the May 1994 injuries.

On June 30, 1994, claimant sought treatment from Dr. Lyon for inner right leg pain. She did not tell him about a specific injury, but explained that her symptoms had worsened during previous weeks with activity, particularly work activity. Dr. Lyon diagnosed a sartorius muscle strain.

Claimant's symptoms worsened during the summer. In the fall, Dr. Lyon referred her to Dr. Maier, who first examined her on November 4, 1994. Claimant told Dr. Maier about her fibromyalgia history, the May 1994 gurney brake incident, and her subsequent symptoms. She had pain with abduction of her right hip. The same day, claimant discussed the two May 1994 incidents with her employer and filed a claim.

Dr. Panum examined claimant in November 1994 and Dr. Hacker examined her in December 1994. Dr. Panum suspected a radicular problem; Dr. Hacker diagnosed mechanical low back pain.

Dr. Hill examined claimant in July 1995. An MRI revealed a right hip degenerative condition consistent with claimant's symptoms, including mechanical low back pain, and the mechanism of the May 1994 injuries.

Claimant's current problems are distinguishable and separable from her prior fibromyalgia problems.

CONCLUSIONS OF LAW AND OPINION

Based on perceived discrepancies in the record and related doubts, the ALJ found the medical evidence supporting compensability unpersuasive. We disagree.

It is true that claimant did not describe the work incidents to Dr. Lyon when she first sought treatment for right thigh pain in June 1994, nor did she attribute her post-May 1994 symptoms to those incidents until months later. We do not find this delay confusing or suspicious, in light of claimant's long-standing, ubiquitous, and often debilitating fibrositis condition. In other words, claimant's initial opinion that her right thigh, hip and low back problems were not work-related does not mean that her doctors' histories are fatally flawed, especially since those histories were later corrected and claimant's pre-injury fibromyalgia convincingly distinguished from her post-injury condition.

We have no reason to disbelieve claimant's descriptions of the work injuries. She described them consistently on many occasions. (See Exs. 7-3, 8a-3-4, 9-1, 18-24). Her contention that the injuries marked the beginning of new symptoms is supported by her co-workers' observations that she walked differently and carried herself differently after May 1994. In addition, based on persuasive evidence distinguishing claimant's fibromyalgia condition from her current problems (and the lack of evidence of any other preexisting contributor), we agree with the ALJ that no preexisting condition contributes to claimant's current condition.[1] Moreover, the medical evidence uniformly describes claimant's current condition as consistent with the injuries as she describes them. Finally, persuasive medical evidence supports a conclusion that claimant's current problems are most likely related to the May 1994 work injuries. (See Exs. 6-1, 9-2, 21-23, 27-26).

We do not share Dr. Hacker's doubts about the relationship between claimant's current condition and the May 1994 work incidents, for the following reasons. First, as we have stated, there is no persuasive reason to suspect that fibromyalgia contributes to claimant's current problems. Second, although the record reveals that claimant complained of low back problems brought on by standing for hours wearing her lead apron (in 1990) and she limped at times previously as a result of fibromyalgia, there is no evidence that she had either of these problems at the time of the May 1994 injuries. (See Exs. 1-1, 21-14-15, 27-33). Third, when complete histories of claimant's prior symptoms were provided, Drs. Lyon and Hill continued to opine that, assuming claimant's description of her injuries was accurate, her current condition is work-related. (Exs. 21-23, 27-26, 27-40-41). As we have stated, we accept claimant's description of the work injuries.

Accordingly, based on the opinions of Drs. Lyon and Hill, we find that claimant has established that her current right thigh, hip, and low back problems are materially related to her May 1994 work injuries. (See Exs. 19, 21-23, 27-26, 27-33, 27-41). Accordingly, the claim is compensable.[2] See ORS 656.005(7)(a).

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 $7,000, payable by the insurer. 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 regarding time invested in the case), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[1] Only Dr. Hacker suspects that fibromyalgia contributes. However, his opinion is not particularly persuasive in this regard because he is not "comfortable" with a fibromyalgia diagnosis in any event. (Ex. 18-20-21). Moreover, the remaining medical evidence persuasively explains how fibromyalgia is separable and distinguishable from claimant's post-May 1994 problems. (See Exs. 19, 21-31-2, see also Ex. 27-42).

[2] Even assuming that claimant is subject to the major contributing cause standard under ORS 656.005(7)(a)(B), we would reach the same result on this record. (See Exs. 21-23, 27-26, 27-33). See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991) (No incantation of "magic words" or statutory language is required).

ORDER

The ALJ's order dated May 9, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $7,000 attorney fee, payable by the insurer.

November 29, 1996 Cite as 48 Van Natta 2389 (1996)

In the Matter of the Compensation of
STEVE H. SALAZAR, Claimant
WCB Case Nos. 95-08169 & 95-08140
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Lundeen, et al, Defense Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Liberty Northwest Insurance Corporation requests review of those portions of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its denial of responsibility for claimant's current right knee condition; (2) upheld Safeco Insurance Company's denial of responsibility for the same condition; and (3) awarded claimant's counsel a $3,500 assessed attorney fee. Safeco cross-requests review of that portion of the ALJ's order that found that claimant had timely filed his request for hearing from Safeco's denial. On review, the issues are timeliness of the hearing request, responsibility, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Request for Hearing for Safeco's Denial

The ALJ found that claimant had established "good cause" under ORS 656.319(1)(b) for his untimely hearing request concerning Safeco's denial. Safeco challenges that finding, asserting that claimant's explanation for his untimely appeal of its denial does not constitute "good cause." We need not resolve that issue because, even if we agreed with the ALJ's "good cause" finding, we would not find Safeco responsible for claimant's current right knee condition.

Responsibility

Under ORS 656.308(1), when a worker sustains a compensable injury, the responsible carrier remains responsible unless the worker sustains a new compensable injury involving the same condition. Apparently finding that claimant had not sustained a "new compensable injury," the ALJ concluded that responsibility for claimant's right knee condition remained with Liberty.

On review, Liberty argues that the ALJ erred in not relying on the opinion of Dr. Whitney, claimant's treating doctor. We generally defer to the opinion of a treating doctor, unless we find persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of Dr. Whitney.

At the time the accepted Liberty knee claim was closed, Dr. Whitney reported that there was a chance of "progressive problems that may need medical attention in the future." (Ex. 11). Additionally, Dr. Whitney originally attributed claimant's condition to his "old medial meniscectomy and the problems thereof." (Ex. 20). Dr. Whitney also agreed with the report of Dr. Coletti, who examined claimant and reported that "the impairment of the right knee is exclusively related to the 11-23-87 injury." (Ex. 26-4; 28).

Accordingly, in light of Dr. Whitney's initial opinions, we are not persuaded by the subsequent "check-the-box" letter, in which Dr. Whitney agreed that the 1995 incident constituted a "new injury." (Ex. 30). Without further explanation by Dr. Whitney, we decline to accept his changed opinion. We therefore find that the ALJ correctly relied on the thorough and well-reasoned opinion provided by Dr. Coletti. Consequently, we agree that Liberty has failed to prove that claimant sustained a "new compensable injury" while employed with Safeco's insured. Therefore, responsibility for claimant's right knee condition remains with Liberty. ORS 656.308(1).

Attorney Fee

On review, Liberty contends that the ALJ's assessed attorney fee of $3,500 is excessive. The ALJ first found that compensability, as well as responsibility, was at issue. Additionally, the ALJ found extraordinary circumstances justifying a fee in excess of the statutory limitation set forth in ORS 656.308(2)(d).

We do not find that either Liberty or Safeco's denials denied compensability of claimant's claim. Both denials provided that they were intended to "disclaim responsibility." Both denials stated that it was believed that another employer was responsible for the claim. Accordingly, we conclude that the denials did not deny compensability. See James D. Lollar, 47 Van Natta 740 (1995).

Furthermore, we disagree with the ALJ that there are extraordinary circumstances. The record consists of approximately 33 exhibits, including a 16-page deposition transcript. Two carriers were joined at hearing. One witness testified at hearing and the hearing transcript was 32 pages. Following the hearing, claimant's attorney submitted a 2-page legal memorandum. On review, claimant's attorney submitted a 2-page respondent's brief and a 3-page cross-respondent's brief.

Under similar facts, we have found that there were no "extraordinary circumstances" under ORS 656.308(2)(d). For instance, Tammy Locke, 48 Van Natta 250, 251 (1996), involved two carriers, a 40-page hearing transcript with one witness, and a record consisting of 26 exhibits, including a 50 minute deposition transcript. In Douglas H. Brooks, 48 Van Natta 736 (1996), there were two carriers, the hearing transcript was 50 pages long with three witnesses, the record had 47 exhibits, including 50 and 15 minute deposition transcripts, and claimant's attorney submitted a 7-page respondent's brief on review.

Based on Locke and Brooks, we conclude that there are no "extraordinary circumstances" here warranting an additional attorney fee beyond the $1,000 statutory requirement. Consequently, claimant's attorney is awarded $1,000 for services at hearing and on review, payable by Liberty. ORS 656.308(2)(d).

ORDER

The ALJ's order dated May 22, 1996 is modified in part and affirmed in part. That portion of the order awarding a $3,500 assessed attorney fee is modified. In lieu of the ALJ's award, claimant is awarded an attorney fee of $1,000 for service at hearing and on review regarding Liberty's responsibility denial, to be paid by Liberty. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JUDY A. TUCKER, Claimant
WCB Case No. 95-03065
ORDER ON REVIEW
Susak, Dean & Powell, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Holtan's order that upheld the insurer's denial of claimant's current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the relevant facts. Claimant has degenerative disc disease (DDD) that preexisted her compensable low back injury in 1991. (Ex. 13). Subsequent to her injury, claimant was diagnosed with "left lumbar radiculitis at L5-S1," "low back pain," "foraminal stenosis at L5-S1," and "lumbar disc disease." (Exs. 11, 14, 14A). The insurer formally accepted a disabling "low back strain." (Ex. 15). A July 1, 1992 Determination Order closed the claim with an award of 7 percent unscheduled permanent disability, which was based on reduced ranges of motion in the low back. (Ex. 16).

Claimant sought palliative treatment from Dr. Takacs on a number of occasions from January 1994 to February 14, 1995. (Ex. 20). By letter dated February 18, 1995, as amended March 27, 1995, the insurer denied claimant's current low back condition on the basis that her low back strain had resolved and that the major contributing cause was now due to preexisting lumbar disc disease. (Exs. 18A, 19).

The ALJ first concluded that claimant's accepted 1991 low back strain had combined with her preexisting DDD. Then, relying on the opinions of Drs. Arbeene and Watson, the ALJ found that claimant's low back strain had resolved. The ALJ finally concluded that the accepted low back strain was no longer the major contributing cause of claimant's current need for treatment.

On review, citing Drews v. EBI Companies, 310 Or 134, 142-43 (1990), and Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995), claimant contends that the insurer's failure to challenge the Determination Order that awarded permanent disability precluded it from later contending that claimant's DDD was not a part of its accepted "low back strain" condition. According to claimant, the DDD was rated in the July 1, 1992 Determination Order, and, therefore, by failing to appeal the Determination Order, the insurer, in effect, accepted the preexisting DDD.

The insurer contends that Messmer does not apply, as the unscheduled award was based solely on claimant's low back strain that was superimposed on the DDD and was not based on any residuals from the DDD itself. We disagree.

In Messmer v. Deluxe Cabinet Works, supra (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;[1] it was that the employer was barred by claim preclusion from denying that it was part of the compensable claim. Id. at 258. Subsequently, in Deluxe Cabinet Works v. Messmer, 140 Or App 548

[1] 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.

(1996) (Messmer II), the court held that amended ORS 656.262(10)[2] did not overrule its prior decision in Messmer I. Deluxe Cabinet Works v. Messmer, supra; Roger L. Wolff, 48 Van Natta 1197 (1996).

In this case, the insurer did not contest the July 1, 1992 Determination Order which awarded permanent disability benefits. Thus, in accordance with Messmer II, we examine the issue of whether the insurer is precluded from denying claimant's DDD as part of its accepted 1991 claim.

Claimant received 7 percent unscheduled permanent disability as a result of the 1991 claim. The evaluator's worksheet referred to the accepted condition as "low back," and indicated that the award was for claimant's range of motion impairment. The worksheet referred to claimant's medically stationary status as of May 14, 1992, when claimant was examined by Dr. Silver, and the range of motion as of Dr. Takacs' May 21, 1992 examination. (Ex. 16).

When he examined claimant on May 14, 1992, Dr. Silver found claimant medically stationary and referred her to Dr. Takacs to perform the closing evaluation. (Ex. 14B). Dr. Takacs stated that claimant was medically stationary "with permanent impairment for L5 disc disease with distributions in the sensory L5 area but normal motor strength," and "Mechanical low back pain from superimposed lumbar strain with maximum lumbar extention (sic) of 20 degrees, flexion of 50 degrees, lateral flexion 26 degrees, to the left and to the right is 8 degrees." (Ex. 14C, emphasis added).

Based on the evaluator's worksheet and the underlying medical evidence, we conclude that claimant's unappealed 7 percent unscheduled permanent disability award included an award for the DDD. 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). Consequently, because the insurer failed to contest the order that awarded permanent disability benefits for claimant's DDD condition, it is now precluded from denying the compensability of that condition. Messmer II, supra; see also Roger L. Wolff, supra.[3]

Because we have concluded that the insurer is precluded from denying the compensability of claimant's DDD condition, we decline to address claimant's remaining arguments.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record 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 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 a fee of $4,500, payable by the insurer.

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[2] 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 amendment to ORS 656.262(10) applies retroactively. See Messmer II, supra, 140 Or App at 551, n. 2.

[3] We note that, although ORS 656.262(6)(c) allows an insurer 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 "acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order." Here, the insurer did not voluntarily accept claimant's DDD condition, nor was it directed to do so by litigation order. Therefore, ORS 656.262(6)(c) is not applicable in this case. See Patricia A. Landers, 48 Van Natta 1720, 1722 (1996).

In the Matter of the Compensation of
DANA W. WOOD, Claimant
WCB Case No. 95-13608
ORDER ON RECONSIDERATION
Scott McNutt, Sr., Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our October 3, 1996 order that affirmed an Administrative Law Judge's (ALJ's) order which set aside its denial of claimant's occupational disease claim for an L4-5 disc condition. Contending that we erroneously found that claimant's work activities were the major contributing cause of his "combined condition," SAIF seeks reconsideration of our order. In order to consider SAIF's contentions, we abated our prior order. Having received claimant's response, we proceed with our reconsideration.

Citing SAIF v. Jones, 138 Or App 484 (1996), and Camilla R. Blanco, 48 Van Natta 1133, on recon 48 Van Natta 1703 (1996), SAIF argues, as it did on review, that Dr. Bert's opinion is insufficient to satisfy claimant's burden of proving that his work activities were the major contributing cause of his combined condition. We disagree.

In SAIF v. Jones, supra, the court remanded the case because the Board did not make a determination as to whether employment conditions were the major contributing cause of the claimant's combined condition.

Here, in contrast, we expressly concluded in our previous order that, based on Dr. Bert's opinion, claimant's employment conditions were the major contributing cause of the pathological worsening of the L4-5 disc bulge and also the major contributing cause of the "combined condition" itself. See ORS 656.802(2)(b); Camilla R. Blanco, supra (medical opinion established that the claimant's work activities were the major contributing cause of the combined condition). We reach the same conclusion on reconsideration.

Claimant has a preexisting disc bulge at L4-5. An October 3, 1990 MRI showed "very mild central bulging at L4-5." (Ex. 9). Dr. Bert testified that, by the time he performed surgery, the mild bulge at L4-5 had progressed to a frank herniation. (Ex. 34-18). Thus, the "combined condition" in this case is the herniation at L4-5, which resulted from the combination of the preexisting L4-5 disc bulge and claimant's subsequent work activities.

We generally 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 Dr. Bert's opinion.

Dr. Bert testified that claimant's work activities between 1990 and 1995, including lifting, bending and stooping, caused increased amounts of loads on claimant's spinal cord, which contributed to the wear and tear on the already damaged tissues around L4-5. (Exs. 34-18, -19, -20). Dr. Bert agreed that claimant's increased problems with his lower back, including increased numbness and pain with his leg, indicated a change in the disc pathology. (Ex. 34-20). Dr. Bert agreed that claimant's work activities were the major cause of the worsening of the disc pathology at L4-5, assuming that claimant had no significant off-work exposure. (Id.) The ALJ found, and we agree, that claimant's off-work activities were not significant. Although Dr. Bert did not expressly state that claimant's work with the employer was the major contributing cause of his "combined 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).

Based on Dr. Bert's opinion, we conclude that claimant's employment conditions were the major contributing cause of the pathological worsening of the L4-5 disc bulge, and also that employment conditions were the major contributing cause of the "combined condition" itself. See ORS 656.802(2)(b).

Claimant's counsel is entitled to an additional assessed attorney fee for time spent responding to SAIF's reconsideration request. 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 $500, 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, on reconsideration, as supplemented herein, we adhere to and republish our October 3, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 2, 1996 Cite as 48 Van Natta 2394 (1996)

In the Matter of the Compensation of
JASON S. PALMER, Claimant
WCB Case Nos. 95-00583 & 94-13017
CORRECTED ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by the Board en banc.

It has come to our attention that our November 26, 1996 Order on Review contained some clerical errors in that portions of our conclusion (at the bottom of page 8 and the top of page 9) were inadvertently omitted. To correct that oversight, we withdraw our November 26, 1996 order and replace it with the following corrected order. The parties' rights of appeal shall begin to run from the date of this order.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) McCullough's order that set aside its denial of claimant's aggravation claim for a bilateral arm condition.[1] In his responent's brief, claimant challenges the ALJ's attorney fee award. On review, the issues are aggravation and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant, a telephone operator, began working for the employer in 1988. In July 1990, he sought medical treatment from Dr. Neumann, orthopedist, for bilateral wrist complaints. Dr. Neumann diagnosed overuse sydnrome/chronic strain. Medication was prescribed, but claimant continued to perform his job duties.

In October 1990, claimant filed a claim alleging that his bilateral upper extremity condition was related to keyboard activities at work. The employer initially denied the claim, but later accepted a nondisabling bilateral overuse syndrome of the and hands and wrists. In December 1990, Dr. Neumann, restricted claimant to 4 hours per day of keyboarding and 4 hours per day at other duties. These restrictions continued until February 1991, when claimant began working 8 hours per day doing keyboard activities. Thereafter, claimant's symptoms increased and Dr. Neumann restricted claimant's keyboarding activities to 5 hours per day. In April 1991, Dr. Neumann recommended that claimant continue with the 5 hour per day restriction and indicated that this restriction was likely permanent. Claimant resigned in May 1991 because of upper extremity pain he was experiencing in connection with his keyboarding work. Because claimant's claim was nondisabling, it was not formally closed.

During the next two years, claimant was mostly unemployed, but did work a few months as a food server in a restaurant. In September 1993, claimant returned to Dr. Neumann to obtain a clearance to return to work at the employer as a telephone operator. Claimant was not having any upper extremity symptoms at that time, nor had he experienced any such symptoms in the preceding two years. Dr. Neumann reported that claimant's examination was normal and released him to return to work as a keyboard operator. Claimant returned to work as a keyboard operator.

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[1] Although claimant originally cross-requested review of those portions of the ALJ's order that declined to award interim compensation from August 19, 1994 to December 6, 1994 and declined to assess penalties or attorney fees for allegedly unreasonable claim processing, he has withdrawn those issues.

After his September 1993 return to work, claimant's upper extremity symptoms returned. By the summer of 1994, claimant was experiencing pain, numbness and tingling in both wrists. On July 25, 1994, claimant stopped working because of his symptoms. In August 1994, claimant returned to Dr. Neumann for treatment of his bilateral wrist symptoms. Dr. Neumann authorized temporary disability benefits from July 25, 1994 through September 23, 1994.

On September 23, 1994, claimant began treating with Dr. Rung, M.D. who prescribed occupational therapy and medication. Dr. Rung released claimant to full time work on a modified basis: a maximum of 30 minutes at a time doing keyboarding with a minimum of 30 minutes rest from keyboarding before returning to keyboarding work again. Thereafter, claimant returned to work at the employer n a modified basis. He continued modified work until November 29, 1994. On December 1, 1994, Dr. Rung released claimant from all work.

The employer denied claimant's aggravation claim on December 6, 1994.

CONCLUSIONS OF LAW AND OPINION

In his initial order, the ALJ concluded that claimant's bilateral upper extremity problems since July 1994 constituted an aggravation of his 1990-91 condition.

The employer sought Board review of the aggravation issue. On review, we concluded that the record was insufficiently developed to assist us in determining whether claimant had sustained an "actual worsening" of his condition under the amended version of ORS 656.273(1). Consequently, we remanded for further proceedings regarding the compensability of claimant's aggravation claim for his bilateral arm condition. Jason S. Palmer, 47 Van Natta 1698 (1995).

On remand, the ALJ adhered to his previous conclusion that claimant had established a compensable aggravation claim supported by objective findings. The ALJ reasoned that, since there was no prior permanent disability award, which would indicate that there was no permanent impairment that might produce future symptom flare-ups, it could not be said that any symptomatic worsening was anticipated. The ALJ concluded that future symptomatic worsening would necessarily be greater than "anticipated" and, therefore, constituted an actual worsening under ORS 656.273(1).

The employer argues that the ALJ erred by concluding that, in cases without a prior award of permanent disability, symptomatic worsening alone is sufficient to establish an actual worsening under ORS 656.273(1). The employer also contends that the ALJ erred by concluding that claimant had objective findings of an actual worsening. We agree that claimant has sustained an actual worsening of his compensable condition, but do so based on the following reasoning.

Former ORS 656.273(1) provides, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings." (Emphasis supplied).

Under that statute, the court defined "worsened condition" as a symptomatic or pathological worsening which resulted in either diminished earning capacity, in the case of an unscheduled condition, or increased loss of use or function, in the case of a scheduled condition. See Fred Meyer, Inc. v. Farrow, 122 Or App 164 (1993). A claimant could establish a "worsened condition" by showing worsened symptoms without showing a worsening of the underlying condition. Consolidated Freightways v. Foushee, 78 Or App 509 (1985), rev den 301 Or 388 (1986).

In 1995, the Legislature amended ORS 656.273(1) to read in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence **of an actual worsening of the compensable condition** supported by objective findings." (Added language in bold-face type).

In Carmen C. Neill, 47 Van Natta 2371 (1995), we found that the 1995 amendments to ORS 656.273(1) did not define the term "actual worsening," nor was it a term defined by prior case law. Consequently, we turned to the legislative history for guidance. After reviewing the history, we said that, while some of Representative Mannix's comments seemed to indicate that a pathological worsening of the underlying condition was required to establish an "actual worsening," other comments acknowledged that a symptomatic flare-up could constitute an "actual worsening" under certain circumstances, i.e., if the flare-up was greater than anticipated by the prior permanent disability award. We concluded that an "actual worsening" is established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the compensable condition that is greater than anticipated by the prior award of permanent disability.

In reaching the latter conclusion, we relied on certain comments by Representative Mannix which indicated that a symptomatic flare-up could constitute an actual worsening, as well as the text of ORS 656.273(8), which was not amended by Senate Bill 369, and provides that where a worker has received a permanent disability award, an aggravation is established if it is shown "that the worsening is more than a waxing and waning of symptoms of the condition contemplated by the previous permanent disability award."

Here, it is undisputed that claimant's original claim for bilateral overuse syndrome of the hands and wrists was accepted by the employer in March 1991 as a nondisabling claim. Consequently, there was no prior award of permanent disability. After claimant returned to work for the employer in September 1993, his upper extremity symptoms returned and he stopped working on July 25, 1994 because of his symptoms. Claimant sought to reopen his claim.[2]

Claimant does not contend, nor does the medical evidence establish, that he suffered a pathological worsening of the underlying condition. In Carmen C. Neill, supra, we did not specifically address whether "actual worsening" includes a symptomatic worsening of a condition for which no permanent disability benefits have been awarded. Therefore, the issue in this case is what constitutes an "actual worsening" in the absence of a prior permanent disability award.

As we stated earlier, under ORS 656.273(1), a worsened condition is an "actual worsening of the compensable condition." The text of the 1995 amendments to the Workers' Compensation Act, Or Laws 1995, ch 332, does not define "actual worsening," nor is it a term defined by prior case law. Carmen C. Neill, supra, 47 Van Natta at 2374. Therefore, we turn to the statutory context.

ORS 656.273(8), which was not amended by Senate Bill 369, provides:

> "If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." (Emphasis added).

The application of ORS 656.273(8) is contingent on a previous permanent disability award. Thus, the statute does not apply in the absence of a prior permanent disability award. ORS 656.214(7) now provides that "[a]ll permanent disability contemplates future waxing and waning of symptoms of the condition." This provision is also contingent on a prior award of permanent disability and is likewise not applicable in cases where no permanent disability has been awarded. Even though ORS 656.273(8) and 656.214(7) are not applicable to this case, we are still left with the task, as a fact-finder, of determining whether claimant sustained an "actual worsening" of his compensable condition.

Although much of the legislative history focused on the situation where a worker had received a prior permanent disability award, there is some discussion regarding symptomatic worsening that is helpful in determining when such a worsening would be considered an "actual worsening." In the March 3, 1995 meeting of the House Labor Committee, Representative Mannix offered the following observation:

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[2] Under ORS 656.277(2), "[a] claim that a nondisabling injury originally was or has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation." Since claimant's claim for reopening was more than one year after the "date of injury," it was necessary for claimant to make a claim for aggravation pursuant to ORS 656.273.

> "This is designed to close the back door aggravation claims where you say even though I'm not worse, I've had more waxing and waning of symptoms than was contemplated. And we get into that. In the aggravation statute we get back to no, ask the doctor has your condition worsened. Condition. It's a code word. Worsened is a code word. Waxing and waning of symptoms is a code phrase, too, because a doctor can give us the opinion based on their medical history, their prior examinations, what they expected in terms of waxing and waning symptoms. And let's be frank about this. At some point somebody's symptoms will have increased so much that the doctor's going to come to the conclusion that there is actually a worsening of the condition. Let the doctor say so. But let's not say that there are any other assumptions that somehow meant to having just the waxing and waning of symptoms reported that meant you have an aggravation. Ask the doctor the question about the aggravation." Tape Recording, House Committee on Labor, March 3, 1995, Tape 42, side A. (Emphasis added).

In light of this testimony, and our reasoning in Carmen C. Neill, supra, we continue to conclude that the legislative changes were not meant to completely eliminate symptomatic worsening as a basis for establishing a compensable aggravation.[3]

We continue to hold that an "actual worsening" is established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the compensable condition that is greater than anticipated by the prior award of permanent disability. Carmen C. Neill, supra. To determine whether a symptomatic worsening, in the absence of a prior permanent disability award, does constitute an "actual worsening" we offer the following: If the persuasive medical evidence establishes that a symptomatic increase does in fact represent a worsening of the condition then an "actual worsening" has been established.[4]

A question remains concerning the effect of amended ORS 656.273(1) on the prior case law. Under the previous case law, the phrase "worsened condition" in former ORS 656.273(1) was defined as a symptomatic or pathological worsening which resulted in either loss of earning capacity, in the case of unscheduled condition, or loss of use or function, in the case of a scheduled condition. See Fred Meyer, Inc. v. Farrow, 122 Or App 164 (1993). That is, in order to establish a compensable aggravation, a claimant not only had to establish a physical worsening, but also prove that the physical worsening had caused diminished earning capacity or increased loss of use or function.

In amending ORS 656.273(1), the legislature has now defined "worsened condition" as an "actual worsening of the compensable condition supported by objective findings." While the specific intent of this language change is not apparent on its face, the legislative history supports a conclusion that it was intended to focus on the worker's physical condition, rather than on a loss of earning capacity or loss of use or function in a legal sense. In this regard, Representative Mannix's testimony before the Senate Committee on Labor and Government Relations is instructive. He stated:

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[3] We acknowledge, as we did in Carmen C. Neill, supra, that Representative Mannix also testified that an aggravation ought to be a "pathological worsening." Representative Mannix made that comment after he was asked whether ORS 656.214(7) would be more appropriately placed in ORS 656.273. Representative Mannix's comment indicates that he was comparing an aggravation to a waxing and waning of symptoms:

> "Well, that's where I think that moving this over to the section dealing with ORS 656.273, the aggravation statute, might be appropriate because this is really intended to take the subjectivity out of the question of aggravation. Aggravation ought to be a pathological worsening and the doctor can tell you whether or not there's been a pathological worsening. It shouldn't be well, gee, this person's had symptom swings and we're trying to nail down that point. Waxing and waning of symptoms does not mean that the person has had an aggravation. So maybe it's best to put this language in there. Because then it's less subjective. What we've got is some objective standards and we're saying this subjectivity stuff doesn't rate an aggravation claim." Tape Recording, House Committee on Labor, March 3, 1995, Tape 41, side B.

[4] In interpreting a statute, "words of common usage should be given their plain, natural and ordinary meaning." PGE v Bureau of Labor and Industries, supra, 317 Or at 611. "Actual" commonly means "existing in fact or reality" Webster II New Riverside University Dictionary, (1984). Thus, the plain language of the statute indicates that the worsening of a compensable condition must be established "in fact." This is consistent with our conclusion of what constitutes an "actual worsening."

> "ORS 656.273(1) is a significant change in the law. All changes to .273 are significant in the sense that they are trying to tell the courts what we thought we told them many times over as to what is an aggravation. An aggravation is a worsening of the compensable condition; that is, it's attributable to the industrial injury, a worsening of the condition. I would like to say the word condition a hundred times, but I won't. The courts keep insisting on coming up with alternatives, even though the last time I counted I think worsened condition is used seven times in the statutes to refer to aggravation. They keep coming up with alternative views of what is an aggravation. Doctors know what a worsened condition is. We should know what a worsened condition is and a worsened condition is not a flare-up of symptoms. Enough said." Tape Recording, Senate Committee on Labor and Government Operations, January 30, 1995, Tape 15, Side B.

In sum, we conclude that in order to establish an actual worsening under ORS 656.273(1), a claimant must establish, by medical evidence supported by objective findings, that he/she has suffered either (1) a pathological worsening of the compensable condition; (2) a symptomatic worsening of the compensable condition that is greater than contemplated by the prior permanent disability award; or (3) a symptomatic worsening, in the absence of a prior award of permanent disability, where the medical evidence establishes that the increased symptoms represent a worsening of the compensable condition. We now apply this analysis.

Dr. Neumann examined claimant on August 4, 1994 and August 18, 1994 and reported positive Tinel's and Phalen's signs bilaterally. (Ex. 10). Dr. Neumann noted that claimant showed some improvement after being off work for a month and he advised claimant to avoid keyboarding for another month. (Exs. 10, 10B). On August 23, 1994, Dr. Neumann signed a "certificate of disability" that listed positive Tinel's and Phalen's signs as objective medical findings. (Ex. 10E). On the same date, Dr. Neumann wrote to the employer and stated that claimant's "symptoms arising from his computer work do represent a material worsening of his condition." (Ex. 10G). Dr. Neumann indicated that claimant's treatment was curative rather than palliative and he authorized time loss.

Dr. Rung, a physical medicine and rehabilitation specialist, is claimant's current treating physician. Dr. Rung first examined claimant on September 23, 1994 for complaints of pain in both wrists and forearms. Dr. Rung found tenderness over the origin of the wrist flexor muscle group in the volar forearm and over the origin of the wrist extensor muscle group over the lateral epicondyle. (Ex. 15). Claimant had a positive Finkelstein test on the right and tenderness in the mid-dorsal forearm along the extensor tendon. Dr. Rung also found weaker strength in claimant's right hand, compared to the left, noting that claimant was right-handed. Dr. Rung prescribed occupational therapy and released claimant to modified work. In a report to the employer, Dr. Rung agreed with Dr. Neumann's authorization of time loss from July 25, 1994 to September 23, 1994, and she also agreed that the symptoms arising from claimant's computer work represented a material worsening of his condition. (Ex. 15A).

Dr. Rungs' and Dr. Neumann's opinions that claimant's symptomatic increase represented a worsening of the underlying condition is supported by a comparison of claimant's condition in April 1991 and August/September 1994. In this regard, claimant was restricted to 5 hours of keyboarding work in April 1991, but was subsequently restricted from all keyboarding work by both Dr. Neumann and Dr. Rung from July 25, 1994 through September 23, 1994. Thereafter, Dr. Rung restricted claimant's keyboarding activity to 30 minutes at a time. Applying the "actual worsening" analysis previously described, we hold that based on the opinions of Dr. Rung and Dr. Neumann, claimant has established that his compensable condition "actually worsened" in the fall of 1994.

Finally, relying on the opinion of Dr. Stevens, the employer argues that claimant did not have objective findings of an actual worsening. We disagree.

To begin, Dr. Steven only examined claimant one time in October 1994. (ex. 19). Moreover, his conclusion that claimant did not have "current, objective finding" did not address claimant's condition in August and September 1994 when evaluations by Dr. Neumann and Dr. Rung produced positive

examination findings.[5] In addition, at the time claimant was examined by Dr. Stevens, claimant had received medication and physical therapy and was performing modified work. For these reasons, we are not persuaded by Dr. Stevens' opinion.

In any event, Dr. Rung reported that claimant consistently showed findings of tenderness on most occasions over the right and left lateral epicondyles and right medial epicondyle at the elbows. (Ex. 24B). In addition, Dr. Rung "took dynamometer strength measurements on several occasions, and he consistently showed lower grasp strength on the right than on the left." (Id.) Under ORS 656.005(19), objective findings may include reduced muscle strength. In light of Dr. Rung's findings that claimant's hand strength measurements were consistently lower on the right than on the left, (Ex. 24B), we conclude that there were objective findings of a worsening. Furthermore, since Dr. Rung's findings of claimant's strength measurements were measurable, they are not excluded from the definition of objective findings under amended ORS 656.005(19).[6] See Gayle A. Jaynes, 48 Van Natta 758 (1996) (tenderness to palpation, limited ranges of motion and positive impingement testing were sufficient to constitute "objective findings" because the findings were measurable and observable); compare Jairo J. Garcia, 48 Van Natta 235 (1996) (no "verifiable indications of injury" where the claimant's treating physician indicated that the claimant had pain but all other findings were normal).

Because Dr. Rung is claimant's treating physician and because her report is well-reasoned, we are persuaded by her opinion that claimant has objective findings of an actual worsening of his compensable bilateral arm condition. In reaching this conclusion, we specifically rely on Dr. Rung's findings of decreased strength and therefore we offer no opinion regarding whether the positive Phalen's and Tinel's signs, reported by both Dr. Neumann and Dr. Rung, would constitute objective findings under amended ORS 656.005(19).

In sum, we conclude that, based on Dr. Rung's reports, as supported by Dr. Neumann's opinion, claimant has established that the symptomatology of the bilateral overuse syndrome of the hands and wrists has worsened to the extent that it represents an actual worsening of his compensable condition. Accordingly, we conclude that claimant has established a compensable aggravation claim.[7]

Attorney Fees

The ALJ awarded claimant a total assessed attorney fee of $3,000 for his counsel's services at hearing. On review, claimant argues that the ALJ failed to award an assessed fee for his attorney's work prior to the Board's remand order, Jason S. Palmer, 47 Van Natta 1698 (1995). We agree.

Under ORS 656.388(1), claimant is entitled to an attorney fee award for his counsel's services before every prior forum, which includes claimant's counsel's services on Board review of the ALJ's

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[5] To the extent that Dr. Neumann opined that claimant did not have objective findings, we do not rely on his opinion. In this regard, Dr. Neumann initially opined claimant had positive Tinel's and Phalen's signs which were objective findings. (Ex. 10E). He later indicated that claimant did not have any objective findings. (Exs. 11, 13). Dr. Neumann did not explain his change of opinion, nor did he explain why, if claimant had no objective findings, he authorized claimant's disability status. Since Dr. Neumann did not explain his apparent change of opinion regarding claimant's objective findings, we assign his opinion little probative value as to whether claimant exhibited objective findings. Compare Kelso v. City of Salem, 87 Or App 630 (1987) (physician had a reasonable explanation for change of opinion).

[6] The employer argues that claimant's strength measurements are not "reproducible" because, when Dr. Stevens measured claimant's grip strength, he found that right hand was stronger than the non-dominant left hand. (Ex. 19-2). We need not resolve this contention because we find that the strength measurements constitute "measurable" findings. In reaching this conclusion, we are not persuaded by the employer's argument because Dr. Rung's conclusion was based on her strength measurements on several occasions, not those of other physicians. (Ex. 24B). Based on Dr. Rung's findings, claimant's strength measurements were "measurable."

[7] We note that ORS 656.273(1)(a) provides, in part, that a worsened condition is not established by "[t]he worker's absence from work for any given amount of time as a result of the worker's condition from the original injury[.]" Here, claimant has not merely missed work because of his condition. Rather, the persuasive medical evidence establishes that claimant's symptoms have worsened to the point that it represents an actual worsening of the compensable condition.

initial order that eventually resulted in the Board's Order on Review (Remanding). After considering the factors in OAR 438-015-0010(4) and applying them to this case, we find that $1,000 is a reasonable attorney fee for claimant's counsel's services during the first Board review. In reaching this conclusion, we have particularly considered the time devoted to the aggravation issue (as represented by claimant's initial respondent's brief), the complexity of the issue, the nature of the proceeding and the value of the interest involved. Accordingly, the ALJ's attorney fee award of $3,000 is modified. In addition to the ALJ's award, claimant is awarded an attorney fee of $1,000 for his counsel's services during the initial Board review, to be paid by the self-insured employer.

Claimant's attorney is also entitled to an assessed fee for services on this current Board 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 current respondent's brief), the complexity of the issue, the nature of the proceedings and the value of the interest involved. We note that no attorney fee for services on review is available for that portion of claimant's counsel's services devoted to the attorney fee issue.

ORDER

The ALJ's order dated April 5, 1996 is affirmed in part and modified in part. The ALJ's attorney fee award is modified. In addition to the ALJ's award, claimant's counsel is awarded an attorney fee of $1,000, to be paid by the self-insured employer. The remainder of the ALJ's order is affirmed. For services on review concerning the aggravation issue, claimant's attorney is awarded $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
JAMES P. MISHLER, Claimant
WCB Case No. 96-02217
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's injury claim for a herniated C6-7 disc. In his brief, claimant contends that the ALJ erred in failing to award penalties or attorney fees for an allegedly unreasonable discovery violation. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

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

On December 5, 1995, claimant reported pain in his left upper arm. (Ex. 3-3). On December 27, 1995, claimant sought treatment for shoulder and neck pain. (Ex. 3-4). On January 4, 1996, claimant reported pain in the left shoulder radiating down the arm, which was made worse by tilting or turning his head, and numbness in the thumb and index finger. (Ex. 5). Claimant denied any injury to Dr. Bohme or to Dr. Ash, to whom he had been referred. (Exs. 5, 6, 17).

On January 18, 1996, Dr. Bohme filed a Form 827 with the insurer. On the form, claimant stated that he had injured himself on December 27, 1995, after lifting a heavy car transmission. (Ex. 9). On January 22, 1996, claimant filed a Form 801 with the employer, in which he stated that his neck injury occurred on December 22, 1995, when he lifted a transmission into the back of a truck to transport it for repairs. (Ex. 4).

On February 7, 1996, Dr. Schmidt, neurological surgeon, examined claimant. (Ex. 10-2).

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ determined that claimant injured his neck as a result of lifting at work and concluded that claimant had met his burden of proving that the industrial injury was the cause of the left herniated C6-7 disc. Therefore, the ALJ set aside SAIF's denial of claimant's herniated disc as an industrial injury. SAIF contends that claimant did not injure his neck when he lifted at work. We agree.

We briefly recap the relevant facts. In October 1995, claimant sought treatment for upper back pain and a stiff neck and shoulder that came on without injury. In early December 1995, Dr. Bohme reported that claimant continued to experience occasional left shoulder problems and pain in the left upper arm. On December 27, 1995, claimant again sought treatment for shoulder and neck pain. On January 4, 1996, claimant complained of pain in the left shoulder radiating down the left arm, with numbness in two fingers. Claimant denied any injury to Dr. Bohme or Dr. Ash, who reported a history of gradual soreness that spread down claimant's arm from his left shoulder since early December. A January 11, 1996 MRI revealed a degenerative condition in claimant's neck, including a disc bulge at C5-6 and a herniated disc at C6-7.

On January 18, 1996, Dr. Bohme submitted a Form 827 in which claimant indicated that his neck was injured as a result of lifting a heavy transmission at work on December 27, 1995. On January 22, 1996, claimant filed a Form 801, in which he stated that he injured his neck after lifting a transmission into the back of a truck on December 22, 1995.

Claimant testified that he lifted a transmission on two occasions about a week apart in early December 1995, and that these lifting incidents were the cause of his herniated disc condition. Claimant testified that he did not experience any symptoms at the time of the lifting incidents, but that pain developed two to three days later and a short time after that, he couldn't work anymore. (Tr. 13, 14, 15, 33). Claimant left work on December 22, 1995.

Claimant also testified that, some time after the lifting incidents, he thought that lifting the transmissions must have been the cause of his neck problem, because that was the only thing that occurred during that time that could have caused the problem. (Tr. 33, 34).

The question presented on review is whether claimant injured his neck while lifting a transmission. The ALJ found that claimant's demeanor at hearing "was not such as to inspire great confidence." Nevertheless, the ALJ concluded on the basis of the record as a whole, that claimant probably lifted something heavy at work close to his last day on the job, reasoning that the alleged mechanism of injury was at least medically possible.

We generally defer to an ALJ's demeanor-based credibility finding and do so in this case. However, unlike the ALJ, we find claimant's testimony that he injured his neck in lifting incidents at work inconsistent with the contemporaneous medical documentation, as evidenced by the medical reports discussed below. 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).

Claimant has treated for left shoulder and neck symptoms since October 6, 1995. (Exs. 1, 3-1). On December 12, 1995, Dr. Bohme noted pain in the left upper arm. (Ex. 3-3). On January 4, 1996, when claimant reported pain in the left shoulder radiating down the arm with finger numbness, Dr. Bohme reported that claimant denied an injury. (Ex. 5). Dr. Ash also reported that claimant denied any neck injuries, instead reporting a history of left shoulder soreness that improved, then reappeared in early December and gradually spread down claimant's left arm. (Ex. 7). In February 1996, Dr. Schmidt also reported the same gradual onset of symptoms. (Ex. 10).

However, on January 18, 1996, Dr. Bohme apparently changed his mind regarding the onset of claimant's condition, when he submitted a Form 827 in which claimant stated that his neck injury resulted from the lifting of heavy transmissions. (Ex. 9). Dr. Bohme subsequently explained that claimant had reported to him that he had pain in the left shoulder radiating down the left arm after lifting a heavy transmission. Dr. Bohme expressed confusion as to the origin of his January 4, 1996 note that claimant had not experienced any injury, although he stated that claimant had not provided him with any extended details regarding on-the-job activities. (Ex. 18).

Dr. Schmidt stated that he had obtained a history that claimant had had some left sternal pain radiating up to his left shoulder which had been diagnosed as a muscular-type injury which improved. Claimant was then relatively asymptomatic for more than a month when he developed pain in his left shoulder and triceps just before Christmas and, within a week or two, the pain radiated down his arm. Dr. Schmidt "vaguely recalled" that the onset of claimant's symptoms may have been related to manipulation of a transmission, but he did not record that information or question claimant about his work history. Dr. Schmidt deferred to Dr. Bohme's or Dr. Ash's history. Dr. Schmidt further opined that it was unclear whether claimant's October symptoms represented a muscular injury or the beginning of a cervical disc problem. He stated that if claimant could accurately date the onset of his symptoms to picking up a transmission, then he would relate his condition to his work activity.

Dr. Ash, in contrast, stated that if there had been a reasonable possibility of work being the cause of claimant's condition, he would have advised him to file a workers' compensation claim. Dr. Ash averred that claimant had not reported a work injury to him, and, based on the history claimant did report to him, work was not a consideration. Dr. Ash further opined that claimant's disc herniation was not caused by work, reasoning that a disc herniation is generally caused by either degeneration of the disc or trauma, such as a blow to the neck, and that lifting heavy objects would not have caused a herniated disc in the neck. In addition, Dr. Ash also indicated that, based upon the MRI findings and his examination, claimant's complaints of left shoulder bursitis and cervical strain were consistent with claimant's left C6-7 disc herniation. (Ex. 17).

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 various medical practitioners, we are not persuaded that claimant injured his neck when he lifted a transmission, particularly since claimant reported no injury when he first sought treatment for his radicular pain and testified that he did not experience any symptoms at the time of the lifting incidents. Moreover, his subsequent reports to Dr. Bohme and Dr. Schmidt regarding the onset of his condition in relation to work are given little weight in light of claimant's testimony that, some time after the lifting incidents, he thought that lifting the transmissions must have been the cause of his neck problem, because that was the only thing that occurred during that time that could have caused the problem. On this record, claimant has failed to meet his burden of proving a herniated disc injury.

Discovery Violation

At hearing, claimant requested a penalty based upon SAIF's alleged discovery violation. However, even if the record did establish a discovery violation, the underlying claim is not compensable. Therefore, there has been no unreasonable resistance to the payment of compensation. James G. Harris, 47 Van Natta 2367 (1995). Under such circumstances, claimant is not entitled to a penalty pursuant to ORS 656.262(11). Boehr v. Mid Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991).

ORDER

The ALJ's order dated July 8, 1996 is reversed in part and affirmed in part. That portion of the order setting aside the SAIF Corporation's denial is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
FERRAL C. CROWDER, Claimant
WCB Case No. 94-12846
CORRECTED ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
David O. Horne, Defense Attorney

It has come to our attention that our November 21, 1996 Order on Review contains a clerical error. Specifically, the opening paragraph refers to Administrative Law Judge "Crumme's" order when, in fact, Administrative Law Judge "Hoguet" authored the appealed order.

To correct this oversight, our prior order is withdrawn and, as corrected herein, republished (including the concurring and dissenting opinion). The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 4, 1996 Cite as 48 Van Natta 2403 (1996)

In the Matter of the Compensation of
JUDITH R. KING, Claimant
Own Motion No. 96-0195M
OWN MOTION ORDER ON RECONSIDERATION
Reeves, Kahn & Eder, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our November 19, 1996 Own Motion Order, in which we declined to authorize the payment of temporary disability compensation because claimant failed to establish that she was in the work force at the time of disability. Contending that, in our November 19, 1996 order, we "found that claimant[']s requested surgery became necessary in March of 1996," claimant requests that the Board authorize claimant's requested surgery and "award an attorney fee for overturning the denial of the surgery." We deny claimant's request.

The Board's Own Motion authority is provided under ORS 656.278. That statute provides that the Board may authorize temporary disability compensation for claimants whose aggravation rights have expired, and who establish a worsening of a compensable injury requiring surgery or inpatient hospitalization. In our prior order, we found that claimant's treating physician recommended surgery in March 1996. However, contrary to claimant's contention, the Board did not find that the requested surgery became necessary in March of 1996. Rather, we found that a request for surgery had been made by Dr. Takacs. Therefore, we concluded that claimant's accepted injury required "either inpatient or outpatient surgery or other treatment requiring hospitalization" pursuant to the requirements set forth in ORS 656.278.

Jurisdiction over the reasonableness and necessity of medical services currently resides solely with the Director subsequent to enactment of Senate Bill 369. Thus, the Board has no jurisdiction to authorize the surgery. See amended ORS 656.245(6), 656.260, 656.327 and 656.704(3). Therefore, claimant is correct in her contention that the Board "failed to authorize the surgery" in this claim, as we have no jurisdiction to make such a determination.

The dispute regarding the reasonableness and necessity of claimant's proposed surgery apparently remains unresolved. Thus, assuming *arguendo* that claimant could establish that she was in the work force at the time of disability (a conclusion at odds with the determination reached in our previous order), because it has not been determined whether SAIF is responsible for claimant's proposed medical treatment, we would still be without authority to authorize temporary disability compensation for a surgery which remains in dispute.

Claimant requests an attorney fee award for "overturning the denial of the surgery" in this claim. As we previously stated, the Director, rather than the Board, has sole authority to set aside a denial of medical services under ORS 656.245, 656.260 and 656.327. Therefore, because we have not "overturned the denial of surgery" in claimant's 1988 injury claim, claimant's attorney is not entitled to an attorney fee award. Further, attorney fee "awards" under ORS 656.278 are controlled by OAR 438-015-0010(4) and 438-015-0080. Had claimant prevailed in her claim for temporary disability compensation, claimant's attorney would have been entitled to a 25 percent out-of-compensation fee, not to exceed $1,050. Here, we have not authorized such a fee because claimant has not established entitlement to temporary disability compensation in her 1988 claim with SAIF.

Accordingly, our November 19, 1996 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 19, 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
THOMAS P. NOTT, Claimant
Own Motion No. 96-0072M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Scheminske, et al, Defense Attorneys

Claimant, pro se, requests review of the insurer's August 23, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from October 11, 1995 through January 9, 1996. The insurer declared claimant medically stationary as of January 9, 1996. Claimant does not dispute that he was medically stationary when his claim was closed. However, claimant contends that he was not medically stationary on January 9, 1996, when the insurer declared him medically stationary and terminated temporary disability compensation.

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 a July 30, 1996 letter, Dr. Thompson, claimant's treating physician, opined that claimant's right knee condition was medically stationary. In an August 6, 1996 letter, Dr. Thompson noted that, in his July 30, 1996 letter to the insurer, he had opined that claimant's right knee was medically stationary, but that claimant's knee had "improved with less vigorous activity." In an August 22, 1996 "check-the-box" response, Dr. Thompson indicated that he last examined claimant on January 9, 1996, and that claimant was medically stationary on that date. In an August 26, 1996 letter, Dr. Thompson clarified his "check-the-box" response, and opined that claimant was medically stationary at the time of his August 6, 1996 examination because claimant's knee had "improved." In a November 13, 1996 letter, Dr. Thompson reiterated that, in his opinion, claimant was not medically stationary on January 9, 1996, and further opined that, because claimant's knee condition had improved by August 6, 1996, claimant was actually medically stationary on that date.

Citing Scheuning v. J.R. Simplot & Co., 84 Or App 622, 625 (1987) and Alvarez v. GAB Business Services, 72 Or App 524 (1985), the insurer contends that Dr. Thompson's opinion that claimant was medically stationary at a time subsequent to January 9, 1996, is tantamount to an "after-the-fact" opinion, and that it "is irrelevant as evidence developed or obtained after claim closure may [be] considered but post closure changes in the claimant's condition cannot." Here, claimant's claim was closed on August 23, 1996. Therefore, Dr. Thompson's August 6, 1996 opinion that claimant was medically stationary on that date was rendered prior to claim closure. No "post-closure changes" in claimant's condition could have been considered. See Scheuning v. J.R. Simplot & Co., supra; Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985). Although Dr. Thompson's August 26, 1996 opinion was rendered several days after claim closure, the opinion merely clarified that he felt that claimant was medically stationary on August 6, 1996 (as does Dr. Thompson's November 13, 1996 letter). Finally, Dr. Thompson's medical opinion is unrebutted.

Accordingly, we modify the insurer's August 23, 1996 closure, to indicate that claimant was medically stationary on August 6, 1996.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICK G. MAHLBERG, Claimant
Own Motion No. 95-0313M
OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The self-insured employer requests reconsideration of our November 7, 1996 Own Motion Order, which authorized the reopening of claimant's 1984 injury claim for the payment of temporary disability compensation and authorized an approved attorney fee for claimant's attorney. Our order was based, in part, on the Director's September 23, 1996 Proposed and Final Contested Case Hearing Order, which affirmed the Department of Consumer and Business Services Medical Review Unit's January 1, 1996 order. The September 23, 1996 Director's order found that claimant's September 29, 1994 fusion revision surgery from L4 through S1 was appropriate medical treatment for claimant's compensable injury, and awarded claimant's attorney an assessed fee.[1] The employer further requests that the own motion matters be held in abeyance pending its appeal of the Director's September 23, 1996 order. On reconsideration, we deny the employer's request for the following reasoning.

Pursuant to OAR 438-012-0050, the Board's rules do not provide for holding a case in abeyance pending judicial review.[2] Our rules do provide, however, that, under extraordinary circumstances, "the Board may, on its own motion, reconsider any prior Board order." OAR 438-012-0065(3). Thus, in the event that the court (or the Director, on remand) were to find that claimant's 1994 surgery was not reasonable and necessary treatment for his compensable injury (and, thus, the employer not held responsible for claimant's 1994 surgery under his 1984 injury claim), the employer may request reconsideration under OAR 438-012-0065(3) at that time.

Accordingly, we withdraw our November 7, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our November 7, 1996 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] The Director's September 23, 1996 order noted that, as provided in ORS 183.460, the parties were entitled to file written exceptions to the Proposed and Final Contested Case Hearing Order within 30 days following the date of service of the order (by October 23, 1996). In the absence of exceptions, the order further provided that the decision would become final. The order also advised the parties that they would have 60 days from the date the hearing order became final within which to petition for Judicial review. (See ORS 656.327(2); ORS 183.310 to 183.550). No exceptions were filed prior to the expiration of the 30 day period. Thereafter, the employer petitioned the court for Judicial review. As with Board orders on review and cases pending under the Board's own motion jurisdiction in the same claim, it is the Board's intention to issue its Own Motion orders in tandem with Director's orders involving medical treatment disputes. In this manner, the aggrieved party may appeal both orders to the court, who will have the opportunity to consider both decisions which involve inter-related issues.

[2] OAR 438-012-0050 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 656.298, ORS 656.307 or ORS 656.308; or (3) the claimant's request for payment of 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. In that case, the Board may postpone its review of the merits of claimant's request for relief if the available remedies set forth above could affect the Board's authority to award compensation under the provisions of ORS 656.278. On October 6, 1995, the Board postponed action on the own motion request pending outcome of the medical services issue. The Director's order became final on October 23, 1996. Therefore, as claimant has exhausted his available remedy under ORS 656.327, under ORS 656.278 and our rules, the reasonableness and necessity of claimant's 1994 surgery has been determined, and it remains within our jurisdiction to award temporary disability compensation, beginning the date claimant underwent that surgery.

In the Matter of the Compensation of
SHANNON L. MATHEWS, Claimant
WCB Case No. 96-00328
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Claimant and the self-insured employer request reconsideration of our September 19, 1996 Order on Review which: (1) set aside the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel condition; and (2) awarded a $3,500 employer-paid attorney fee. Contending that our attorney fee award was inadequate, claimant asks that the award be increased to $5,000. Asserting that the majority of the persuasive medical evidence does not satisfy claimant's requisite burden of proof, the employer requests that we reconsider our compensability decision.

In order to consider the parties' motions, we withdrew our prior order on October 16, 1996. We now address the motions.

The employer's contentions were adequately addressed in our prior order. Accordingly, we adhere to the compensability portion of our September 19, 1996 Order on Review.

On reconsideration, claimant contends that a reasonable fee, based on typical assessed fees involving a bilateral carpal tunnel syndrome compensability case, would be $5,000 for services at hearing and before the Board, in light of the risk that his efforts might have gone uncompensated and his counsel's round trip travel between Medford and Klamath Falls for the hearing. Claimant's attorney has not submitted a statement of services.[1]

When we evaluate a case in order to assess a reasonable attorney fee, we evaluate each case on its own merits by applying the factors set forth in OAR 438-015-0010(4). These factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The file consists of 10 exhibits, three of which were provided by claimant. The hearing, which was held in Klamath Falls, lasted one hour and 45 minutes and consisted of 48 pages of hearing transcript. Three witnesses testified at hearing and oral closing arguments were presented. The issue in this case involved the compensability of claimant's bilateral carpal tunnel syndrome, which presents factual and medical questions of a complexity similar to those generally submitted for Board consideration. The value to claimant is significant, as it involves potential surgery. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner, identifying the relevant factual and legal issues for our resolution. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering claimant's contentions, we conclude that the fee of $3,500 awarded by our September 19, 1996 order is reasonable and appropriate in this case. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and claimant's counsel's submission), the complexity of the issue, the value of the interest involved, and the contingent risk that claimant's counsel may go uncompensated. See Schoch v. Leupold & Stevens, 144 Or App 259 (1996).

Claimant's attorney is also entitled to an assessed fee for services on reconsideration for defending against the employer's request for reconsideration regarding the compensability issue. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on reconsideration concerning the compensability issue is $200, 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 response to the insurer's request for reconsideration), the complexity of the issue, and the value of the interest involved. We have not considered claimant's attorney's services concerning the attorney fee issue.

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[1] We note that OAR 438-015-0029 provides a means by which a claimant's attorney may file a request for a specific fee, which the attorney believes to be reasonable, in order to assist the Board in determining on review the amount of a reasonable assessed fee for services at hearing and/or on Board review. This was not done in this case.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our September 19, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 4, 1996 Cite as 48 Van Natta 2407 (1996)

In the Matter of the Compensation of
ROSA P. SANTANA, Claimant
WCB Case No. 95-11346
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
John E. Snarskis, Defense Attorney

Reviewed by Board Members Christian and Hall.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. We change the first paragraph of the findings of fact to read:

> "Claimant, age 53 and right-hand dominant, underwent right carpal tunnel release surgery in the 1970's for numbness and tingling in her right hand. She testified that she had relief of symptoms following surgery."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's carpal tunnel syndrome (CTS) symptoms, rather than the underlying neuropathy, were the "disease" for the purpose of establishing an occupational disease claim under ORS 656.802(2)(a). See Georgia-Pacific Corp. v. Warren, 103 Or App 275 (1990), rev den 311 Or 60 (1991). Relying on the opinion of Dr. Ellison, the ALJ concluded that claimant's work activities were the major contributing cause of her left CTS.

The insurer argues that the ALJ erred by concluding that claimant's CTS symptoms were the "disease." The insurer asserts, however, that the medical evidence in this case does not turn on a distinction between symptoms versus the underlying condition. Rather, the insurer contends that the case hinges on the persuasive expert evidence on causation. The insurer argues that the opinions of Drs. Nathan and Wilson are the most persuasive and do not support compensability.

Claimant contends that Dr. Ellison's opinion persuasively establishes that her work activities are the major contributing cause of her left CTS. She also asserts that her need for surgery was for the symptoms and her left CTS is the "disease" for purposes of ORS 656.802.

We agree with the ALJ that claimant did not have a preexisting disease or condition in the left arm and, therefore, ORS 656.802(2)(b) does not apply. In order to establish an occupational disease claim, claimant must establish that employment conditions were the major contributing cause of the left CTS. ORS 656.802(2)(a). We need not decide whether claimant's symptoms are the "disease" because, even if we assume that claimant's symptoms were not the disease, we are persuaded by Dr. Ellison's opinion that claimant's work activities were the major contributing cause of her left CTS.

Dr. Ellison examined claimant on July 11, 1995 and diagnosed severe left CTS. (Ex. 4-5). Dr. Ellison requested authorization for surgery, commenting that claimant's condition was due to her repetitive work activities. (Id.) In an October 25, 1995 report, Dr. Ellison reported that claimant's work activities were "consistent with her symptomology and are the reason that she needs treatment at this time." (Ex. 12). Dr. Ellison explained:

> "The compression of the nerve at the wrist occurs secondary to increase in the carpal canal and this can be affected by flexion or extension maneuvers, and the activities which she describes are consistent with both of those mechanically inefficient positions." (Id.)

Dr. Ellison commented that claimant's home activities would not be expected to precipitate CTS. (Id.)

On April 12, 1996, Dr. Ellison reiterated that repetitive activities cause carpal tunnel syndrome. (Ex. 18). He based his opinion on research literature indicating that repetitive passive flexion and extension of the wrist increases carpal tunnel pressure and on his clinical experience that computer and keyboard work was related to the causation and progression of CTS. (Id.) Dr. Ellison disagreed with Dr. Nathan's assertion that it was impossible for the median nerve at the carpal tunnel to be affected by dorsiflexion. (Id.) Dr. Ellison considered other potentially causal factors, such as claimant's obesity, but found them to be "secondary" risk factors.

Dr. Dodds opined that claimant's repetitive hand activities at work were the major contributing cause of her left hand symptoms, although he commented that her age and obesity were likely contributory. (Ex. 13A). Dr. Thomson concluded that claimant's work activities were the major contributing cause of her CTS. (Ex.16).

The insurer relies on the opinions of Drs. Nathan and Wilson. Dr. Nathan concluded that the major contributing cause of claimant's symptoms and need for treatment was the neuropathic process. (Ex. 7-5). According to Dr. Nathan, claimant's avocational activities included assisting with chores on a cattle ranch and caring for her grandchild. (Id.) He commented that claimant's "vigorous activities at home" would be just as likely to develop symptoms as her work activities. (Id.) Dr. Nathan found no evidence that claimant's work activities had initiated, altered or accelerated the underlying neuropathies. (Id.)

At hearing, Dr. Nathan testified that claimant's work activities were not the major contributing cause of her left CTS and entrapment neuropathy. (Tr. 107). Dr. Nathan said that the location of claimant's neuropathy was independent of any activity of the wrist. (Tr. 111). Dr. Nathan testified that keyboarding activities involved muscles which had nothing to do with the median nerve. (Id.)

For the following reasons, we are not persuaded by Dr. Nathan's opinion. Dr. Nathan reported that claimant's avocational activities included assisting with chores on a cattle ranch and caring for her grandchild and he commented that claimant's "vigorous activities at home" would be just as likely to develop symptoms as her work activities. (Ex. 7-5). Claimant testified, however, that she did not do any ranch work, except that she occasionally drove the unloaded pickup truck. (Tr. 21, 26, 47). Claimant said that she did not tell Dr. Nathan that she was involved in the ranch work. (Tr. 21, 37). Claimant also testified that her son assumed most of the care for the grandson. (Tr. 22). We discount Dr. Nathan's opinion because he had an inaccurate history of claimant's non-work activities. Furthermore, we discount Dr. Nathan's opinion because he assumed that claimant had preexisting neuropathy in the left arm. (Ex. 15-2).

Drs. Wilson and Strum diagnosed left CTS. (Ex. 14). They reported that claimant's CTS was idiopathic and not related to her work activities. They opined that claimant's work activities were not the type of activities that would normally lead to CTS. (Id.) At hearing, Dr. Wilson testified that claimant's work activities were not the major contributing cause of her CTS. (Tr. 57, 58). He did not believe that typing was sufficiently hand intensive to cause CTS. (Tr. 62). Dr. Wilson thought claimant's age and obesity were probably more of a factor than any of claimant's work activities. (Tr. 61).

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).

Here, we find no persuasive reasons not to rely on Dr. Ellison's opinion. Dr. Ellison's opinion was based on a complete and accurate history. Moreover, Dr. Ellison's opinion is thorough and well-reasoned. Although Dr. Ellison considered claimant's risk factors, he concluded that her work activities were the primary contributing factor. Based on Dr. Ellison's opinion, we find that claimant has sustained her burden of proving that her left CTS 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 $2,900, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 20, 1996 is affirmed. For services on review, claimant's attorney is awarded $2,900, payable by the insurer.

December 5, 1996 Cite as 48 Van Natta 2409 (1996)

In the Matter of the Compensation of
HELEN M. CALLANDER, Claimant
WCB Case No. 94-10978
ORDER ON REVIEW
Emmons, et al, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Moller and Christian.

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

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

In her first order, the ALJ set aside the insurer's denial of claimant's aggravation claim, finding that claimant had sustained her burden of proving a compensable aggravation claim. In reaching this conclusion, the ALJ reasoned that the award of 15 percent unscheduled permanent disability in a Determination Order did not contemplate future waxing and waning and that claimant had experienced an acute flare-up of her low back condition in August 1994 which rendered her less able to work. The insurer sought Board review.

We noted that, subsequent to the ALJ's order, the 1995 legislature had amended ORS 656.273(1) to require that a "worsened condition" be established by evidence of an "actual worsening" of the compensable condition. We vacated the ALJ's order and remanded for further evidence taking. Helen Callander, 47 Van Natta 1626 (1995). We reasoned that the record was incompletely and insufficiently developed to determine whether claimant had sustained a compensable aggravation because the record was devoid of documentary or testimonial evidence regarding whether her low back condition had "actually worsened."

On remand, the ALJ found that claimant had failed to establish that her compensable low back condition had "actually worsened" since claim closure. Specifically, the ALJ determined that claimant's waxing of symptoms in 1994 did not exceed what was anticipated by her award of permanent disability. Thus, the ALJ upheld the insurer's denial of claimant's aggravation claim.

In response to the Board's remand for further evidence taking, the parties supplemented the record. Claimant obtained a January 6, 1996 medical report from Dr. Durrant, claimant's chiropractor. (Ex. 43). The insurer obtained an October 2, 1995 report from an examining physician, Dr. Duff. (Ex. 42). Claimant contends that Dr. Durrant's medical report satisfies her burden of proving an "actual worsening." We disagree.

An "actual worsening" under amended 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. Carmen C. Neill, 47 Van Natta 2371 (1995); see also Helen K. Lara, 48 Van Natta 469 (1996). 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."

Claimant received a 15 percent unscheduled permanent disability award for her compensable low back injury. Thus, future waxing and waning of her symptoms were contemplated. ORS 656.214(7); Annie M. Neuberger, 48 Van Natta 1492 (1996); Paul Bilecki, 48 Van Natta 97 (1996). If her low back condition has not pathologically worsened, claimant must prove that her waxing and waning is greater than that anticipated by the prior permanent disability award in order to establish a compensable aggravation. Carmen C. Neill, supra.

Dr. Durrant reported that, in August 1994, claimant was not able to function in normal day-to-day household activities, that she had to stop several times while driving to Dr. Durrant's office for treatment, and that her pain was "excruciating." (Ex. 43-1). Dr. Durrant also reported that claimant's lower extremities were "areflexic" in comparison to her condition at closure when she had regained lower extremity reflexes. Id. Dr. Durrant opined that claimant's loss of ability to function and very positive response to manipulative therapy "should satisfy" the statutory criteria. (Ex. 43-3). Moreover, Dr. Durrant stated that claimant's aggravation was most identifiable by increased pain and loss of function. Id.

However, Dr. Durrant did not opine that claimant's low back condition had pathologically worsened. Moreover, to the extent Dr. Durrant's report can be construed as supporting a symptomatic worsening of claimant's condition, we find it less persuasive than the medical opinion of Dr. Hubbard, who had the advantage of examining claimant both before and after claimant's alleged aggravation.

On September 16, 1994, while noting that claimant's lower extremities were "areflexic," Dr. Hubbard observed that claimant could walk on her heels and toes and concluded that "we are back where we were in April with no evidence of an anatomic cause for her complaints." (Ex. 30). Dr. Hubbard specifically noted that there were "no major differences in her exam...." Id. Because Dr. Hubbard examined claimant both before and after the alleged aggravation, his opinion is entitled to considerable weight. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Based on Dr. Hubbard's persuasive medical opinion, we find that claimant failed to prove a symptomatic worsening of her low back condition. In addition, we note that Dr. Doughton, who also treated claimant in September 1994, reported that claimant's symptoms were not a material aggravation and were identical to what she had been experiencing since her original injury, a statement with which Dr. Durrant agreed in her deposition. (Exs. 31, 39, 41-30).

Based on this record, we agree with the ALJ that claimant failed to satisfy her burden of proving a compensable aggravation.[1] We, therefore, affirm.

ORDER

The ALJ's order dated March 4, 1996 is affirmed.

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[1] Given our conclusion that the record does not establish a symptomatic worsening of claimant's low back condition, we need not address whether claimant's symptoms were greater than anticipated by her prior award of permanent disability.

December 5, 1996 Cite as 48 Van Natta 2410 (1996)

In the Matter of the Compensation of
RANDY S. HATLELI, Claimant
WCB Case No. 96-01350
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of claimant's left ankle injury claim. On review, the issue is whether claimant's injury arose out of and in the course and scope of his employment. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's left ankle fracture occurred within the course and scope of claimant's employment under the parking lot exception to the going and coming rule. However, reasoning that the injury was unrelated to an employment risk, the ALJ concluded that the injury is not compensable because it did not arise out of claimant's employment as a courier driver. We agree that the claim is not compensable, but base our conclusion on the following reasoning.

ORS 656.005(7)(a) provides that a " 'compensable injury' is an accidental injury * * * arising out of and in the course of employment. . . ." "The 'arising out of' prong of the compensability test requires that some causal link exist between the employee's injury and his or her employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366, (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." Krushwitz v. McDonald's Restaurants, 323 Or 520, 525-26 (1996). The two prongs are viewed "as two parts of a single 'work connection' analysis, in order to determine whether an employee suffered a compensable injury." Id. at 526 (citation omitted).

Claimant argues that the "special errand" exception to the going and coming rule applies to the facts of this case, bringing his injury within the course and scope of his employment. We disagree.

Under the "going and coming" rule, injuries sustained while an employee is traveling to or from work do not occur in the course of employment and, consequently, are not compensable. E.g., Cope v. West American Ins. Co., 309 Or 232, 237, 785 P2d 1050 (1990). The rule is grounded on the rationale 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 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).

The Supreme Court has recognized a number of exceptions to the going and coming rule which "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." 323 Or at 527. One such exception, the "special errand" exception, "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)." Id. at 527. However, "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." Id. at 528 (emphasis in original).

In this case, claimant's regular work for the employer as a courier driver involved travel. However, before his daily shift began, claimant regularly drove his own car from home and parked it at the employer's dispatch location. After parking the car,[1] claimant normally entered the employer's premises, visited with his co-workers (if he was early), then punched in on the time clock (at 3:15 p.m., the beginning of his shift), checked out a company van, and began driving his route.

On January 25, 1996, claimant received an early afternoon call from his supervisor, asking him to go to Northwest Natural Gas before beginning his regular work that day.[2] Claimant left his home at about 2 p.m., went to the gas company, spent a few minutes there in order to obtain instruction on the

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[1] There is no evidence that the area where claimant parked his car was a parking lot within the employer's control. Under these circumstances, the "parking lot rule" does not apply. See Norpac Foods, Inc. v. Gilmore, supra; compare Lisa M. Bean, 48 Van Natta 1216, 1217 n.2.

[2] Claimant was under the impression that his supervisor would "clock him in early" if he stopped at Northwest Natural Gas on his way to work. (Tr. 32). Claimant's supervisor testified that, although she asked him to check in at work and get a company van before going to the gas company, she did not forbid him from doing the errand on his way to work. (Tr. 21-22). She did not recall any telephone discussion of "punching him in" early. (Tr. 22). In any event, claimant was not "punched in" at the time of his injury.

gas company's alarm system, then proceeded to the employer's office. He parked his car on the street near the office about 45 minutes before his normal work shift was to begin. Upon exiting his car, claimant fractured his left ankle.

Claimant had performed a "special errand" for the employer before his injury on January 25, 1996. However, by the time claimant parked his vehicle, he was no longer performing that errand, nor was he "acting in the furtherance of the employer's business." He had simply arrived at work early, with no work-related business to attend to until his shift began at 3:15 p.m. There is no evidence that the employer had a right to control the claimant's travel in any respect at the time of the injury. We do not find that these circumstances "justify treating the employee as if he [] continued in the course of employment at the time of an injury that occurred while the employee was going to or coming from work." Id. at 527. Accordingly, we conclude that the "special errand" exception to the going and coming rule does not apply in the case. See id. at 528 ("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.")

Claimant's injury happened off the employer's premises when he exited his own vehicle before the beginning of his regular work shift. Considering the time, place, and circumstances, we cannot say that the injury occurred within the course and scope of claimant's employment. In addition, we agree with the ALJ that claimant's injury did not arise out of his employment[3] and we adopt his reasoning and conclusions in this regard. Because claimant has not established that his injury arose out of and in the course of his employment, i.e., that his injury is sufficiently work-related, the claim is not compensable.

ORDER

The ALJ's order dated May 23, 1996 is affirmed.

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[3] Claimant argues that the risk of exiting a vehicle is a risk of his employment as a courier driver. Although we agree that risks associated with exiting a company van during work hours would likely be risks of claimant's employment, we do not find that the risk of exiting claimant's own car on the way to work is similarly a risk of employment.

In the Matter of the Compensation of
GARY D. HORD, Claimant
WCB Case No. 95-09350
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Herman's order that set aside its partial denial of claimant's low back injury claim. On review, the issue is compensability.

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

We agree with the ALJ that claimant's January 6, 1995 injury was a material contributing cause of his subsequent disability and need for treatment for his low back and therefore that claimant has carried his burden under ORS 656.005(7)(a). In addition, we offer the following supplementation.

Several months after claimant's January 6, 1995 injury at work, physical therapy prescribed for his compensable left knee condition (resulting from the work injury) caused claimant's low back to become increasingly symptomatic. (Ex. 23). Deconditioning and altered gait (also resulting from the compensable knee injury) may also have contributed to claimant's low back problems. (Ex. 22).

Under these circumstances, based on Dr. Chapman's opinion, we further find that, insofar as the low back claim includes disability and treatment arising from medical treatment for the compensable knee injury and/or as an indirect result of that injury, claimant has carried any burden he may have under ORS 656.005(7)(a)(A). See Barrett Business Services v. Hames, 130 Or App 190, 196-97, rev den 320 Or 492 (1994) (Where a claimant suffers an injury as the direct result of reasonable and necessary treatment for 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)); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

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 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 29, 1996 is affirmed. For services on review, claimant is awarded an $800 attorney fee, payable by the insurer.

December 5, 1996 Cite as 48 Van Natta 2413 (1996)

In the Matter of the Compensation of
CARRIE RAMEY, Claimant
WCB Case No. 94-10605
SECOND ORDER OF DISMISSAL
G. Joseph Gorciak III, Claimant Attorney

On November 8, 1996, we issued an Order of Dismissal dismissing claimant's request for review of an Administrative Law Judge (ALJ) Bethlahmy's order which affirmed the Department of Consumer and Business Services' determination that he was not a subject worker. Our order also remanded the claim to the Director for issuance of a corrected order. On our own motion, we have reconsidered our November 8, 1996 decision. After conducting our reconsideration, we withdraw our prior decision and replace it with the following order.

Board review of the ALJ's order was suspended to await issuance of the court's decision in Lankford v. Copeland, 141 Or App 138 (1996). Pending Board action, claimant also directly petitioned the Court of Appeals for judicial review of the ALJ's order.

On October 23, 1996, in response to claimant's motion, the court dismissed her petition for judicial review of the ALJ's order. Claimant has also moved for dismissal of her request for Board review of the ALJ's order. Asserting that we are without appellate review authority, the Department has joined in claimant's motion for dismissal. In accordance with claimant's request, we dismiss her pending appeal.

In taking this action, we note that in certain cases we have remanded to the Department for the issuance of a corrected order with the appropriate notice of appeal rights. See Cindy Lankford, 48 Van Natta 1870 (1996) (on remand from the Lankford court, a claimant's request for Board review of an ALJ's order affirming a Department "non-subjectivity determination" was dismissed and the case was remanded to the Department for the issuance of an order containing a correct notice of appeal); Vollina Draper, 48 Van Natta 1505, on recon 48 Van Natta 1862 (1996). However, in Lankford, we were remanding to the Department as expressly mandated by the court's decision. In Draper, we were dismissing a claimant's request for Board review where she had not also petitioned the court for judicial review of the ALJ's order.

Here, in contrast to the Lankford and Draper holdings, claimant has also filed a direct appeal of the ALJ's order with the Court of Appeals. Moreover, rather than expressly remanding the case to us for further action, the court has simply dismissed claimant's appeal. Since the court has appellate review authority over the ALJ's order and because it has dismissed claimant's petition for judicial

review, we conclude that we are not authorized to remand this case to the Department.[1] See David Grey, 48 Van Natta 2177 (1996) (Board review of a claimant's appeal from an ALJ's "non-subject worker determination" dismissed without remand to the Department because the Court of Appeals had previously affirmed the ALJ's order.)

IT IS SO ORDERED.

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[1] Although it is not apparent from claimant's unqualified motions for dismissal of its appeals to the court and Board, it is conceivable that she assumes that the ALJ's order will be automatically remanded to the Department for the issuance of an order containing the correct notice of appeal rights. Should that be claimant's unstated assumption, for the reasons expressed above, we are not authorized to take such an action under these particular circumstances. Instead, where, as here, a party has also filed a direct petition for judicial review of the ALJ's order, our authority to remand a case to the Department is dependent on the court's decision to return the appealed case to us with express instructions to remand to the Department for the issuance of a corrected order. In other words, in this situation, the "remand" authority originates from the court and, in the absence of such a directive, we cannot issue an order remanding this case to the Department.

In the Matter of the Compensation of
CARL M. SANDS, Claimant
WCB Case No. 95-13035
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld its denial of his claim for a herniated disc at L4-5. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Analyzing claimant's claim as an occupational disease claim, the ALJ concluded that claimant did not carry his burden of proving that his work activities were the major contributing cause of his herniated L4-5 disc condition. On review, claimant contends that his claim should be analyzed as an injury claim and, alternatively, that the medical evidence in the record is sufficient to carry his burden of proof under the "major contributing cause" standard. We agree with claimant's latter contention, and reverse.

To establish an occupational disease claim, claimant must prove that employment conditions were the major contributing cause of the disease (herniated disc condition). ORS 656.802(2)(a). Determination of the "major contributing cause" involves evaluating the relative contribution of different causes of the disease and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994) (applied the "major contributing cause" standard in the injury context). Claimant has the burden of proving his claim by a preponderance of the evidence. ORS 656.266. We find that the causation of claimant's herniated disc condition presents a complex medical question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993).

The medical evidence is divided. Expert medical opinions regarding the causation issue were submitted by Dr. Wiltse, claimant's family physician, and Dr. Goodwin, consulting neurosurgeon. Dr. Wiltse opined that the disc herniation was related in major part to claimant's work activity. (Ex. 16-15). Dr. Goodwin, on the other hand, could not state to a degree of medical probability that work activity was the major cause of the disc herniation. (Ex. 15, pp. 11, 13, 16). The ALJ was most persuaded by Dr. Goodwin's opinion because of his greater expertise concerning herniated disc conditions and because the ALJ was uncertain that Dr. Wiltse's history was as accurate and complete as Dr. Goodwin's. We disagree and rely, instead, on Dr. Wiltse's opinion for the following reasons.

Though a family physician, Dr. Wiltse was claimant's treating physician and had the unique opportunity to examine claimant's low back condition both before and after the onset of severe low back pain on October 1, 1995. On September 27, 1995, claimant saw Dr. Wiltse primarily for follow-up concerning a left shoulder problem. (Exs. 1-1, 16-6). At the same time, claimant complained of mild pain in the low back and right hip area. (Id.) Dr. Wiltse found tenderness in the right trochanter and sacroiliac area. (Id.) Claimant was treated with anti-inflammatories and returned to work the next day. (Id.) Claimant worked the next two days (September 28 and 29), operating the "notcher" machine; the work was repetitive and often fast-paced, and required pulling boards off the belt, frequent lifting of up to 30 pounds maximum, frequent twisting at the waist and occasional bending at the waist. On the evening of September 29, 1995, claimant felt tired and sore, particularly when bending at the waist; however, the symptoms were typical for a normal work day. (Tr. 23-24)..

The next morning (September 30, 1995), claimant's low back symptoms worsened significantly. He awoke with increased low back pain and was unable to bend. He stayed home from work to rest his back. (Tr. 24-25). The next day (October 1, 1995), he was not scheduled to work. While standing and talking to his father, his back stiffened and he was unable to sit or lie down. On October 2, 1992, he was carried into Dr. Wiltse's office with severe low back pain which the doctor described as "dramatic." (Ex. 16, pp. 7-9, 19; Tr. 30). Dr. Wiltse found muscle spasms and distinct radiculopathy which was significantly disabling. (Ex.16, pp. 7-9). Ultimately, claimant was diagnosed with a herniated disc at L4-5 for which he underwent surgery in February 1996.

Based on the significant worsening of claimant's low back symptoms between September 27 and October 2, 1995, Dr. Wiltse opined that the disc herniation was related in major part to work activity. (Ex. 16, pp. 9, 15). Relying on history that claimant performed only work activities during that interval, Dr. Wiltse reasoned that the disc herniation must have occurred in close temporal proximity (i.e., within a day or two) to October 2. (Ex. 16-19).

As the treating physician who examined claimant's low back both before and soon after the onset of his severe back symptoms, Dr. Wiltse was in the best position to evaluate the relative contribution of factors contributing to the low back condition. See Weiland v. SAIF, 64 Or App 810, 814 (1983); see also Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986) (greater weight accorded to physicians who observed the claimant's condition before and after the critical event).

In addition, unlike the ALJ, we are persuaded that Dr. Wiltse had an accurate and complete history. He knew of the work activities and off-work activities (i.e., car repair and porch construction) claimant performed in September 1995 before the onset of his severe pain. At one point in his deposition, Dr. Wiltse stated that if claimant's symptoms began during off-work activities, then the causation issue is "clouded." (Ex. 16-18). However, that statement is unreliable because he was asked to make an assumption which is not supported by the record. Specifically, Dr. Wiltse was asked to assume that claimant testified his back symptoms "gradually progressed" during September 1995. (Ex. 16-18). However, claimant testified that he had mild back symptoms in early September which remained largely constant until September 30.[1] (Tr. 71-72). In fact, Dr. Wiltse examined claimant specifically for his mild back pain on September 27. Moreover, the progression, or worsening, of back symptoms did not occur until after Dr. Wiltse's September 27 examination. Thus, Dr. Wiltse's history of a "dramatic" worsening occurring after work activities on September 28 and 29 was accurate.

We also disagree with the ALJ's finding that Dr. Wiltse's opinion was focused solely on the question of whether the work activity was the "precipitating factor" in the onset of the disc herniation. Rather, we are persuaded that Dr. Wiltse weighed the relative contribution of work and off-work activities and concluded the work activity was the major cause. He specifically excluded as a causative factor the car repair activity, which totaled three hours during the first week of September 1995, because of the substantial lapse of time between that activity and the onset of severe pain. (Ex. 16-13). He also excluded the porch construction as a causative factor based on history that claimant had no back problems after completing that activity. (Ex. 16, pp. 13-14). This history is supported by claimant's uncontroverted testimony at hearing that he had no physical problems after working on the porch. (Tr. 39). Because Dr. Wiltse's opinion is thorough and well-reasoned, we find it persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986).

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[1] We acknowledge that on cross-examination claimant agreed he had a "progression" of low back symptoms in September 1995. (Tr. 47). However, on redirect examination, it was clear that claimant did not understand the term "progression"; he testified that his symptoms remained the same during September. (Tr 71-72).

Finally, we note that Dr. Goodwin did not rule out work activity as the major causal factor. On the contrary, he opined that claimant's work activity could have caused the disc herniation. (Ex. 15-7). He was unable to say to a degree of medical probability that work activity was the major cause because the onset of pain did not coincide with work activity. (Ex. 15, pp. 10, 16). Thus, Dr. Goodwin's opinion alone would not carry claimant's burden of proof, but when it is considered in conjunction with Dr. Wiltse's opinion, we conclude that claimant has carried his burden of proof by a preponderance of the evidence in the record. Accordingly, we conclude the claim is compensable, and the insurer'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 $4,500, 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 claimant's attorney may go uncompensated.

ORDER

The ALJ's order dated June 21, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded an assessed fee of $4,500, to be paid by the insurer.

December 6, 1996 Cite as 48 Van Natta 2416 (1996)

In the Matter of the Compensation of
LOWELL D. ARMON, Claimant
Own Motion No. 96-0457M
OWN MOTION ORDER
Coughlin, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable large central perforation right tympanic membrane with conductive hearing loss injury. Claimant's aggravation rights expired on May 10, 1984. SAIF opposes reopening of the claim, contending that claimant was not 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 May 2, 1996, Dr. Petrusek, claimant's treating physician, recommended that claimant undergo surgery to open up the "meatus" in his ear "to allow better aeration of the canal and cavity." Surgery was scheduled for September 1996. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. 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). Claimant has the burden of proof on this issue, and must establish that he was in the work force during the relevant time period.

Claimant submitted an October 22, 1996 letter from Mr. Manwiller, an employer, who "confirm[ed] that [claimant] has been employed by me for casual labor during the past few months." In that letter, Mr. Manwiller specifically related that:

> "In February [1996, claimant] did some cat (bulldozer) work on my driveway and building pad. In September [1996, claimant] was employed to help design and construct a concrete pad for a wood stove."

Claimant submitted a copy of a February 14, 1996 check for $450 signed by Mr. Manwiller, which indicated that the check was tendered in payment for "cat work."

In his October 22, 1996 letter to the Board, claimant asserted that "I do work at small jobs when I am able." Claimant further contended that "I also maintain and keep the subdivision roads open during the winter months where I live, 'the South Fork River' when I am able."

With a November 13, 1996 letter, the SAIF claims adjuster forwarded to the Board information obtained by "further investigation in this claim." The SAIF investigator noted in writing that on November 12, 1996, he / she had verified with "Scott" (the owner of the bulldozer) that "when [claimant] does any cat work he pays rent to Scott for the use of the cat." The investigator further noted that on November 8, 1996, the investigator spoke with "Links," an employer, by telephone. The investigator noted that:

> "On 5/05/96[, claimant] performed minor cat work for [L]inks, opening up an area for additional parking. [Claimant] was paid $25.00, by check. Links left the pay to space open. When the check was returned[,] Links noticed it was made out to Ed Scott (the owner of the bulldozer)."

Here, claimant has established that he performed work for remuneration in May and in September of 1996. Therefore, we find that claimant was performing work at the time of disability. Because claimant has established that he worked, albeit sporadically, he is entitled to temporary disability to replace any lost wages, beginning the date of surgery. See Robert D. Hyatt, 48 Van Natta 2202 (1996) (the claimant was entitled to temporary partial disability when, although retired, the claimant established that he continued to work part-time).

SAIF further asserts that "[i]t appears as though [claimant] is on social security with only intermittent work, with great lapses," and thus, not entitled to temporary disability compensation. Although claimant may receive social security benefits, because we have concluded that claimant was working at the time of disability, we are not persuaded that the contention is pertinent to our inquiry.[1] Here, we do not find the receipt of social security benefits determinative, because claimant has established that he was working at the time of disability, and, thus, entitled to temporary disability benefits. See Robert D. Hyatt, supra.

Finally, SAIF contends that claimant is not entitled to temporary disability benefits because, although unable to work in the woods, he refused vocational services in 1988 which could have retrained him for "working on ground level." We find this argument unpersuasive because claimant has already established that he was working at the time of disability. Therefore, claimant's refusal of vocational rehabilitation or his choice of the "type" of work he performs is irrelevant if he has established that he was in the work force during the relevant time. See Marlene J. Andre, 48 Van Natta 404 (1996) (the claimant received vocational rehabilitation services, but her return to work was negatively affected by her lack of motivation or willingness to work); Martin L. Moynahan, 48 Van Natta 103 (1996) (the claimant refused work for which he was qualified and released, and thus, was not in the work force at the time of disability).

On this record, we conclude that claimant has established that he was in the work force at the time of disability.

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

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

Finally, claimant's attorney is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve such a fee unless claimant's attorney files a retainer agreement. See OAR 438-015-0010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

December 6, 1996 Cite as 48 Van Natta 2418 (1996)

In the Matter of the Compensation of
MARIA D. AVILA, Claimant
WCB Case No. 96-02675
ORDER ON REVIEW
Max Rae, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes, Christian and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) T. Lavere Johnson's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

Claimant's attending physician released claimant to regular work with no restrictions and found no permanent impairment. (Ex. 7). The medical arbiter panel found a limitation due to pain in repetitive use of the right shoulder, but provided no permanent limitations. (Ex. 10). Under such circumstances, regardless of whether "objective findings" support claimant's claim of permanent disability, we are not persuaded that claimant has any permanent impairment due to the accepted injury. Consequently, we agree with the ALJ's conclusion that claimant is not entitled to a 5 percent "chronic condition" award.

ORDER

The ALJ's order dated June 14, 1996 is affirmed.

Board Member Biehl dissenting.

The majority adopts the ALJ's order which declines to award claimant a 5 percent chronic condition award for his right shoulder injury. I disagree with the majority's decision.

First, I disagree with the ALJ's reliance on Christopher R. Garza, 47 Van Natta 99 (1995). In Garza, the claimant had low back pain which his physician reported was "limiting his physical activity to some extent" The claimant's physician further indicated that there was an "increased risk of recurrent injury." The Board found that neither of these statements established a partial loss of ability to repetitively use the low back. In the present case, unlike in Garza, there is evidence of a partial loss of ability to repetitively use a body part. Here, the medical arbiter panel found that claimant "has some partial loss of ability to repetitively use the right shoulder due to the above accepted condition of an acute right trapezius strain." This evidence is sufficient to establish a chronic condition award.

Secondly, I would conclude that there are "objective findings" to establish impairment. Although the medical arbiter panel attributed claimant's limitation in repetitively using his shoulder to pain, the disability rating standards take pain into account if it results in measurable impairment. See OAR 436-35-320(2). Here, as evidenced by the arbiter panel's findings, claimant's pain has resulted in measurable impairment. Because claimant's discomfort is reproducible, it qualifies as an "objective finding," since it is a verifiable indication of injury. See ORS 656.005(19).

Under the circumstances, I believe that claimant has established an entitlement to a 5 percent award for a chronic condition in the right shoulder. Thus, I respectfully dissent from the majority's opinion which fails to make such an award.

In the Matter of the Compensation of
JULIO FILIPPI, Claimant
WCB Case Nos 96-00397, 96-00383, 95-04502 & 95-07470
ORDER ON RECONSIDERATION
Maureen McCormmach, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney
David O. Horne, Defense Attorney

Claimant requests reconsideration of our October 11, 1996 order that affirmed the Administrative Law Judge's (ALJ's) order which: (1) set aside Wausau Insurance Company's (Wausau) denial of claimant's aggravation claim for an L4-5 disc condition; (2) upheld the SAIF Corporation's denial on behalf of Oregon Parks and Recreation (SAIF/Parks) of claimant's medical services claim for the same condition; and (3) upheld SAIF's denial of claimant's "new injury/occupational disease" claim for the same condition on behalf of Circle C Farms (SAIF/Circle C).

On November 8, 1996, we abated our October 11, 1996 order and granted the remaining parties an opportunity to respond to claimant's motion. Inasmuch as the time for submitting responses has elapsed, we proceed with our reconsideration.

Claimant asserts, on reconsideration, that our October 11, 1996 order incorrectly failed to award an attorney fee under ORS 656.382(2). Claimant argues that because his compensation was not disallowed or reduced, he is entitled to an insurer-paid attorney fee under ORS 656.382(2) for his counsel's services on Board review.

ORS 656.382(2) provides that if a request for Board review is initiated by an employer or insurer and the Board finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay a reasonable attorney fee in an amount set by the Board.

Here, both compensability and responsibility were decided by the ALJ. By virtue of our de novo review authority, compensability remained at risk on Board review, as well. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53(1992), mod on recon, 119 Or App 447 (1993). Thus, Wausau's request for review of the ALJ's order placed claimant's compensation at risk of being reduced or disallowed. Under such circumstances, because claimant's compensation was not disallowed or reduced, claimant's attorney is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by Wausau. See ORS 656.382(2); Charles R. Morgan, 48 Van Natta 841, on recon 48 Van Natta 960 (1996).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $500, payable by Wausau. 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 proceedings and the value of the interest involved.

Accordingly, claimant's attorney is awarded a $500 attorney fee, payable by Wausau. As supplemented and modified herein, we republish our October 11, 1996 order in its entirety.[1]

IT IS SO ORDERED.

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[1] We note that Wausau has already petitioned the court for judicial review of our October 11, 1996 order. However, because our October 11, 1996 order had not become final prior to our November 8, 1996 abatement order, we retain authority under ORS 656.295(8) to reconsider our prior decision. See SAIF v. Fisher, 100 or App 288 (1990); Elmer F. Knauss, recon den 47 Van Natta 1064 (1995).

In the Matter of the Compensation of
DAVID A. LEE, Claimant
WCB Case No. 95-08006
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) upheld the self-insured employer's denial of his right knee injury claim; and (2) declined to assess a penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for his findings of ultimate fact, with the following supplementation.

Claimant, a deputy sheriff, injured his right knee while playing basketball in 1988, 1991 and 1994. Following the 1994 injury, he treated with Dr. Matteri, orthopedic surgeon, who performed knee surgery to remove a loose body and debride a complex tear of the posterior horn of the lateral meniscus. During surgery, Dr. Matteri observed that the anterior cruciate ligament (ACL) was intact; he also noted the presence of grade I chondromalacia in the patellofemoral compartment. In May 1994, claimant was released for regular work without restrictions. He had no subsequent limitations or symptoms in the right knee until June 10, 1995.

On the evening of June 10, 1995, claimant was inspecting a stolen vehicle that had been abandoned in Drain. It was dark so claimant used his flashlight to look into the vehicle. While sidestepping and looking into the vehicle, his foot slipped on a wet curb with an uneven surface,[1] and he twisted his right knee. The knee swelled and became painful. He sought treatment with Dr. Matteri on June 14, 1995. Dr. Matteri suspected a loose body in the knee joint.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that a preexisting condition in the right knee, rather than the June 10, 1995 work incident, was the major contributing cause of claimant's disability and need for treatment following that incident. The ALJ apparently reasoned that preexisting knee pathology both contributed to the occurrence of the June 10 incident and was the major cause of the need for treatment following the incident. On review, claimant argues that he established a compensable knee injury claim, even under the "major contributing cause" standard. We agree and reverse.

Before addressing the issue of medical causation, however, we first must determine if claimant has established legal causation. The employer contends that claimant has not carried the burden of proving that his right knee injury "arose out of" his employment. Citing James Hoffman, 47 Van Natta 394 (1995), the employer argues that claimant's knee injury occurred as a result of preexisting knee instability, a risk personal to claimant, not a risk associated with his employment. We disagree.

In Hoffman, supra, the medical evidence established that preexisting knee weakness was the primary cause of the claimant's fall at work which resulted in his knee injury. Although the fall occurred on the employer's premises, the Board found it was not due to any risk connected to employment. Accordingly, the Board concluded a work connection was not sufficiently established.

In this case, the employer relies on the opinion of examining orthopedist, Dr. Thompson, who wrote, in part:

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[1] Claimant testified that the curb either tapered off or had a "cut" in it. (Tr. 10).

"Had there been no preexisting [knee] condition it is extremely unlikely that the simple act of stepping off of a curb would have caused any injury at all. [Claimant's] preexisting ligamental instability, in the right knee is, in my opinion, the reason that stepping off the curb caused him to slip and thus cause a symptomatic flare of the right knee condition." (Ex. 22-1).

Based on Dr. Thompson's opinion, the employer argues that claimant has not proven legal causation by a preponderance of the evidence. While Dr. Thompson was the only medical expert to address the issue of whether claimant's preexisting knee condition caused him to slip and fall on June 10, 1995, his opinion on that issue is not persuasive because his history of the June 10 accident was incomplete.

When Dr. Thompson first examined claimant, he took the following history regarding the June 10 accident: "On June 10, 1995, [claimant] was walking off a curb or stepping off the sidewalk and somehow slipped as he went over the curb and twisted his knee." (Ex. 19-2). Thus, Dr. Thompson relied on history that claimant was doing nothing more than stepping off a curb or sidewalk when he slipped and twisted his knee. There is no indication that Dr. Thompson was aware of other facts, i.e., that claimant was inspecting a vehicle with a flashlight in the dark and that he was sidestepping and looking into the vehicle when he slipped on the wet surface of the curb and twisted his knee. Those additional facts were reported to Dr. Matteri, (Exs. 2-12, 10, 16-1), and were supported by claimant's testimony at hearing, (Tr. 10).

We conclude that Dr. Thompson did not have a complete history of the June 10, 1995 accident. In particular, Dr. Thompson did not appreciate the fact that claimant was sidestepping in the dark, while inspecting a vehicle, and that he slipped on a wet, uneven surface. Because Dr. Thompson did not have a complete and accurate history of the accident, his assessment of the risk of injury associated with claimant's activity on June 10 is wholly unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977); Clive G. Osbourne, 47 Van Natta 2291, 2293 (1995).

Furthermore, because we find that the conditions under which claimant inspected the abandoned vehicle on June 10, 1995 put him at a substantial risk for injury, we are persuaded that claimant's knee injury "arose out of" his employment as a deputy sheriff. See Norpac Foods, Inc. v. Gilmore, 318 Or 363, 368-69 (1994); Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983) (to satisfy the "arising out of employment" element, the claimant must show a causal link between the occurrence of the injury and a risk connected with employment). Accordingly, claimant has carried his burden of proving legal causation.

Turning to medical causation, we disagree with the ALJ's conclusion that claimant has not carried his burden of proving that the June 10, 1995 incident was the major contributing cause of the knee injury. Causation opinions were offered by Drs. Matteri and Thompson. Dr. Matteri, who treated claimant's right knee both before and after the June 10 incident, acknowledged that claimant had preexisting post-traumatic arthritis and ligamentous instability in the knee prior to the incident. (Ex. 17). Nevertheless, he opined that the June 10 incident further damaged the knee joint surface, causing the formation of a new loose body within the knee joint. (Id.) He further opined that the incident was the major contributing cause of subsequent disability and need for treatment. (Ex. 18).

Dr. Thompson, who examined claimant once in December 1995, disagreed. He opined that claimant's preexisting knee instability was the major contributing cause of his need for treatment subsequent to the June 10, 1995 incident. (Ex. 19-6). He believed that claimant had "major" knee problems prior to the incident and that the incident caused a temporary flare-up of symptoms. (Id.)

We are most persuaded by Dr. Matteri's opinion. As claimant's treating orthopedic surgeon both before and after the June 10, 1995 incident, Dr. Matteri was in the best position to evaluate the relative contributions of the preexisting condition and the June 10 incident to claimant's need for treatment following the incident. See McIntyre v. Standard Utility Contractors, Inc., 135 Or App 298, 302 (1995); Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986); Weiland v. SAIF, 64 Or App 810, 814 (1983). In addition, Dr. Matteri had a complete history of claimant's preexisting knee condition and the circumstances of the June 10, 1995 incident.

By contrast, as we previously discussed, Dr. Thompson did not have a complete history regarding the June 10 incident. Moreover, he erroneously assumed that claimant had a preexisting

partial tear of the ACL. (Ex. 19-4). Although a torn ACL was suspected as early as 1988, (Ex. 2-1), it was never confirmed. Dr. Matteri ruled out that diagnosis during surgery in 1994 when he specifically observed that the ACL is "intact." (Exs. 6-2, 2-12). Dr. Thompson interpreted "intact" to mean a partial tear. (Ex. 19-5). However, we find Dr. Thompson's interpretation to be contrary to the record and, therefore, erroneous. Because he based his causation opinion on incomplete and inaccurate history, we find his opinion to be unreliable and discount it accordingly. See Miller v. Granite Construction Co., supra; Clive G. Osbourne, supra.

The employer argues that Dr. Matteri failed to weigh the relative contribution of claimant's preexisting condition. We disagree. Dr. Matteri gave two reasons to support his opinion that the June 10 incident was the major contributing cause of resultant disability and need for treatment. He noted that claimant had not required any treatment just prior to the incident. (Ex. 18). This history is supported by the lack of treatment records between May 4, 1994 and June 14, 1995, a period of more than one year, (Exs. 2, pp. 11-12), and by claimant's unrebutted testimony that he returned to unrestricted work and had no subsequent symptoms or limitations until the June 10 incident, (Tr. 20-23).

Dr. Matteri also based his causation opinion on his belief that the June 10 incident further damaged the knee joint, causing new pathology, specifically a loose body. (Ex. 17). Although new knee pathology has not been confirmed, it has also not been ruled out. Under these circumstances, we give great deference to Dr. Matteri's diagnosis because of his status as claimant's treating orthopedic surgeon. See Weiland v. SAIF, supra. Because Dr. Matteri gave persuasive reasons to support his causation opinion, we find his opinion is well-reasoned. Based on Dr. Matteri's thorough and well-reasoned opinion, see Somers v. SAIF, 77 Or App 259, 263 (1977), we conclude that claimant has carried his burden of proving that the June 10, 1995 incident was the major contributing cause of his subsequent disability and need for treatment. Accordingly, the right knee injury claim is compensable, and the employer'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 $5,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability 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 claimant's attorney may go uncompensated. We have not considered claimant's attorney's services concerning the penalty issue.

Penalties

Claimant requests assessment of a penalty pursuant to ORS 656.262(11)(a) for the employer's allegedly unreasonable denial. A denial is deemed to be unreasonable if the employer lacked a legitimate doubt as to its liability for the claim. Brown v. Argonaut Insurance Co., 93 Or App 588, 591 (1988). The reasonableness of the denial must be determined based upon all the evidence available to the employer at the time of its denial. Id.

The record shows that, at the time of its June 23, 1995 denial, the employer had in its possession Exhibits 2 (pages 1 through 11 only), 9 and 11. Those exhibits are claimant's knee treatment records from March 22, 1988 through May 4, 1994, Dr. Matteri's "work status report" releasing claimant for a "desk job only" on June 14, 1995, and claimant's 801 claim form. The remaining exhibits are either stamped with receipt dates after June 23, 1995 or bear receipt date stamps that are illegible.

We find that the aforementioned exhibits that were available to the employer when it issued its denial, did not raise a legitimate doubt as to its liability for a knee injury occurring on June 10, 1995. While the exhibits show that claimant sustained prior injuries to the same knee in 1988 and 1991 and underwent knee surgery in February 1994, they did not show that claimant had any limitations or symptoms concerning the knee for more than one year prior to the June 10, 1995 incident. According to claimant's unrebutted description of the June 10 incident on the 801 claim form, he twisted his knee when he slipped on a curb while performing his work duties. (Ex. 11). At the time of its denial, the employer did not have any medical opinion which evaluated the relative contributions of the preexisting condition and the June 10 incident to claimant's subsequent disability and need for treatment. In fact, the only medical opinion it had in its possession was Dr. Matteri's "work status report" which diagnosed "knee joint disorder" and released claimant for a "desk job only." (Ex. 9).

Notwithstanding the limited information available to the employer, it elected to issue its denial 13 days after the alleged date of injury. In light of the fact that carriers are afforded 90 days in which to investigate a claim prior to issuing an acceptance or denial of a claim, see ORS 656.262(6)(a), we find that the employer's denial in this case was hasty and issued without adequate investigation or information. Therefore, based on the information available to the employer at the time of its denial, we conclude that its denial was unreasonable. The employer shall be assessed a 25 percent penalty based on compensation due at the time of hearing, payable in equal shares to claimant and his attorney. See ORS 656.262(11)(a).

ORDER

The ALJ's order dated July 16, 1996 is reversed. The self-insured employer's denial is set aside, and the right knee injury claim is remanded to the employer for processing according to law. Claimant's attorney is awarded an assessed fee of $5,000, payable by the employer. The employer is assessed a penalty equal to 25 percent of amounts of compensation due at the time of hearing (as a result of this order), payable in equal shares to claimant and his attorney.

December 6, 1996 Cite as 48 Van Natta 2423 (1996)

In the Matter of the Compensation of
LINDA L. CRAIG, Claimant
WCB Case No. 94-04340
ORDER ON RECONSIDERATION
Hollander, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

The insurer requests reconsideration of our November 13, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order upholding its denial of claimant's mental disorder claim. The insurer states that it cross-requested review of that portion of the ALJ's order assessing a penalty and asks that we modify our order to set aside that portion of the ALJ's order. Claimant has responded and opposes the motion.

The ALJ assessed a penalty based on the parties' stipulation that claimant was entitled to $2,948.37 in interim compensation and such sum was untimely paid. Although the insurer did not file a brief on review, it cross-requested review of that portion of the ALJ's order. The insurer contends that claimant is not entitled to the penalty because her claim was found not compensable.

ORS 656.262(4)(a) provides that, if authorized, the first installment of temporary disability compensation must be paid no later than the 14th day after the employer has notice of knowledge of the claim. This provision has been interpreted as requiring interim compensation if the carrier does not accept or deny the claim within 14 days of notice or knowledge, whether or not the claim eventually is found to be not compensable. E.g., Jones v. Emanuel Hospital, 280 Or 147 (1977); Gene T. Lapraim, 41 Van Natta 956 (1989) (carrier is obliged to pay interim compensation for noncompensable claims from date carrier received notice of disability).

Here, the parties agreed at hearing that interim compensation was not timely paid. (Tr. 12-14 (Day 1)). The only contention made by the insurer against a penalty is that it is not warranted if the claim is found not compensable. As explained above, compensability is not necessary to entitlement of interim compensation. Because the insurer provides no explanation for the late payment of the interim compensation, we agree with the ALJ that the insurer unreasonably resisted payment of the interim compensation. Consequently, imposition of a penalty is appropriate. ORS 656.262(11)(a). Inasmuch as a penalty is not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on reconsideration concerning the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

Accordingly, we withdraw our November 13, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our November 13, 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
CHARLES L. DUNN, Claimant
WCB Case No. 95-12234
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) directed the self-insured employer to "recalculate" claimant's scheduled and unscheduled permanent disability awards in accordance with Senate Bill 369, Section 18; and (2) awarded an "out-of-compensation" attorney fee payable from the "increased" compensation. The self-insured employer cross-requests review of that portion of the order that held that claimant was not precluded by res judicata from contesting the rate at which his permanent disability awards were paid. On review, the issues are claim processing and res judicata.[1]

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

We have previously addressed the calculation of permanent disability for claimants injured between January 1, 1992 and December 31, 1995 in Sharon L. Hand, 48 Van Natta 1798 (1996). In Hand, after analyzing the text and context of Section 18 and amended ORS 656.214(2), as well as the related legislative history, we concluded that Section 18 of Senate Bill 369 controls the calculation of permanent disability for claimants injured between the aforementioned dates.

Here, claimant was injured in May 1993. Therefore, Section 18 of Senate Bill 369 controls the calculation of his permanent disability award. Hand, supra. Moreover, because the only change to Section 2, Or Laws 1991, chapter 745 by Section 18 reduces the period over which Section 18 controls by one day (from January 1, 1996 to December 31, 1995), application of Section 18 does not change the calculation of claimant's permanent disability award.

Because there is no change in the calculation of claimant's permanent disability award, we decline to address the employer's cross-request on the res judicata issue, as it would have no effect on the outcome of the case.

Finally, the ALJ directed the employer to recalculate claimant's award of permanent disability and granted an out-of-compensation attorney fee of any "increased" compensation. Inasmuch as the employer' calculation was correct, it was not necessary for the ALJ to direct it to recalculate claimant's award of permanent disability. Moreover, since the employer's calculation was correct, there is no "increased" compensation on which to base an approved fee. Consequently, we modify the ALJ's order to vacate the award of an approved attorney fee.

ORDER

The ALJ's order dated February 26, 1996 is modified in part and affirmed in part. That portion of the ALJ's order which awarded an "out-of-compensation" attorney fee is vacated. The remainder of the order is affirmed.

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[1] We note that the parties have failed to provide us with a copy of Exhibit 6 as requested. Exhibit 6, which is missing from the evidentiary record, is identified in the Exhibit List as an October 4, 1995 letter from claimant's attorney requesting withdrawal of his hearing request. It is clear from an October 13, 1995 Order of Withdrawal in WCB Case No. 95-08359 that claimant withdrew his July 17, 1995 hearing request in its entirety. See Leslie G. Mullenix, 41 Van Natta 2068, 2069 (1989) (Board will take administrative notice of facts that are capable of accurate and ready determination whose accuracy cannot reasonably be questioned such as ALJ, Board, or Department orders). Thus, the absence of Exhibit 6 has no effect on the outcome of this case. Consequently, we proceed with our review.

In the Matter of the Compensation of
DANIEL G. EVANS, Claimant
WCB Case No. 96-00171
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Bostwick, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its partial denial of claimant's medical services claim for left knee anterior cruciate ligament instability.[1] On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In October 1989, claimant was diagnosed with a substantial knee injury with a medial collateral tear, possible transient patellar dislocation and rupture of the anterior cruciate ligament (ACL). (Ex. a). Claimant's knee injury was not related to employment. Although Dr. Lundsgaard had planned to perform an ACL reconstruction, he elected instead to performed an arthroscopic examination on March 7, 1990. (Ex. b-2). During surgery, Dr. Lundsgaard found a transverse tear of the lateral meniscus, which was debrided, and a large cartilaginous loose body, which was removed. (Exs. b-2, d).

Claimant fell from a ladder at work on September 12, 1995, twisting his knee. On November 13, 1995, the insurer accepted a disabling claim for "internal derangement" of the left knee. (Ex. 11). On the same date, the insurer issued a partial denial of treatment and disability related to claimant's chronic ACL insufficiency of the left knee on the basis that it was a preexisting condition and was not related to the September 12, 1995 work injury. (Ex. 12).

Relying on Dr. Walton's opinion, the ALJ reasoned that ORS 656.225 did not apply because the treatment and disability related to the preexisting ACL laxity was not solely directed to the preexisting condition. Further, the ALJ found that ORS 656.005(7)(a)(B) did not apply because there was no proof that the compensable injury combined with the preexisting condition to cause or prolong disability. The ALJ set aside the insurer's partial denial of treatment and disability related to claimant's chronic ACL insufficiency of the left knee.

The insurer argues that the ACL reconstruction procedure was a noncompensable medical service pursuant to ORS 656.225.[2] According to the insurer, the treatment of the preexisting ACL laxity was solely directed to the preexisting condition. We disagree.

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[1] We have 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 Arthur R. Morris, 48 Van Natta 349 (1996); Richard L. Wheeler, 47 Van Natta 2011 (1995).

[2] ORS 656.225 provides, in part:

"In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:

"(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.

"* * * * *

"(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) * * *, and not merely as an incident to the treatment of a compensable injury or occupational disease."

The medical evidence establishes that claimant has a long-standing ACL insufficiency that preexisted his September 1995 work injury. There is no contrary medical evidence. Therefore, claimant's ACL insufficiency of the left knee constitutes a "preexisting condition." See ORS 656.005(24).

On September 22, 1995, Dr. Walton, claimant's treating physician, explained that claimant had two knee conditions. (Ex. 7). Claimant had a preexisting injury to the ACL in his left knee. Dr. Walton said that a tendon graft was necessary for the ACL injury to stabilize the knee so it would be at less risk for future injuries. (Id.) Claimant also had an acute left knee injury caused by the September 1995 work incident. For the acute injury, Dr. Walton recommended an arthroscopic evaluation and debridement of the knee. (Id.)

In a deposition, Dr. Walton further explained claimant's October 17, 1995 surgery. Dr. Walton reconstructed claimant's ACL using a graft of hamstring tendon in order to stabilize his knee. (Ex. 15a-5). Dr. Walton also debrided the lateral compartment of the knee and put multiple drill holes into areas where there were articular cartilage defects in an attempt to stabilize the joint surface. (Ex. 15a-7). Dr. Walton explained that the drilling served to provide a vascular growth of new cells that will modify to become a fibrocartilage covering. (Id.)

Dr. Walton testified that, if he had not done the ACL reconstruction at the time he debrided the lateral compartment and drilled the holes, claimant would have had further instability episodes and he would have further damaged the medial lateral compartments of his knee. (Ex. 15a-8). Although Dr. Walton said that the principal reason to reconstruct the ACL was because of the preexisting laxity, the other reason was to benefit the part of the knee that was injured in September 1995. (Ex. 15a-9, -10, -13). Dr. Walton explained that it takes at least three months for the fibrocartilage to grow and become stable. If claimant had had an instability episode and had torn off the early fibrocartilage, it would not have come back. (Ex. 15a-9). In addition, with the ACL reconstruction, further blood is introduced to the joint, which is helpful to the fibrocartilage. (Id.) If the ACL reconstruction had not been performed, Dr. Walton said that would have compromised the healing of the September 1995 injury. (Ex. 15a-13).

In light of Dr. Walton's opinion, we are not persuaded that claimant's treatment for the ACL insufficiency of the left knee is "solely" directed to his preexisting ACL condition. Dr. Walton explained that the ACL reconstruction was performed, in part, to benefit the healing process of the part of the knee that was injured in September 1995. Consequently, we conclude that ORS 656.225 does not apply to this case.[3] See Colin J. McIntosh, 47 Van Natta 1965 (1995).

Alternatively, the insurer argues that ORS 656.005(7)(a)(B) applies because claimant's compensable injury combined with the preexisting condition to cause the need for the ACL reconstruction procedure.

Claimant argues that there is no evidence in the record that his 1995 injury combined with the preexisting ACL instability to cause disability. Claimant contends that he had two separate knee conditions. On the other hand, claimant asserts that the ACL treatment was directed to his preexisting condition as well as to the lateral compartment injured in 1995.

Under ORS 656.005(7)(a)(B), when a compensable injury combines with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if the compensable injury is the major contributing cause of the disability or need for treatment of the combined condition.

Dr. Walton agreed that the work injury did not "worsen" claimant's ACL instability (Ex. 14-2), and he said there was relatively no difference in the laxity since 1989. (Ex. 15a-8, -9, -11). However, Dr. Walton reported that the acute injury caused a "recurrence of problems within his knee." (Ex. 12a-2). On December 6, 1995, Dr. Walton wrote to the insurer:

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[3] Although the insurer relies on Michael L. Wofford, 48 Van Natta 1087, on recon 48 Van Natta 1313 (1996), that case is inapposite. In Wofford, we concluded that the prescribed medication was solely directed to the claimant's preexisting fungal condition. We applied ORS 656.225 and concluded that the claimant's fungal medication treatment was not compensable. Here, in contrast, the medical evidence establishes that claimant's ACL reconstruction was directed to the preexisting condition and the September 1995 injury.

> "[Claimant], as you know, has a long standing ACL problem in this knee. He re-aggravated this injury when the ladder broke. This injury resulted in further damage to the chondral surface of his lateral joint. I recommended that he have a concurrent ACL reconstruction at that time." (Ex. 11a; emphasis added).

As we discussed earlier, the ACL reconstruction surgery was performed, in part, to benefit the healing process of the part of the knee that was injured in the September 1995 incident.

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995)). Although Dr. Walton did not expressly state that claimant's September 1995 injury "combined" with the preexisting ACL insufficiency, 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). Based on Dr. Walton's reports, we conclude that claimant's September 1995 work injury combined with the preexisting ACL insufficiency to cause the need for treatment of claimant's left knee ACL instability. Therefore, since this is a "combined condition," the insurer was obligated to provide only those medical services "directed to medical conditions caused in major part by the injury." ORS 656.245(1)(a).

In a concurrence letter from the insurer, Dr. Walton agreed that the ACL instability was caused in major part by preexisting degenerative changes. (Ex. 14). In addition, in an earlier report, Dr. Walton said that the long-standing ACL insufficiency was not the responsibility of the workers' compensation carrier. (Ex. 6-2). Dr. Walton testified that the principal reason to reconstruct the ACL was because of the preexisting laxity, although that was not the only reason. (Ex. 15a-9, -10)

We conclude that claimant has not met his burden of proving that the ACL reconstruction was "directed to medical conditions caused in major part by the injury." ORS 656.245(1)(a). Therefore, we reverse the ALJ's order that set aside the insurer's partial denial of medical services for claimant's left knee anterior cruciate ligament instability.

ORDER

The ALJ's order dated July 23, 1996 is reversed. The insurer's partial denial of medical services for claimant's left knee anterior cruciate ligament instability is reinstated and upheld. The ALJ's attorney fee award is also reversed.

December 6, 1996 Cite as 48 Van Natta 2427 (1996)

In the Matter of the Compensation of
JOHN B. SHAW, SR., Claimant
Own Motion No. 96-0277M
OWN MOTION ORDER
Craine & Love, Claimant Attorneys
Sedgwick James & Co., Insurance Carrier

The self-insured employer initially submitted claimant's request for temporary disability compensation for claimant's compensable neck, arm and shoulder injury. Claimant's aggravation rights on that claim expired on November 24, 1992.

On February 21, 1996, the employer issued a denial of the compensability of and responsibility for claimant's current C-5 compression fracture, cervical spondylosis, C5-6, C6-7 spondylosthesis, and cervical radiculopathy conditions. The employer further opposed reopening of claimant's 1987 injury claim on the following grounds: (1) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (2) claimant was not in the work force at the time of disability. Claimant requested a hearing. (WCB Case No. 95-08430).

By Opinion and Order dated April 4, 1996, Administrative Law Judge (ALJ) Michael Johnson set aside the employer's denial. The employer requested Board review of ALJ Johnson 's order. On June 4, 1996, the Board postponed action pending resolution of the continuing litigation. On October 30, 1996, the Board affirmed the ALJ's order.

On October 31, 1996, we requested the parties' positions regarding whether claimant was in the work force at the time of disability. We have received the parties' responses, and proceed with our review of the record.

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

On December 13, 1994, Dr. Franks, claimant's treating physician, performed claimant's two-level anterior cervical discectomy and interbody fusion at C5-6 and C6-7. Thus, we conclude that claimant's 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, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proof on this issue.

In a November 18, 1996 affidavit, claimant stated that he retired from his job in the mining and metal trades in October 1994. However, claimant contends that "I was in the work force in December 1994 and have continued to be in the work force since that time." Because claimant retired in October 1994 and was not working in December 1994, he must establish that he was willing to work and, either that he was seeking work, or that he did not seek work because the compensable condition made such efforts futile at the time of disability. Dawkins v. Pacific Motor Trucking, supra.

In his affidavit, claimant stated that, after retiring in October 1994, he "did not try to work in late 1994 or in 1995 because it would have been futile to look for work then due to my neck condition." Claimant further contended it was futile for him to seek work at that time because Dr. Franks did not release him to work in 1995; however, claimant's post-surgical work status is not relevant to our inquiry here.[1]

Claimant voluntarily retired from work in October 1994 and was not working at the time of disability. Claimant contends that it would have been futile to work in late 1994. However, evidence in the record suggests that claimant had been released to regular work prior to his retirement. Claimant was referred to Dr. Eusterman in May 1994 to assume case management of his neck and bilateral arm problem. In his May 4, 1996 medical report, Dr. Eusterman noted that, regarding claimant's medical treatment, claimant "wants to get things taken care of before I retire." Dr. Eusterman prescribed physical therapy (cervical traction) for several weeks, and advised that claimant should continue regular work. In a June 1, 1996 report of work status, Dr. Eusterman again released claimant to "continued regular work." There is no evidence in the record to establish that claimant was not released to work after that time. See Martin L. Moynahan, 47 Van Natta 2238 (1995) (claimant was not in the work force where claimant released to work prior to retirement and time of disability). Further, the record does not establish that claimant sought work after he retired in October 1994. Finally, there is no evidence in the record which would establish that it would have been futile for claimant to seek work because of the compensable injury at the time of disability. See Dawkins v. Pacific Motor Trucking, supra; Robert D. Hyatt, supra; Fred Vioen, supra; Martin L. Moynahan, supra.

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[1] Claimant apparently contends that it was futile for him to seek work after his December 1994 surgery. ORS 656.278(1) authorizes the Board to assume that a claimant is disabled due to a compensable condition after surgery or inpatient hospitalization, and to award temporary disability compensation to qualified claimants to replace wages lost during recuperation. Here, although claimant may not have been released to work for a period of time after his surgery, the dispositive question in this case is whether claimant was released to work at the relevant time; that is, whether claimant was in the work force at the time of current disability. See ORS 656.278(1). Thus, in order to qualify for time loss benefits, claimant must establish that, although retired, he continued to work, to seek work, or that he was unable to work due to the compensable injury at the time of disability. See Robert D. Hyatt, 48 Van Natta 2202 (1996) (although retired, the claimant continued to work part-time, establishing eligibility for temporary partial disability benefits); Fred Vioen, 48 Van Natta 2110 (1996) (inasmuch as temporary disability under ORS 656.278 is only authorized beginning on the date of surgery or inpatient hospitalization, the previously retired claimant was not in the work force by the time he underwent surgery).

On this record, we conclude that claimant has not carried his burden of proving he was in the work force at the time of disability. Because we are only authorized to award temporary disability compensation beginning the date claimant entered the hospital for surgery (which occurred after claimant retired), we conclude that we are without authority to authorize the payment of temporary disability benefits in claimant's 1987 injury claim. ORS 656.278(1). Accordingly, claimant's request for temporary disability compensation is denied. See id. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

December 9, 1996 Cite as 48 Van Natta 2429 (1996)

In the Matter of the Compensation of
FRED E. FERRY, Claimant
WCB Case No. 96-03044
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order which affirmed an Order on Reconsideration's award of 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of each hand. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has compensable bilateral Reynaud's syndrome. A June 1995 Notice of Closure awarded 5 percent scheduled permanent disability for each of claimant's hands. Claimant requested reconsideration, including appointment of a medical arbiter.

On February 5, 1996, a medical arbiter panel examined claimant. Thereafter, a March 8, 1996 Order on Reconsideration reduced claimant's scheduled permanent disability in each hand to 3 percent. Claimant requested a hearing.

Relying on the arbiter's report, claimant requested an additional scheduled award for each hand based on loss of range of motion. The ALJ declined to award additional scheduled permanent disability and affirmed the Order on Reconsideration. The ALJ found that claimant had not sustained his burden of proving entitlement to an increased award of scheduled permanent disability because the medical arbiter panel did not say that his lost range of motion was due to the compensable injury.

On review, claimant contends that he is entitled to additional scheduled permanent disability for loss of range of motion based on the arbiter's report, citing Kim Danboise, 47 Van Natta 2163, 2164, on recon 47 Van Natta 2281(1995) and Edith N. Carter, 46 Van Natta 2400, 2401 (1994). We agree.

Because the arbiters' examination was conducted closer in time to the reconsideration order and because the arbiters' report is a thorough and well-reasoned evaluation of claimant's injury-related impairment, we rely on the arbiters' findings. See Kenneth W. Matlack, 46 Van Natta 1631 (1994) (Board does not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

To be entitled to permanent disability compensation for his bilateral hand condition, claimant must establish that his permanent impairment is due to the compensable injury. ORS 656.214(2). If a 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, supra; Edith N. Carter, supra. However, where a medical arbiter relates 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).

Here, the Department advised the medical arbiter panel to report any objective findings of permanent impairment resulting from the accepted condition. The medical arbiter found that claimant had lost range of motion involving the digits of each hand. The arbiter panel did not attribute the bilateral hand findings to causes other than the compensable injury, nor did they indicate that their findings were inconsistent with the compensable condition. In fact the panel noted that their findings were valid. Under these circumstances, we conclude that the arbiters' impairment ratings for lost range of motion relate to the work injury. Kim E. Danboise, supra.[1]

We now proceed to determine claimant's permanent disability considering the medical arbiters' range of motion findings. Claimant asserts that his permanent disability is 10 percent in the right hand and 7 percent in the left hand. We agree with claimant that the applicable standards are those in Administrative Order 6-1992. Furthermore, applying those standards, we agree with claimant that he has 7 percent impairment of the right hand for reduced range of motion. OAR 436-35-050, 436-35-060. When combined with the impairment for vascular disease (3 percent), OAR 436-35-110(6)(a), claimant's permanent disability is 10 percent of the right hand. Moreover, we agree with claimant that he has 4 percent impairment of the left hand for reduced range of motion of the left thumb. OAR 436-35-050. When combined with 3 percent impairment for claimant's vascular disease (OAR 436-35-110(6)(a)), claimant's permanent disability in the left hand is 7 percent.

Accordingly, we modify the ALJ's order. In lieu of the ALJ's and the reconsideration order's award of permanent disability, claimant is awarded 10 percent scheduled permanent disability for the right hand and 7 percent for the left hand.

Because we have modified the ALJ's order which affirmed the scheduled awards made by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is 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 ORS 656.386(2); OAR 438-015-0055(1). In the event that a portion of this substantively increased permanent disability award has already been paid to claimant,[2] 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 July 1, 1996 is modified. In lieu of the ALJ's and Order on Reconsideration's award of scheduled permanent disability, claimant is awarded 10 percent (15 degrees) scheduled permanent disability for the right hand and 7 percent (10.5 degrees) scheduled permanent disability for the left hand. Claimant's counsel is 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" 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.

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[1] Although a signatory to this order, Board member Haynes directs the reader to her dissent in Danboise.

[2] We note that the Order on Reconsideration reduced claimant's scheduled permanent disability awards for each hand from 5 percent to 3 percent.

In the Matter of the Compensation of
LARRY A. RANEY, Claimant
WCB Case No. 96-01248
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

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

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

Finding that claimant's attending physician's opinion was based solely on exclusion of non-work causes of claimant's degenerative hip and low back conditions, the ALJ found that opinion legally insufficient to establish compensability under ORS 656.266. We agree.

ORS 656.266 precludes a worker from proving compensability solely by disproving other possible explanations of how the injury or disease occurred. Claimant relies on Bronco Cleaners v. Velazquez, 141 Or App 295 (1996), which issued after the date of the ALJ's order, to argue that the medical opinion of his physician, Dr. Kilpatrick, was legally sufficient to establish compensability under ORS 656.266.

We find Velazquez to be distinguishable from the present case. There, the court stated that, among other things, ORS 656.266 provides that a claimant may not solely rely on the deductive reasoning that, because the condition did not occur until after the exposure to the work environment and cannot be proven to have been caused by another causative agent, it must have been caused by the work environment. The court reasoned that if the claimant had merely demonstrated that before she worked for the employer, she did not have the condition, and now she does, her proof would be legally insufficient under the statute. However, the court found that the claimant's proof went beyond that chronological connection and demonstrated a pattern of diminishment and enhancement of the condition which correlated to the existence of or lack of exposure to the work place. On this basis, the court found that the prohibition of ORS 656.266 was not implicated.

Here, claimant's attending physician, Dr. Kilpatrick, opined that claimant's persistent heavy working for many years as a grave yard attendant "most certainly has contributed to his developing disc disease of the spine and may also have contributed to the wear and tear of his knees and hips."[1] Dr. Kilpatrick based her opinion on the following reasoning: "Since I know of no other cause of strain to [claimant's] back, I believe that his job activities were a significant contributing factor and probably the major contributing factor to his situation."

Here, unlike in Velazquez, the physician based her opinion totally on the fact that she was aware of no other cause of claimant's degenerative condition. Dr. Kilpatrick does not give any additional reasoning for her conclusion. Under such circumstances, we find this case distinguishable from Velazquez where, in addition to noting a chronological connection between work and the dermatitis condition, the physician also noted a pattern of diminishment and enhancement correlating with exposure or lack of exposure to the work place. By contrast, in the present case, Dr. Kilpatrick does not support her opinion with any reasoning other than that she did not know of any other cause for claimant's back condition. Under such circumstances, we agree with the ALJ that claimant has not overcome the prohibition in ORS 656.266.

Claimant argues that his proof goes beyond deductive reasoning because he established that he had no condition preexisting his employment, that no off-the-job factor contributed, that he had no family history of osteoarthritis and that his osteoarthritis was more advanced than normal for his age.

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[1] We note that Dr. Kilpatrick's opinion is insufficient to establish compensability of claimant's left hip condition since it suggests only a possibility that claimant's work activities contributed to that condition. See Gormley v. SAIF, 52 Or App 1055 (1981) (physician's opinion framed in terms of possibility, rather than probability, found unpersuasive).

Had Dr. Kilpatrick relied on any of these factors, we would agree with claimant's reasoning. However, Dr. Kilpatrick did not rely on any of the factors listed by claimant. Dr. Kilpatrick's opinion was based solely on her exclusion of other causes. Under such circumstances, we find that claimant has not met his burden of proof.

Finally, we agree with the ALJ's alternative reasons for not relying on Dr. Kilpatrick's opinion. Most notably, the ALJ noted that Dr. Kilpatrick's opinion was conclusory and did not address the opinion of Drs. Fuller and Reimer that claimant's degenerative condition was "idiopathic." Thus, even if Dr. Kilpatrick's opinion was legally sufficient under ORS 656.266, we would still find the opinion inadequate to establish the compensability of claimant's claim.

ORDER

The ALJ's order dated May 23, 1996 is affirmed.

December 9, 1996 Cite as 48 Van Natta 2432 (1996)

In the Matter of the Compensation of
KENNETH D. LEGORE, Claimant
WCB Case No. TP-96006
THIRD PARTY ORDER OF DISMISSAL
Nancy F.A. Chapman, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Claimant has petitioned the Board "for intervention" into a third party action for damages.[1] Specifically, claimant asserts that he objects to the "Assignment of Cause of Action" form provided to him by the paying agency.

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. We are also authorized to resolve any conflict regarding the "just and proper distribution" of the proceeds of a third party settlement. ORS 656.593(3). The Board does not, however, have the authority to "intervene" into a third party action and grant the relief claimant seeks.

Apparently, there is a dispute in this case arising out of the assignment of claimant's third party cause of action to the paying agency. See ORS 656.583; 656.591. Notwithstanding that apparent conflict, the record does not establish that the third party action has settled or that a judgment has been finalized. In the absence of any such settlement or recovery of proceeds, we are without authority to consider claimant's petition.[2] See, e.g., Julio G. Mejia, 44 Van Natta 764 (1992) (where claimant has not accepted a settlement offer, no third party compromise exists for us to consider); Delores M. Shute, 41 Van Natta 1028 (1989) (Board lacks jurisdiction to determine just and proper distribution where claimant has not settled third party claim).

Accordingly, claimant's petition for third party relief is premature and is dismissed without prejudice.

IT IS SO ORDERED.

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[1] Claimant previously petitioned the Board to resolve a dispute regarding the proposed distribution of recovery from this third party claim, then withdrew the petition on the grounds no third party settlement had yet been reached and therefore his request for relief was premature. We dismissed the petition without prejudice. Kenneth D. Legore, WCB No. TP-96003.

[2] We may address an "assignment" issue within the context of a proposed third party settlement or distribution of proceeds dispute. However, because no settlement has been proposed or no judgment has been finalized in this case, claimant's request for relief remains premature.

In the Matter of the Compensation of
HORST ZUNKER, Claimant
WCB Case No. 95-12184
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) found that claimant's asthma claim should be analyzed as an occupational disease; and (2) upheld the insurer's denial of that claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Since 1983, claimant has experienced seasonal allergy symptoms during spring and summer and uses an "inhaler" when symptomatic. Claimant's seasonal symptoms include nasal congestion and shortness of breath.

In 1991, claimant began working on a finger jointer machine. In performing this job, claimant was required to mix glue, then apply the glue while running the machine. Within three or four days of beginning this job, claimant began experiencing watery eyes, nasal congestion and shortness of breath. (Tr. 8). During the three and one-half years that claimant worked on the finger jointer machine, these symptoms worsened, along with waxing and waning. In April 1994, claimant sought treatment for his condition from Dr. Tribelhorn, a doctor of internal medicine. Claimant was also subsequently examined by Dr. Montanaro, an allergy and clinical immunologist specialist at the Oregon Health Sciences University.

Claimant suffers from chronic bronchial asthma and very significant chronic infectious paranasal sinusitis. Claimant also has chronic allergic rhinitis with multiple non-occupational inhalent sensitivities. Claimant's occupational exposure to workplace irritants contributed to worsened symptoms of his preexisting conditions without a worsening of the underlying conditions themselves.

CONCLUSIONS OF LAW AND OPINION

Analyzing claimant's condition as an occupational disease, the ALJ found that claimant failed to prove compensability because the medical evidence showed only that employment conditions had caused a symptomatic worsening. See ORS 656.802(2)(b). Claimant argues that his asthmatic condition should be treated as an accidental injury under ORS 656.005(7)(a) because the onset of his symptoms corresponded with beginning his job on the finger jointer machine and occurred within a discrete period of time. Claimant further contends that his condition is compensable as an industrial injury.

We find that, whether treated as an occupational disease or an accidental injury, claimant's burden of proof is major contributing cause. That is, under an accidental injury theory, we would apply ORS 656.005(7)(a)(B) since claimant's preexisting asthma condition has combined with his exposure to glue fumes, making it necessary for claimant to prove that the work "injury" was the major contributing cause of his combined condition. Under an occupational disease theory, claimant must show that employment conditions were the major contributing cause of a pathological worsening of his preexisting asthma condition. ORS 656.802(2)(a), (b).

According to claimant's treating physician, Dr. Tribelhorn, as expressed in a signed concurrence with a brief letter from claimant's attorney, claimant's job "was the cause, in major part, to [sic] an exacerbation of the asthma condition such that he became symptomatic and required medical treatment and became disabled at work." (Ex. 16-1). Dr. Montanaro, on the other hand, prepared an exhaustive report addressing claimant's medical history in considerable detail, discussing in depth both claimant's workplace exposures and the results of clinical testing. Dr. Montanaro diagnosed asthma, allergic rhinitis and sinusitis and found that "it was possible" that claimant's work may have symptomatically aggravated these conditions without causing a pathological worsening. (Ex. 15-7).

We are inclined to find the opinion of Dr. Montanaro more persuasive than the opinion of Dr. Tribelhorn. Dr. Montanaro is a specialist in the area of allergies and clinical immunologies. It does not

appear from the record that Dr. Tribelhorn possesses any such specialized background. Further, Dr. Tribelhorn did not begin treating claimant until approximately two-and-one-half years after the onset of claimant's increased symptoms. Moreover, the causation issue in this case requires expert medical analysis rather than expert observation over time. For these reasons, we do not find Dr. Tribelhorn's opinion entitled to special deference.

However, even if we were to defer to Dr. Tribelhorn's opinion, we would conclude that claimant has nevertheless failed to sustain his burden of proof under an industrial injury theory. The reason for this is that Dr. Tribelhorn's opinion regarding causation states, in essence, that claimant's work was the major cause of his need for treatment because it precipitated a symptomatic exacerbation of his underlying condition. Dr. Tribelhorn fails to weigh the relative contributions of claimant's preexisting asthmatic condition and his work exposure. Instead, she concludes that the work exposure is the major cause because it was the precipitating cause. Therefore, her opinion is unpersuasive. See Dietz v. Ramuda, 130 Or App 397, 401 (1994) (determining the "major contributing cause" involves evaluating the relative contributions of different causes; the precipitating cause of symptoms is not necessarily the major cause of those symptoms).

Similarly, Dr. Montanaro could, at most, state that "it is possible that [claimant] has been rendered more susceptible to airborne irritants in his workplace." Not only does Dr. Montanaro fail to weigh the relative contributions of the preexisting conditions and the work exposure to the need for treatment of claimant's combined condition, but he also expresses his opinion in terms of possibility rather than probability. This evidence, like that from Dr. Tribelhorn, is insufficient to establish that claimant's employment exposure during a discreet period of time in November 1993 was the major contributing cause of claimant's need for treatment of his symptomatically exacerbated preexisting asthma condition. Moreover, claimant does not contend -- and the evidence does not establish -- that the employment conditions pathologically worsened the preexisting condition. Therefore, claimant has failed to carry his burden of proof under either an occupational disease or an industrial injury theory of compensability. ORS 656. 005(7)(a)(B), 656.802(2)(a), (b).

ORDER

The ALJ's order dated June 24, 1996 is affirmed.

In the Matter of the Compensation of
DONNA A. GOODMAN-HERRON, Claimant
WCB Case No. 94-09926
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) upheld the SAIF Corporation's denial of claimant's claim for her psychological disorder; and (2) declined to award penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees.

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

On review, claimant contends that the ALJ incorrectly relied on Carr v. U.S. West Direct Co., 98 Or App 30 (1989). Claimant argues that Carr is not a workers' compensation case and, therefore, the ALJ should not have relied upon it as precedent. We disagree.

Although Carr was a civil case, the court first determined whether, under workers' compensation law, the employer was exempt pursuant to the exclusive remedy statute. Former ORS 656.018(1). In reaching its conclusion that the plaintiff's injury was not compensable under Chapter 656, the court, citing Rogers v. SAIF, 289 Or 633 (1980), addressed whether the plaintiff was injured in the course of employment and whether the injury arose out of the employment.

Accordingly, we conclude that, because the court was required to address the course and scope issue in conjunction with the workers' compensation act and case law, the decision in Carr is binding precedent in our forum.[1] Additionally, we do not find that claimant has proven that the facts of Carr are distinguishable from the facts in the present case. Under the circumstances, we conclude that the ALJ did not err in following the court's decision in Carr.[2]

Claimant also argues that, in reaching his conclusion, the ALJ should have considered whether claimant was a traveling employee. SAIF argues that the issue was not raised until claimant's written reply (closing argument), and therefore, the ALJ correctly did not address claimant's argument.

We conclude that it is not necessary to determine whether claimant's argument was timely raised, as we do not find that claimant would prevail under such a theory. The traveling employee rule provides that, where travel is a necessary incident of the employment, the risk inherent in travel remains an incident to the employment even though the employee may not actually be working at the time of the injury. See e.g. SAIF v. Reel, 303 Or 210 (1987); Proctor v. SAIF, 123 Or App 326 (1993).

Here, we conclude that, even if we found that claimant's injury arose out of the course of employment (i.e., while claimant was traveling on business for the employer), claimant must also show that her employment put her in a position to be injured, and therefore, her injury "arose out of" the employment. See David F. Ierulli, 47 Van Natta 2092 (1995). Again, we are bound by the court's decision in Carr, in which the court held that the fact that the employment placed the plaintiff and her supervisor together was not, in itself, enough. Because claimant has not shown any other causal link between the occurrence of the assault and the risk connected with the employment, we conclude that, even if analyzed under the traveling employee rule, claimant has not established that her injury arose out of her employment.[3] Therefore, her claim is not compensable. ORS 656.005(7)(a).

ORDER

The ALJ's order dated April 19, 1996 is affirmed.

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[1] We note that we have previously cited Carr as authority in a prior Board decision. See Pamela E. Fleischer, 44 Van Natta 1258 on recon 44 Van Natta 1531 (1992), aff'd mem, 118 Or App 540 (1993).

[2] Although the course and scope test has been restated in the Court's decision in Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994), we do not find that an analysis under Norpac would lead to a different result. In Norpac, the Court stated that course and scope cases are to be analyzed using a unitary work-connection test in which the "arising out of" and the "in the course of" elements are both part of a single inquiry, which is whether the relationship between the injury and the work is sufficient to make the injury compensable. Norpac, supra. Similarly, in Carr, the court held that there must be some causal link between the occurrence of the injury and a risk connected with employment. Carr, supra, citing Phil A. Livesley Co. v. Russ, 296 Or 25 (1983).

[3] Claimant contends that her psychological problems arose from both the assault and harassment by her supervisor, and the actions of her employer after she reported the assault. However, we agree with the ALJ that the evidence shows that the main stressors identified as causing claimant's condition were the incidents involving Hirsch, the supervisor.

Member Christian specially concurring.

Because I believe that Carr v. U.S. West Direct Co., 98 Or App 30, rev den 308 Or 608 (1989) is indistinguishable and therefore binding precedent, I agree with the ALJ's determination. I write separately, however, to note that if I were deciding this case on a clean slate (i.e., in the absence of Carr), I would likely find that claimant's psychological condition bears a sufficient causal relationship to her employment simply because her work placed her in a position to be assaulted by her supervisor.

The underlying facts in Carr are very similar to those in the case at hand. In Carr, the plaintiff was employed as an outside sales representative. It was common practice for supervisors to accompany sales representatives on sales calls. One day, when Carr's supervisor accompanied her on such calls, he sexually harassed, assaulted and raped her. The supervisor then continued to sexually harass her in the office. Because she feared reprisal or the loss of her job, Carr did not report the rape and harassment for several months.

Carr ultimately sued the employer for intentional infliction of emotional distress, assault, battery and negligence. The trial court granted summary judgment for the employer. The first issue before the Court of Appeals was whether the employer was exempt from liability due to the exclusive remedy provision of the workers' compensation law, former ORS 656.018(1). In this regard, the court addressed whether Carr's rape and harassment were conditions that "arose out of" her employment. The court concluded as follows:

> "Here, the connection to the work is weak. The source of the injury bears little or no relationship to the employment. There is no evidence that the assaults were provoked by anything related to the work. * * * There is no evidence that the nature of the job or the environment created or enhanced the risk of assault. *The fact that the employment placed plaintiff and [her supervisor] together is not, in itself, enough.* * * * An employer is not subject to the workers' compensation law for all injuries to an employee irrespective of the cause merely because the employee is injured while working at the place of employment. *There must be some causal link between the occurrence of the injury and a risk connected with the employment.* * * * That link has not been established here[.]" Carr, supra 98 Or app at 35 (emphasis added).

Thus, Carr holds that a "but for" analysis of causation is insufficient to establish a work connection between an injury and the employment. Rather, even when the claimant's injuries arise out of an assault or sexual harassment by a supervisor, the claimant must show a direct causal link between the assault and the nature of the work activity to come within the coverage of the workers' compensation laws. See also Pamela E. Fleischer, 44 Van Natta 1258 on recon 44 Van Natta 1531 (1992) (no causal connection between assault and work where claimant failed to prove attack was motivated by any factor related to her employment). Given this rule, I agree that, in this case, claimant has not proven that her injuries "arose out of" her employment because there is no evidence that Hirsch's assault and harassment of claimant were provoked by anything related to the work. See Carr, supra.

Nevertheless, as I noted at the outset, if I were not constrained by Carr, I would conclude that claimant had established a sufficient work connection by virtue of the fact her work activity caused her to be in a position to be assaulted and harassed by her supervisor. At the time of the assault, claimant was on a business trip, preparing for the next day's meetings with Hirsch in her hotel room. Although claimant had stopped working and laid down to rest, Hirsch remained in the room working on the presentation until claimant fell asleep. In this situation, I believe the work environment appreciably increased the opportunity for, or risk there of, Hirsch's assault later that same night, because it allowed Hirsch access to claimant's room that he would not otherwise have had.

Finally, I realize that, insofar as we have found that claimant's psychological disorder did not arise out of and in the course of her employment, the employer is not exempt from tort liability for claimant's condition pursuant to ORS 656.018. See Carr v. U.S. Direct Co., supra.

Chair Hall dissenting.

Unlike the majority, I do not believe that Carr v. U.S. West Direct Co., 98 Or App 30, rev den 308 Or 608 (1989) compels a finding in this case that claimant's claim is not compensable. Therefore, I respectfully dissent.

Carr was an evidentiary case. It concerned the court's review of a summary judgment. In reversing a summary judgment, the court held that the employer did not show, as a matter of law, that the occurrence (the sexual assault of Carr by her supervisor) was covered by the workers' compensation law. In other words, the court found genuine issues of material fact concerning the causal link and no affirmative evidence that the assault was provoked by anything related to Carr's employment. 98 Or App at 35. Contrary to the majority's determination, Carr does not stand for the proposition that all sexual assaults by a supervisor against an employee fall outside the course and scope of employment. Rather, each case must be evaluated on its own facts to determine whether the claimant's employment

created or enhanced the risk of assault.[1] See, e.g. Barkley v. Corrections Division, 111 Or App 48 (1992).

The court did not pronounce new law in Carr. Rather, the court repeated fundamental principles of law then commented on the weakness of the evidence before it. The court concluded:

> "There must be some causal link between the occurrence of the injury and a risk connected with the employment. Phil A. Livesley Co. v. Russ, 296 Or 25, 672 P2d 337 (1983). That link has not been established here and we conclude, therefore, that the evidence on summary judgment does not compel the conclusion that the occurrence was covered by the workers' compensation law. US West is therefore not entitled to summary judgment on the ground that it is exempt from liability pursuant to ORS 656.018." Carr, supra 98 Or App at 35 (fn. omitted).

While the evidence in Carr was "weak" and while there was apparently no evidence that the "nature of the job or the job environment created or enhanced the risk of assault," that certainly does not mean that Carr forecloses workers' compensation coverage in a case where the evidence is not as weak. Therefore, the determinative issue in the present case is whether the evidence demonstrates that the nature of claimant's job or the job environment created or enhanced the risk of assault.

The majority errs in finding the facts in this case indistinguishable from Carr. There, the pertinent fact noted by the court was that the employment placed Carr and her supervisor together. Carr invited her supervisor to join her on sales calls to businesses to solicit telephone book advertisements, and in the course of the day, the supervisor assaulted and raped her. There was no evidence as to whether the nature of the job or the work environment affected the risk of assault.

Here, on the other hand, the evidence goes far beyond the mere fact that the employment placed claimant and Hirsch together. As set forth in the ALJ's order, Hirsch asked claimant to travel with him and other employees to Virginia for meetings with customers. During the trip, Hirsch and claimant spent time working together in claimant's hotel room, including evening hours. In fact, claimant's hotel room served as a field office for her and Hirsch's work activity; claimant's room was the location for the computer, printer, paperwork and other materials used for meetings with and presentations to the employer's customers. (Tr. 219, 1590). On the night of the assault, after a dinner meeting, claimant and Hirsch returned to claimant's hotel room where they discussed work and prepared for the next day's meetings and presentations. Claimant had turned on the television while they were working. At one point, claimant stopped working and moved from the table to sit at the head of her bed to watch television while Hirsch continued to work. At approximately 10:00 p.m., claimant took some pain medication for her cervical condition, which made her drowsy. She fell asleep with Hirsch still in the room. Sometime later, she was awakened by Hirsch sexually assaulting her.

On this record, I cannot conclude (as did the majority in affirming the ALJ's opinion) that the only connection between the assault and claimant's employment is the fact the employment placed claimant and Hirsch together. On the contrary, I believe that by virtue of the fact claimant and Hirsch used what was, in essence, claimant's bedroom (her hotel room) as the field office for their work on the business trip, claimant has shown that her job environment enhanced the risk of the assault.

In summary, I would find that the evidence presented in the extensive record in this case establishes the necessary causal relationship thus making this case distinguishable from Carr, which was the review of a summary judgment, decided based on the absence or weakness of evidence which would not compel judgment as a matter of law. Because I disagree with the majority's overly broad construction of Carr, and find persuasive evidence that the risk of claimant's assault was enhanced by work-related factors, I respectfully dissent.

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[1] For example, in Pamela E. Fleischer, 44 Van Natta 1258 (1992), we found an assault on the claimant was not compensable where the assault on claimant was directed at her personally and the claimant failed to prove that her work environment appreciably increased the risk of attack. See also Margaret B. Sparkes, 47 Van Natta 1365 (1995) (the claimant's work environment did not, in itself, expose her to an increased hazard of assault or other violent crimes); But see Jody N. Hayes, 47 Van Natta 1425 (1995) aff'd mem 141 Or App 439 (1996) (the claimant's employment exposed her to an increased risk of assault because the employer required her to park at the fringes of the parking lot in an area that was not well lit).

In the Matter of the Compensation of
RAMONA E. HAMILTON, Claimant
WCB Case No. 95-00721
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Garaventa's order that upheld the insurer's "precautionary" denial of claimant's degenerative arthritis and vascular conditions. On review, the issue is the validity of the denial under ORS 656.262(7)(a). We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin by briefly summarizing the background of the claim. Claimant, a medical aide, compensably injured her low back lifting a patient on January 10, 1994. Dr. Neuberg provided claimant's initial treatment and diagnosed radicular low back pain and a suspected herniated disc. (Ex. 4). Diagnostic studies revealed spondylolisthesis at L4-5 and L5-S1 and degenerative joint disease. (Exs. 7, 9). Dr. Neuberg opined that claimant had preexisting "structural" problems, but that the January 10, 1994 lifting incident aggravated the previously asymptomatic underlying condition. (Ex. 9).

In March 1994, Dr. Soldevilla performed a decompressive lumbar laminectomy at L4-5 with decompression, foraminotomy of L5-S1, and L4-5 disc exploration. (Ex. 23). On August 25, 1994, a Determination Order closed the claim with an award of 10 percent unscheduled permanent disability. (Ex. 31).

In November 1994, claimant again sought medical treatment, complaining of recurrent low back pain and bilateral leg discomfort. On December 5, 1994, Dr. Neuberg diagnosed recurrent low back pain and degenerative disc disease/degenerative joint disease of the lumbar spine. (Ex. 41). After a December 16, 1994 MRI showed a right-sided disc herniation at L4-5, Dr. Neuberg again referred claimant to Dr. Soldevilla. Claimant, however, changed physicians to Dr. Poulson, an orthopedic surgeon. Dr. Poulson later referred claimant to Dr. Pittman, a vascular surgeon, for an evaluation of her leg pain. Dr. Poulson reported that Dr. Pittman had discovered a vascular problem. (Ex. 54).

A February 3, 1995 Order on Reconsideration affirmed the Determination Order. (Ex. 56). In June 1995, claimant underwent vascular surgery.

On October 23, 1995, the insurer denied the compensability of claimant's treatment and disability for her degenerative arthritis and vascular conditions. (Ex. 72). Claimant requested a hearing. On January 12, 1996, the claim was again closed by Determination Order, which increased claimant's unscheduled permanent disability to 17 percent. (Ex. 80).

At hearing, the insurer's counsel clarified that the October 1995 denial was of degenerative disc disease and the vascular condition only, and that it was not intended to deny claimant's current low back condition. Rejecting claimant's contention that the insurer's denial of her degenerative arthritis and vascular conditions was procedurally improper, the ALJ initially concluded that the insurer's denial was an appropriate "precautionary" denial. Inasmuch as claimant did not contest the compensability of the denied conditions, the ALJ upheld the insurer's denial with respect to the degenerative arthritis and vascular conditions. However, finding that claimant's attorney was instrumental in gaining clarification from the insurer that its denial was not intended to be of claimant's current condition, the ALJ awarded an attorney fee for efforts expended in obtaining a "rescission" of a portion of the insurer's denial.

Claimant requested reconsideration of the ALJ's order, alleging that she filed no claim for the degenerative and vascular conditions and that, therefore, the insurer's denial was procedurally improper under ORS 656.262(7)(a). The ALJ rejected claimant's contention, concluding that, given the holding in

Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), the insurer was not required to wait for a new medical condition claim to be filed under ORS 656.262(7)(a) before it could clarify the scope of its acceptance. The ALJ reasoned that an insurer should be able to clarify its acceptance prior to issuance of a Determination Order which might award permanent disability for an unaccepted, unclaimed condition.

On review, claimant contends that the insurer's denial was procedurally improper, i.e. "premature," in the absence of a "new medical condition" claim made pursuant to ORS 656.262(7)(a). We agree.

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."

Pursuant to this statute, in order to assert a "new medical condition" claim, a claimant "must clearly request formal written acceptance" of a condition. Here, claimant made no "clear request" that either her degenerative arthritis or her vascular condition be accepted. The insurer does not contend otherwise. Thus, we find that no "new medical condition" claim was made pursuant to ORS 656.262(7)(a). Since a denial issued in the absence of a claim is a nullity, the insurer's denial has no legal effect. Altamirano v. Woodburn Nursery, Inc., 133 Or App 16, 19-20 (1995); Larry J. Bergquist, 46 Van Natta 2397 (1994).

The insurer asserts, however, that the ALJ correctly reasoned that a carrier should be able to issue a "precautionary" denial to avoid a Determination Order that awards impairment for unaccepted conditions. Citing Messmer, supra, the insurer argues that making a carrier wait until a Determination Order issues before it can challenge the compensability of an unaccepted condition places an unfair burden on a carrier. We disagree.

Inasmuch as there has been no claim for a "new medical condition," any Determination Order or Notice of Closure is unlikely to award permanent disability for an unaccepted condition. There is no allegation that the January 12, 1996 Determination Order did so. Moreover, should a closure notice or a Determination Order award permanent disability for an unaccepted condition, the carrier's appeal of the permanent disability award will afford it an appropriate opportunity to establish that any permanent disability due to the unaccepted condition is not due to the compensable injury. ORS 656.214(2), (5); see e.g. Robin W. Spivey, 48 Van Natta 2363 (1996) (disability attributable to preexisting degenerative disc disease eliminated from permanent disability award when not "due to" compensable injury). We are not persuaded that an "unfair burden" is placed on a carrier by prohibiting issuance of a denial before a new medical condition claim is made.

The insurer also contends that its preclosure denial was procedurally proper under ORS 656.262(7)(b), which 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." The insurer asserts that the medical evidence establishes that claimant's vascular and degenerative conditions "combined" with her compensable injury to prolong her need for treatment. See ORS 656.005(7)(a)(B). Thus, the insurer argues that, based on the medical evidence, its denial was procedurally and substantively proper with respect to a "combined condition." We disagree.

The insurer's denial stated that "it appears that your preexisting degenerative arthritis is combining with your vascular condition creating the need for treatment and disability at this time." (Ex. 72, emphasis added). While the language of the denial refers to a "combining," the denial does not allege that claimant's compensable injury "combined" with the preexisting degenerative and vascular conditions. Accordingly, we find that the insurer's denial itself was not based on a "combined condition." See Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993) (employers are bound by the express language of their denials).

Moreover, the insurer's counsel orally amended the denial to be a denial of degenerative disc disease and the vascular condition. The record does not reveal that the parties intended to litigate a denial based on a "combined condition" under ORS 656.005(7)(a)(B). (Tr. 2). Under these circumstances, we conclude that the insurer's denial was not procedurally valid under ORS 656.262(7)(b).

In summary, we conclude that the insurer's denial was "premature" inasmuch as claimant had not made a "new medical condition" claim under ORS 656.262(7)(a). Therefore, we reverse the ALJ's decision to uphold the insurer's denial.

Finally, claimant will not receive any benefits as a result of our holding that the insurer's denial was premature and, therefore, a "nullity." Thus, we conclude that claimant has not "prevailed" over a denied claim and is not entitled to an attorney fee under ORS 656.386(1). See William C. Becker, 47 Van Natta 1933 (1995) (where the claimant withdrew his claim and would not receive benefits as a result of the Board's decision that the carrier's denial of a "withdrawn" claim is a nullity, the claimant did not prevail over a denied claim and was not entitled to an attorney fee award under ORS 656.386(1)); see also Jacquelyne M. Schulte, 48 Van Natta 1649, on recon 48 Van Natta 1873 (1996) (following Becker).

ORDER

The ALJ's order dated April 18, 1996, as reconsidered on June 20, 1996, is reversed. That portion of the ALJ's order which upheld the insurer's denial of claimant's degenerative arthritis and vascular conditions is reversed. The insurer's denial of claimant's degenerative arthritis and vascular conditions is set aside as a nullity. The ALJ's attorney fee award is reversed.

December 11, 1996 Cite as 48 Van Natta 2440 (1996)

In the Matter of the Compensation of
LAVERNE W. MOORE, Claimant
Own Motion No. 94-0403M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Dennis O'Malley, Claimant Attorney
VavRosky, et al, Defense Attorneys

The self-insured employer requests reconsideration of our October 10, 1996 Own Motion Order Reviewing Carrier Closure, which set aside the employer's April 4, 1996 Notice of Closure as premature. The employer argues that the Board erred in relying on Dr. Grewe's medical opinion that claimant was not medically stationary at claim closure. On October 31, 1996, we withdrew our order for reconsideration. Having received claimant's response, we proceed with our reconsideration.

After reconsidering the record, as well as the parties' arguments, we conclude that we have nothing further to add to our October 10, 1996 order. We continue to rely on Dr. Grewe's well-reasoned, objective pre-closure medical opinion that further medical treatment would materially improve claimant's compensable condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 10, 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
LOIS M. RORDEN, Claimant
WCB Case No. 95-10721
ORDER ON REVIEW
Silven, Schmeits, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order which upheld the SAIF's Corporation's denial of her left hip injury claim. On review, the issue is compensability.

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

In upholding SAIF's denial, the ALJ reasoned that claimant had failed to sustain her burden of proving under ORS 656.005(7)(a)(B) that an incident at work on June 3, 1995 in which she lost her balance and fell, was the major contributing cause of her disability or need for treatment. On review, claimant contends that the medical evidence from her attending physician, Dr. Schoenfelder, satisfies her burden of proving major causation. Claimant cites Freightliner Corporation v. Arnold, 142 Or App 98 (1996) and Bronco Cleaners v. Velazquez, 141 Or App 295 (1996). We disagree with claimant's contention.

In Arnold, the court affirmed our finding that a medical expert's opinion that the claimant's work activities were a "material" contributing cause of his need for treatment was sufficient to establish major causation. The court reasoned that, despite the use of the term "material," the physician's testimony as a whole could reasonably be read as concluding that the "major" cause of the claimant's need for treatment was the occupational exposure.

In Velazquez, 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.

In contrast to the expert opinion in Arnold, Dr. Schoenfelder's opinion does not satisfy claimant's burden of proof in this case. Dr. Schoenfelder conceded that she could not say that the June 1995 incident was the major contributing cause of claimant's condition. (Ex. 12). Dr. Schoenfelder had earlier indicated that she was unsure of the etiology of claimant's pain complaints. (Ex. 12). Viewing Dr. Schoenfelder's opinion as a whole, we are unable to read it as concluding that the June 1995 incident was the major contributing cause of claimant's need for treatment. Moreover, we also find that claimant's evidence does not go beyond a chronological connection between claimant's symptoms and the June 1995 incident. Velazquez, supra.

Accordingly, we conclude that the ALJ properly upheld SAIF's denial. We, therefore, affirm.

ORDER

The ALJ's order dated June 10, 1996 is affirmed.

In the Matter of the Compensation of
ROBERT W. STEPHENSON, Claimant
WCB Case No. 95-06940
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Claimant requests reconsideration of our November 14, 1996 Order on Review in which we: (1) affirmed that portion of the ALJ's order which set aside the insurer's denial of claimant's current respiratory condition as premature; and (2) reversed that portion of the order which awarded an assessed fee pursuant to ORS 656.386(1). Arguing that we incorrectly reversed the ALJ's attorney fee award, claimant requests that we reconsider that portion of our order. For the following reasons, we adhere to our prior decision.

In our prior order, we agreed with the ALJ that the insurer's denial was prematurely issued because claimant had not made a "claim." However, we reversed the ALJ's award of an assessed attorney fee pursuant to ORS 656.386(1) because claimant would receive no benefits as a result of our holding that the insurer's denial was premature and a nullity. We cited William C. Becker, 47 Van Natta 1933 (1995); Jacquelyne M. Schulte, 48 Van Natta 1649, on recon 48 Van Natta 1873 (1996).

Claimant asserts that Becker and Schulte are distinguishable because the claimants in those cases had withdrawn their claims; whereas, in this case, claimant had not filed a claim and was forced into litigation by the insurer's premature denial. While Becker and Schulte differ somewhat factually from this case, the distinction that claimant draws is one without a significant difference. Regardless of whether a claim is withdrawn (as in Becker and Schulte) or, on the other hand, not made (as in this case), the fact remains that, in each case, the claimant received no benefits as a result of our decision that the carrier's denial was a nullity because there was no "claim" to deny. Accordingly, we continue to conclude that the ALJ's attorney fee award was improper.

Claimant also faults us for deciding the attorney fee issue even though no party raised the issue on review. However, the Board has de novo review authority and is free to make any disposition of the case it deems appropriate, including reaching issues that were before the ALJ but not raised by the parties on review. See ORS 656.295(5), (6); Destael v. Nicolai Co., 80 Or App 596 (1986); Miller v. SAIF, 78 Or App 158 (1986); Neely v. SAIF, 43 Or App 319, 323, rev den, 288 Or 493 (1979). Moreover, it naturally follows that, when it sought reversal of the ALJ's decision and reinstatement of its denial, the insurer was also requesting reversal of the ALJ's attorney fee award. Under such circumstances, we are free to address the issue on review.[1]

Accordingly, we withdraw our November 14, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our November 14, 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 further asserts that the award of an attorney fee under ORS 656.386(1) would serve as a "warning shot across the bow" to insurers who are contemplating issuing premature denials. Claimant's policy concerns notwithstanding, ORS 656.386(1) is premised on the existence of a "denied claim." Thus, in the absence of a "claim," the statutory predicate for an attorney fee award has not been satisfied. To the extent that claimant is concerned about future premature denials, we would note that a potential deterrent to such actions (if found unreasonable) is ORS 656.382(1). Since no such award was sought and since we would not find the insurer's conduct to have been unreasonable, ORS 656.382(1) is not applicable in this case.

Board Chair Hall specially concurring.

In accordance with the reasoning in my dissent in William C. Becker, 47 Van Natta 1933 (1995), I would, on a clean slate, construe the term "prevail" in amended ORS 656.386(1) to mean "obtain a rescission of the denial" rather than "obtain compensation" and conclude that where, as here, a claimant is successful in invalidating the carrier's denial in a hearing before the ALJ and/or on review by the Board, he or she is entitled to an assessed attorney fee, whether or not the claimant actually obtains compensation. My reasoning in Becker is even more appropriate in this case where the insurer issued a premature denial and claimant would have been adversely affected if the denial (albeit prematurely issued) was allowed to stand. Clearly, claimant in this case was forced to either litigate or to suffer the

consequences of allowing the insurer's denial to stand. Under these circumstances, were it not for our decision in Becker, I would conclude that claimant has prevailed against the insurer's denial and should receive an assessed fee pursuant to ORS 656.386(1).

Having said that, however, I am bound by Board precedent which includes the Becker decision. That precedent (wrongly decided in my view) requires that a claimant not only prevail in having a denial set aside, but he or she must also "obtain compensation." Since claimant will not obtain any benefits as a result of our decision that the insurer's denial was premature, and given the applicable Board precedent, I am forced to conclude once more that claimant's attorney is not entitled to an assessed fee.

December 13, 1996 Cite as 48 Van Natta 2443 (1996)

In the Matter of the Compensation of
TONY D. HOUCK, Claimant
WCB Case No. 95-11555
ORDER ON REVIEW
Cheek & Tiscornia, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by the Board en banc.

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

FINDINGS OF FACT

Claimant is right-handed. Claimant complained of left wrist and forearm symptoms in October and into December of 1993 while incarcerated. (Exs. 1, 2, 3, 4). These symptoms included left forearm and hand pain with some paresthesias and numbness in the left hand. Id. Claimant had a negative Phalen's test and a positive Tinel's test and was diagnosed with carpal tunnel syndrome (CTS). (Ex. 1). In December 1993, Dr. Sund, M.D., performed an EMG/NCV study that was normal, with no evidence of CTS, radiculopathy, or other peripheral neuropathic process. (Ex. 4). Claimant's left wrist symptoms improved thereafter and he had no other symptoms in that area until August of 1994, when he reported straining his left wrist while using a hammer. The left wrist strain resolved after one medical treatment. (Ex. 6, Tr. 20).

After being released by the Department of Corrections, claimant began working for the present employer in January 1995 as a "bagger." Within a few weeks, claimant was transferred to the painting room, where his job consisted of pushing carts containing twenty racks of nuts and bolts into the painting room, unloading and reloading each rack for painting. These racks weighed between 5 and 30 pounds. He also painted these racks of product using a spray gun with a one quart tank and hoses attached. This process required several passes back and forth over the racks of product while pulling the sprayer trigger with his index and middle fingers. Claimant estimated he made from 6,000 to 8,000 passes per shift. He performed this painting task alternatively with his left and right hand. After painting a cart of product, he would push the cart back and start the process over. He worked five days per week, totaling between 40 and 55 hours per week. (Ex. 17). Dr. Gulick was aware of claimant's job duties.

On June 15, 1995, claimant first sought treatment from Dr. Gulick for bilateral hand and wrist numbness. (Ex. 8). At that time, claimant had been working in the painting room approximately five months and had experienced bilateral hand and wrist symptoms for one week. Id. Dr. Gulick's examination showed positive Phalen's and Tinel's tests. Dr. Gulick diagnosed bilateral CTS, prescribed medications and splints, and took claimant off work for three days. Claimant then returned to a job as a machine operator.

On July 13, 1995, claimant returned to Dr. Gulick with continued complaints in his wrists and additional complaints in his left elbow. (Ex. 9). Examination of the wrists revealed bilaterally positive Tinel's tests and negative Phalen's tests, complaints of paresthesias in the second to fourth fingers

bilaterally, no visible wasting, weakness, or other findings. Id. Examination of the left elbow revealed medial epicondyle tenderness, exacerbated by wrist flexion. Dr. Gulick diagnosed probable bilateral CTS and definite left medial epicondylitis. Id.

On July 28, 1995, claimant returned to Dr. Gulick with worsened symptoms with continued work. (Ex. 11). Following examination, Dr. Gulick diagnosed probable CTS "with now muscle spasms from apparent pain" as well as lateral and medial epicondylitis. Id. Due to the degree of problems and claimant's lack of response to the prior medications, Dr. Gulick administered a regimen of steroid injections and restricted claimant to modified work. Id.

On August 3, 1995, claimant underwent electrodiagnostic testing, which was normal, with no evidence of bilateral median or ulnar entrapment neuropathy. (Ex. 13). By August 29, 1995, the steroid injections relieved claimant's symptoms and Dr. Gulick released claimant to full work duty. (Ex. 14).

On September 6, 1995, the employer issued a denial of claimant's claims for bilateral CTS and left epicondylitis. (Ex. 15). Thereafter, claimant continued to see Dr. Gulick, complaining of ongoing bilateral wrist symptoms.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to establish compensable occupational disease claims for the three claimed conditions: (1) left wrist and forearm condition; (2) right wrist and forearm condition; and (3) left epicondylitis condition. Regarding the left wrist and forearm condition, the ALJ found that claimant had failed to prove a pathological worsening of his condition, concluding that a preexisting CTS condition combined with claimant's current condition, requiring claimant to meet the higher standard of proof under ORS 656.802(2)(b). Regarding the other two conditions, the ALJ found that claimant failed to establish the required "objective findings" to support compensable occupational disease claims. See ORS 656.005(19); ORS 656.802(2)(d). We disagree.

We first determine which provisions of the Workers' Compensation Law are applicable to the three claimed conditions. See Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995); Dibrito v. SAIF, 319 Or 244, 248 (1994) (it is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim). There is no evidence that claimant had any preexisting conditions regarding his right wrist/forearm and his left elbow. Therefore, in order to establish a compensable occupational disease claim for the right wrist/forearm condition and the left epicondylitis condition, claimant must prove that employment conditions were the major contributing cause of those conditions. Amended ORS 656.802(2)(a); see also amended ORS 656.802(1)(a)(C). In addition, the existence of an occupational disease must be established by medical evidence supported by objective findings. Amended ORS 656.802(2)(d).

However, regarding the left wrist/forearm condition, the employer argues that the requirements of amended ORS 656.802(2)(b)[1] apply, contending that "[b]ecause Dr. Gulick believed claimant's preexisting condition and current problem elicited the same symptoms it stands to reason claimant['s] prior and current injuries are the same injury." (Employer's Respondent's Brief, page 4). We disagree.

Amended ORS 656.802(2)(b) references amended ORS 656.005(7) in establishing the standard of proof in an occupational disease claim based on the worsening of a preexisting disease. We have previously determined that, in order for amended ORS 656.005(7)(a)(B) to apply, there must be evidence of a preexisting condition combining with the work injury to cause or prolong disability or a need for treatment before compensability is analyzed under amended ORS 656.005(7)(a)(B). Leon M. Haley, 47 Van Natta 2056 (1995). Because numerous factors could potentially contribute to claimant's conditions, the cause of his occupational disease conditions, including the issue of whether there was a "combining" of the 1993 and 1995 left wrist conditions, is a complex medical question which requires expert medical opinion to resolve. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

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[1] Amended ORS 656.802(2)(b) provides that "[i]f 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." Amended ORS 656.005(7)(a)(B) provides that where an otherwise compensable injury combines with a preexisting condition, claimant must establish that the compensable injury is the "major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

The only medical opinion regarding claimant's condition in 1995 is provided by Dr. Gulick, attending physician. While acknowledging that claimant had a prior episode of CTS in 1993, with similar symptoms and test results in 1993 and 1995, Dr. Gulick does not opine that these conditions combined. (Exs. 18-10, -11). Also, during his deposition, Dr. Gulick suggested that the 1993 CTS resolved prior to the work activities in 1995. (Ex. 18-11-12). Although we recognize that "magic words" are not required, we do not find that Dr. Gulick's reports and testimony establish that the 1993 left hand condition combined with the 1995 left hand condition.[2] McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

Accordingly, on this record, there is no evidence that claimant's 1995 work injury combined with his preexisting 1993 left CTS condition to cause or prolong disability or need for treatment. Therefore, neither amended ORS 656.802(2)(b) nor amended ORS 656.005(7)(a)(B) apply to this claim. Consequently, the same standards apply in determining compensability of the left wrist/forearm condition as apply to the right wrist/forearm and left epicondylitis conditions. Amended ORS 656.802(1)(a)(C); amended ORS 656.802(2)(a); amended ORS 656.802(2)(d). Accordingly, claimant must establish by medical evidence supported by objective findings that employment conditions were the major contributing cause of his bilateral wrist/forearm conditions and his left epicondylitis condition. Id.

Dr. Gulick provides the only medical opinion regarding the cause of the bilateral wrist/forearm conditions and the left epicondylitis condition. After reviewing a complete description of claimant's painting work activities and claimant's medical records regarding his prior treatment for the left wrist condition, Dr. Gulick opined that the painting work activities were the major contributing cause of all three conditions. (Ex. 17). In addition, Dr. Gulick further explained his opinion in a deposition. (Ex. 18). Regarding the bilateral wrist/forearm conditions, Dr. Gulick noted that claimant's only positive findings for CTS were the positive Phalen's and Tinel's tests. However, he also stated that positive nerve tests are not required for a valid diagnosis of CTS. (Ex. 18-16). He opined that, although the conclusion as to whether claimant has CTS or an overuse syndrome is not solid, the painting work is the major contributing cause of the condition, unless claimant was not truthful about his lack of contributing off-work activities or something else in his history. (Ex. 18-20). There is nothing in the record to indicate that claimant was not truthful about his off-work activities or anything else in his history.

Whether the bilateral wrist/forearm condition is diagnosed as CTS or an overuse syndrome, the condition is compensable if claimant proves the necessary elements to establish compensability. Dr. Gulick persuasively opined that the painting activities were the major contributing cause of claimant's bilateral wrist/forearm conditions and his left epicondylitis condition. Furthermore, contrary to the employer's argument, we do not find Dr. Gulick's opinion conclusory. In reaching his conclusion, Dr. Gulick considered the fact that claimant had no medical conditions that would predispose him to developing these conditions, no contributing off-work activities, and the painting work claimant did was the type of activity that would cause these conditions. (Exs. 17, 18).

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 reasons not to defer to Dr. Gulick's causation opinion in that it is well-reasoned and based on a complete history. Somers v. SAIF, 77 Or App 259 (1986).

Finally, we must determine whether the existence of the bilateral wrist conditions and the left epicondylitis condition are established by medical evidence supported by objective findings. Amended ORS 656.802(2)(d). For the following reasons, we find that they are.

Amended 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

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[2] The employer argues that James F. Rutledge, Jr., 47 Van Natta 2036 (1995), supports its argument that claimant's 1993 left CTS condition combined with his 1995 left wrist condition. We find Rutledge distinguishable on the facts. In Rutledge, we relied on evidence of ongoing problems and a chronic knee condition to determine that there was a "combining" of a preexisting knee condition with a compensable knee injury to cause or prolong the claimant's disability or need for treatment. Here, unlike Rutledge, there is no evidence of any ongoing problems or chronic condition. Therefore, Rutledge does not support the employer's argument.

findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

In Jairo J. Garcia, 48 Van Natta 235 (1996), we interpreted amended ORS 656.005(19) and determined that the clear intent of the legislature was to overrule the holding in Suzanne Robertson, 43 Van Natta 1505 (1991). In Robertson, we held that, under former ORS 656.005(19), the requirement of "objective findings" could be satisfied by a worker's description of the pain he was experiencing, as long as the physician indicated that the worker in fact experienced symptoms and did not merely recite the worker's complaints of pain. In Garcia, after examining the legislative history for amended ORS 656.005(19), we concluded that "only a physician's indication that the worker experiences pain no longer is sufficient to be 'objective findings.'" 48 Van Natta at 237.

In Garcia, because the physician indicated only that the claimant had pain and all other findings were normal, there were no "verifiable indications of injury" as required by amended ORS 656.005(19). Furthermore, the physician reported only a "subjective response" in that the claimant showed no findings that were "reproducible, measurable or observable." Therefore, we found that the claimant's claim failed due to an absence of "medical evidence supported by objective findings." 48 Van Natta at 237.

Here, relating to the bilateral wrist condition, Dr. Gulick noted that claimant's nerve studies were normal and he did not have the more serious signs of "wasting weakness, frank numbness." (Ex. 18-5). However, Dr. Gulick reported as objective findings claimant's positive Phalen's and Tinel's tests. (Exs. 17-2, 18-5). He acknowledged that these tests rely on the patient's response. (Ex. 18-5). However, he opined that "physicians usually find the Tinel's and Phalen's tests as fairly objective because not many patients know how to fake them."[3] (Ex. 18-14). In addition, Dr. Gulick indicated that the Tinel's and Phalen's test results were reproducible.[4] (Ex. 18-9-10).

The employer argues that, because the Tinel's and Phalen's test results are dependent on claimant's subjective response, they do not constitute "objective findings." We disagree. Although the tests were based on claimant's response, the record shows that the results were "verifiable indications of disease" under amended ORS 656.005(19) which were "reproducible." For the following reasons, we find that this record meets the requirements of "objective findings" as defined by amended ORS 656.005(19).

Our task is to determine what the legislature intended by amending ORS 656.005(19). We begin with the text and context of the provision, resorting to extrinsic aids only if those sources are unavailing. PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993). The first sentence of amended ORS 656.005(19) provides that "'[o]bjective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength, and palpable muscle spasm." The term "verifiable indications of injury or disease" is not defined in the statute, although a list of possible examples that meet that criteria is provided. Furthermore, the second sentence of amended ORS 656.005(19) is written in the negative and states, in pertinent part, that "'[o]bjective findings' does not include . . . subjective responses to physical examinations that are not reproducible, measurable or observable." The terms "subjective responses" and "reproducible, measurable or observable" are not defined in the statute. Because we find that such language is ambiguous, we look to the legislative history for guidance.

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[3] We note that the employer states that the term "objective findings" as used in amended ORS 656.005(19) is a legal term, not a medical term. Craig H. Ayer, 43 Van Natta 2619 (1991), aff'd mem SAIF v. Ayer, 116 Or App 515 (1992). After our review of the record and for the reasons that follow, we conclude that claimant's findings meet the legal term's standard of "objective findings" under amended ORS 656.005(19).

[4] The employer focuses on Dr. Gulick's response that, if the Tinel's and Phalen's tests had been conducted by several different examiners on the date Dr. Gulick first performed them, the positive results would have been reproducible. The employer argues that this response is based on speculation and does not establish that the tests were reproducible. However, that is not the extent of Dr. Gulick's opinion. The record establishes that, on various subsequent exams, claimant had positive Phalen's and/or Tinel's tests. (Exs. 9, 16). This demonstrates that the test results were "reproducible." Dr. Gulick explained that claimant's varying Tinel's and Phalen's test results were due to the timing of the tests in relationship to claimant's work activities and medical treatment. (Ex. 18-9-10).

We acknowledge that, after examining the legislative history for amended ORS 656.005(19), we have previously determined that the legislature intended that "only a physician's indication that the worker experiences pain no longer is sufficient to be 'objective findings.'" Jairo J. Garcia, 48 Van Natta at 237. We do not revisit that determination. However, the present case involves not merely reports of pain, but subjective responses to physician testing. Such circumstances do not fall within the parameters of Garcia, and require further examination of legislative history to determine whether the legislature intended to include such subjective responses to physical testing within the meaning of "objective findings."

Before the House Committee on Labor, Representative Mannix testified:

> "The case law has moved in the direction of saying that the physician believes the patient's complaints of pain, that that in effect is an objective finding. This will change that. This says that you have to have verifiable pathologic indication of injury or disease, and then we give examples. It's not an exclusive list. * * * * Then we try to define what 'objective findings' does not include, sort of in the negative. It does not include physical findings or subjective responses -- meaning I say something rather than you see something -- to physician examinations, and -- here's the important standard -- that are not consistently reproducible, measurable or observable or do not fit an anatomic pattern and that cannot be demonstrated after reasonable medical evaluation." March 1, 1995, Tape 39A.

Representative Mannix went on to explain this concept using range of motion testing as an example, stating:

> "Well, the way you test this sort of thing is you don't just accept that [a worker's statement that a certain level of range of motion is starting to bother him] at face value, you have the person do it in another mode or unless they are really medically sophisticated they don't realize they are testing the same physiology as to whether or not there truly is a pain response. And if you repeat this test a couple of different times or in a couple of different modes -- if it is reproducible at about the same point of extension range of motion the person complains of pain -- that is a reproducible finding and so when the worker tells you he hurts that's one thing, but if you run this test a couple of times at a couple of different times or in a couple of different ways you could start verifying whether or not this is true. Then you can have another doctor examine the person and see whether or not they come up with the same findings. That is something which is consistently reproducible. Sometimes you will have other things that are measurable and you can actually do a measurement as to the physiology at the time. Fine. If that's measurable or observable you can see it, okay. What we are getting at, though, is if someone says "I hurt, I fell down yesterday and I hurt," that is not enough. They need to go beyond that and find out what really happened and what is the physiology and ask the physician to provide a report that's consistent with these standards." Id.

Representative Mannix also offered testimony before the Senate Committee on Labor and Government Operations, stating:

> "It is almost an impossible task, but the point is that we are looking for verifiable pathologic indications of injury or disease. Then we list the kind of things that are, in our mind, objective findings. But we also list things that are not and that includes the subjective responses to physical examinations that are not consistently reproducible, measurable or observable or do not fit in an anatomical pattern and which can't be demonstrated after a reasonable medical evaluation. The point here is there are ways physicians can repeat a test on an individual a few minutes later under different circumstances and, for instance, you are trying to test to see whether or not a nerve is being impinged upon and they perform one kind of test in the sitting position and then they perform a different test lying down. And it's the same test lying down but the individual being tested doesn't know that unless they know their anatomy real well and they don't reproduce the same finding. You suddenly know you are getting an unverified complaint that doesn't really fit an anatomic pattern. That's the kind of thing we are talking about." February 17, 1995, Tape 47A.

Regarding Senator Leonard's interpretation that "claims currently that depend upon a doctor's interview of a patient and the responses from the patient that are now authorized, with this language would not be," Representative Mannix responded:

> "That's a fair statement. If it's just based on an interview, unless it's a psychiatric claim in which you can learn a lot of things about the brain through interviews. But you can't learn much about the body just through statements. What physicians who are practicing in these areas usually do is they conduct a physical examination. They do range of motion studies. If you have a person who fell off a ladder, they are likely to have some stiffness on range of motion studies and you will be able to reverify that by doing a similar study five minutes later. On the other hand, if they are making it up, doing a different form of range of motion study they probably won't be anatomically sophisticated enough to reproduce that inability to move or stiffness on another test. Then the physician can report that.
>
> Senator Leonard: "You are saying there are some injuries that, like a back injury, that may not show up on an x-ray, may not have any bruises, that there are tests to confirm that in fact there is a strain? That produce objective results?"
>
> Representative Mannix: "Yes, this is where we come up with the verifiable. We talk about the range of motion. And if it's repeated consistently, reproducible in various ways, that does tell you something eventually. After you have repeated it in a different position at a different time, unless the person is a very sophisticated person and very few of us are sophisticated enough to falsify that kind of a result. You've got a pretty good verification." Id.

Based on this testimony, we find that the legislature distinguished between a physician merely adopting a worker's complaint of pain and a physician interpreting a worker's subjective responses to clinical testing. Although rejecting the former, the legislature intended that the latter be relied on, provided it was "reproducible, measurable or observable."[5]

As further support of this interpretation, we offer the following. First, regarding the reference to "verifiable indications of injury or disease" in the first sentence of amended ORS 656.005(19), we note the dictionary definition of "verifiable" is "capable of being verified[;] . . . susceptible to the possibility of being either theoretically or actually proved true or false by reference to empirical facts." Webster's Third New International Dictionary of the English Language Unabridged 2453 (1993). The definition of "verify" includes "to confirm or establish the authenticity or existence of by examination, investigation, or competent evidence." Id. As Dr. Gulick's unrebutted testimony establishes, Tinel's and Phalen's tests are medical tests that are considered competent evidence to confirm the existence of CTS. Moreover, claimant tested positively at various times when Dr. Gulick rendered these tests. Therefore, on this record, we find that claimant's positive responses to Tinel's and Phalen's tests constitute "verifiable indications of injury or disease" under amended ORS 656.005(19).

In addition, we note that two of the four examples provided in amended ORS 656.005(19) that meet the definition of "objective findings" are based on a worker's subjective responses -- "range of motion" and "muscle strength." In this regard, both a loss of range of motion and a loss of muscle strength may be due to a worker's subjective response to pain in performing certain tasks. In other words, it is pain that limits the worker's motion and/or strength. However, the legislature specifically included these "subjective" limitations as examples of permissible "objective findings." Therefore, although the legislature intended that a physician's indication that the worker experiences pain would not satisfy the requirement of "objective findings," it obviously did not intend to eliminate the consideration of a worker's verifiable subjective responses to pain. This is demonstrated by the legislative history from Representative Mannix, as quoted above.

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[5] We note that the ALJ's interpretation of amended ORS 656.005(19) was based, in part, on Representative Mannix's January 30, 1995 legislative testimony. So, too, was a portion of our analysis in Garcia. The proposed amendments to ORS 656.005(19) underwent substantial modification during the 1995 legislative session. Our analysis here takes into consideration those changes and relies on Representative Mannix's subsequent testimony. For example, between January 30, 1995 and the date of the legislative sessions referenced above, the term "consistently" was deleted before the word "reproducible," and the term "measurable or observable" was added.

Finally, we note that the second sentence of amended ORS 656.005(19) is written in the negative and states, in pertinent part, that "'[o]bjective findings' does not include . . . subjective responses to physical examinations that are not reproducible, measurable or observable." Furthermore, the requirements of "reproducible, measurable or observable" are expressed in the disjunctive, rather than the conjunctive. Thus, meeting any one of these requirements is sufficient to support a finding of "objective findings." Consequently, it follows that subjective responses to physical examinations that are reproducible are included in "objective findings." In other words, the statutory definition of "objective findings" does not rule out reproducible subjective responses. This, too, is supported by Representative Mannix's quoted testimony.

Here, as discussed above, we find claimant's positive responses to the Tinel's and Phalen's tests constitute verifiable subjective responses to pain that are reproducible and come within the definition of "objective findings." Accordingly, we conclude that claimant has established compensable bilateral wrist/forearm conditions supported by "objective findings" under amended ORS 656.005(19).

We turn to the left epicondylitis condition. Dr. Gulick initially opined that claimant's objective findings were "pain at [the] medial epicondyle increased with muscle use." (Ex. 17-2). However, in his deposition, Dr. Gulick stated that he noted "tenderness" or, more specifically, he was "evoking pain in finding tenderness." (Ex. 18-6, -7). When asked if he was depending on the patient's response in order to report a finding, Dr. Gulick responded:

> "Not as much, because there's ways to trick patients. And there's consistencies or inconsistencies such as with patients oftentimes not showing which muscles you're going to exacerbate that pain and those which are not. So when he [claimant] showed pain with resisted extension of his wrist, to me that was a strong confirmation that this was lateral epicondylitis, whereas a lot of my patients who are trying to cheat me will show that pain here and there, but the exacerbating features of that tenderness and pain don't fit." (Ex. 18-7).

In addition, Dr. Gulick noted that he performed "wrist extensors and flexors" in diagnosing medial or lateral epicondylitis. Id. Finally, he indicated that he performed these tests on claimant and the results confirmed the diagnosis of left epicondylitis. (Exs. 9, 18-7). In other words, Dr. Gulick verified claimant's symptoms, or indications of disease, through clinical testing involving resisted extension and flexion of the wrist. We find that Dr. Gulick's unrebutted validity testing establishes that claimant has "verifiable indications of disease" under amended ORS 656.005(19) which are "reproducible." Therefore, on this record, we conclude that claimant has established a compensable left epicondylitis condition supported by "objective findings." Accordingly, we find that claimant has established all elements of a compensable occupational disease claim for his wrist/forearm conditions and the left epicondylitis condition.

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 $3,800, 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 issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 9, 1996 is reversed. The self-insured employer's September 6, 1995 denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,800, payable by the employer.

Board Member Haynes dissenting.

I disagree with the majority's conclusion that the existence of claimant's conditions were established by medical evidence supported by objective findings. I base this disagreement on the following reasoning.

As the majority points out, in Jairo J. Garcia, 48 Van Natta 235 (1996), we determined that, by amending ORS 656.005(19), the legislature intended to overrule the holding in Suzanne Robertson, 43 Van Natta 1505 (1991). In Robertson, we held that, under former ORS 656.005(19), the requirement of "objective findings" could be satisfied by a worker's description of the pain he or she was experiencing, as long as the physician indicated that the worker in fact experienced symptoms and did not merely recite the worker's complaints of pain. See also Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992). In Jairo J. Garcia, supra, we examined the legislative history for the 1995 amendments and concluded that only a physician's indication that the worker experiences pain was no longer sufficient to constitute "objective findings."

Regarding claimant's left epicondylitis condition, the majority concludes that Dr. Gulick found objective findings of that condition essentially because he believed claimant's response of pain. That is no different than the standard we set forth in Suzanne Robertson, supra, and which the legislature rejected by amending ORS 656.005(19). The majority's "reincarnation" of Suzanne Robertson, supra is clearly contrary to legislative intent.

Regarding claimant's wrist conditions, the majority concludes that, although the Tinel's and Phalen's test results were dependent on claimant's subjective response, the positive response to either test that is reproducible constitutes a "verifiable indication[] of injury or disease" and meets the definition of "objective findings" under amended ORS 656.005(19).

Under amended ORS 656.005(19), "objective findings" are "verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm." The majority defines "verifiable" as "capable of being verified[;] . . . susceptible to the possibility of being either theoretically or actually proved true or false by reference to empirical facts." Webster's Third New International Dictionary of the English Language Unabridged 2453 (1993).

Although I agree with the majority's definition of "verifiable," I do not agree with its application to this case. Even if the worker gives the same subjective response to a Phalen's and/or Tinel's test on more than one occasion, that does not mean that it is a "verifiable" indication of an injury or disease. Here, Dr. Gulick agreed that, by performing a Phalen's test and Tinel's test, he was basically depending upon the patient's response to determine whether it was positive or negative. (Ex. 18-5). As such, that response is not "verifiable" because it is not "susceptible to the possibility of being either theoretically or actually proved true or false by reference to empirical facts." Webster's, supra, at 2453. The legislative history we discussed in Jairo J. Garcia, supra, establishes that the legislature did not intend to rely merely on the subjective responses of the worker.

For the foregoing reasons, I respectfully dissent.

December 12, 1996 Cite as 48 Van Natta 2450 (1996)

In the Matter of the Compensation of
PATRICIA J. HOFSTETTER, Claimant
WCB Case Nos. 96-01165 & 95-10561
ORDER OF ABATEMENT
Welch, Bruun, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our November 19, 1996 order which set aside its denial of claimant's claim for a left shoulder condition. In its motion, the employer objects to the portion of our order which finds that the employer's denial was based solely on a lack of objective findings and declines to consider medical causation.

In order to further consider this matter, we withdraw our November 19, 1996 order. Claimant is granted an opportunity to respond to the employer's motion. In order to be considered, claimant's response must be received within 14 days of the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIE C. JOHNSON, Claimant
WCB Case Nos. 95-05792, 95-05496 & 95-03836
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Christian and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Johnstone's order that upheld the self-insured employer's denial of her occupational disease claim for a right rotator cuff tear.[1] Claimant also requests that we remand the case for a new hearing before a new ALJ, contending that she failed to receive a fair and impartial hearing. In response to claimant's motion to remand, the employer seeks sanctions against claimant's attorney for a frivolous motion. On review, the issues are remand, sanctions and compensability.

We deny the claimant's request for remand and the employer's request for sanctions and adopt and affirm the ALJ's order with the following supplementation.

Remand

Claimant contends that the case should be remanded for a new hearing before a new ALJ because ALJ Johnstone appeared to be "biased" in favor of the employer's attorney at hearing.[2] Claimant also argues that ALJ Johnstone's acceptance of employment with the employer's attorney's firm shortly after issuing the Opinion and Order in this case had the "appearance of impropriety" and shed further light on his alleged partiality at hearing. For the reasons set forth below, we deny claimant's motion to remand.

To the extent that claimant felt during the January 12, 1996 hearing that the ALJ was biased in favor of the employer's attorney, she should have objected at that time and requested a change of ALJ. See OAR 438-006-0095(2).[3] Claimant's request for a new hearing at this stage of the litigation is neither timely nor in accordance with the applicable administrative rule. See Philip G. Michael, 46 Van Natta 519 (1994); Virginia L. Baker, 44 Van Natta 217 (1992). Even assuming claimant's objection to the ALJ's demeanor was timely, because our review of the record is de novo, we are statutorily authorized to make our own appraisal of the documentary and testimonial evidence. See Sueyen A. Yang, 48 Van Natta 1626 (1996). Therefore, we find no compelling reason to remand for a new hearing before a new ALJ.[4]

With regard to claimant's charge of bias based on ALJ Johnstone's change of employment, we find no reasonable likelihood that the ALJ's acceptance of employment with the employer's attorney's firm in late April 1996 affected the outcome of this case. Further, we again note that we review this matter de novo. Therefore, we also find no compelling reason to remand based on the ALJ's subsequent employment with the employer's attorney's firm. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986) (remand is appropriate upon a showing of good cause or other compelling basis).

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[1] The employer has withdrawn its cross-request for review of that portion of the ALJ's order that awarded interim compensation.

[2] In sworn affidavits, claimant, her husband and claimant's counsel all attested to the ALJ's manner at hearing.

[3] OAR 438-006-0095(2) provides, in pertinent part, that any party may request that the ALJ be removed from the case on grounds of personal bias by promptly filing an affidavit with the Presiding ALJ setting forth the matters believed to constitute the grounds for disqualification.

[4] Notwithstanding claimant's contention that the ALJ improperly sustained the employer's objections to certain questions asked during the direct examination of claimant, we find no abuse of discretion in the ALJ's evidentiary rulings. See Brown v. SAIF, 51 Or App 389, 394 (1981) (an ALJ has broad discretion concerning the admission of evidence at hearing).

Sanctions

The employer requests sanctions pursuant to ORS 656.390(1), contending that claimant's motion to remand is frivolous, in that it was "initiated without reasonable prospect of prevailing."[5] See ORS 656.390(2); Winters v. Woodburn Carcraft Co., 142 Or App 182 (1996). We disagree.

With regard to Board review, ORS 656.390(1) expressly pertains to "appeals" that are frivolous or filed in bad faith.[6] The statute does not expressly refer to frivolous motions for remand, and it is questionable whether such motions 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 claimant had at least a colorable argument for seeking a remand for rehearing based on the ALJ's acceptance of employment with the employer's law firm shortly after issuing the order in this case. Therefore, assuming ORS 656.390(1) was applicable, we cannot say that claimant's motion for remand was initiated without any reasonable prospect of prevailing.

Compensability

We briefly summarize the facts. Claimant, who at all pertinent times worked as a receptionist/member assistant at the Bess Kaiser Emergency Room, compensably injured her right shoulder in October 1990, when she struck it against the end of a steel pipe. She sought treatment and was diagnosed with a contusion of the right shoulder. Claimant filed an 801 claim form, and the employer accepted a nondisabling right shoulder contusion.

Between 1990 and February 1994, claimant continued to have right arm and shoulder pain that would wax and wane. She would occasionally obtain prescriptions for Motrin from the urgency care physicians, and regularly took Motrin for her pain. She also received Cortisone injections on one or two occasions.

On February 24, 1994, claimant sought treatment for her shoulder from Dr. Utterback. A right shoulder arthrogram revealed a partial thickness tear of the rotator cuff. Dr. Utterback surgically repaired the rotator cuff tear on May 31, 1994. Shortly thereafter, the employer accepted claimant's disabling right rotator cuff as an aggravation of her October 10, 1990 injury.

Claimant continued to experience right shoulder pain post-surgery, and was evaluated by Drs. Browning, Tilson and Loch through the Kaiser system. A repeat arthrogram revealed a recurrent right rotator cuff tear, which Dr. Loch surgically repaired on January 20, 1995. On February, 8, 1995, claimant, through her counsel, filed a new occupational disease claim for her right shoulder condition, which the employer denied on May 11, 1995.

The ALJ upheld the insurer's denial of claimant's occupational disease claim for a right rotator cuff tear, finding that claimant failed to prove that her employment activities were the major contributing cause of her condition. Specifically, the ALJ found the medical opinions supporting the compensability of claimant's rotator cuff tear as a new occupational disease unpersuasive because they were based on an inaccurate history.

On review, claimant asserts that the medical opinions of Drs. Loch and Puziss are based on a complete and accurate understanding of claimant's symptoms and her work activities between October 1990 and February 1994. Like the ALJ, we find to the contrary.

To prove the compensability of her condition as a new occupational disease, claimant must prove that her employment conditions were the major contributing cause of her right rotator cuff tear. ORS 656.802(2). To the extent the occupational disease claim is based on the worsening of a preexisting disease or condition, i.e., her compensable shoulder injury, claimant must prove that her employment conditions were the major contributing cause of her combined condition and a pathological worsening of the disease. ORS 656.802(2)(b). Because the causation issue in this case presents a complex medical question, it must be resolved by expert medical opinion. See Uris v. Compensation Dept., 247 Or 420

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[5] The employer does not contend that claimant's request for review is frivolous, nor do we find that to be the case.

[6] ORS 656.390(1) provides, in pertinent part, that if either party "requests review of an Administrative Law Judge's decision before the Workers' Compensation Board" 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 * * *."

(1967). In this regard, we give the most weight to opinions that are well-reasoned and complete, and give little weight to those that are based on an incomplete or inaccurate history. See Somers v. SAIF, 77 Or App 259, 263 (1986); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Although both Dr. Loch and Dr. Puziss opined that claimant's work activity was the major contributing cause of her rotator cuff tear diagnosed in February 1994, their opinions were premised on the understanding that claimant's full time medical receptionist duties involved "a great deal of overhead reaching," including "frequent (5 to 7 times an hour) reaching overhead or behind her desk to obtain medical records, [and] reaching high into a cabinet to pull down books." (Ex. 38, 47). This history of "a great deal of overhead reaching" is inconsistent with claimant's own testimony concerning her work duties. For example, at hearing, claimant specifically testified that although she frequently swiveled in her chair and reached around the receptionist desk to retrieve medical records, this and her other frequent work activities did not involve overhead reaching. (Tr. 49).

Further, both doctors assumed that claimant's symptoms progressively worsened between October 1990 and February 1994, yet the preponderance of the evidence indicates that claimant's symptoms simply waxed and waned with her work activity following her October 10, 1990 shoulder injury. Indeed, in a statement recorded in April 1994, claimant reported that her then-current pain was "identical" to pain she experienced when she injured her shoulder in October 1990. (Ex. 19-11). At hearing, claimant testified that subsequent to her shoulder injury, she began taking Motrin whenever she experienced symptoms, sometimes up to two 800 milligram pills a day when the pain became excruciating. When her symptoms would wane, she would reduce or stop her Motrin intake. She further testified that between October 1990 and February 1994, the longest period of time she went without taking pain medication was two weeks. (Tr. 86). Claimant's husband similarly testified that claimant "constantly" complained about pain in her right shoulder from the time she injured it in October 1990 until he convinced her to seek treatment from Dr. Utterback in February 1994. (Tr. 109).

Accordingly, after considering the record as a whole, we agree with the ALJ that claimant has not established the compensability of her right rotator cuff tear as a new occupational disease arising in major part from her work activity subsequent to October 1990.[7] We therefore uphold the insurer's denial of the occupational disease claim.

ORDER

The ALJ's order dated April 15, 1996 is affirmed.

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[7] Although the ALJ did not consider claimant a credible historian, we do not necessarily share that conclusion. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987) (Board is in as good a position as the ALJ to evaluate claimant's credibility based on an objective evaluation of the substance of claimant's testimony and other inconsistencies in the record). Rather, as set forth in this order, we find that claimant has failed to sustain her burden of proof on causation because the medical opinions on which she relies are based on an inaccurate work and/or medical history, and are therefore unpersuasive. Miller v. Granite Construction Co., supra.

December 13, 1996 Cite as 48 Van Natta 2453 (1996)

In the Matter of the Compensation of
RONALD D. FULLER, Claimant
Own Motion No. 96-0503M
OWN MOTION ORDER ON RECONSIDERATION AND
ORDER REFERRING FOR CONSOLIDATED HEARING
Pozzi, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our November 7, 1996 order in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to established that he was in the work force at the time of disability. With his request for reconsideration, claimant contends that: (1) he is not retired; (2) he was in the work force at the time of disability; and (3) a hearing is pending in order to contest SAIF's suspension of permanent total disability (PTD) benefits. On November 14, 1996, we abated our prior order to allow SAIF sufficient time to respond to claimant's motion.

The SAIF Corporation submitted claimant's request for temporary disability compensation for his compensable bilateral knee strain and low back strain injury. Claimant's aggravation rights expired on October 18, 1988. SAIF recommends against reopening on the ground that claimant has withdrawn from the work force. SAIF asserts that claimant's claim "was a permanent total disability claim which has been reversed." Because a permanent total disability (PTD) issue is pending, the decision in that matter may have an effect on whether claimant was in the work force at the time of disability, and, thus, entitled to temporary disability compensation. See Morris B. Grover, 48 Van Natta 486 (1996); William L. Halbrook, 46 Van Natta 79 (1994).

WCB Case No. 95-04992 is currently awaiting docket assignment. At the hearing, we request that the assigned Administrative Law Judge (ALJ) make findings of fact and conclusions of law and opinion on the issue of whether claimant was in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

At the conclusion of the hearing, the ALJ shall forward to the Board a separate, unappealable recommendation with respect to the own motion matter and a copy of the appealable order issued in WCB Case No. 95-04992. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding own motion relief.

Accordingly, on reconsideration, we consolidate the own motion matter with the hearing and postpone action pending resolution of the aforementioned matter before the Hearings Division.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS J. KOLLEN, Claimant
WCB Case No. 96-03549
ORDER ON REVIEW
Flaxel & Nylander, 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) Livesley's order that: (1) set aside a Director's "Proposed and Final Order on Weekly Wage for Computing Temporary Disability Rate;" and (2) recalculated claimant's rate of pay and awarded additional temporary disability benefits. On review, the issue is the rate of temporary total disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant, a carpenter, began working for the employer on October 2, 1995, at a wage of $10 per hour. (Tr. 3). He worked until November 27, 1995, when he was laid off due to a lack of work. Claimant returned to work for the employer on January 2, 1996 at the same wage. He injured his right leg on January 3, 1996 and SAIF accepted a disabling claim for a right lower leg contusion and torn anterior horn of the lateral meniscus of the right knee. (Ex. 4).

On February 22, 1996, SAIF informed claimant that his time loss rate had been recalculated and notified him of an overpayment of $96.52. (Ex. 4a). Claimant appealed to the Director. On April 5, 1996, the Director issued a "Proposed and Final Order on Weekly Wage for Computing Temporary Disability Rate," affirming SAIF's recalculation. Claimant requested a hearing.

The ALJ cited OAR 436-060-0025(5)(a) (WCD Admin. Order No. 96-053) and concluded that the lay-off between November 27, 1995 and January 2, 1996 constituted an "extended gap," which was not to be computed in determining claimant's average weekly wage. SAIF argues that claimant's layoff was not an "extended gap."

Although we agree with the ALJ's conclusion, we base our decision on the following reasoning.

Former OAR 436-60-025(1) provides that the rate of compensation shall be based on the wage of the worker at the time of injury, except in occupational disease cases. Here, claimant was injured on January 3, 1996. Thus, the rules contained in Workers' Compensation Department Order No. 94-055 apply to this claim. Former OAR 436-60-025(5) (WCD Admin. Order 94-055)[1] provides, in part:

> "The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * *
>
> "(a) 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."

Claimant was employed less than 52 weeks before he was injured. Although claimant was laid off from November 27, 1995 to January 2, 1996, there was no change in the amount or method of the wage earning agreement during his employment. Claimant continued to earn $10 per hour. Compare Patsy G. Harper, 48 Van Natta 1454 (1996) (the amount and method of the wage earning agreement changed since the claimant was hired). Former OAR 436-60-025(5)(a) provides that, for workers employed less than 52 weeks, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks.[2] Thus, since claimant was employed less than 52 weeks, SAIF was to calculate claimant's temporary total disability by using claimant's actual weeks of employment. We agree with the ALJ that SAIF incorrectly recalculated claimant's temporary total disability benefits.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(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 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 July 23, 1996 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the SAIF Corporation.

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[1] In Hadley v. Cody Hindman Logging, 144 Or App 157 (1996), the court interpreted an earlier version of former OAR 436-60-025(5)(a) (WCD Admin. Order 12-1992), which provided, in part:

> "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 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."

The Hadley case is inapposite because a later version of former OAR 436-60-025(5)(a) applies here.

[2] Former OAR 436-60-025(5)(a) provides, in part: "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." (Emphasis added). Since claimant was employed less than 52 weeks, we need not determine whether an "extended gap" existed.

In the Matter of the Compensation of
DAVID D. HUFFMAN, Claimant
WCB Case No. C602860
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On October 16, 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 November 15, 1996, we received a "Notice of Claim for Attorney's Lien" from claimant's former attorney. By letter dated November 18, 1996, we granted the self-insured employer and claimant an opportunity to give their respective positions regarding the lien notice. In giving their responses, we invited the parties to address the effect on this matter, if any, of the following cases: Cheri A. Wilson, 48 Van Natta 14 (1996); Ewell McCrae, 47 Van Natta 207, recon den 47 Van Natta 260, recon den 47 Van Natta 422 (1995); Billy Lemons, 46 Van Natta 2428 (1994), Michael J. Galbraith, 46 Van Natta 910, on recon 46 Van Natta 1144 (1994). Having received the employer's and claimant's responses, we now proceed with our review of the CDA.[1]

Claimant's former attorney submitted a supporting affidavit with his lien notice. In the affidavit, claimant's former counsel states that he represented claimant regarding his workers' compensation claim until September 12, 1996. On that date, claimant ended his former attorney's representation citing the distance to the attorney's office and no need for attorney representation. The affidavit further states that claimant's former attorney had written to the self-insured employer's attorney in June 1996 to convey an offer from claimant to settle his claim by CDA in return for $40,000. On September 16, 1996, after discharging his attorney on September 12, 1996, claimant negotiated a $15,000 CDA with the employer. Claimant's former attorney asserts his belief that claimant terminated his representation solely to avoid paying an attorney fee in violation of the attorney retainer agreement.

In its November 22, 1996 response, the employer (through its counsel) indicates that, in July 1996, it rejected an offer by claimant's former attorney to settle claimant's claim by CDA for $40,000. Arguing that the facts of this claim are similar to the facts in Cheri A. Wilson, supra, and Ewell McCrae, supra, the employer asserts that the $40,000 settlement proposed by claimant's former counsel is a "substantially different" agreement than the $15,000 CDA eventually negotiated between claimant and the employer. The employer further indicates that it has no objection if the Board decides to "provide claimant's former attorney with some fee out of the $15,000 settlement proceeds * * *."

In his response dated November 25, 1996, claimant acknowledges that he retained his former attorney to represent him in his workers' compensation claim. However, claimant denies that he discharged his attorney to avoid paying an attorney fee. Claimant indicates that, on June 13, 1996, his former attorney sent a letter to the employer's attorney proposing a $40,000 settlement. Claimant asserts that the offer was rejected by the employer and no further mention of negotiation regarding the amount of the claim was made to claimant by his attorney or the employer. Claimant indicates that he discharged his attorney on September 12, 1996 because, at that time, there was no foreseeable settlement. Claimant asserts that the subject of settlement was brought up during a September 16, 1996 telephone discussion between claimant and the employer's claim processing agent. Claimant states that the employer's processing agent later contacted him with an offer of a $15,000 settlement, which claimant accepted. Finally, claimant argues that any attorney fee should be paid by the employer in addition to, and not out of, the $15,000 CDA proceeds.

In Ewell McCrae, supra, the claimant's former attorney submitted notice of an attorney fee lien, claiming entitlement to 25 percent of the $3,000 CDA proceeds. The claimant's former attorney had previously recommended that the claimant accept a $10,500 CDA offered by the insurer. The former counsel asserted that, after being fired by the claimant, the claimant and the insurer entered into a disputed claim settlement (DCS) for $9,000, and a CDA for $3,000.

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[1] Although we granted claimant's former attorney the opportunity to reply to the responses of claimant and the employer, no reply from claimant's former attorney was received within the time allowed by our letter.

In McCrae, we concluded that the claimant's eventual settlement was apparently not the same as the settlement previously negotiated by the claimant's former counsel. Thus, we were unable to find that the claimant's former counsel rendered services on behalf of claimant in reaching the CDA. In addition, we found that it would be highly speculative for us to determine what, if any, of claimant's former attorney's services contributed to the parties' eventual settlement.

Here, as in McCrae, the settlement offer relayed by claimant's former attorney is apparently not the same as the settlement that claimant eventually reached with the employer. In this regard, it is undisputed that in June 1996, claimant's former attorney offered to settle claimant's claim in a CDA for $40,000. This offer was rejected by the employer. Based on claimant's former attorney's affidavit, there were apparently no further specific negotiations between former counsel and the employer, although former counsel had further contact with the employer's counsel. After claimant ended his attorney's representation, claimant negotiated a $15,000 CDA directly with the employer. We find that the $15,000 CDA is a substantially different settlement from the $40,000 offer made by claimant's former attorney. Finally, we note that, as in McCrae, claimant disputes his attorney's entitlement to a fee.[2]

Under the circumstances presented here, we are unable to find that claimant's former counsel rendered services on behalf of claimant regarding this particular CDA. Accordingly, for the reasons given above, we decline to approve an attorney fee payable from the CDA or to enforce claimant's former attorney's lien. See Ewell McCrae, supra; see also Cheri A. Wilson, 48 Van Natta 14 (1996) (Board declined to approve lien where former attorney and the claimant disputed former attorney's entitlement to an attorney fee from the CDA, and other avenues were available to former attorney to pursue his lien).

The parties' CDA, as clarified by this order, 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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[2] This case is distinguishable from Billy Lemons, supra, in which the claimant raised no objections to his former attorney's request for a fee from the CDA proceeds. This case is also different from Michael J. Galbraith, supra, in which the claimant's former counsel asserted a lien on a portion of the attorney fee awarded in the CDA to the claimant's current counsel.

In the Matter of the Compensation of
PATRICK G. MAHLBERG, Claimant
Own Motion No. 95-0313M
OWN MOTION ORDER OF ABATEMENT
Emmons, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The self-insured employer requests reconsideration of our November 7, 1996 Own Motion Order, as reconsidered on December 3, 1996, in which we authorized the reopening of claimant's 1984 claim for the payment of temporary disability compensation, and authorized an approved fee for claimant's attorney. The employer requested that the own motion matters in this claim be held in abeyance pending its appeal to the court of a September 23, 1996 Director's order. In our December 3, 1996 order, we declined to reconsider our November 7, 1996 order because the Board's rules do not provide for holding a case in abeyance pending judicial review. With its second request for reconsideration, the employer contends that, pursuant to a December 4, 1996 DCBS "Order Granting Stay Request," the Board should recognize that the employer would be irreparably harmed by our order requiring the payment of time loss compensation in this 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
DORIS A. BAILEY, Claimant
WCB Case No. 95-04385
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Cobb & Woodworth, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Schultz's order that: (1) found that claimant's neck and upper back strains were part of its accepted 1989 claim; and (2) set aside its denial of claimant's medical services claim for her current cervical, thoracic and low back conditions. In her brief, claimant contends that, if we find her current condition noncompensable, we should apply the Americans with Disabilities Act (ADA). On review, the issues are scope of acceptance, compensability, and application of the ADA. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the last paragraph beginning on page 5, for which we substitute the following:

In 1992, Dr. Fuller and Dr. Snodgrass examined claimant for the insurer. In March 1995, Dr. Fuller examined claimant on behalf of a different employer.

CONCLUSIONS OF LAW AND OPINION

We begin by recapping the relevant facts. Claimant was treated for low back symptoms in 1979 and 1980, after operating a jackhammer for the employer in Arkansas. In 1984, while still working in Arkansas, claimant compensably injured her low back. This injury resulted in a diskectomy/laminectomy at L5-S1 on the right. Claimant, who continued to have episodes of back pain, was subsequently laid off when no modified work was available. In 1984 and 1988, claimant was involved in two minor motor vehicle accidents. There is no evidence of any significant treatment or disability that resulted from these accidents.

Claimant was rehired by the employer in Oregon. On October 15, 1989, claimant injured her back while trying to pull a jackhammer from a core. She was treated by the plant doctor, who referred her to Dr. Reynolds. Claimant complained of pain in the low back, dorsal and cervical areas, as well as pain in the left leg. Dr. Reynolds diagnosed claimant's condition as neck, upper back, mid-back and low back strains which, he opined, were a direct result of the 1989 injury. (Exs. 6, 10). On October 19, 1989, claimant filed a claim for a back strain. (Ex. 5). On December 7, 1989, the insurer accepted the claim. (Ex. 9; Insurer's Brief at 10).

Claimant was found medically stationary on June 11, 1991. She enrolled in an authorized training program and became a computer medical secretary. A different employer, no longer a party to this claim, hired her in its dental business office, where she was working at the time of hearing.

An April 27, 1992 Determination Order closed claimant's claim with an award of 15 percent unscheduled permanent disability, which was increased to 22 percent by a December 4, 1992 Order on Reconsideration.

In May 1992, claimant sought treatment from Dr. Reynolds for neck, upper back and low back pain. (Ex. 61). Dr. Reynolds diagnosed a cervical, dorsal and lumbosacral strain. Dr. Reynolds saw claimant in August and September 1992 for right neck and upper back pain. Claimant again sought treatment from Dr. Reynolds on several occasions in 1993 for complaints of low back pain radiating down the legs, which he opined was waxing and waning of her symptoms, as expected from her permanent impairment. (Id.)

In May 1994, claimant changed her treating physician to Dr. Johnson. Claimant complained of right low back pain radiating down her right leg. She was treated conservatively through September 1994. In January 1995, claimant again sought treatment for back pain that came on suddenly. On April 5, 1995, the insurer denied compensability of claimant's current condition. (Ex. 39).

Claimant was examined by Drs. Marble and Williams for the insurer; Dr. Rabie; and Drs. Snodgrass and Fuller for a different employer.

Credibility

Despite the ALJ's finding that claimant was credible based on demeanor, the insurer argues on review that claimant's testimony concerning the work incident on October 15, 1989 is not to be believed. It is well settled that, unless the substance of the witness' testimony and other inconsistencies in the record raise such doubt that we are unable to conclude that the material testimony is credible, we will generally defer to the ALJ's finding that the witness is credible. See, e.g., Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Gail A. Albro, 48 Van Natta 41 (1996); David A. Peper, 46 Van Natta 1656 (1994). In this case, we find no persuasive reason to overturn the ALJ's demeanor-based credibility determination.

The insurer argues that claimant's failure to report neck, upper and mid-back pain to the company doctor on October 17, 1989, and her failure to report motor vehicle accidents in 1984 and 1988, fatally undermine her credibility. We disagree.

The medical record confirms that claimant sought treatment on October 25, 1989 from Dr. Reynolds for pain in the low back, dorsal and cervical areas with pain down the left leg. Dr. Reynolds found muscle spasm and tenderness with reduced range of motion in those areas, which he attributed to the October 15, 1989 injury. (Ex. 6). The fact that the company doctor reported that claimant initially experienced her symptoms in the low back does not conclusively establish that her symptoms were limited to her low back, particularly in the face of Dr. Reynolds' more comprehensive report. Moreover, claimant's immediate focus on her low back does not mean that her neck, upper and mid back were not involved as part of her back strain injury. (See Exs. 17-3, 55-1). In addition, we agree with the ALJ's assessment of the two motor vehicle accidents as minor and without permanent injury. (See Exs. 4A, 4B, 4C, 4D).

Scope of Acceptance

The ALJ concluded that the scope of the insurer's 1989 acceptance involved cervical and thoracic (dorsal) strains, in addition to claimant's lumbar strain. The insurer contends that claimant's accepted 1989 injury was limited to a lumbar strain. We affirm the ALJ's opinion on this issue with the following supplementation.

Whether an acceptance has occurred is a question of fact. SAIF v. Tull, 113 Or App 449 (1992) (citing Stevenson v. Blue Cross of Oregon, 108 Or App 247, 251 (1991) and EBI Ins. Co. v. CNA Insurance, 95 Or App 448, 451 (1989)). Here, the preponderance of the evidence establishes that claimant sustained a cervical, dorsal and lumbar strain as a result of her October 15, 1989 injury.

Claimant was injured on October 15, 1989, when she was operating a jackhammer. She initially sought treatment from the plant doctor for low back and left leg pain. (Ex. 1-22). On October 19, 1989, claimant filed a claim in which she described the nature of her injury as a "back strain." (Ex. 5). On October 25, 1989, claimant sought treatment from Dr. Reynolds, who reported her complaints as pain in the low back, dorsal and cervical areas with pain down the left leg suggestive of nerve root compression, all of which he attributed to claimant's injury while operating a jackhammer. Dr. Reynolds diagnosed an acute cervical, dorsal and lumbar strain; ruled out disc herniation, and took claimant off work until November 8, 1989. (Exs. 6, 7). On December 7, 1989, the insurer filed a form 1502, with a copy to claimant, in which it accepted the claim as disabling. (Ex. 9). Accordingly, based on the information the insurer had at the time it accepted claimant's claim, we conclude that the insurer's acceptance of claimant's "back strain" claim included claimant's low back, dorsal and cervical areas.

Compensability - Current Condition

On January 13, 1995, claimant sought treatment from Dr. Johnson for a flare-up of back pain that came on suddenly while she was sitting at work. (Ex. 63-3). Dr. Johnson found muscle spasm in claimant's back and right buttocks and diagnosed claimant's condition as "low back pain secondary to muscle spasm." (Id.) On January 24, 1995, claimant returned, complaining of pain in her shoulder and neck. Dr. Johnson diagnosed "back pain secondary to muscle spasm" and prescribed physical therapy.

(Ex. 63-4). On February 25, 1995, claimant complained of ongoing pain in her left neck and left sciatic nerve. (Ex. 63-5). Dr. Johnson diagnosed "low back pain, secondary to muscle spasm and deconditioning," for which he prescribed a swimming and exercise program. (Id.)

Based on Dr. Johnson's opinion and the medical record as a whole, the ALJ concluded that claimant's current condition (cervical, dorsal and lumbar sprain) was related to her 1989 industrial injury and, accordingly, set aside the insurer's current condition denial. The insurer contends that claimant has failed to prove that the 1989 injury is the major contributing cause of her current condition. We agree.

Claimant concedes that, because she had a low back condition (L5-S1 herniated disc and subsequent disc surgery) that preexisted her 1989 injury, the major contributing cause standard of ORS 656.005(7)(a)(B) applies to determine the compensability of her current condition. (Claimant's Respondent's Brief at 5, 6).[1]

Medical opinions regarding claimant's current condition were provided by Dr. Johnson (Exs. 71, 94); Drs. Marble and Williams (Ex. 72); Dr. Rabie (Ex. 78); Drs. Snodgrass and Fuller for claimant's current employer (Ex. 87); and Dr. Fuller for the insurer (Ex. 95).

Dr. Johnson began treating claimant in 1994. In his 1994 chart notes, Dr. Johnson noted that claimant had had episodic complaints of low back pain and pain in her right leg for about 10 years that started with the 1979 on-the-job injury and subsequent 1984 spinal surgery. (Ex. 63-1). In 1995, when claimant again sought treatment for back pain, Dr. Johnson opined that claimant's current back and neck problems were the result of deconditioning, and were a waxing and waning of symptoms related to her 1989 back injury. (Exs. 71, 94).

Because a determination of major contributing cause requires the assessment of the relative contribution of different causes, Dietz v. Ramuda, 130 Or App 397 (1994), rev den 321 Or 416 (1995), it is necessary to consider the effect of all possible causes of a condition; in this case, that includes assessing the relative contribution to claimant's current condition by claimant's preexisting injuries, surgery and degenerative condition. Dr. Johnson did not discuss the relative contribution of these possible causes to claimant's current condition. Consequently, absent such an assessment, we are not persuaded by his opinion that the major contributing cause of claimant's current need for treatment is the 1989 back strain injury.

The opinions of Drs. Snodgrass and Fuller, relying on records from Dr. Johnson, do not support claimant's claim for the same reason. The doctors opined that claimant's current condition is "simply a continuation of waxing and waning of symptoms relating to an injury in 1979, surgery in 1984, and a repeat injury in 1989." (Ex. 87-5). Because they do not evaluate the relative contributions of the aforementioned injuries and surgery to claimant's current condition, their opinion fails to support compensability. Moreover, Drs. Marble and Williams and Dr. Rabie, who were likewise aware of claimant's medical history since 1979, also failed to evaluate their relative contributions to claimant's current condition.

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[1] Claimant also asserts that current medical treatment is directed at her low back. Based on the 1995 medical records, we conclude that her current complaints involve the neck, dorsal spine, shoulders and low back. After our review of the record, we agree with the ALJ's conclusion that claimant did not experience a separate strain to the shoulders arising out of the 1989 injury, although she may have referred pain into the shoulder girdle. (Exs. 63-3 through 63-6; 71; 72-3; 78-3). We further note that, prior to the closure of claimant's compensable 1989 claim, Dr. Morris, claimant's former treating neurologist, and Dr. Dineen, arbiter, each opined that claimant's 1989 low back injury was superimposed on the preexisting 1984 lumbar laminectomy and degenerative changes. (Exs. 19, 55). Dr. Dineen also noted that claimant had some evidence of degeneration (spurring) in her neck, although an MRI did not reveal any nerve impingement. (Ex. 55-2). Dr. Brooks, neurologist, also diagnosed degenerative changes in claimant's lumbar spine, to which he attributed some of claimant's ongoing pain. He opined that these degenerative changes did not stem from claimant's surgery or the 1989 injury. (Ex. 25). Because both claimant's compensable back strain and her current complaints involve her back from the cervical to lumbar areas, we conclude that the major contributing cause standard is not limited to claimant's low back.

Based on this record, we conclude that claimant has failed to establish that the 1989 back strain injury was the major contributing cause of her current condition and need for treatment.[2] Therefore, we uphold the insurer's denial.

Finally, claimant contends that, because she had a preexisting condition under ORS 656.005(24), we must apply the ADA, even though we lack jurisdiction to enforce the ADA. Specifically, claimant argues that the ADA preempts ORS 656.007(a)(B), 656.005(24) and 656.245(1)(a), and that, therefore, we must interpret these statutes in a manner consistent with the ADA's protection against discrimination for individuals with disabilities.

We have previously held that the Board is not the proper forum for an ADA challenge. See Gary W. Benson, 48 Van Natta 1161 (1996); Rex Brink, 48 Van Natta 916 (1996). Moreover, even if we had jurisdiction to consider claimant's ADA arguments, we would find that the record lacks sufficient evidence to establish the first element of a prima facie case of discrimination under the ADA, i.e., that claimant is an "individual with a disability" under the terms of the Act. See Gary W. Benson, supra.[3]

ORDER

The ALJ's order dated March 27, 1996 is reversed in part and affirmed in part. The insurer's denial of claimant's current condition and need for treatment is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

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[2] Because claimant has failed to affirmatively establish the compensability of her claim, we need not evaluate Dr. Fuller's deposition opinion obtained by the insurer.

[3] Claimant contends that, unlike in Benson, she has satisfied the ADA's definition of disability. We disagree. In order to satisfy the ADA's definition of disability, there must be medical evidence establishing that claimant's current back condition is a physical impairment that substantially limits a major life activity such as working. See 42 U.S.C. §12102(2). In Gary W. Benson, supra at 1163 n. 2, we noted that in order to show that a claimant is substantially limited in the major life activity of working, the claimant must prove that he or she is "significantly restricted in ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person with comparable training, skills and abilities. The inability to perform a single, particular job does not constitute a substantial limitation in the major life activity or work." 29 C.F.R. § 1630.2(j)(3)(i).

Here, claimant relies on Dr. Fuller's deposition testimony to establish that she has satisfied the ADA's definition of disability. Dr. Fuller's testimony, however, consists of his explanation of his general approach to releasing persons with a one-level diskectomy to work, rather than establishing that claimant's disability substantially limited claimant from working. (Exs. 95-31, -32, -33). Consequently, there is insufficient medical evidence to establish that claimant is substantially limited in the major life activity of working or in any other major life activities.

In the Matter of the Compensation of
JAMES W. JONES, Claimant
WCB Case No. 93-06575
SECOND ORDER ON REMAND
Peter O. Hansen, Claimant Attorney
Julene M. Quinn (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's December 10, 1996 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Stipulation and Disputed Claim Settlement Agreement," which is designed to resolve all issues raised or raisable between them, in lieu of all prior orders.

Pursuant to the settlement, claimant agrees that the SAIF Corporation's denial, as supplemented in the agreement, "shall remain in full force and effect." In addition, claimant withdraws his hearing request "in full settlement of all issues raised or raisable." Finally, the settlement provides that this matter "shall be dismissed with prejudice."

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

IT IS SO ORDERED.

December 17, 1996 Cite as 48 Van Natta 2462 (1996)

In the Matter of the Compensation of
NANETTE K. KORTUM, Claimant
WCB Case No. 95-02296
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) declined to admit three of the insurer's exhibits and allow testimony of one witness; (2) denied the insurer's request to make an offer of proof concerning the exhibits and testimony; and (3) increased claimant's award of unscheduled permanent disability for a low back injury from 5 percent (16 degrees), as awarded by an Order on Reconsideration, to 25 percent (80 degrees). On review, the issues are evidence and extent of permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, the insurer offered three exhibits and the testimony of one witness for purposes of impeachment. The insurer conceded that the exhibits were not part of the record on reconsideration.

Based on amended ORS 656.283(7), the ALJ declined to admit the evidence. The ALJ reasoned that the specific provision in amended ORS 656.283(7) relating to reconsideration proceedings controlled over the general provision relating to impeachment evidence.

The insurer argues that the ALJ erred in refusing to allow the impeachment evidence. The insurer contends that amended ORS 656.283(7) allows the introduction of impeachment at any time in the history of a claim and not just at the reconsideration level. We disagree.

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. Newell v. SAIF, 136 Or App 280, 282 (1995); Volk v. America West Airlines, 115 Or App 565, 572-73 (1995). There are no express exceptions applicable to the amendment of ORS 656.283(7). Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

In Precision Castparts Corp. v. Plummer, supra, the court held that amended ORS 656.283(7) does not apply to evidence previously and properly admitted, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Because the claimant's testimony in Plummer was admissible when it was offered and considered by the ALJ and the Board, the court held that the admission of the testimony was not error.

In Dean J. Evans, 48 Van Natta 102 (1996), we acknowledged that the holding in Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), was overruled by Precision Castparts Corp. v. Plummer, supra, to the extent that it applies to cases where the hearing was held before June 7, 1995. 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. In Evans, we continued to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995.

Here, the hearing was held on September 26, 1995, after the effective date of Senate Bill 369. Therefore, the holding in Precision Castparts Corp. v. Plummer, supra, does not apply. Dean J. Evans, supra. Thus, the issue in this case is whether the impeachment evidence was admissible when it was offered by the insurer.

In Joe R. Ray, supra, we held that the 1995 amendments by Senate Bill 369 to ORS 656.283(7) retroactively apply to exclude any evidence (including at-hearing testimony), which was not submitted at the reconsideration proceeding, at a subsequent hearing concerning the extent of permanent disability. In Tim L. Besheone, 48 Van Natta 2337 (1996), we held that impeachment evidence not submitted at reconsideration, and not made a part of the reconsideration record, is not admissible at a subsequent hearing concerning the extent of a permanent disability.

Here, the impeachment evidence the insurer sought to introduce was not submitted at reconsideration and was not made a part of the reconsideration record. Consequently, the impeachment evidence is not admissible at a subsequent hearing concerning the extent of claimant's permanent disability. Tim L. Besheone, supra. We agree with the ALJ that the evidence was not admissible.[1]

Extent of Unscheduled Permanent Disability

Chronic Condition Award

The extent of claimant's permanent disability is determined by an application of the "standards." The claim was closed by Notice of Closure on August 18, 1994. Accordingly, the disability standards contained in Workers' Compensation Department Administrative Orders Nos. 6-1992 and 93-056 apply to claimant's claim. Former OAR 436-35-003(2).

We agree with the ALJ's reasoning and conclusion that claimant has established a chronic low back condition that limits her ability to repetitively use that body part. See former OAR 436-35-320(5). Accordingly, claimant is entitled to an impairment value of 5 percent.

Adaptability

Adaptability is measured by comparing the Base Functional Capacity (BFC) to the worker's maximum Residual Functional Capacity (RFC) at the time of becoming medically stationary. Former OAR 436-35-310(2). Here, there is no dispute that claimant's RFC is light. Claimant's BFC is determined by the highest strength category assigned in the DOT for the most physically demanding job she successfully performed in the five years prior to determination. Former OAR 436-35-310(4)(a). When a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of codes applies. Id. Claimant has the burden of proving the nature and extent of any disability resulting from the compensable injury. ORS 656.266.

Claimant injured her lower back while working as a waitress in January 1994. Claimant indicated on a "Work/Educational History" form that, in the previous five years, she had worked as a waitress, a cashier, a "stacker" and a motel housekeeper.

The ALJ found that claimant's BFC was "heavy." The ALJ found that the most appropriate DOT code for the motel housekeeper job was "HOUSECLEANER (hotel & rest.)," DOT # 323.687-018, which assigns a strength category of "heavy" and a specific vocational preparation (SVP) value of 2. The ALJ reasoned that since claimant's housekeeper job was the most physically demanding job that she had performed in the last 5 years, claimant's BFC was "heavy."

The insurer contends that claimant has not met her burden of proving that her BFC was "heavy." The insurer asserts that there are two DOT codes that could apply to people who clean hotels or motels: "HOUSECLEANER (hotel & rest.)," DOT # 323.687-018, which assigns a strength category of

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[1] The insurer also argues that the ALJ abused his discretion when he refused to allow an offer of proof of the impeachment evidence. We need not address this issue inasmuch as we have determined that the evidence was not admissible. We note, however, that allowing an offer of proof would have allowed us to proceed with our review if we had reversed the ALJ's evidentiary ruling.

"heavy," and "CLEANER, HOUSEKEEPING (any industry)" DOT # 323.687-014, which assigns a strength category of "light." According to the insurer, since claimant's only evidence of the job duties performed is that she "cleaned rooms," her own description described only the light level job, DOT # 323.687-014.

The DOT description for "HOUSECLEANER (hotel & rest.) alternate titles: hall cleaner; mover; night cleaner," DOT # 323.687-018, provides:

> "Performs any combination of following duties to maintain hotel premises in clean and orderly manner. Moves and arranges furniture. Turns mattresses. Hangs draperies. Dusts venetian blinds. Polishes metalwork. Prepares sample rooms for sales meeting. Arranges decorations, apparatus, or furniture for banquets and social functions. Collects soiled linens for laundering, and receives and stores linen supplies in linen closet. Performs other duties as described under CLEANER (any industry) I Master Title. May deliver television sets, ironing boards, baby cribs, and rollaway beds to guest rooms. May clean swimming pool with vacuum. May clean and remove debris from driveway and garage areas. May be designated according to specialization as Curtain Cleaner (hotel & rest.); Housecleaner, Floor (hotel & rest.); Linen-Room Worker (hotel & rest.) Porter, Lobby (hotel & rest.) Vacuum Worker (hotel & rest.)"

DOT # 323.687-018 assigns a strength category of "heavy."

The DOT description for "CLEANER, HOUSEKEEPING (any industry) alternate titles: maid)," DOT # 323.687-014, provides:

> "Cleans rooms and halls in commercial establishments, such as hotels, restaurants, clubs, beauty parlors, and dormitories, performing any combination of following duties: Sorts, counts, folds, marks, or carries linens. Makes beds. Replenishes supplies, such as drinking glasses and writing supplies. Checks wraps and renders personal assistance to patrons. Moves furniture, hangs drapes, and rolls carpets. Performs other duties as described under CLEANER (any industry) I Master Title. May be designated according to type of establishment cleaned as Beauty Parlor Cleaner (personal ser.); Motel Cleaner (hotel & rest.); or according to area cleaned as Sleeping Room Cleaner (hotel & rest.)."

DOT # 323.687-014 assigns a strength category of "light."

Claimant argues that the ALJ correctly concluded that her most physically demanding job within the last five years was her work as a housekeeper, DOT # 323.687-018, described as "heavy" work. We disagree.

Claimant indicated on a "Work/Educational History" form that she had worked at the motel as a "housekeeper" from "?92" to "?92." Claimant described her specific duties as "cleaning rooms." There is no other evidence in the record of claimant's job duties at the motel. Both DOT code descriptions at issue refer to cleaning rooms. The DOT description for "CLEANER, HOUSEKEEPING (any industry) alternate titles: maid," DOT # 323.687-014, refers specifically to cleaning rooms and making beds. Although the DOT description for "HOUSECLEANER (hotel & rest.)," DOT # 323.687-018, does not refer specifically to cleaning rooms, it refers to "other duties as described under CLEANER (any industry) I Master Title" and that description refers to cleaning rooms.

Nevertheless, although both DOT descriptions include the job duty of cleaning rooms, it is apparent when comparing the DOT descriptions that "cleaning rooms" is only a minor part of DOT # 323.687-018, whereas it is the major part of the duties for DOT # 323.687-014. The record contains no evidence that claimant's job at the motel included any of the other duties listed in DOT # 323.687-018. We conclude that the record does not establish that claimant's job duties at the motel and the physical demands satisfied the DOT criteria for classification as "HOUSECLEANER (hotel & rest.)" classification, DOT # 323.687-018, which assigns a strength category of "heavy." See Mary Hoffman, 48 Van Natta 730 (1996); compare William L. Knox, 45 Van Natta 854 (1993) (applying an earlier version of the standards, the Board found it reasonable to consider both the claimant's job duties and the physical demands of the job in determining a proper DOT to be assigned to his job; there, the record was adequate to determine that lifting and handling materials were significant elements of claimant's work, thereby satisfying a DOT classification with a higher strength rating).

Furthermore, the record does not support a finding that a combination of DOT codes most accurately described claimant's duties at the motel. See former OAR 436-35-310(4)(a) (when a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of codes applies); Ilene A. Mayfield, 48 Van Natta 550 (1996) (because the claimant's job involved elements of two DOT code categories, a combination of DOT codes most accurately described the claimant's duties). Here, there is no evidence that DOT code # 323.687-018 applied to claimant's duties at the motel or that the physical demands of claimant's job at the motel were "heavy." Because claimant failed to prove that either the DOT code # 323.687-018 or a combination of the two DOT codes applied to the motel housekeeper job, we conclude that former OAR 436-35-310(4)(a) does not apply to this case.

Under these circumstances, we conclude that claimant has failed to establish that her job at the motel should be classified as requiring a strength category of "heavy." Rather, we conclude that the DOT description for "CLEANER, HOUSEKEEPING (any industry)," DOT # 323.687-014, which assigns a strength of "light," most accurately describes claimant's work at the motel.

The question remains whether claimant's work at the motel was the most physically demanding job she successfully performed in the five years prior to determination. See former OAR 436-35-310(4)(a). We conclude that it was not.

As we mentioned earlier, claimant indicated on a "Work/Educational History" form that, in the previous five years, she had worked as a waitress, a cashier, a "stacker" and a housekeeper. Claimant's work as a waitress, DOT # 311.477-030 and her work as a cashier, DOT # 211.462-014, both assign strength categories of "light." Claimant's "Work/Educational History" form indicated that she worked as a "stacker" from "?92" to "?92" and her job duties were to "stack wood, tie it off, grade wood." The most appropriate DOT code for that job is a "LUMBER SORTER (woodworking) alternate titles: Lumber puller, racker; separator," DOT # 922.687-074, which assigns a strength category of "medium." We conclude that claimant's job as a "stacker" was the most physically demanding job she performed in the five years prior to determination.

Former OAR 436-35-300(3)(b)(A) provides: "A worker is presumed to have met the SVP training time after completing employment with one or more employers in that job classification for the maximum period specified in the table in section 4 of this rule." The DOT for "LUMBER SORTER," DOT # 922.687-074, states that the SVP is 2, which requires a training time of "[s]hort demonstration up to 30 days." See former OAR 436-35-300(4).

In Edward F. Ebert, 47 Van Natta 2170 (1995), on recon 48 Van Natta 37 (1996), we held that, although the claimant had not worked the maximum time period prescribed for the SVP value for his job during the five years prior to the time of determination for the extent of his permanent disability, the SVP value was appropriate because the claimant had worked more than the minimum time period prescribed for proficiency. We reasoned that the performance of work beyond the minimum time period constitutes a rebuttable presumption of proficiency. We found no evidence that the claimant was not proficient or unable to perform the work of a finish carpenter. Consequently, we determined that the claimant's 3 1/2 years of experience as a finish carpenter was sufficient to satisfy the requirements for the SVP value.

Former OAR 436-35-300(3)(b)(A) incorporates the "SVP" values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. Edward F. Ebert, supra; Michael W. Davison, 42 Van Natta 1820 (1990). In this case, the DOT for "LUMBER SORTER," DOT # 922.687-074, states that the SVP is 2. The DOT provides that, for an SVP of 2, the length of time to proficiency is "[a]nything beyond short demonstration up to and including 1 month." Dictionary of Occupational Titles, Vol. II, at 1009 (4th ed. 1991).

Claimant indicated on the "Work/Educational History" form that she worked as a "stacker" from "?92" to "?92" and her job duties were to "stack wood, tie it off, grade wood." There is no evidence that claimant was not proficient or was unable to perform the work as a "stacker." Under these circumstances, we conclude that claimant satisfied the SVP for the DOT for "LUMBER SORTER," DOT # 922.687-074. See Edward F. Ebert, supra.

As we mentioned earlier, the DOT for "LUMBER SORTER," DOT # 922.687-074, assigns a strength category of "medium," and, therefore, claimant's BFC is "medium." We agree with the ALJ that claimant's RFC is "light." Under former OAR 436-35-310(6), claimant's adaptability factor is rated as 3.

Having determined claimant's adaptability value, we recalculate claimant's unscheduled permanent disability under the standards.

Age

Since claimant is under 40 years of age, the appropriate value for her age is 0. Former OAR 436-35-290(2).

Formal Education

Claimant did not graduate from high school and has not obtained a GED certificate. Therefore, she is entitled to a value of 1 for her lack of formal education. Former OAR 436-35-300(2)(b).

Skills

Under former OAR 436-35-300(3)(b), claimant's SVP value is the highest SVP of any job that she has met in the five years prior to determination. The job titles with the highest SVP number during the 5 years prior to determination were waitress, DOT # 311.477.030, and cashier, DOT # 211.462-014, both of which assign an SVP number of 3. Therefore, claimant is entitled to a skills value of 3. Former OAR 436-35-300(4).

The total value of claimant's age (0), education (1) and skills (3) is (4). That value is multiplied by the adaptability value of (3) for a total of 12. Former OAR 436-35-280(6). When this value is added to the value for impairment (5), the result is 17. Former OAR 436-35-280(7). Therefore, claimant's unscheduled permanent disability is 17 percent (54.4 degrees). Consequently, we modify the ALJ's order to reduce claimant's unscheduled disability award from 25 percent to 17 percent.

ORDER

The ALJ's order dated November 15, 1995, as reconsidered December 1, 1995, is modified in part and affirmed in part. In lieu of the ALJ's award and in addition to the Order on Reconsideration award of 5 percent (16 degrees) unscheduled permanent disability, claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability, for a total award of 17 percent (54.4 degrees) unscheduled permanent disability. Claimant's attorney fee, as awarded by the ALJ's order, is modified accordingly. The remainder of the ALJ's order is affirmed.

December 17, 1996 Cite as 48 Van Natta 2466 (1996)

In the Matter of the Compensation of
MARY A. LONGORIA, Claimant
WCB Case No. 94-09194
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Otto's order that: (1) declined to dismiss claimant's supplemental request for hearing on a post-authorized training program ("post-ATP") Notice of Closure; and (2) increased claimant's scheduled permanent disability award for loss of use or function of both forearms to 15 percent (22.5 degrees) per forearm, whereas the "post-ATP" Notice of Closure awarded no permanent disability in addition to the 3 percent (4.5 degrees) scheduled permanent disability per forearm awarded by a "pre-ATP" November 12, 1993 Notice of Closure. On review, the issues are dismissal, evidence and extent of scheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the second finding of ultimate fact, and briefly summarize the pertinent facts as follows:

In October 1985, claimant began working for the employer as a production and wax assembler. Her job duties required that she work with chemicals, including Dilimonene, a citrus-based solution, and D-Solv-It, a petroleum distillate.

In March 1992, claimant sought treatment for an itchy red rash on her hands and swelling around her eyes. She was diagnosed with contact dermatitis caused by handling chemicals on the job. In May 1992, the employer accepted claimant's claim.

Claimant's contact dermatitis claim was closed by a November 12, 1993 Notice of Closure, which awarded 3 percent scheduled permanent disability for each forearm. A July 27, 1994 Order on Reconsideration affirmed the Notice of Closure in all respects. Claimant continued to experience symptomatic flare-ups on both hands and the area around her left eye.

Claimant requested a hearing on the Order on Reconsideration. Thereafter, claimant entered an authorized training program. Pursuant to former ORS 656.268(9), her claim was reclosed by a Notice of Closure dated April 19, 1995 (as amended May 10, 1995). This "post-ATP" Notice of Closure awarded no additional scheduled permanent disability and no unscheduled permanent disability. Claimant then filed a supplemental request for hearing on the "post-ATP" Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Dismissal

Prior to the hearing, the employer moved to dismiss claimant's supplemental request for hearing, contending that claimant was required to request reconsideration of the "post-ATP" Notice of Closure before requesting a hearing. The ALJ denied the motion based upon Weyerhaeuser v. Purdy, 130 Or App 322 (1994), in which the court held that, under former ORS 656.268(9), reconsideration review was not a prerequisite to a request for hearing on a "post-ATP" notice of closure or determination order.

On review, the employer asserts that the ALJ erred in relying upon former ORS 656.268(9) and Weyerhaeuser v. Purdy, because the 1995 amendments to ORS 656.268(9)[1] apply retroactively to this proceeding. We disagree.

In Richard La France, 48 Van Natta 427 (1996), we held that, in light of Section 66(4) of SB 369, which expressly states that the amendments to ORS 656.268(9) shall apply only to claims that became medically stationary on or after the effective date of the Act, the former versions of ORS 656.268(8) and (9) continued to apply to claims that became medically stationary before the Act's effective date.[2] See also Mary E. Cordeiro, 48 Van Natta 1178 (1996). In this case, claimant became medically stationary in 1993, well before the effective date of SB 369. Therefore, the provisions of amended ORS 656.268(9) do not apply.

As the court recognized in Weyerhaeuser v. Purdy, supra, the method for appeal from a "post-ATP" determination order or notice of closure under former ORS 268(8) and (9) was to request a hearing within 180 days from the date the order or notice was mailed. In this case, the "post-ATP" Notice of Closure was mailed April 19, 1995 (and amended May 10, 1995). Claimant filed her supplemental request for hearing on October 4, 1995, within the 180 day time period. Consequently, like the ALJ, we deny the employer's motion to dismiss claimant's supplement request for hearing.

Evidence

At hearing, the employer objected to the admission of Exhibits 17 through 23 as well as claimant's testimony based on the evidentiary limitations imposed by amended ORS 656.283(7).[3] The

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[1] Amended ORS 656.268(9) provides, in pertinent part, that a post-ATP determination order or notice of closure "is appealed in the same manner as are other determination orders or notices of closure under this section."

[2] Notwithstanding the employer's contention that we decided Richard La France in error, we adhere to our determination that the retroactivity exception of subsection 66(4) applies to all of the amendments to ORS 656.268(9), those deleting former ORS 656.268(9) as well as those renumbering and amending the provisions of former ORS 656.268(8).

[3] This section provides, in pertinent part: "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

ALJ concluded that amended ORS 656.283(7) did not preclude the admission of claimant's testimony and additional exhibits because, in this case, claimant's "post-ATP" Notice of Closure was not subject to reconsideration. We agree.

As discussed above, amended ORS 656.268(9) does not apply to this claim. Therefore, this matter is properly before the Hearings Division and the Board on a direct appeal from the April 19, 1995 "post-ATP" Notice of Closure. Although the amendments to ORS 656.283(7) limit the evidence that can be considered at hearing to that submitted "at the reconsideration required by ORS 656.268," this provision is inapplicable where, as here, reconsideration was not required. See Jamil Ghores, 48 Van Natta 607, n.1 (1996) (evidentiary limitation does not apply on direct appeal of determination order issued in response to a carrier's reevaluation of the claimant's permanent total disability pursuant to ORS 656.206(5)).

Accordingly, we affirm the ALJ's admission of claimant's testimony and Exhibits 17 through 23 at hearing.

Extent of Scheduled Disability

The ALJ determined that claimant's testimony, when coupled with the medical evidence, established that claimant had a Class II impairment for both forearms as a result of her compensable contact dermatitis, because her condition significantly affected her performance of activities of daily living. On review, the employer argues that, in light of the opinions of claimant's treating physician, Dr. Cook, and the medical arbiter, Dr. Weiss (who both rated claimant's impairment as Class 1) the ALJ erred in concluding that claimant's impairment was Class 2. We agree.

OAR 436-35-110(5) provides the standard for rating impairment from contact dermatitis of an upper extremity as follows:

> "Class 1: 3% for the affected body part if there are signs and symptoms of a skin disorder and treatment results in no more than minimal limitation in the performance of activities of daily living, although exposure to physical or chemical agents may temporarily increase limitations:
>
> "Class 2: 15% for the affected body part if there are signs and symptoms of a skin disorder requiring intermittent treatment and prescribed examinations and there are limitations that require assistance in the performance of activities of daily living."

Under the worker's compensation law, 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. ORS 656.245(2)(b)(B).[4] "Impairment" is established by a preponderance of medical evidence based on objective findings. ORS 656.726(3)(f)(B). In this regard, lay testimony alone is insufficient to establish impairment under the standards. William K. Nesvold, 43 Van Natta 2767, 2768 (1991); see OAR 436-35-005(5) (impairment defined as decrease in function as measured by a physician).

Accordingly, to prove a Class II impairment under OAR 436-35-110(5), claimant must offer medical evidence based on objective findings showing that her condition imposes limitations that require assistance in the performance of activities of daily living. Although claimant has testified that her condition results in the need for assistance in the performance of the activities of daily living, this lay testimony is insufficient to meet her burden of proof. ORS 656.726(3)(f)(B); William K. Nesvold, supra; see also Georgia E. Wilson, 47 Van Natta 387 (1995) (the claimant's testimony that her pain limited her ability to engage in activities involving repetitive use of her left arm was insufficient to establish "impairment" under the standards).

In his April 7, 1995 closing examination, Dr. Cook concluded that claimant had "no permanent impairment beyond the apparent unmasked tendency for easy drying of the skin and subsequent potential for hand eczema to develop." (Ex. 16B). Dr. Cook noted that claimant is restricted from skin

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[4] The one exception to this rule is ORS 656.268(7), which permits a medical arbiter to make findings concerning the worker's impairment on reconsideration if the parties disagree with the impairment used in rating the worker's disability at claim closure.

contact exposure to d-limonene, and advised that she wear protective gloves whenever doing any wet work except personal hygiene. In a supplemental report, Dr. Cook opined that claimant's impairment as a result of her contact dermatitis fell within the Class I category. (Ex. 23).

Previously, Dr. Weiss reached the same conclusion following his July 15, 1994 medical arbiter examination of claimant.[5] Dr. Weiss rated claimant's dermatological impairment as Class I, noting that exposure to water, solutions or solvents resulted in a symptomatic flare-up of the dermatitis condition. (Ex. 15-2).

On this record, we find insufficient medical evidence supported by objective findings that claimant's contact dermatitis imposed limitations that require assistance in the performance of activities of daily living. Rather, based on the expert medical opinions of claimant's long-term treating physician and the medical arbiter, we conclude that claimant's condition results in minimal limitation in the performance of activities of daily living and that her impairment is Class I. Consequently, we reinstate the April 19, 1995 "post-ATP" Notice of Closure (as amended May 10, 1995), and affirm the July 27, 1994 Order on Reconsideration (which affirmed the November 12, 1993 Notice of Closure in all respects).

ORDER

The ALJ's order dated May 23, 1996 is affirmed in part and reversed in part. That part of the order that awarded claimant 15 percent (22.5 degrees) scheduled permanent disability for the left forearm and 15 percent (22.5 degrees) scheduled permanent disability for the right forearm is reversed, and the April 19, 1995 Notice of Closure, as amended May 10, 1995, which awarded no additional permanent disability beyond claimant's prior award of 3 percent (4.5 degrees) for each forearm is affirmed. The "out-of-compensation" attorney fee is also reversed. The July 27, 1994 Order on Reconsideration is affirmed. The remainder of the order is affirmed.

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[5] This examination was performed in connection with claimant's request for reconsideration from the original November 12, 1993 Notice of Closure.

Chair Hall dissenting in part.

I agree with the majority's determination on the dismissal and evidentiary issues. I disagree, however, with the majority's resolution of the extent issue. Like the ALJ, I believe that claimant has established a Class II impairment under OAR 436-35-110(5). Therefore, I respectfully dissent.

In determining the extent of a claimant's permanent disability, we look to expert medical opinion to establish "impairment," i.e., limitations or restrictions on the use or function of a particular body part. We do not look to medical experts to determine "disability," however, because "disability" is a legal term. In OAR 436-35-110(5), the Department has designated various classes of impairment due to contact dermatitis, which designations are dependent upon the severity of symptoms, the need for treatment and the limitations resulting from the condition. More specifically, if a claimant's skin disorder and treatment "results in no more than minimal limitation in the performance of activities of daily living" the impairment should be rated as Class I. If, on the other hand, there is evidence that the condition requires intermittent treatment and imposes "limitations that require assistance in the performance of activities of daily living" then the impairment should be rated as Class II.

In this case, I believe the majority errs in relying on the doctors' conclusions that claimant had a "Class I" impairment, since that the particular class designation is a legal conclusion rather than an objective finding. Instead of focusing on a medical expert's use of a legal term, we should look to the medical record to determine the extent of claimant's symptoms and restrictions, and then decide whether those symptoms and restrictions fall into Class I or Class II impairment.

Here, in his closing examination of claimant, Dr. Cook noted dryness of the fingers and hands and increased skin markings. Dr. Cook also restricted claimant from skin contact with solvents, and advised her to wear protective gloves whenever she is doing any wet work except personal hygiene. (Ex. 16B). Like the ALJ, I believe that the medical evidence of permanent restrictions, coupled with claimant's credible testimony that she requires assistance with a number of relatively innocuous

activities, including handling citrus fruit, chopping vegetables, changing diapers, bathing her children, and working in the garden,[1] establishes that claimant's skin disorder imposes "limitations that require assistance in the performance of daily living."[2] Under these facts, I would find that claimant's impairment is Class II and affirm the ALJ's order in its entirety.

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[1] Contrary to the majority's determination, claimant's lay testimony is not being used as a substitute for medical proof of her condition-related restrictions. See William K. Nesvold, 43 Van Natta 2767 (1991) (lay testimony alone insufficient to establish impairment under the standards). Rather, in this case, claimant's testimony is probative in establishing how the restrictions identified by Dr. Cook apply and manifest themselves in her life on a daily basis. In that regard, claimant's testimony is consistent with the restrictions (impairment) listed by Dr. Cook.

[2] Indeed, I would consider the protective (barrier-type) gloves recommended by Dr. Cook to be a form of "assistance," as claimant was advised to wear them whenever doing any wet work aside from personal hygiene.

In the Matter of the Compensation of
STEPHANIE K. OLANDER, Claimant
WCB Case Nos. 94-15559 & 94-15558
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys
Jim B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Beverly Enterprises (Beverly), a self-insured employer, requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that upheld its partial denial of claimant's current left wrist condition only to the extent of finding the July 11, 1994 treatment is not compensable. Claimant cross-requests review of the same portion of the order, contending that compensability of claimant's current left wrist condition was not at issue and, therefore, the ALJ should not have addressed that issue. On review, the issue is compensability. We modify in part and reverse in part.

FINDINGS OF FACT

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

The first sentence of the last paragraph should read: "On December 16, 1994, Dr. Witczak wrote Beverly's attorney regarding claimant's condition." (Ex. 38).

In an October 20, 1994 letter to the Department responding to a request for information regarding designation of an ORS 656.307 paying agent, Beverly stated, in part: (1) compensability of claimant's condition after July 3, 1994 was still at issue; (2) responsibility was not the only issue; and (3) the claim was in deferred status. (Ex. 36). This letter indicates that a copy of the letter was sent to claimant's attorney. Id. Claimant's attorney does not contend that he did not receive a copy of this letter.

On October 25, 1994, the Department issued an order denying designation of a paying agent pursuant to ORS 656.307 based on Beverly's October 20, 1994 letter notifying the Department that compensability was at issue. (Ex. 36A).

In her hearing request, claimant raised the issue of compensability and referenced Beverly's December 13, 1994 denial. Claimant's hearing request did not raise responsibility as an issue.

CONCLUSIONS OF LAW AND OPINION

While identifying the issue as Beverly's denial of claimant's July 11, 1994 condition, the ALJ explicitly limited his decision to the compensability of claimant's July 11, 1994 treatment, finding that claimant had not established compensability of that treatment. On review, claimant argues that "compensability was never properly raised as an issue for hearing." (Respondent/Cross-Appellant's Brief, page 7). In support of this argument, claimant contends that Beverly never properly denied

compensability of either her condition or her treatment as of July 11, 1994. Therefore, claimant argues, the ALJ should not have addressed any compensability issue. Beverly argues that it denied compensability of claimant's current condition and the ALJ should not have limited his decision to the July 11, 1994 treatment. Based on the following reasoning, we find that compensability of claimant's current left wrist condition was properly raised at hearing.

On July 18, 1993, claimant suffered a left wrist injury while working as a CNA for Beverly. Beverly initially accepted a nondisabling left wrist strain injury. Subsequently, claimant began treating with Dr. Witczak, who diagnosed a tear of the triangular fibrocartilage and performed arthroscopic surgery to repair that condition on November 12, 1993. Dr. Witczak saw claimant periodically following the surgery. On November 24, 1993, Beverly accepted a disabling tear to the triangular cartilage. On February 26, 1994, claimant discontinued working for Beverly.

In late April 1994, claimant worked for one week as a telemarketer for a noncomplying employer. Claimant experienced increased left wrist pain while performing this work. On May 4, 1994, claimant returned to Dr. Witczak, who diagnosed ulnar nerve neuritis. Claimant filed a workers' compensation claim with the noncomplying telemarketing company. On October 4, 1994, the SAIF Corporation (SAIF/NCE) denied the claim on behalf of this noncomplying employer. (Ex. 34B). Claimant requested a hearing on this denial and the ALJ upheld the SAIF/NCE denial, finding that Beverly remained responsible for the left wrist condition. This portion of the ALJ's order is not contested on review.

On July 11, 1994, claimant again saw Dr. Witczak for her left wrist. Claimant reported to Dr. Witczak that she was moving furniture at home with her mother on July 3, 1994, and had pain in her wrist, which had remained painful since. (Ex. 34). On September 19, 1994, claimant was examined by Dr. Rosenbaum, neurologist, on behalf of SAIF/NCE. (Ex. 34A). At that time, claimant reported that: (1) on June 8, 1994, she began working as a CNA for Troutdale Foster Care Agency (Troutdale); (2) on July 3, 1994, she felt a pop and crack in her left wrist while helping to move furniture for clients at Troutdale; and (3) she then went home and had a recurrence of her symptoms while moving furniture for her mother. (Ex. 34A-2).

In October 1994, the Department issued an order denying designation of a paying agent based on Beverly's representation to the Department that compensability of claimant's condition after July 3, 1994 was at issue. (Exs. 36, 36A). On December 13, 1994, Beverly issued a partial denial regarding the left ulna injury and ulna neuritis conditions. (Ex. 37). Claimant requested a hearing. Claimant's hearing request referenced the December 13, 1994 denial and raised, among other issues, the issue of compensability. The hearing request did not raise responsibility as an issue.

At hearing, Beverly contested compensability of claimant's condition from July 3, 1994 forward, contending that claimant sustained a new injury on that date either at home or while working for Troutdale. (Tr. 2, 3, 7). Claimant responded that she was not conceding that Beverly could raise compensability as an issue, contending that the December 13, 1994 denial was strictly a responsibility denial that disclaimed responsibility only against SAIF/NCE. (Tr. 6).

On review, claimant argues that the issue of compensability was never raised in this claim. In support of her argument, claimant contends that no denial of compensability was ever issued. We disagree with claimant's underlying premise that compensability was never raised as an issue.

In an October 20, 1994 letter responding to an inquiry to the Department regarding the possibility of designating a paying agent pursuant to ORS 656.307, Beverly stated that "compensability of [claimant's] condition after July 3, 1994 is still at issue." (Ex. 36). Thus, Beverly's letter to the Department explicitly challenged compensability of claimant's condition after July 3, 1994. Furthermore, this letter indicates that a copy of the letter was sent to claimant's attorney. Id. Claimant's attorney does not contend that he did not receive a copy of this letter. Based on Beverly's statement that compensability remained at issue, the Department denied designation of a paying agent under ORS 656.307. Subsequently, Beverly issued a denial on December 13, 1994. Finally, and of most importance, in her hearing request, claimant explicitly raised the issue of "compensability," referencing Beverly's December 13, 1994 denial. Claimant's hearing request did not raise the issue of responsibility.

At hearing, Beverly stated that it was contesting compensability of claimant's condition from July 3, 1994 forward. (Tr. 2, 3, 7). In response, claimant stated that she would not concede that Beverly could raise compensability, contending Beverly's denial denied only responsibility, not compensability. (Tr. 6).

On this record, we find that compensability of claimant's left wrist condition after July 3, 1994 was at issue. Claimant herself raised the issue of compensability in her hearing request. Moreover, claimant did not withdraw that issue at hearing. Furthermore, if claimant was surprised by Beverly's statement at hearing that it was contesting compensability of claimant's condition from July 3, 1994 forward, she could have requested, for the ALJ's consideration, a continuance for further development of that issue. OAR 438-006-0091. She did not do so. Instead, she merely stated that she did not concede that Beverly could raise the issue of compensability. However, under the facts of this case, compensability of claimant's left wrist condition was already at issue.[1]

Therefore, having found that the issue of compensability of claimant's left wrist condition after July 3, 1994 was properly raised at hearing, we proceed to address the merits.

As to the merits, given the multiple possible causes of claimant's left wrist condition after July 3, 1994, we find the issue of the compensability of claimant's current left wrist condition to be a complex medical question requiring expert medical opinion. Barnett v. SAIF, 122 Or App 279 (1993). Dr. Witczak provides the only opinion regarding the cause of claimant's left wrist condition after July 3, 1994.

On July 11, 1994, when claimant returned to Dr. Witczak for treatment of left wrist pain, she reported injuring her left wrist at home on July 3, 1994 while helping her mother move furniture. (Ex. 34). Claimant did not report to Dr. Witczak any work-related furniture moving injury occurring at Troutdale on July 3, 1994. On December 16, 1994, Dr. Witczak opined that the major contributing cause of claimant's current left wrist condition was the reinjury of the wrist that occurred as a result of moving furniture at home on July 3, 1994. (Ex. 38).

Subsequently, Dr. Witczak was deposed. (Ex. 40). During his deposition, Dr. Witczak was informed that claimant had subsequently reported to Dr. Rosenbaum that she felt a "pop and crack" in her left wrist when moving furniture at Troutdale on July 3, 1994, and later that day, she had a return of her symptoms while moving furniture for her mother at home. (Ex. 40-61). Dr. Witczak stated that he could not distinguish which of those incidents was the more significant injury. (Ex. 40-61, -62). Moreover, he was unable to say the accepted left wrist injury remained a material contributing cause of claimant's left wrist condition. (Ex. 40-62).

Thus, on this record, claimant has failed to prove that the compensable left wrist injury remains a material contributing cause of her left wrist condition after July 3, 1994. Accordingly, we conclude that claimant's current left wrist condition after July 3, 1994 is not compensable.[2]

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[1] Claimant's statement that she did not "concede" that point does not change the fact that compensability of claimant's left wrist condition from July 3, 1994 forward was already at issue at hearing. As explained above, claimant's remedy was to request a continuance if she was surprised by Beverly's statement at hearing that it was contesting compensability of claimant's condition from July 3, 1994 forward. OAR 438-006-0091. Furthermore, because we find that the issue of compensability of claimant's left wrist condition was raised at hearing independent from the December 13, 1994 denial, we need not address claimant's argument that the December 13, 1994 denial did not deny compensability. In any event, claimant apparently interpreted this denial as a denial of compensability, since she referenced this denial in her hearing request that specifically raised the issue of compensability.

[2] In reaching this conclusion, we emphasize that we are addressing the issue before us: compensability of claimant's current left wrist condition after July 3, 1994. Our conclusion does not affect the accepted left wrist strain injury and left triangular cartilage tear injury. Having accepted these injuries, Beverly cannot revoke acceptance and issue a denial of these injuries except as provided in ORS 656.262(6)(a), which provides for denials of accepted conditions under the following circumstances: (1) "at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker"; and (2) within two years from the date of initial acceptance when the denial is based on later obtained evidence that the injury is not compensable or the carrier is not responsible for the claim. Neither of these provisions apply to claimant's claim, and no such denial of the accepted conditions has been issued. Thus, the left wrist strain injury and the left triangular cartilage tear injury remain accepted conditions. Therefore, claimant is not precluded from making a claim in the future that the accepted conditions are responsible for any subsequent left wrist condition. Of course, the success of any such claim would depend on the medical evidence. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989), rev den 309 Or 645 (1990) (whether the causation issue previously litigated is the same as the causation issue in the present case depends on whether claimant's condition has changed in the interim); Edwin W. Pearle, II, 46 Van Natta 1568 (1994) (where prior litigation determined claimant's current condition was unrelated to compensable injury, "issue preclusion" bars current claim unless claimant proves current condition is different from earlier condition found not compensable).

ORDER

The ALJ's order dated January 19, 1996 is affirmed in part, modified in part, and reversed in part. That portion of the order that partially set aside Beverly Enterprises' December 13, 1994 partial denial is modified. Beverly Enterprises' December 13, 1994 partial denial of claimant's current left wrist condition from July 3, 1994 forward is reinstated and upheld in its entirety. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

Board Chair Hall specially concurring.

While I agree with the lead opinion that compensability of claimant's left wrist condition after July 3, 1994 was at issue at hearing and on review, I base my decision on the pleadings, wherein claimant raised the issue of compensability, and the framing of the issues by the parties at hearing. I do not find the prehearing correspondence with the Department affects whether compensability was properly raised as an issue at hearing or on review. Therefore, I did not consider that correspondence in reaching my decision.

December 17, 1996 Cite as 48 Van Natta 2473 (1996)

In the Matter of the Compensation of
LEE R. PARKER, Claimant
Own Motion No. 94-0653M
OWN MOTION ORDER
Darris K. Rowell, Claimant Attorney
SAIF Legal Department, Defense Attorney

Claimant requests that the Board enforce its July 18, 1996 Own Motion Order Reviewing Carrier Closure, as reconsidered on September 4, 1996, which set aside the SAIF Corporation's June 14, 1996 Notice of Closure in this claim. In addition, claimant requests the Board assess a penalty for SAIF's allegedly unreasonable failure to pay compensation.

FINDINGS OF FACT

On April 26, 1968, claimant sustained a compensable injury to his right knee. SAIF subsequently accepted claimant's back condition as a compensable component in this claim. Claimant's aggravation rights expired on February 6, 1974.

On May 11, 1995, claimant underwent excision of the patellar component of his right knee. On May 24, 1995, the Board issued an order reopening claimant's claim for the payment of temporary disability compensation (TTD).

On June 14, 1996, SAIF closed claimant's 1968 injury claim, declaring claimant medically stationary on May 29, 1996. SAIF paid claimant temporary disability compensation from May 11, 1995 through May 29, 1996. Claimant appealed SAIF's June 14, 1996 closure.

In a July 18, 1996 Own Motion Order Reviewing Carrier Closure, the Board set aside SAIF's closure as premature. SAIF requested reconsideration of our July 18, 1996 order, and, on September 4, 1996, we republished our July 18, 1996 order in its entirety. On September 24, 1996, SAIF again requested reconsideration of our prior orders. On October 1, 1996, we denied SAIF's motion for abatement and reconsideration of our prior orders. Our October 1, 1996 order contained no appeal rights.

On October 4, 1996, our September 4, 1996 Own Motion Order Reviewing Carrier Closure on Reconsideration became final by operation of law. Therefore, claimant's claim remains reopened. On October 24, 1996, claimant moved the Board for an order enforcing its prior orders. Contending that SAIF failed to comply with our September 4, 1996 order which set aside SAIF's closure of this claim, claimant requested that: (1) the Board require SAIF to pay all compensation due beginning the date SAIF terminated compensation in the claim, from May 30, 1996 through the present; and (2) assess penalties / attorney fees pursuant to ORS 656.262(11) in the amount of 25 percent "of all past due compensation."

On November 29, 1996, claimant submitted a copy of SAIF's payment ledger regarding this claim. The payment ledger indicates that SAIF made payment of back due amounts of temporary disability compensation (from May 30, 1996 through October 23, 1996) on October 30, 1996.

CONCLUSIONS OF LAW AND OPINION

The Board has exclusive jurisdiction to authorize the reopening of a claim under ORS 656.278 and OAR Chapter 438, Division 012. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Moreover, the Board's authority extends to enforcing its own motion orders. See Larry P. Karr, 48 Van Natta 2183 (1996); Jeffrey T. Knudson, 48 Van Natta 1708 (1996); Thomas L. Abel, 45 Van Natta 1768 (1993); David L. Waasdorp, 38 Van Natta 81 (1986).

Because SAIF has recommenced payment of temporary disability compensation in this claim, we need not address the enforcement issue.

Therefore, the sole issue remaining is whether SAIF unreasonably refused the payment of temporary disability compensation. Under ORS 656.262(11)(a), if the insurer "unreasonably delays or unreasonably refuses to pay compensation," it shall be liable for an additional amount of 25 percent of the amounts "then due."

Here, pursuant to ORS 656.278(1), we authorized the reopening of claimant's 1968 right knee and back claim for the payment of temporary disability, commencing the date he underwent surgery. SAIF terminated TTD on May 29, 1996, and closed the claim on June 14, 1996. Our July 18, 1996 Own Motion Order Reviewing Carrier Closure order set aside SAIF's closure as premature. We republished our July 18, 1996 order (as reconsidered) on September 4, 1996. Because we declined to reconsider it on October 1, 1996, our September 4, 1996 order became final by operation of law on October 4, 1996 (once the 30-day period within which to seek Judicial review of our September 4, 1996 order expired. See ORS 656.295(8); 656.278(4)). Therefore, SAIF was required to pay claimant's "retroactive" temporary disability 14 days after our September 4, 1996 order became final, or by October 18, 1996.[1] Furthermore, SAIF was required to pay any "prospective" temporary disability compensation within 14 days after the issuance of our September 4, 1996 order, or by September 18, 1996. SAIF did not pay any TTD until October 30, 1996.

SAIF did not timely pay compensation pursuant to our September 4, 1996 order, nor does it offer any explanation for its failure to do so. Thus, we find SAIF's conduct to be unreasonable. Therefore, under ORS 656.262(11)(a), we are authorized to assess a 25 percent penalty of the amounts "then due" claimant at the time of SAIF's untimely payment of temporary disability, payable in equal shares to claimant and his attorney. See John R. Woods, 48 Van Natta 1016 (1996); Jeffrey T. Knudson, supra.

IT IS SO ORDERED.

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[1] Claimant argues that a penalty in this claim is due because the employer was more than 44 days late in the payment of temporary disability compensation. OAR 438-012-0035 provides that the insurer shall make the first payment of temporary disability "within 14 days from the date of an order of the Board reopening the claim." However, for purposes of establishing guidelines for penalty assessments on "amounts then due" in claims where a carrier did not make timely payment of benefits, we have previously made the distinction between "prospective" and "retroactive" temporary disability. See Larry P. Karr, 48 Van Natta 2183 (1996); Jeffrey T. Knudson, 48 Van Natta 1708 (1996); John R. Woods, 48 Van Natta 1016 (1996).

Unlike OAR 438-012-0035, the Department's rule, OAR 436-060-0150(5)(h), makes the distinction between "retroactive" and "prospective" TTD in that it provides that timely payment of TTD means that payment has been made no later than 14 days after the date of any "litigation" order which authorizes "retroactive" TTD becomes final, i.e., within 44 days from the date of its issuance. However, that rule further provides that temporary disability accruing from the date of the order ("prospective" TTD) shall begin no later than the 14th day after the date the order is filed. We find that the Board's rule is applicable only to timeliness of prospective temporary disability compensation. Our rule does not, however, address "litigation" or reconsideration orders, where "retroactive" timeloss has been previously authorized by a Board order and has not been timely paid.

In the Matter of the Compensation of
ALAN WELBURN, Claimant
WCB Case No. 95-10494
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Christian and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of claimant's genitofemoral neuralgia and pain syndrome; (2) found that claimant's claim had been prematurely closed; and (3) awarded an attorney fee of $3,500. In its brief, the insurer contends that the ALJ improperly admitted evidence. On review, the issues are compensability, premature closure, evidence and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Claim Closure

The ALJ concluded that claimant's claim had been prematurely closed. The insurer contends that the ALJ's conclusion is based on improperly admitted evidence. We affirm the ALJ's opinion on this issue with the following supplementation.

A claim shall not be closed if the worker's condition has not 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). Claimant has the burden to prove that he was not medically stationary on the date of 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 March 15, 1995 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. 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 his February 14, 1995 chart note, Dr. Merhoff, claimant's attending physician, noted that claimant was having "neuritic discomfort going down his medial left thigh which he states is worse if he does any exertion on the left side of his body like lifting with his left upper extremity." Dr. Merhoff diagnosed "neuritic pain left medial thigh - probable post operative phenomenon that I would expect to improve with time. * * * He will follow up on a PRN basis." (Ex. 9). Because Dr. Merhoff identified a condition related to the accepted claim which was expected to improve with time, and because Dr. Merhoff did not indicate that claimant was medically stationary as to that condition, we conclude that claimant's claim was prematurely closed. Weiland v. SAIF, 64 Or App 810 (1983); Somers v. SAIF, 77 Or App 259 (1986). We consequently agree with the ALJ's conclusion that claimant has carried his burden of proving that he was not medically stationary when his claim was closed.

Because claimant has established that his claim was prematurely closed based on undisputed "reconsideration record" evidence, we need not resolve the issue of whether the specific exhibits to which the insurer objects were submitted at the reconsideration process.

Denial

We agree with the ALJ's conclusion that the insurer issued an express denial of claimant's genitofemoral neuralgia and post-operative pain syndrome. (See Exs. 37, 38, 39). Johnny M. Davis, 45 Van Natta 2282, 2283 (1993) (compensability issue raised where letter stated it was a denial of claim for

benefits and contained notice of hearing provisions). Because the insurer issued an express denial of claimant's nerve conditions, we need not address its arguments regarding the applicability of ORS 656.262(6)(d) or ORS 656.262(7)(a) in this case. Moreover, because claimant prevailed on the compensability issue, an attorney fee award under ORS 656.386(1) is appropriate here.[1]

Attorney Fee - ORS 656.386(1)

The ALJ awarded claimant a $3,500 attorney fee for his counsel's services at hearing. The insurer asserts that the ALJ's attorney fee award was excessive and should be reduced. We affirm the ALJ's attorney fee award.

A claimant is entitled to an attorney fee in cases involving denied claims where a claimant prevails finally in a hearing. ORS 656.386(1). Here, at the hearings level, claimant prevailed against the insurer's denial of compensability for his genitofemoral nerve condition. Thus, he is entitled to a carrier-paid attorney fee award under ORS 656.386(1) for his counsel's services provided at the hearings level.

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. Claimant's counsel prepared for a hearing on the insurer's compensability denial. Prior to hearing, the parties agreed that the compensability issue would be decided on the basis of the documentary evidence and written arguments. The hearing record consists of 48 exhibits, 10 of which were submitted by claimant's counsel. Claimant's counsel submitted a 10-page opening argument and a two-page reply argument, the greater portions of which addressed the compensability issue.

The value of the compensability issue is above average, as claimant stands to gain medical expenses, including surgery, time loss, and a probable award of permanent disability compensation. The issue in dispute involved factual and legal matters that were more complex than those compensability disputes that are generally presented at hearing and for Board resolution. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner, identifying the relevant factual and legal issues for our resolution. Based on counsel's statement of services, somewhat over 14 hours of attorney time were expended on the case at the hearing level.[2] Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering all these factors, we conclude that the ALJ's attorney fee award of $3,500 was reasonable for services rendered at the hearings level regarding the compensability issue.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability and premature closure issues is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interests involved. Claimant is not entitled to an attorney fee for services on review regarding the ALJ's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

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[1] Citing Michael J. Galbraith, 48 Van Natta 351 (1996), the insurer contends that, because all treatments for claimant's genitofemoral neuralgia condition have been paid, no attorney fee should be awarded under ORS 656.386(1). The insurer's argument is inapposite. In Galbraith, we held that there was no "denied claim" under ORS 656.386(1) where the carrier had paid all benefits for the compensable condition and did not expressly contend that the allegedly "de facto" denied condition was not compensable. Here, in contrast, the insurer issued an express denial of claimant's condition. Thus, an attorney fee under ORS 656.386(1) is appropriate.

[2] The statement does not differentiate between services devoted to the compensability issue from those directed at the premature closure issue. Services devoted to the premature closure issue are not considered in determining a reasonable fee under ORS 656.386(1) for services on the compensability issue at the hearings level.

ORDER

The ALJ's order dated May 22, 1996 is affirmed. For services on review, claimant's counsel is awarded $1,500, to be paid by the insurer.

December 17, 1996 Cite as 48 Van Natta 2477 (1996)

In the Matter of the Compensation of
MICHAEL D. WINGO, Claimant
WCB Case No. 96-01814
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Lipton's order that found that claimant was entitled to temporary total disability payments after December 22, 1995. On review, the issue is entitlement to temporary total disability (TTD). We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has accepted claims for nondisabling right forearm and right hand injuries. Claimant did not miss any time from work as a result of his injuries. He returned to work performing light duty. However, claimant's wage for light duty was the same as his regular wage.

Claimant is a member of the Carpenter's Union. The union's labor agreement with the employer provides that the union has the right to require removal of employees for failure to pay dues. Under the agreement, the employer agrees to terminate an employee no later than the end of the next shift following the employer's receipt of the union's written request for such termination.

Claimant fell behind in his dues payments to the union and an arrangement was reached with the union whereby claimant would make partial payments to get caught up with his dues. When the union did not receive payment in compliance with this arrangement, the union prepared a letter to the employer on December 13, 1995 which requested that claimant be removed from employment for failing to comply with the labor agreement. The letter was delivered to the employer a few days after it was prepared. The employer verified the letter with the union on December 21, 1995 and claimant was terminated that day.

As of December 19, 1995, prior to his termination, claimant had brought his dues obligation up to date and was in compliance with his union agreement. Claimant brought this to the union's attention and on December 22, 1995, the union prepared a letter advising the employer that claimant was now in compliance with his union obligation and was approved to return to work. However, claimant was not offered employment by the employer.

The ALJ concluded that, because claimant's modified job no longer existed or was withdrawn, TTD was due.[1] We disagree and reverse.

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[1] The ALJ relied on Arturo G. Vasquez, 44 Van Natta 2443 (1992), as support for his decision that SAIF was obligated to begin paying TTD on claimant's termination from employment. We find Vasquez distinguishable. There, we held that where the claimant is notified that the job no longer exists or that the job offer is withdrawn, TTD benefits must be reinstated. Here, the modified job offer was not withdrawn. Moreover, the only reason that claimant's modified job ceased to exist was because claimant was terminated from that job for failing to pay his union dues. But for claimant's termination, which was unrelated to his compensable injury, the record suggests that claimant's modified job would have continued.

This case is indistinguishable from those cases which hold that where a worker leaves work for reasons unrelated to the injury, she is not entitled to temporary disability benefits. Terri Link, 47 Van Natta 1711 (1996); Patricia K. Stodola, 48 Van Natta 613 (1996); see also Teresa L. Rodriguez, 46 Van Natta 2183 (1994) (claimant terminated from employment for failing to join union, as required by employer's labor contract, left work for reasons unrelated to the injury and was not entitled to TTD).

In Link, (as here), the claimant returned to modified work at her regular wage and then was fired for reasons unrelated to her compensable injury. The claimant did not lose wages until her termination and did not leave work or lose wages as a result of the injury. Under such circumstances, the Board held that the claimant had not established an entitlement to temporary disability.

Similarly, in Stodola, the claimant had returned to modified work and was receiving her regular wage. She was terminated from her employment for reasons unrelated to the compensable injury. Because the claimant did not leave work or suffer diminished earning capacity due to the injury, the Board held that the carrier had no obligation to begin paying temporary disability benefits on the claimant's termination.

Here, as in Stodola and Link, claimant did not leave work or suffer diminished earning capacity until he was fired for reasons unrelated to his compensable injury. Thus, claimant is not entitled to temporary disability benefits.[2]

Finally, we note that this is not a case where a modified job offer was withdrawn or where the modified job no longer exists.[3] Here, there was never any "withdrawal" of the modified job. Instead, claimant was fired as required by the labor agreement for not paying his union dues. (In other words, he was fired for reasons unrelated to the injury). Moreover, this is not a case where the modified job no longer exists. But for his termination at the union's request, claimant would still be working and would never have lost wages.

Citing former OAR 436-60-030(11)(b), claimant argues that he was not terminated for violation of a normal employment standard and that, consequently, his termination amounted to a withdrawal of the modified job by the employer. We disagree. Because claimant was fired in accordance with the labor agreement with his union, we find that claimant's termination was for violation of a normal employment standard.

Claimant may well have a cause of action stemming from the manner in which he was terminated. Nevertheless, this Board is not the appropriate forum for such an action. Rather, as previously discussed, our review is limited to determining whether claimant left work for reasons related to his compensable injury, which includes an examination of whether his termination was for a violation of a normal employment standard. For the reasons expressed above, the record supports a conclusion that claimant did not leave work for reasons related to his compensable injury because he was terminated for a violation of a normal employment standard (nonpayment of union dues). Under such circumstances, he is not entitled to the reinstatement of temporary total disability benefits.

ORDER

The ALJ's order dated April 19, 1996 is reversed. The ALJ's temporary total disability award, including an "out-of-compensation" attorney fee, is reversed.

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[2] Claimant also argues that temporary disability benefits could not be terminated under ORS 656.268(3). ORS 656.268(3) does not apply to this case. Temporary disability benefits were never begun because claimant never lost any wages due to the compensable injury. Thus, there is no "termination" issue.

[3] We find this case distinguishable from Safeway Stores, Inc. v. Hanks, 122 Or App 582 (1993). In Hanks, the claimant was not fired for a reason unrelated to her compensable injury. Rather, her modified work was temporarily withdrawn because the employer locked out its employees as a result of a labor dispute.

Board Chair Hall dissenting.

At the time he was terminated by the employer, claimant had brought his dues obligation up to date and was in compliance with his agreement with the union.[1] Thus, claimant did not lose wages because of his voluntary choice or because of any fault of his own. In addition, claimant remained temporarily and partially disabled due to the injury. Under such circumstances, I believe that claimant was entitled to TTD.

This case is similar to Safeway Stores, Inc. v. Hanks, 122 Or App 582 (1993). In Hanks, the claimant was offered modified work by the employer as a result of her compensable injury. Because of a labor dispute, the employer locked out its employees. After the labor dispute was resolved, the claimant returned to her modified job.

The court noted that the claimant was unable to perform her regular job due to her compensable injury and that the employer's lock out had separated the claimant from her job. The court held that when the employer barred the claimant from her modified job, she was unable, due to the injury, to work and earn wages. In reaching its conclusion, the court noted that the claimant did not remove herself from the work force and her separation from employment was not due to her voluntary choice. Under those circumstances, the court agreed with the Board that the employer had withdrawn its offer of modified employment and that the claimant was entitled to temporary disability for the period during which she was locked out from her modified job.

Here, as in Hanks, claimant's separation from his employment was not due to his voluntary choice. Rather, claimant was separated from his employment due to the union's error and his consequent termination at the union's request. After his termination, claimant remained partially disabled due to the injury. Claimant was, and remained at all relevant times, willing to continue his employment, including after the union notified the employer of the union's error. The employer, however, refused or failed to return claimant to his employment. Under such circumstances, I believe that the employer's erroneous termination of claimant amounted to a withdrawal of the modified work offer and that claimant is entitled to temporary total disability benefits. See also William K. Bowler, 48 Van Natta 74 (1996) (plant shutdown was a withdrawal of modified work).

Finally, I do not believe that the employer's erroneous termination of claimant constitutes a discharge for violation of normal employment standards. Under such circumstances, the employer's action represents a withdrawal of an accepted offer for modified work. See former OAR 436-60-030(11)(b). In this regard, it is indisputable that, when claimant was terminated by his employer for noncompliance with his union's dues payments, he was actually in compliance with his union obligations. Thus, under these particular circumstances, claimant's termination does not represent a discharge for violation of normal employment standards. If any other conclusion were reached, claimant would be deprived of temporary total disability benefits despite the fact that he remained temporarily disabled from returning to his regular work activities and, through an administrative snafu, was prohibited from performing the only modified job offer which had been offered to him. Under these circumstances, I dissent from the majority opinion.

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[1] Contrary to the Majority's characterization, claimant was not "fired as required by the labor agreement for not paying his union dues." Indeed, as the majority acknowledges, claimant had paid his union dues and was in compliance with the labor agreement when he was fired. Thus, the very foundation of the majority opinion is flawed, as claimant was not terminated for violation of a normal employment standard.

In the Matter of the Compensation of
JERRIE L. BARRETT, Claimant
WCB Case No. 96-04502
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Nancy Meserow, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that awarded claimant an assessed attorney fee for her counsel's services in obtaining a rescission of the insurer's "de facto" denials. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had satisfied the notice requirements of ORS 656.262(6)(d) and was therefore entitled to an attorney fee pursuant to ORS 656.386(1) because his counsel was instrumental in obtaining the rescission of the insurer's "de facto" denials. While we agree with the ALJ that claimant satisfied the requirements of ORS 656.262(6)(d) by means of her letter to the employer's processing agent, we disagree that this, in itself, results in entitlement to an attorney fee pursuant to ORS 656.386(1).

Under 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." 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." We have concluded that there is no "denied claim" where the carrier has paid all benefits and the carrier has not expressly contended that a condition was not compensable. E.g., Michael J. Galbraith, 48 Van Natta 351 (1996).

Here, there is no evidence that the employer refused to pay compensation.[1] Moreover, the record does not establish that the employer 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. Accordingly, we conclude that claimant failed to establish a "denied claim" under ORS 656.386(1). Thus, her attorney is not entitled to an assessed fee. Michael J. Galbraith, supra.

ORDER

The ALJ's order dated August 15, 1996 is reversed. The ALJ's award of a $2,000 assessed attorney fee is reversed.

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[1] Claimant conceded in closing arguments that all benefits for her compensable injury have been paid.

In the Matter of the Compensation of
SANDRA A. BURNS, Claimant
WCB Case No. 96-01451
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order which: (1) affirmed the Order on Reconsideration's award of 11 percent (35.2 degrees) unscheduled permanent disability for claimant's upper extremity overuse syndrome; (2) affirmed an award of 5 percent (9.6 degrees) scheduled permanent disability for the loss of use and function of the left arm, as awarded by a Determination Order (and affirmed by an Order on Reconsideration); and (3) increased an award of 5 percent (9.6 degrees) scheduled permanent disability for the loss of use and function of the right arm, as awarded by a Determination Order, by 1 percent (1.92 degrees), for a total of 6 percent scheduled permanent disability for the right arm.[1] In her brief, claimant contends that the ALJ's award of $1,000 for services at hearing should be increased. On review, the issues are extent of unscheduled and scheduled permanent disability and attorney fees. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the first sentence of the last paragraph on page 2, and with the following modification and supplementation.

An April 11, 1995 Opinion and Order set aside the employer's denial of claimant's bilateral overuse syndrome. (Ex. 7).

The January 25, 1996 Order on Reconsideration awarded claimant 11 percent unscheduled permanent disability, based on a 5 percent impairment value for a chronic condition in the right shoulder, in lieu of the Determination Order's 5 percent scheduled permanent disability award based on a chronic condition of the right arm. (Exs. 28-2, 29-1).

Dr. Weirich's remarks regarding claimant's impairment related to claimant's right arm only. (Exs. 20, 24).

We briefly recap the relevant facts.

On August 18, 1994, claimant filed a claim for a March 1994 onset of bilateral hand pain with numbness and loss of strength. Claimant's subsequent complaints involved the hands, wrists, elbows, and right shoulder, which Dr. Weirich diagnosed as multiple overuse syndromes. (Ex. 2). An April 11, 1995 Opinion and Order set aside the employer's denial of claimant's bilateral upper extremity overuse syndrome. The claim was closed by Determination Order on October 3, 1995, with an award of 5 percent scheduled permanent disability for each arm.

Both parties requested reconsideration and a medical arbiter, Dr. Martens, was appointed to evaluate permanent disability due to claimant's compensable injury. Based on Dr. Martens' report, a January 25, 1996 Order on Reconsideration awarded claimant 11 percent unscheduled permanent

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[1] The ALJ found that the Order on Reconsideration awarded 11 percent unscheduled permanent disability and affirmed the Determination Order's award of benefits (5 percent chronic condition awards for each arm). For the right arm, the ALJ awarded 1 percent scheduled permanent disability, which he combined with the 5 percent chronic condition award, for a total award of 6 percent scheduled permanent disability for the right arm. The record, however, shows that the Order on Reconsideration awarded claimant 5 percent for a chronic condition affecting the right shoulder in lieu of the Determination Order's 5 percent award for a chronic condition for the right arm on the basis that only one chronic condition may be awarded for a body part. (Exs. 28-2, 29-1). Thus, the Order on Reconsideration awarded a total of 11 percent unscheduled permanent disability for the right shoulder and affirmed the Determination Order's 5 percent scheduled disability award for the left arm only. In effect, the ALJ's order resulted in a reinstatement of the Determination Order's award of 5 percent for a chronic condition of the right arm, which he increased by 1 percent, for a total of 6 percent scheduled permanent disability for the right arm.

disability in lieu of the Determination Order's award of 5 percent scheduled permanent disability for the right arm, and affirmed the Determination Order's award of 5 percent scheduled permanent disability for the left arm. (Ex. 28). Each party requested a hearing contesting the Order on Reconsideration.

The ALJ increased claimant's scheduled permanent disability award for the right arm by 1 percent and otherwise affirmed the awards of scheduled and unscheduled permanent disability, relying on the impairment rating of Dr. Martens. The ALJ also awarded an assessed fee of $1,000 under ORS 656.382(2) because the employer had failed to reduce claimant's permanent disability award as a result of its request for hearing.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

On review, the employer argues that claimant is not entitled to an award of unscheduled permanent disability based on right shoulder impairment, because her right shoulder impingement condition is not a part of her accepted bilateral overuse syndrome. We agree that claimant's right shoulder impingement condition is not a part of her compensable claim. Nevertheless, we conclude that claimant has established a right shoulder impairment due to her compensable overuse syndrome.

To be entitled to permanent disability compensation for her right shoulder impairment, claimant must establish that the impairment is due to her compensable occupational disease. ORS 656.214(2). Separate awards are required when a disease involving a scheduled portion of the body results in disability to both scheduled and unscheduled 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).

Here, the Department referred claimant to Dr. Martens, medical arbiter, to evaluate impairment due to her accepted upper extremities overuse syndrome. Dr. Martens examined claimant and reviewed her medical records, including the records regarding the bilateral impingement syndrome. (Ex. 26-2). The arbiter identified claimant's accepted condition as "overuse syndrome, upper extremities." (Ex. 26-1). He found that claimant had reduced ranges of motion in the right shoulder and a partial loss of the ability to repetitively use the right shoulder due to the overuse syndrome. Because the arbiter did not attribute the right shoulder findings to causes other than the compensable occupational disease and, in fact, indicated that the findings were the result of the accepted overuse syndrome (see Ex. 26-5), we conclude that Dr. Martens' impairment findings relate to the work injury. See Kim E. Danboise, 47 Van Natta 2163, on recon 47 Van Natta 2281 (1995) (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).

Dr. Martens found that claimant had a loss of adduction in the right shoulder joint, which results in a 1 percent impairment value, former OAR 436-35-330(7), and a loss of internal rotation in the right shoulder joint, which results in a 1 percent impairment value, former OAR 436-35-330(9). These values are added for a total of 2 percent for decreased range of motion. Former OAR 436-35-330(17). Where the worker has less than 5 percent total ratable impairment in a body area, the worker is entitled to 5 percent unscheduled chronic condition impairment in lieu of all other unscheduled impairment in that body area. Former OAR 436-35-320(5)(b). Claimant, therefore, is entitled to 5 percent impairment value for the right shoulder. This impairment value is added to the non-impairment disability factors to establish the total unscheduled permanent disability award. Former OAR 436-35-280(7).

Inasmuch as the parties do not dispute the Department's calculation of the non-impairment disability factors (6), we affirm the Order on Reconsideration's award of 11 percent unscheduled permanent disability. Consequently, we affirm this portion of the ALJ's order.

Scheduled Permanent Disability

The employer contends that there is no persuasive medical evidence that there was a permanent loss of repetitive use of either upper extremity due to the accepted condition. The employer further contends that the ALJ erred in failing to use the opinions of Dr. Scheinberg, an independent examiner, in weighing the preponderance of evidence regarding impairment. We address the latter argument first.

With the exception of a medical arbiter, findings concerning a claimant's impairment can be made only by the attending physician at the time of claim closure. Dennis E. Conner, 43 Van Natta 2799 (1991). Medical evidence regarding permanent impairment must come from the findings of the attending physician or other physicians with whom the attending physician agrees. See Roseburg Forest Products v. Owen, 129 Or App 442 (1995); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). Reports of insurer-arranged medical examiners are not admissible for the purpose of rating impairment unless those findings are ratified by the claimant's attending physician. Tektronix, Inc. v. Watson, 132 Or App 483 (1995) (attending physician rated claimant's impairment where he incorporated the findings of the consulting physician and noted that claimant had no significant impairment).

Here, Dr. Weirich, claimant's attending physician, evaluated claimant's condition, finding her medically stationary, and restricting her work hours. However, even though he mentioned that he had reviewed Drs. Reimer and Scheinberg's August 15, 1995 report of their examination for the employer, Dr. Weirich did not expressly incorporate their findings in his report. Moreover, although Dr. Weirich's post-closure responses to the employer's questions regarding that report agree in one particular respect with Drs. Reimer and Scheinberg's findings, they differ in other respects. (See Exs. 12, 20, 24). Accordingly, Drs. Reimer and Scheinberg's findings are not admissible for purposes of evaluating claimant's impairment. See Tektronix, Inc. v. Watson, supra.

Impairment is established by a preponderance of the medical evidence, considering the medical arbiter's findings and any prior relevant impairment findings. We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994). Neither are we required to accept the opinion of an attending physician in making our evaluation of a claimant's disability. Agripac, Inc. v. Beem, 130 Or App 170 (1994); Libbett v. Roseburg Forest Products, 130 Or App 50 (1994). 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).

Here, in comparing the reports authored by Dr. Weirich, claimant's attending physician, and Dr. Martens, arbiter, we are more persuaded by Dr. Weirich's reports that claimant has no permanent impairment of her left arm and that the restrictions he placed on claimant's work activities were unrelated to the left arm, than by Dr. Martens' finding that claimant has a partial loss of ability to repetitively use both upper extremities on the basis of overuse. We reason as follows.

Dr. Martens based his chronic condition findings on the fact that claimant limited her work hours to 20 hours per week. The work limitation instruction originated with Dr. Weirich. In light of the fact that Dr. Weirich specifically did not limit claimant's work hours on the basis of any permanent impairment affecting the left arm (compare Exs. 20, 24 with 26-4), we conclude that the employer has established by a preponderance of the evidence that the standards for evaluation of the worker's permanent impairment of the left arm had been incorrectly applied in the reconsideration order. ORS 656.283(7). Accordingly, we reverse the scheduled permanent disability award for the left arm.

As to the right arm, Dr. Weirich, did not rate claimant's impairment. (Exs. 12, 20, 24[2]). Dr. Martens found that claimant was permanently limited in the use of her right arm due to a chronic medical condition (overuse syndrome), because she had limited her work activities to 20 hours a week. As in the case of claimant's left arm, the work restrictions originated with Dr. Weirich. On September 29, 1995, when Dr. Weirich last examined claimant prior to claim closure, he stated that he "suspect[ed] that [claimant] will have some full time restrictions under which she is currently working." In addition, Dr. Weirich stated that he was going to keep the restrictions until his evaluation in two weeks. (Ex. 2-14). These statements do not indicate that it was medically probable that claimant required permanent restrictions, and there is no affirmative statement by Dr. Weirich that claimant was permanently restricted from repetitive use of her right arm. Consequently, we conclude that claimant is not entitled to an impairment value for a permanent chronic condition for the right arm.

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[2] In Exhibit 24, dated December 7, 1995, Dr. Weirich states, "At the time of my closing evaluation, remarks regarding impairment all related to the patient's right upper extremity." In Exhibit 2-14, dated September 26, 1995, Dr. Weirich states: " I would like to send [claimant] for a physical capacities evaluation at occupational therapy. She will return to see me in two weeks to close her case." There are no further reports from Dr. Weirich dated prior to the October 3, 1995 Determination Order. A physical capacities evaluation took place on October 18, 1995, but was not concurred in by Dr. Weirich. (Ex. 17).

Dr. Martens, however, found that claimant had decreased ulnar deviation of the right wrist, which results in an impairment value of 1 percent of the right arm. Former OAR 436-35-080(7); 436-35-090(1). We accordingly affirm the ALJ's 1 percent scheduled permanent disability award for the right arm.

Attorney Fee

The ALJ awarded claimant's counsel an assessed attorney fee of $1,000 for defending against the employer's request for hearing. Claimant contends that the ALJ's $1,000 attorney fee award is inadequate. We disagree.

The Order on Reconsideration awarded: 11 percent unscheduled permanent disability (in lieu of the Determination Order's 5 percent scheduled permanent disability award for the right arm); and 5 percent scheduled permanent disability for the left wrist. The ALJ awarded: no additional unscheduled permanent disability; no additional scheduled permanent disability for the left wrist; and a total of 6 percent scheduled permanent disability for the right wrist.

Because we affirm the ALJ's order on the unscheduled permanent disability award, claimant is entitled to an assessed attorney fee for services at hearing in successfully defending that award. ORS 656.382(2); Edward L. Eddington, 47 Van Natta 1466, 1457 (1995); Debra Cooksey, 44 Van Natta 2197, 2198 (1992) (when conditions are considered separately for purposes of rating permanent disability and the carrier appeals compensation awarded for every condition, and compensation for at least one condition is not reduced, we award an assessed attorney fee for the claimant's counsel's efforts with regard to that condition). Here, the ALJ correctly found that claimant had successfully defended the challenge to the unscheduled permanent disability (shoulder) award. Because we affirm the ALJ's order on that issue, claimant is entitled to an assessed attorney fee for services at hearing in defending the shoulder award. ORS 656.382(2); Eddington, supra. However, because we reverse the left arm award and reduce the right arm award, the ALJ's assessed fee award must be reduced. After considering the factors set forth in OAR 438-015-0010(4) and applying them to the unscheduled permanent disability issue, we find that $750 is a reasonable fee. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearings record), the complexity of the issue, and the value of the interest involved. Therefore, we modify the ALJ's assessed fee award.

Claimant is also entitled to an assessed attorney fee for services on review concerning the issue of unscheduled permanent disability. ORS 656.382(2). After considering the factors set forth in OAR 438-0015-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the unscheduled permanent disability award is $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that no attorney fee is available for claimant's unsuccessful defense of the right and left arm awards, or on claimant's unsuccessful request for an increased attorney fee award.

ORDER

The ALJ's order dated June 20, 1996 is reversed in part, modified in part, and affirmed in part. That portion of the order that affirmed the Order on Reconsideration's award of 5 percent scheduled permanent disability for the left arm is reversed. That portion of the order which awarded claimant 6 percent (11.52 degrees) scheduled permanent disability for the right arm is modified. In lieu of the ALJ's scheduled permanent disability award, claimant's total scheduled permanent disability award to date for the right arm is 1 percent (1.92 degrees). The ALJ's "out-of-compensation" attorney fee is modified accordingly. In lieu of the ALJ's assessed fee award of $1,000 for services at hearing, claimant's attorney is awarded $750, payable by the self-insured employer. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded a fee of $750, to be paid by the self-insured employer.

In the Matter of the Compensation of
FE D. DELARIARTE, Claimant
WCB Case No. 95-11827
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that upheld the SAIF Corporation's denial of claimant's neck and right shoulder conditions. On review, the issue is compensability.

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

Claimant has an accepted claim for a cervical and trapezius strain as a result of a June 24, 1995 work injury. On August 29, 1995, the same day that SAIF accepted the strain injury claim, SAIF denied claimant's current disability and need for treatment on the basis that the major contributing cause of claimant's symptoms was preexisting degenerative disc disease rather than the compensable injury.

On review, claimant first asserts that the denial should be set aside because she proved that her accepted injury is the major contributing cause of her need for treatment and disability. We agree with the ALJ's conclusion that a preexisting degenerative condition, rather than the accepted conditions, was the major contributing cause of claimant's need for treatment. Consequently, claimant failed to prove compensability. See ORS 656.005(7)(a)(B). We address only claimant's assertion that the denial is not procedurally proper because it does not comply with ORS 656.262(7)(b) and 656.268(1)(a). Claimant contends that SAIF's denial is improper because "it is not based on the existence of a 'combined condition'," but instead on the ground that "claimant's compensable condition has resolved."

Under ORS 656.268(1)(a), if the worker is not yet medically stationary, the claim may not be closed unless the "accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7)[.]" This provision pertains to claim closure. At issue in this case, however, is SAIF's "preclosure" denial. Because the matter of claim closure is not a part of this proceeding, we find ORS 656.268(1)(a) inapplicable to this case.

ORS 656.262(7)(b) provides that, once a claim has been accepted, the carrier "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." Based on the statute's terms, its context, and legislative history, we recently held that ORS 656.262(7)(b) "cannot apply unless the accepted condition, whether voluntary or by litigation, is a 'combined condition.'" Robin W. Spivey, 48 Van Natta 2363 (1996).

Here, SAIF's Notice of Acceptance was for "cervical/ trapezius strains." There is no evidence that SAIF accepted a combination of the preexisting degenerative condition and the strains. Thus, ORS 656.262(7)(b) does not apply to this case.[1]

ORDER

The ALJ's order dated February 15, 1996 is affirmed.

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[1] Alternatively, even if we agreed with claimant's theory regarding SAIF's denial, we would continue to find the denial to be procedurally proper. That is, if the denial did not satisfy ORS 656.262(7)(b) because it did not pertain to a "combined condition," we would find the denial valid under Guerrero v. Stayton Canning Company, 92 Or App 209 (1988). In Guerrero, the court held that a carrier "may not issue a partial denial of a previously accepted inseparable condition while the claim is in open status." 92 Or App at 212-13. If claimant is correct in arguing that SAIF's denial is based on a contention that the accepted conditions "resolved," leaving only the preexisting degenerative disease (which was not accepted), the preexisting condition would be "separable" from the accepted conditions and, thus, could be properly denied before claim closure.

In the Matter of the Compensation of
GARY S. DUDLEY, Claimant
WCB Case No. 96-00701
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order which: (1) upheld the SAIF Corporation's denial of claimant's low back injury claim; and (2) declined to award penalties and attorney fees for SAIF's allegedly unreasonable denial. On review, the issues are subjectivity, compensability, penalties and attorney fees.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated May 24, 1996 is affirmed.

Board Member Biehl dissenting.

The majority adopts without opinion the ALJ's order which upholds SAIF's denial of claimant's low back injury claim. Because I disagree with the majority's decision, I must respectfully dissent.

The majority's opinion contains no explanation of the background of this unusual case. Therefore, I begin with a brief recitation of the facts and procedural posture of the claim.

Claimant, an inmate at a county correctional facility, allegedly injured his low back while cutting brush for SAIF's insured, the Oregon Department of Transportation (ODOT), as part of a "work incentive" program. Claimant received no monetary remuneration for this work, but the correctional facility would reduce his sentence in exchange for the time he would spend in the voluntary work incentive program.

The ALJ upheld SAIF's denial of claimant's injury claim, finding that claimant had not met his burden of proving that he was an employee of ODOT.[1] In reaching this conclusion, the ALJ determined that claimant had not established that he was a "worker" pursuant to ORS 656.005(30). The ALJ reasoned that, although "remuneration" as used in the statute encompassed payment beyond wages, there was no case or principle which established that a reduction in criminal sentence constituted "remuneration."

On review, claimant contends that a reduction in criminal sentence is "remuneration" under ORS 656.005(30) and that the August 27, 1995 injury was the major contributing cause of his L4/L-5 disc herniation. For the reasons explained below, I agree with claimant that he was a subject worker when allegedly injured and that his low back claim is compensable.

Subjectivity

ORS 656.005(30) provides:

> "'Worker' means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant." (Emphasis supplied).

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[1] The county was not joined in the proceedings as a potential employer.

The term "remuneration" is not defined in the statute. However, in ORS 656.005(29), "wages" are defined as:

> "...the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes the amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips reported, whichever amount is greater...."

Although SAIF contends that a reduction in criminal sentence does not have a direct monetary equivalent of the kind contemplated by ORS 656.005(29), I am not persuaded that "remuneration" in ORS 656.005(30) is controlled by the definition of "wages" in ORS 656.005(29). If the legislature had intended "remuneration" to mean the same thing as "wages" in ORS 656.005(29), then it would have used the term "wages" in the definition of "worker" in ORS 656.005(30).

Instead, I conclude that "remuneration" is a broader term than "wages" and does not necessarily exclude a non-monetary form of compensation such as a reduction in sentence. Black's Law Dictionary (Fifth Edition) defines "remuneration" as "reward; recompense; salary; compensation." Using this definition, I would find that a reduction in claimant's sentence, which would amount to a reward or recompense for labor provided to ODOT, constitutes "remuneration" as used in ORS 656.005(30). Accordingly, I am persuaded that claimant met the definition of a "worker" in ORS 656.005(30).[2]

SAIF, contends, however, that claimant is excluded by the definition of a "worker" in ORS 656.005(30) because he was performing services as a inmate of a "state institution." I disagree. Claimant is not excluded by the statutory definition of a "worker" because he was not incarcerated in a "state institution," but rather he was an inmate in a county facility.[3]

SAIF next asserts that claimant was not a subject worker of ODOT because ODOT did not contract with claimant to pay a remuneration for his services. SAIF argues that ODOT was not claimant's employer because the alleged remuneration (reduction in sentence) was provided by the county. I disagree and find that this case is analogous to the circumstances under which the "loaned-servant" doctrine is applied.

In Thomas v. A-1 Sandblasting and Steam Cleaning Co., 112 Or App 185 (1992), the court applied the "loaned-servant" doctrine and found that when a general employer lends an employee to a special employer, the special employer becomes liable for workers' compensation if:

> "(a) the employee has made a contract of hire, express or implied, with the special employer;
>
> "(b) the work being done is essentially that of the special employer; and

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[2] In Dykes v. SAIF, 47 Or App 187, 190 (1980), the claimant broke his leg while taking a mandatory agility test to qualify for the position of deputy sheriff. The agility test was required of all job applicants. In determining that the claim was not compensable, the Dykes court held that the mere possibility of future employment did not qualify as remuneration. In BBC Brown Boveri v. Lusk, 108 Or App 623 (1991), the claimant was found not to be providing services for remuneration when he failed a welding test and was subsequently not hired; even though his hearing loss was first discovered during this same testing period. In both Dykes and Lusk, the claimants were participating in testing activities which bore no benefit to the employer other than to gauge the potential employee's qualifications for a specific position. Here, in contrast, ODOT was receiving a direct benefit from claimant in that he was cutting brush for the Department, and in turn, claimant received significant reward or recompense in the form of a reduced sentence. Under these circumstances, I would conclude that claimant did receive "remuneration" for his services to ODOT.

[3] A procedure has been implemented for providing benefits to injured inmates of penitentiary, correctional institutions or work camps. See ORS 655 et seq. However, ORS 656.505(5) defines "inmate" as a "person committed to the physical and legal custody of the Department of Corrections." Inasmuch as claimant was not under the physical and legal custody of the Oregon Department of Corrections, but rather was under the custody of the Coos County correctional facility, the "inmate injury fund" does not apply.

"(c) the special employer has the right to control the details of the work." See Newport Seafood v. Shine, 71 Or App 119 (1984).

Application of the loaned-servant doctrine requires the following analysis. First, the finder of fact must determine if the worker was loaned by the general employer to the special employer. If he was, then the finder of fact must determine whether the work being done was essentially that of the special employer. Finally, the finder of fact must determine whether claimant was an employee of the special employer. Newport Seafood v. Shine, supra, 71 Or App at 123; Multnomah County v. Hunter, 34 Or App 718, 721 (1981)

Here, the course of conduct between the county (analogous to general employer) and ODOT (analogous to special employer) persuades me that the county was in the habit of lending workers to ODOT for road work. (Tr. 32). In this instance, the county loaned claimant to ODOT. There is no question that claimant was doing ODOT's work when he was clearing brush. Moreover, ODOT had the right to control the details of claimant's work. (Trs. 13, 14, 32).

I now turn to the existence of an employment relationship. A determination of an employment relationship in workers' compensation law focuses first on the claimant's perspective. Newport Seafood v. Shine, supra at 124. Here, claimant agreed to do work for ODOT in exchange for a reduced sentence. The fact that the county provided the "remuneration" for claimant's work does not preclude the existence of an employment relationship between ODOT and claimant. See Van M. Gibson, 41 Van Natta 2182 (1989) (the claimant was determined to be an employee of special employer even though wages were paid by general employer). Moreover, claimant knew that he was working to further ODOT's business purposes. These facts are sufficient to establish an implied contract for hire, and I would so conclude.

In summary, the county loaned claimant to ODOT. Claimant was doing ODOT's work; there was an implied contract for hire between ODOT and claimant; and ODOT controlled claimant. Consequently, I would find that, at the time of the alleged injury, ODOT was claimant's employer.

Compensability

Inasmuch as he determined that claimant was not a subject worker, the ALJ did not reach the issue of whether claimant sustained a compensable injury.[4] SAIF contends that the medical opinion of the only physician to address the causation issue, Dr. Adams, is insufficient to establish the compensability of the claim under ORS 656.005(7)(a)(B). I disagree.

Dr. Adams opined that claimant had an injury "superimposed" on preexisting degenerative changes. (Ex. 2-1). However, Dr. Adams never clarified how he used the term "superimposed." Thus, I am 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).

In the absence of medical evidence of a "combined" condition, I would apply the material contributing cause standard of ORS 656.005(7)(a). Leon M. Haley, 47 Van Natta 2056 (1995). Based on Dr. Adams' uncontradicted medical opinion that claimant 's back condition was secondary to the August 23, 1995 work incident (Ex. 2-1), I would find that claimant has carried his burden of proving that he sustained a compensable low back injury consisting of a herniated L4-5 disc. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992) (magic words are not necessary to establish medical causation); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986) (same).

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[4] SAIF's denial was based exclusively on the subjectivity defense. The parties, however, agreed to litigate compensability should claimant be determined to be a subject worker. (Tr. 2).

In the Matter of the Compensation of
JANET L. GAFFER, Claimant
WCB Case No. 95-03460
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Christian, Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's occupational disease claim for right carpal tunnel syndrome. Claimant cross-requests review, arguing that her cervical condition is compensable. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Cervical Condition

We adopt the ALJ's reasoning and conclusion regarding claimant's cervical condition.[1]

Right Carpal Tunnel Syndrome

The ALJ found that claimant's work activities as a shipping clerk with the employer from November 1992 through February 1995 were the major contributing cause of her right carpal tunnel syndrome (CTS). See ORS 656.802(2)(a).

Claimant relies on Dr. Long's April 3, 1995 and June 2, 1995 reports, which concluded that her work activities as a shipping clerk with the employer were the major contributing cause of the right CTS condition. (Exs. 10-5 & 12-2). Claimant also relies on the opinion of Dr. Hill to prove compensability.

SAIF argues that there is no persuasive medical opinion that establishes that claimant's right CTS condition was caused by her employment. SAIF contends that Dr. Long's final opinion was that claimant's upper extremity symptoms were caused in major part by the noncompensable cervical condition. SAIF also asserts that Dr. Hill's opinion is not persuasive because it is conclusory.

On January 24, 1994, Dr. Long diagnosed bilateral forearm and wrist pain with paresthesias, with mild median compression neuropathy in the palms and myofascial pain involving shoulder girdle and forearm muscle groups. (Ex. 2-3). On April 3, 1995, Dr. Long found no change on the right side and actual improvement on the left side. (Ex. 10-4). Dr. Long reported that claimant's symptom pattern was "much more consistent with the diagnosis of chronic myofascial trigger points involving forearm flexors and extensors than it is with the diagnosis of uncomplicated carpal tunnel syndrome." (Id.) Dr. Long said that a "more accurate diagnosis would be chronic myofascial pain involving the forearm flexors and extensors, developing in association with relatively hand intensive work, and complicated by the presence of mild median compression in the right palm, possibly symptomatic." (Ex. 10-5). Dr. Long believed that claimant's forearm and wrist conditions constituted an occupational disease, which developed in association with hand intensive work beginning in late 1993. (Id.)

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[1] The dissent contends that there is no persuasive evidence that claimant had a preexisting C5-6 disc bulge, arguing that she only had to establish that her work activities were the major contributing cause of her cervical condition. Although we agree with the ALJ's analysis, even if we assume that claimant did not have a preexisting C5-6 disc bulge, we disagree with the dissent's conclusion that Dr. Long's reports establish compensability of the cervical condition under that standard. We find that Dr. Long's reports establish, at most, that claimant's work activities caused symptoms, not the C5-6 disc bulge itself. Furthermore, in light of claimant's testimony that the carpal tunnel surgery "dramatically" improved her symptoms (Tr. 21- 22), it is questionable whether her cervical disc bulges were actually causing her symptoms.

On June 2, 1995, Dr. Long reported that claimant's "forearm and hand conditions represent an overuse syndrome developing in major part because of her work in the shipping department at [the employer]." (Ex. 12-2).

Dr. Long next saw claimant on August 15, 1995. Claimant had been seeing a physical therapist and Dr. Long noted that claimant had improved substantially. (Ex. 18-3). Claimant had not worked since February 1995. (Ex. 27A-2). Dr. Long commented that he was "still not quite sure whether [claimant's] fundamental symptoms involve carpal tunnel syndrome or simply reflect chronic myofascial tightness." (Ex. 18-3).

On December 7, 1995, Dr. Long reported that claimant's symptoms had worsened over the past four months. (Ex. 22). Dr. Long noted that claimant's symptom pattern suggested the possibility that a cervical condition was producing headaches and secondary aching in the arm, forearms and wrist and he scheduled an MRI. (Ex. 22-4).

The MRI showed a paramedian annulus bulge at the C5-6 level. (Ex. 25). Dr. Long reported that claimant had a "significant cervical problem" that "has almost certainly been the source of neck and upper trunk aching, headaches, aching in the arms and especially in the wrists, and probably also aching in the calves and ankles." (Ex. 26-4). Dr. Long commented that the cervical findings explained why claimant had aching in the left forearm and wrist even though she did not have a median lesion in the left palm. He explained that the forearm and hand pain reflected cervical root and/or cord irritation rather than median compression in the palms. (Id.) Dr. Long also stated that the cervical condition tended to explain why claimant developed recurring tightness in the shoulder girdle and forearm muscles and also in the plantar flexor, despite stretching exercises. (Id.) Based on the new information, Dr. Long concluded that claimant was not a candidate for a carpal ligament release. (Ex. 26-5).

In a letter to Dr. Hill, Dr. Long commented that Dr. Hill had discussed the pros and cons of doing a right carpal ligament release vs. cervical surgery with claimant. (Ex. 28A). Since the right carpal tunnel release was a much simpler procedure and had less morbidity, Dr. Hill felt it should be the first treatment option. (Id.) Dr. Long reported that a carpal ligament release had significant potential to relieve claimant's symptoms. (Id.)

In a letter to claimant's counsel, Dr. Long reported that claimant has had "consistent mild median compression neuropathy in the right palm and may have some element of right carpal tunnel syndrome." (Ex. 32-2; emphasis added). However, in a letter to SAIF, Dr. Long reported:

> "She does have a mild median lesion at the distal edge of the right carpal ligament with no evidence of a contralateral median lesion. Whether the right median lesion is actually a significant symptom source is not clear. It is my impression that cervical spondylosis with very mild cervical radiculopathy and/or myelopathy is a much more important source of neck and upper extremity symptoms than median compression in the right palm." (Ex. 33-2).

Although in earlier reports Dr. Long opined that claimant's work activities were the major contributing cause of her right CTS condition (Exs. 10-5 & 12-2), his final opinion was that claimant's upper extremity symptoms were caused in major part by the cervical condition. Thus, it was Dr. Long's ultimate conclusion that claimant's upper extremity symptoms were not caused by a work-related CTS condition. We conclude that claimant's reliance upon Dr. Long's earlier opinions is insufficient to carry her burden of proof.

Similarly, we do not find Dr. Hill's opinions persuasive. On April 4, 1994, Dr. Hill reported that claimant was a "shipping clerk and uses her hands a good deal" and he felt that her CTS was "work related." (Ex. 3). On June 13, 1995, Dr. Hill concurred with Dr. Long's June 2, 1995 report. (Ex. 14). Dr. Long had concluded that claimant's "forearm and hand conditions represent an overuse syndrome developing in major part because of her work in the shipping department at [the employer]." (Ex. 12-2). Since Dr. Long subsequently rejected that diagnosis, Dr. Hill's concurrence with that report is entitled to little weight.

In January 1996, Dr. Hill became aware of the MRI finding of a cervical bulge at C5-6. (Ex. 28). Dr. Hill commented that "[t]he bulge at C5-6 may or may not be causing some of her problems, it is difficult to tell." (Id.)

On February 20, 1996, Drs. Hamby and Smith reported that claimant had a chronic pain syndrome involving the neck and bilateral upper extremities and C4-5 and C5-6 disk bulges. (Ex. 29). They concluded that the major contributing cause of claimant's subjective symptomology was nonorganic and unrelated to her work exposure. (Ex. 29-10). In a "check-the-box" report, Dr. Hill indicated he did not concur with the report from Drs. Hamby and Smith. (Ex. 31). In the space reserved for an explanation, Dr. Hill wrote "work related." (Id.)

Although Dr. Hill opined that claimant's condition was work related, his reports provide no explanation or foundation for this opinion. Dr. Hill's unexplained opinion is therefore entitled to little weight. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Marta I. Gomez, 46 Van Natta 1654 (1994) (least weight given to conclusory, poorly analyzed opinions).

The remaining medical reports do not support compensability. Dr. Radecki found no objective findings and opined that claimant's subjective findings pointed to functional interference or non-organic etiology. (Ex. 6-4). Dr. Montanaro found no evidence of CTS and could not identify an occupational disease. (Ex. 27A). Drs. Hamby and Smith reported that the major contributing cause of claimant's neck and upper extremity complaints was nonorganic and unrelated to her work exposure. (Ex. 29-10). We conclude that claimant has failed to sustain her burden of proof. See ORS 656.802(2)(a).

ORDER

The ALJ's order dated May 16, 1996 is affirmed in part and reversed in part. That portion of the ALJ's order that set aside the SAIF Corporation's denial of claimant's right carpal tunnel syndrome condition is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Board Chair Hall concurring in part and dissenting in part.

Although I agree that claimant has not established that her right CTS condition is compensable, I disagree with the majority's conclusion that her cervical condition is not compensable. The majority adopts that portion of the ALJ's order which found that: (1) claimant had a preexisting C5-6 disc bulge that combined with her work activities beginning in November 1992; and (2) claimant failed to prove that her work activities were the major contributing cause of her combined condition and the major contributing cause of a pathological worsening of the C5-6 disc bulge. See ORS 656.802(2)(b). Because I find that both the ALJ and the majority incorrectly analyzed this claim, I respectfully dissent.

ORS 656.802(2)(b) applies only "[i]f the occupational disease claim is based on the worsening of a preexisting disease or condition." Here, there is no persuasive evidence that claimant had a preexisting C5-6 disc bulge. Dr. Long reported:

> "She may well have had some preexisting degenerative change in the cervical spine prior to November 1992, when she started working in the Shipping Department. However, it is quite clear that she did not have symptoms of cervical disc disease or cervical spondylosis prior to November 1992, and she clearly describes that she was able to be very active avocationally, caring for horses, bucking bales of hay, etc. prior to November 1992. Within two or three months of starting to work in the Shipping Department, she began to develop her current symptom complex, and by the summer of 1993, she found that her tolerance for physical activity both vocationally and avocationally had diminished substantially." (Ex. 26-5; emphasis added).

Dr. Long eluded only to the possibility that claimant may have had preexisting degenerative changes in her cervical spine. Such reasoning is speculative and is not based on reasonable medical probability. It is axiomatic that such speculative evidence is not sufficient to establish the existence of something as fact. This Board has, rightfully, rejected such speculative evidence in cases too numerous to cite. It is unclear why the majority accepts such in this case. Absent persuasive evidence that claimant had a preexisting condition, she need only establish that her work activities were a major contributing cause of her cervical condition. See ORS 656.802(2)(a). I agree with claimant that Dr. Long's reports establish the compensability of her cervical condition under that standard.

In the Matter of the Compensation of
MARGARET A. KOHL, Claimant
WCB Case No. 96-02857
ORDER ON REVIEW
Bettis & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl, Christian and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order which set aside its denial of claimant's thoracic spine injury. On review, the issue is whether claimant's injury arose out of and in the course of employment.

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

Claimant slipped and fell on snow and ice in a parking lot adjacent to the building leased by her employer as she was attempting to report for work. SAIF denied the compensability of claimant's thoracic spine injury on the ground that her injury did not arise out of and in the course of employment. Claimant requested a hearing.

The ALJ set aside SAIF's denial. The ALJ reasoned that claimant's injury occurred in the course and scope of her employment because the employer exercised some actual control over the parking lot in which claimant was injured. In reaching this conclusion, the ALJ determined that the employer had leased the parking lot as well as the building in which claimant worked and had demonstrated control over the lot by designating where cars were to be parked, designating handicapped parking zones, constructing those zones, and occasionally having unauthorized automobiles removed from the parking lot. The ALJ also noted that the employer had prepared the lease agreement, which delegated maintenance duties to the Lessor/Landlord, and required the Lessor/Landlord to approve it.

On review, SAIF contends that the employer did not lease or "control" the parking lot in which claimant was injured. Thus, it asserts that the ALJ erroneously determined that claimant was in the course of her employment when she was injured. We disagree.

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, 173 (1991). There are, however, exceptions to the general rule. One such exception is the so-called "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, 243 (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. 318 Or 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, 461 (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).

In this case, there is no dispute that claimant's injury was brought about by a hazard (icy and snowy pavement) associated with the parking lot. The dispositive issue here is whether the employer exercised at least partial control over the parking lot at the time the accident took place. See Montgomery Ward v. Malinen, supra; See also Cope v. West American Ins. Co., 309 Or 232, 238 (1990) (employer need only exercise "some" control over the premises). Year-round control is not even required. Montgomery Ward v. Malinen, supra, 71 Or App at 461. In Henderson, the court concluded that sufficient employer control was established by a lease giving the employer a nonexclusive right to use an elevator where the claimant was injured, providing the employer the right to require repairs of the elevator and requiring that the employer pay a share of operating expenses.

SAIF contends that the employer's lease agreement for the building in which claimant was employed gave the employer only the exclusive right to park in the adjacent parking lot and that the parking lot was not part of the leased premises. SAIF cites the testimony of the employer's building coordinator, Mr. Long, who was asked whether the employer leased the parking lot or merely the right to park there. Mr. Long testified that the employer leased the "right to park there." (Tr. 50). SAIF also notes that the "premises" in the lease agreement were described on the first page of the lease agreement as the "building." (Ex. A-1). For the following reasons, we conclude that, regardless of whether the parking lot was part of the leased "premises," the employer had at least some control over the area in which claimant was injured.

The lease agreement, in the section entitled "Maintenance and Repair of Premises," described the parking lot as one of the areas "located on the Premises." (Ex. A-3). That portion of the agreement further provided that the Lessor was required to maintain the premises in "hazard-free" condition. If the Lessor failed to do so, the Lessee/employer could, after notice to the Lessor, contract for the necessary labor, equipment and material to bring the "Premises" within the requirements of the lease. (Ex. A-4). Based on our review of the unambiguous lease agreement, we find that the ALJ correctly concluded that the employer had at least some control over the parking lot.

SAIF, however, cites those portions of the lease which provided that the Lessor/Landlord was responsible for maintenance of the parking lot. (Ex. A-3). Moreover, SAIF notes that the employer testified that employees were specifically instructed not to engage in snow removal or other maintenance of the parking lot. (Tr. 47-48). SAIF contends that this evidence establishes that the employer did not "control" the parking lot.

SAIF's assertions notwithstanding, we conclude, as did the court in Henderson, that the lease is evidence that the employer exercised at least some control over the area where claimant was injured. That the employer could, pursuant to the terms of the lease agreement, take action independently of the Landlord to correct hazardous conditions such as slick or icy pavement lends additional force to our conclusion that the employer had control over the area where claimant fell. See Linda J. Morss, 46 Van Natta 2382 (1994) (the employer had "control" over area of injury where lease provided that, after 30 days' written notice to the other party describing repairs needed, except in an emergency, the employer could make repairs if the landlord failed or refused to do so and could recoup expenses from the landlord). Moreover, we find that the factors cited by the ALJ as evidence of employer "control" over the parking lot also establish that claimant was injured by a hazard associated with premises over which the employer had at least "some control." Cope v. West American Ins. Co., supra.

We, therefore, conclude that, under the specific circumstances here, claimant's injury occurred in the course of her employment. Since there is no dispute that claimant's injury arose out of her employment, we conclude that the ALJ properly set aside SAIF'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 regarding the compensability issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 9, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

Board Member Haynes dissenting.

I agree with the majority's statement of the law regarding the "parking lot" exception to the coming and going rule. However, because the employer did not have sufficient control over the area of injury, I would find that the "parking lot" exception does not apply here. Therefore, for the following reasons, I respectfully dissent.

Claimant's injury occurred when she slipped and fell on snow and ice in a parking lot adjacent to the employer's building while she was reporting to work. Therefore, the determination as to whether the "parking lot" exception applies to this case turns on whether the employer had control over the area of injury.

Here, there is no evidence of any actions or special hazards created by the employer that would manifest its control over the area of injury. Montgomery v. SAIC, 224 Or 380 (1960); Nelson v. Douglas Fir Plywood Co., 260 Or 53 (1971). Inasmuch as snow is a temporary condition in Oregon, it would not constitute an employer created hazard. Furthermore, I agree with SAIF that the employer neither owns nor leases the parking lot. As the lease agreement makes clear, the employer only leased the building, not the parking lot. (Ex. A-1). Therefore, the only way the employer's control might be manifested is through maintenance of the area of injury. Montgomery Ward v. Cutter, 64 Or App 759 (1983), Janet V. Dollens, 42 Van Natta 2004 (1990), aff'd mem 107 Or App 531 (1991).

As the majority notes, the lease agreement between the employer and the landlord indicates that the landlord had the duty to maintain the parking lot. (Ex. A-3). The majority gets around this by finding that the employer could, after notice to the landlord, take action to insure that any hazards in the parking lot were remedied. (Ex. A-4). Therefore, the majority finds that the employer had "some control" over the parking lot through its lease agreement with the landlord.

In my view, the connection the majority creates is too tenuous to support its finding. Conspicuously absent in this case is the direct control the employer should have over the area of injury. See Henderson v. S.D. Deacon Corp., 127 Or App 333 (1994) (the employer's lease gave the employer the right to require the landlord to repair the elevator, the area of injury); Montgomery Ward v. Malinen, 71 Or App 457 (1984) (city ordinance required the employer to keep the sidewalk where the claimant fell clear of now and ice and it was the employer's policy to do so); Montgomery Ward v. Cutter, supra (the employer's lease gave the employer the right to require the mall operator to repair the hole in the parking lot where the claimant was injured). In the absence of evidence of direct control over the parking lot, the employer should not be held legally responsible under workers' compensation law for injuries occurring in that location.

The court has held that control may be established where an employer assumes responsibility for upkeep of the area of injury, even where it has no contractual obligation to do so. Willis v. State Acc. Ins. Fund, 3 Or App 565 (1970). However, that is not the case here. The evidence is that the employer had no duty to maintain the parking lot free of snow and ice and specifically instructed its employees not to do so. Unlike Walter R. Adams, 46 Van Natta 1742 (1994), where the employer had control of the area of injury when a lease established that the landlord for whom the employer was the exclusive managing agent was responsible for maintaining the area of injury, the lease agreement here clearly provided that the landlord, not the employer, had the duty to maintain the parking lot. While the lease agreement gave the employer some right to insure that the premises were maintained in a hazard free condition, I would find that this is insufficient evidence that the employer had assumed responsibility for upkeep of the area of injury. The majority's requirement that the employer maintain only "some control" over the area of injury is not justified by the case law and makes the employer responsible for injuries not properly covered under workers' compensation law.

For these reasons, I would find that the parking lot exception to the going and coming rule does not apply here. Since the majority's holding is erroneous, I must part company with their decision.

In the Matter of the Compensation of
GUADALUPE L. SARMIENTO, Claimant
WCB Case No. 95-12429
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
John M. Pitcher, Defense Attorney

Review by Board Members Moller and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's lumbosacral strain injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, 54 years old at the time of hearing, has preexisting multi-level low back degenerative disc disease and lateral spinal stenosis. She has had prior episodes of low back symptoms. She was released from work for approximately two weeks following a May 1988 episode. She suffered an acute strain in December 1992 while moving furniture and putting up her Christmas tree.

On September 23, 1994, claimant slipped and fell at work on the wet floor of the restroom, landing on her back and striking her left elbow and low back. (Ex. 2, 4). That same date, claimant reported this incident to the employer. (Ex. 2).

Claimant did not seek medical treatment until June 9, 1995, at which time Dr. Kadwell, treating physician, recorded symptoms of "[b]ack pain from the right SI to the buttocks, down the leg to the calf for five days." (Ex. 3-1). Claimant treated with Dr. Kadwell three times in June 1995 and did not report any work injury or any symptoms related to any work injury. (Exs. 3-1, -2). On July 10, 1995, Dr. Kadwell reported that claimant recalled an injury at work "in January" when she slipped on a wet restroom floor, recalling discomfort since that time. (Ex. 3-3).

On October 4, 1995, Dr. Miller, neurosurgeon, examined claimant on referral from Dr. Kadwell. (Ex. 7). Claimant was also examined by Drs. Fuller, orthopedist, Snodgrass, neurologist, and Duff, orthopedist, on behalf of the insurer. (Exs. 5, 11).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant established a compensable low back strain injury. We find to the contrary.

As a fact finder, it is our obligation to apply the appropriate legal standards to determined the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995), and Michele K. Dibrito, 47 Van Natta 970 (1995)). The record establishes that claimant has degenerative lumbar disc disease that preexisted her September 23, 1994 injury. (Exs. 3, 6, 7, 9, 10A, 11, 12, 13). Therefore, we conclude that claimant had a preexisting low back condition.

In determining whether ORS 656.005(7)(a)(B) applies, we must determine whether claimant's preexisting low back condition "combined" with her September 1994 injury to cause disability or a need for medical treatment. Based on the opinions of Drs. Kadwell, attending physician, Miller, consulting physician, and Fuller, examining physician, we find that claimant's September 1994 injury "combined" with her preexisting low back condition to cause disability and/or a need for treatment. (Exs. 7-3, 9, 13). We, therefore, conclude that ORS 656.005(7)(a)(B) is applicable and decide the compensability issue pursuant to that statute, which requires that claimant prove that her September 1994 injury is the major contributing cause of the disability or the need for treatment of the "combined condition." See Rickey C. Amburgy, 48 Van Natta 106 (1996). On review, the parties agree that ORS 656.005(7)(a)(B) is applicable.

Claimant has the burden of proof on this issue. ORS 656.266. Due to claimant's preexisting degenerative lumbar disc disease and the fact that she did not seek medical treatment until more than eight months after the work incident, 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). Five physicians have offered causation opinions: Drs. Kadwell, Miller, Fuller, and Duff, examining orthopedist.

In June 1995, Dr. Kadwell examined claimant on three occasions and diagnosed lumbosacral strain with right sciatica, which he suspected was due to degenerative disc disease. (Exs. 3-1, -2). On July 10, 1995, claimant first reported to Dr. Kadwell that she recalled falling at work "in January" and had suffered discomfort since that time. (Ex. 3-3). At that time, Dr. Kadwell diagnosed "[a]cute lumbosacral strain with suspected lumbar radiculopathy secondary to degenerative lumbar disc disease with a possibility of it being related to a Workers' Comp[ensation] injury January 1995." (Ex. 3-3). Following a July 14, 1995 examination, Dr. Kadwell continued to diagnose "[a]cute lumbosacral strain with suspected lumbar radiculopathy secondary to degenerative lumbar disc disease [and] [r]ight sciatica." Id.

Subsequently, on May 17, 1996, Dr. Kadwell agreed that the September 23, 1994 work incident was the major contributing cause of claimant's disability and need for treatment, beginning with the office visit on June 9, 1995. (Ex. 13). He agreed that:

> "[t]he reason for this conclusion is that [claimant] reports the onset of back pain with the slipping incident at [the employer], and that pain eventually worsened to the point she was unable to continue working, although this did not ultimately develop for several months. Although [claimant] had prior episodes of back pain, this incident caused a new back strain. She is predisposed to such incidents of back strain as a result of her underlying degenerative disease." (Ex. 13-2).

Dr. Miller first examined claimant on October 4, 1995. (Ex. 7-1). At that time, claimant reported the September 23, 1994 fall incident, reporting a gradual increase in back pain until a marked increase in pain on June 9, 1995 rendered her unable to continue working. (Ex. 7-1). Dr. Miller noted that a September 13, 1995 MRI showed degenerative lumbar disc disease from L3 to S1, with lateral stenosis at L3-4 and L4-5. He opined that claimant's "symptoms are secondary to degenerative disc disease with hypertrophied facets at L3-4/4-5 level compressing the L4 and L5 nerve roots causing her symptoms." (Ex. 7-2). Dr. Miller examined claimant again on December 13, 1995, at which time he reviewed the MRI, noting that it demonstrated "congenital spinal stenosis with evidence of mild disc disease at L4-5 as well as 3-4." (Ex. 10-1). Subsequently, Dr. Miller opined that, while claimant had preexisting degenerative lumbar disc disease, she had a "recurrent lumbosacral strain as a result of the fall on September 23, 1994," the major contributing cause of which was the fall. (Exs. 10A, 12).

On August 23, 1995, Drs. Snodgrass, neurologist, and Fuller examined claimant on behalf of the insurer. (Ex. 5). Although opining that, provided there was no "pre-existing history of grumbling back pain", the September 1994 fall "could produce sufficient trauma to cause a herniated disc with right sided sciatica," they deferred their causation opinion pending receipt of Dr. Kadwell's records and a recommended MRI. (Exs. 5). The recommended MRI was performed on September 13, 1995.

Upon receipt of the MRI report and Dr. Kadwell's records, Dr. Fuller noted that the MRI report revealed a congenitally narrow spinal canal with disc bulges combining to cause spinal stenosis. (Ex. 6-2). He also noted that an accurate history showed "preexisting episodic right sided low back and leg pain," with the "presentation in June 1995 appear[ing] to be identical to many of [claimant's] low back episodes in the past." (Ex. 6-2).

Therefore, Dr. Fuller found no relationship between claimant's presentation in June 1995 and the fall in September 1994, noting that, "[i]f the September 1994 fall had truly caused a problem, over and above [claimant's] prior low back picture, one would expect to see cause and effect more closely related in time than 9 months." Id. After reviewing the MRI, Dr. Fuller noted that nothing in the MRI changed his prior opinion, concluding that claimant's presentation related to the underlying condition rather than the September 1994 fall incident. (Ex. 9).

On January 30, 1996, Dr. Duff examined claimant and noted claimant's degenerative disc disease, prior history of right sacroiliac joint pain, and the fact that she did not seek medical treatment or miss time from work until June 1995. (Ex. 11-5). He opined that it was not probable that the fall at work in September 1994 was causally related in any material way to the development of sciatic pain in June 1995. (Ex. 11-5).

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 addition, we generally give greater 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.

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. Dr. Kadwell ultimately agrees that the September 1994 fall at work is the major contributing cause of claimant's disability and need for treatment beginning in June 1995. However, although noting that, as a result of claimant's underlying degenerative disease, claimant is predisposed to incidents of back strain, Dr. Kadwell does not evaluate the relative contribution of this preexisting degenerative disease. In addition, even after claimant reported the September 1994 work fall, Dr. Kadwell appeared to relate claimant's symptoms to the degenerative disc disease. Dr. Kadwell does not explain her subsequent change of opinion that the work injury was the major contributing cause of claimant's disability and need for treatment. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (an unexplained change of opinion is given little probative weight). Finally, Dr. Kadwell does not persuasively explain why the work injury did not require medical treatment for more than eight months, a fact that the examining physicians found not medically probable. For these reasons, we find Dr. Kadwell's opinion unpersuasive.

Likewise, Dr. Miller's opinion does not support compensability because it focuses only on the low back strain, without evaluating the relative contribution of claimant's preexisting degenerative disc disease. Dietz v. Ramuda, supra. In addition, even though aware of the September 1994 work fall, Dr. Miller initially opined that the cause of claimant's symptoms was the degenerative disc disease. (Ex. 7-2). He does not explain his subsequent change of opinion. Moe v. Ceiling Systems, supra. For these reasons, we find Dr. Miller's opinion unpersuasive.

Finally, the opinions of Dr. Fuller and Dr. Duff do not support compensability of a low back strain. Both of these physicians attribute claimant's disability and need for treatment to the preexisting disc disease.

Accordingly, on this record, claimant has failed to establish compensability of a low back strain. Consequently, we reverse the ALJ's order and reinstate the insurer's denial.

ORDER

The ALJ's order dated June 17, 1996 is reversed. The assessed attorney fee awarded by the ALJ is reversed. The insurer's denial dated October 9, 1995 is reinstated and upheld.

In the Matter of the Compensation of
MICHAEL L. BAILEY, Claimant
WCB Case Nos. 96-00762, 94-12579, 95-08095, 95-08094 & 95-08093
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
David O. Horne, Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Employers Insurance of Wausau (Wausau), requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denials of compensability and responsibility for claimant's June 1994 and May 1995 low back "new injury" claims; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty) denials, on behalf of the same employer, of compensability/aggravation and responsibility for the same claims. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following supplementation. We do not adopt his findings of ultimate fact.

On October 7, 1994, as amended January 10, 1995, Wausau denied compensability and responsibility for claimant's June 29, 1994 low back "new injury" claim. (Exs. 99, 102). On March 16, 1995 Liberty denied responsibility for the same claim. (Ex. 105).

On August 30, 1995, Wausau denied compensability and responsibility for claimant's May 30, 1995 low back "new injury" claim. (Ex. 114). On July 6, 1995, Liberty denied compensability and responsibility for the same claim. (Ex. 113).

CONCLUSIONS OF LAW AND OPINION

We begin by recapping the relevant facts. Claimant has worked for the same employer for the past 11 years. In 1986, claimant experienced a compensable lumbar strain when an insurer no longer a party to this dispute was on the risk. In January 1993, claimant experienced a compensable lumbar strain when Liberty was on the risk. In October 1993, claimant experienced low back pain in an incident that took place off the job. Claimant was diagnosed with mild degenerative disc disease (DDD) at L4-5 and L5-S1, which Liberty denied. This denial became final as a result of a June 1994 Disputed Claim Settlement. (Ex. 66).

On March 2, 1994, Wausau became the employer's insurer. On June 29, 1994, claimant experienced a low back strain after lifting and flipping 16-by-4 foot panels at work. Liberty denied responsibility and Wausau denied compensability and responsibility for the 1994 low back strain. The strain resolved in August 1994.

On May 30, 1995, claimant experienced a low back and left hip sprain and left sciatica while framing doors. Wausau and Liberty each denied compensability and responsibility for this claim.

The ALJ concluded that claimant experienced a series of sudden low back strain injuries, which should be analyzed as injury claims as opposed to an occupational disease. The ALJ also concluded that claimant's series of industrial injuries did not combine with the preexisting degenerative disc disease in his lumbar spine. Relying on the medical record, the ALJ finally concluded that claimant's on-the-job injuries were the major contributing cause of his current low back condition and that, therefore, his claim is compensable.

Because claimant has made two claims, one for a 1994 work injury and one for a 1995 work injury, we analyze the claims separately.

Wausau begins by asserting that claimant's back condition should be analyzed as an occupational disease rather than injury, because it developed gradually.[1] We disagree.

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[1] We note that Wausau defines claimant's condition as "degenerative disease." The parties agreed at hearing that claimant made no claim for his degenerative condition. (Tr. 6). Claimant's claims are for low back strains. (Exs. 75, 109A).

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's low back strains were "events," 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").

On June 29, 1994, claimant was working as a panel finisher, constructing walk-in coolers and freezers. His duties included lifting 16-by-4 foot panels from stacks onto carts, which required bending and lifting the panels, flipping the panels over, kneeling down, punching metal out around electrical boxes in the panels, and then flipping them back to the other side. Claimant's low back began to hurt and worsened throughout the day. Claimant self-medicated with anti-inflammatories and muscle relaxants. A few days later, finding the medication unsuccessful in reducing symptoms, claimant sought medical treatment. (Tr. 17, 18; Exs. 67, 69, 75).

On May 30, 1995, claimant was framing doors. (Tr. 20). While lifting a door to turn it over, claimant felt a twinge in his low back and hip. Symptoms gradually increased to the point that he sought medical attention the next day. (Ex. 109A; Tr. 20).

We disagree with Wausau's assertion that claimant's low back strains arose gradually. Rather, we find that each of claimant's low back strain conditions arose over a discrete time period, each occurring during a single day of heavy or relatively heavy work. Moreover, the medical record supports the occurrences of injuries that took place on June 29, 1994 and on May 30, 1995. Therefore, the ALJ appropriately analyzed the claims as accidental injuries rather than as an occupational disease.

Compensability

If a preexisting condition combines with an otherwise compensable injury to cause or prolong disability or the need for treatment, the combined condition is compensable only so long as the compensable injury remains the major contributing cause of the disability or need for treatment for the combined condition. ORS 656.005(7)(a)(B). Absent evidence that claimant's preexisting condition combined with his June 1994 or May 1995 work injury, claimant need only establish that his work injury was a material contributing cause of his disability and need for treatment. ORS 656.005(7)(a); Leon M. Haley, 47 Van Natta 2056 (1995), on recon 47 Van Natta 2206 (1995).

Due to the passage of time and the number of potential causes for each of claimant's low back conditions, the causation issue is a complex medical question. Resolution of the issue requires expert medical evidence. 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).

June 1994 Injury

Opinions regarding the cause of claimant's June 1994 low back condition were provided by Dr. Dixon, claimant's treating physician for that injury, and Dr. Markham, who had treated claimant in October and November 1993, and who evaluated claimant's June 1994 condition for Wausau. We find no persuasive reason not to defer to Dr. Dixon's opinion.

Dr. Markham, who was the only physician to implicate claimant's DDD as the cause of his June 1994 back pain, did not examine claimant subsequent to November 1993, and was apparently unaware of claimant's June 1994 work activities on that date. (Ex. 116) Moreover, Dr. Markham changed his earlier opinion regarding the onset and causation of claimant's 1993 low back incident without explanation when he concurred with Drs. Hill and Duff's opinion that claimant's October 1993 incident, rather than his DDD (which Markham had previously identified as the cause of claimant's October 1993 condition), was the major contributing cause of claimant's need for treatment in 1993. (Ex. 120). Consequently, we do not find his opinion persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Miller v. Granite Construction Co., 28 Or App 474 (1977).

Dr. Dixon, who had a complete history of claimant's prior injuries and DDD, opined that the major contributing cause of claimant's June 1994 low back strain was his activities at work. Dr. Dixon explained that claimant had experienced an acute strain at work, given the duration of his "healing time" from June 29 to August 25, 1994, and the absence of abnormal neural findings. (Exs. 73, 101, 121, 124). We are persuaded by Dr. Dixon's opinion that the major contributing cause of claimant's June 1994 injury was his lifting and flipping panels at work when Wausau was on the risk. Somers v. SAIF, 77 Or App 259 (1986). Consequently, claimant has established that his June 1994 work injury was a material contributing cause of his disability and need for treatment.[2]

May 1995 Injury

Opinions regarding claimant's May 1995 low back strain were provided by Dr. Quarum, who evaluated claimant's condition for an insurer no longer a party to this dispute, and Dr. Eales, claimant's attending physician for the 1995 injury.

Dr. Quarum opined that, although claimant's DDD was likely to contribute to his low back pain, the major contributing cause of claimant's May 1995 injury was the "low back injuries sustained on 1/26/93, 10/11/93, or 7/5/94" (in contrast to injuries sustained when the earlier insurer was on the risk). (Exs.112, 115).

Dr. Eales diagnosed claimant's 1995 condition as lumbosacral sprain, left hip sprain and left sciatica. He opined that the major contributing cause of claimant's condition was his door lifting activities at work. We are more persuaded by Dr. Eales' opinion that by that of Dr. Quarum. Weiland v. SAIF, supra; Somers v. SAIF, supra. Consequently, claimant has established that his 1995 work injury was a material contributing cause of his disability and need for treatment.[3]

Responsibility

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

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by Wausau. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services), the complexity of the issues, 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 $1,500, to be paid by Wausau.

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[2] We agree with the ALJ that there is no persuasive medical evidence that claimant's June 1994 work incident combined with claimant's DDD, and that a material contributing cause standard applies to establish compensability. Nevertheless, even if claimant's 1994 work incident had combined with his DDD, Dr. Dixon's persuasive opinion would be sufficient to establish compensability of claimant's June 1994 injury claim under ORS 656.005(7)(a)(B).

[3] We note that the only medical report to mention claimant's DDD in relation to the 1995 injury claim is Dr. Quarum's. However, that conclusory report is not persuasive evidence that claimant's DDD combined with his 1995 injury. Thus, the appropriate standard to be applied here is material contributing cause. ORS 656.005(7)(a); Leon M. Haley, supra. Furthermore, to the extent that claimant's 1995 injury could constitute an injury involving the "same condition" as his accepted 1994 injury claim with Wausau, we are persuaded that the 1995 injury was the major contributing cause of his disability and need for medical treatment. Thus, "responsibility" for the "same condition" would shift from Wausau, under the 1994 injury claim, to Wausau, under the 1995 injury claim. See ORS 656.308(1); Dan D. Cone, 47 Van Natta 1010, on recon 47 Van Natta 2220, on recon 47 Van Natta 2343 (1995); David L. Large, 46 Van Natta 96 (1994).

In the Matter of the Compensation of
KENNETH P. BUNDY, Claimant
WCB Case No. 95-07510
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorney
Craig A. Staples, Defense Attorney

Reviewed by the Board en banc.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) awarded claimant additional temporary disability; and (2) assessed a penalty for 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.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts. In May 1993, claimant filed an aggravation claim and a request for a repeat surgery for his worsened right carpal tunnel syndrome, which the employer denied. On August 30, 1994, a prior ALJ set aside the denial, remanding the claim for acceptance and payment of benefits according to law. The employer requested Board review of the prior ALJ's order. On March 20, 1995, the Board affirmed the prior ALJ's order. The Board's order has become final.

On September 20, 1994, Dr. Wenner, claimant's attending physician, reported in a chart note that claimant's symptoms had increased after working in a gas station. He again recommended surgery, reporting that claimant's worsened CTS condition "is really interfering with his life, [it] is keeping him from working * * *." (Ex. 105).

In May 1995, claimant requested that he be paid temporary disability benefits from 1992 to the present. (Ex. 105E). On May 24, 1995, Dr. Wenner, claimant's attending physician, authorized the payment of temporary partial disability compensation from November 29, 1992 through April 1995. (Ex. 105). On June 8, 1995, the employer acknowledged receipt of Dr. Wenner's authorization and records verifying claimant's wages and unemployment earnings. (Ex. 106A; Tr. 8). No temporary disability compensation was paid. On June 23, 1995, claimant requested a hearing on the temporary disability matter.

On August 16, 1995, the employer issued a Notice of Closure, affirmed by a November 17, 1995 Order on Reconsideration, that awarded temporary disability compensation from April 25, 1995, the date of claimant's surgery, to August 3, 1995, the medically stationary date. (Exs. 105D, 111, 112, 113). On November 21, 1995, claimant requested a hearing on the Order on Reconsideration. Claimant's hearing requests were consolidated.

Temporary Disability Benefits

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation.

Citing SAIF v. Taylor, 126 Or App 658 (1994), and Gladys K. Kygar, 47 Van Natta 947 (1995), the ALJ distinguished between entitlement to "procedural" temporary disability on an open claim and entitlement to "substantive" temporary disability upon claim closure. The ALJ then concluded that claimant had proven substantive entitlement to temporary disability from May 11, 1993 through April 24, 1995, based on Dr. Wenner's May 11, 1993 report that claimant's condition had worsened and his May 24, 1995 letter verifying that claimant was at least partially disabled due to the compensable injury from May 11, 1993 through April 24, 1995.[1]

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[1] The employer paid temporary disability from April 25, 1995 forward.

The employer asserts that claimant is not entitled to additional temporary disability benefits because Dr. Wenner's authorization was barred by ORS 656.262(4)(f)'s limitations on retroactive authorization of temporary disability. The employer contends that, by promulgating ORS 656.262(4)(f), the 1995 Legislature intended to prohibit retroactive authorization of temporary disability not only for establishing an employer's procedural claim processing obligations, but also upon claim closure. The employer argues that if the legislature had intended the limitation on retroactive authorization to be limited to an employer's claim processing obligations, it would have included language permitting retroactive appraisals upon claim closure. The employer also contends that, because former ORS 656.262(4) contained no limitation on a physician's ability to retrospectively authorize temporary disability, the holdings in SAIF v.Taylor, supra, and Gladys K. Kygar, supra, are not dispositive in interpreting the scope of ORS 656.262(4)(f).

When interpreting a statute, our task is to discern the intent of the legislature; this process begins with an examination of the text and context of the statutory provision. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). Statutes that are part of the same act should be construed together to give effect to the legislature's intent and to give meaning to each provision of the act, if possible. Davis v. Wasco IED, 286 Or 261 (1979).

ORS 656.262(4)(f), 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." (Emphasis added.)

The underlined citations to "ORS 656.268" are apparent references to ORS 656.268(3)(d), also added by the 1995 Legislature, which refers back to ORS 656.262 by authorizing termination of temporary disability based on "[a]ny 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 [656]." (Emphasis added.) It has long been established that the function of ORS 656.268[2] is to provide for the

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[2] ORS 656.268 provides in pertinent part:

"(1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed if the worker's condition has not become medically stationary unless:

"(a) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition * * * and the worker is not enrolled and actively engaged in training. * * *

"(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 * * *.

"(2)(a) Unless the insurer or self-insured employer has elected to close the claim pursuant to this section * * * the insurer or self-insured employer shall so notify the Department of Consumer and Business Services, the worker, and the employer, if any, and request the claim be examined and further compensation, if any, be determined.

"* * * *

"(4)(a) When the worker's condition resulting from an accepted disabling injury has become medically stationary, and the worker has returned to work or the worker's attending physician releases the worker to return to regular or modified employment, or when the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition * * *, the claim may be closed by the insurer or self-insured employer * * *.

"* * * *

"(13) 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 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." (Emphasis added).

orderly processing of claims, i.e., the carrier's procedural obligations. See Fazzolari v. United Beer Distributors, 91 Or App 592, 595, on recon 93 Or App 103, rev den 309 Or 236 (1988); Vip's Restaurant v. Krause, 89 Or App 214 (1988); see also Thomas M. Aldrich, 46 Van Natta 1025 (1994) (holding that the 1990 version of ORS 656.268(3) applies to procedural entitlement to temporary disability benefits); Soledad Flores, 43 Van Natta 2504 (1991) (same); see also Ivan E. Dame, 48 Van Natta 1228, 1229 (1996) (Amended ORS 656.268 continues to address a claimant's entitlement to "procedural" temporary disability benefits); Benjamin G. Santos, 48 Van Natta 1514, 1516 (1996).

Thus, the payment of temperary disability "pursuant to ORS 656.268," as provided in ORS 656.262(4)(f), concerns the payment of temporary disability during the carrier's processing of open claims to closure. ORS 656.268 does not, as the dissent argues, set forth the requirements for substantive entitlement to temporary disability; those requirements are set forth in ORS 656.210 and 656.212.

In Dame, the claimant argued that ORS 656.268(3)(d), added by the 1995 legislature, eliminated the distinction between procedural and substantive entitlement to temporary disability benefits, thus entitling him to temporary disability payments through the date of claim closure. We addressed a similar question after the 1990 amendments to ORS 656.268 in Jimmie G. Clark, 45 Van Natta 2308 (1993), and Soledad Flores, 43 Van Natta 2504 (1991). In Clark and Flores, we held that the 1990 amendments, which identified the specific conditions for termination of temporary disability benefits while the claim is open, did not eliminate the distinction between procedural and substantive entitlement to temporary disability benefits. We concluded in Dame that the enactment of ORS 656.268(3)(d) provided another avenue for terminating "procedural" temporary disability benefits during an open claim and found nothing in the 1995 amendments to ORS 656.268 to indicate an intention to eliminate the distinction between substantive and procedural entitlement to temporary disability benefits. Accordingly, we conclude that ORS 656.268(3)(d)'s reference to ORS 656.262(4) indicates that ORS 656.262(4)(f) is simply an additional requirement regarding the authorization of "procedural" temporary disability compensation during an open claim.

Our conclusion is supported by the terms used in ORS 656.262(4)(f), specifically that temporary disability compensation "is not due and payable" when the attending physician "ceases" to authorize temporary disability or for any time period not authorized by the attending physician. (Emphasis added.) Those terms are in the present tense and, thus, address the contemporaneous payment of temporary disability compensation while the claim is in open status, i.e., in the "procedural" context. Those terms do not address the "post-closure" determination of substantive entitlement to temporary disability.

Here, inasmuch as claimant's claim has been closed, the issue is claimant's substantive right to temporary disability benefits. A claimant's substantive entitlement to temporary disability benefits, which is set forth in ORS 656.210 and 656.212, is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). ORS 656.210, the temporary total disability statute, was not amended in 1995 in any way material to this analysis; it continues to provide, in pertinent part, that a worker whose total disability is temporary "shall receive during the period of that total disability compensation equal to [a designated percentage] of wages." (Emphasis added.) ORS 656.212, the temporary partial disability statute, also was not amended in 1995 in any way material to this analysis; it continues to provide that a worker who is temporarily and partially disabled "shall receive" a proportion of temporary total disability based on loss of wages. (Emphasis added.) Neither ORS 656.210 nor ORS 656.212 contains any language which limits a worker's substantive entitlement to temporary disability to only those periods for which there is contemporaneous authorization by the attending physician.

Therefore, we conclude that the 1995 amendments to the Workers' Compensation Law had no effect on the principle that a worker is substantively entitled to temporary disability benefits for those periods during which he is able to prove that he was unable to work as a result of his compensable injury, and that substantive entitlement to such benefits is not contingent upon authorization of time loss by the attending physician. Esther C. Albertson, 44 Van Natta 521, aff'd Albertson v. Astoria Seafood Corporation, 116 Or App 241 (1992).

The dissent quotes extensively from the legislative history to support its contention that the 1995 Legislature intended to eliminate the procedural-substantive distinction for temporary disability. However, the courts have cautioned against leaping into legislative history without first examining the statutory text and context. The Court of Appeals recently stated:

> "[W]e 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." Deluxe Cabinet Works v. Messmer, 140 Or App 548, 553 (1996) (Citations omitted.)

Here, as we discussed earlier, the statutory text and context cannot reasonably be read to make substantive entitlement to temporary disability contingent on "time loss" authorization. To summarize our analysis, the text of ORS 656.262(4)(f) makes the "time loss" authorization requirement applicable to temporary disability payable "pursuant to ORS 656.268" only. As the courts have long held, ORS 656.268 addresses the carrier's procedural obligations in processing the claim to closure; it does not address substantive entitlement to temporary disability, which is the precise issue in this case. Thus, when ORS 656.262(4)(f) is viewed in its proper context, it does nothing more than make "procedural" temporary disability contingent on "time loss" authorization. Finally, and most importantly, the temporary disability statutes, ORS 656.210 and 656.212, do not make a worker's substantive entitlement to temporary disability contingent on an attending physician's "time loss" authorization. In the absence of textual or contextual support, we decline to resort to legislative history as the sole basis for imposing a significant (and potentially onerous) requirement. See PGE v. Bureau of Labor and Industries, supra, 317 Or at 611.

We are mindful of the court's statement in SAIF v. Christensen, 130 Or App 346, 350 (1994), rev allowed 320 Or 567 (1995), that an attending physician's "time loss" authorization applies to substantive entitlement to temporary disability benefits, as well as in the procedural context. However, substantive entitlement to temporary disability was not at issue in Christensen; rather, the dispute was solely over the carrier's procedural obligation to pay temporary disability in the processing of an aggravation claim. Moreover, the statement in Christensen is directly contradictory to the holding in SAIF v. Taylor, supra, that the claimant is substantively entitled to temporary disability benefits during the period for which he had no attending physician and, thus, no "time loss" authorization. Because the statement in Christensen was not necessary to that decision and is contrary to the court's holding in Taylor, we view the statement as dicta and not controlling.

We now turn to the facts of this case. On May 11, 1993, Dr. Wenner requested reopening of claimant's claim, indicating that claimant's right CTS had worsened, as demonstrated by significant weakness in the thenar musculature and that he needed surgery. (Exs. 90, 91). Dr. Wenner's May 24, 1995 letter establishes that claimant was at least partially disabled from May 11, 1993 through April 24, 1995. Based on the record as a whole, we conclude that claimant has established that he was disabled as of May 11, 1993. Accordingly, we affirm the ALJ's opinion that claimant is entitled to temporary partial disability benefits as of that date. ORS 656.210, 656.212; SAIF v. Taylor, supra; Lebanon Plywood v. Seiber, supra; Dorothy E. Bruce, 48 Van Natta 518 (1996).

Penalty for Allegedly Unreasonable Failure to Pay Procedural Temporary Disability

The ALJ found that the employer had notice of a worsening of claimant's right carpal tunnel condition on May 11, 1993 and medical verification of claimant's inability to work on September 20, 1994. The ALJ reasoned that temporary disability benefits were properly stayed until May 11, 1995, 14 days after the Board's March 20, 1995 order (setting aside the employer's aggravation denial) became final and claimant's right to receive temporary disability benefits vested. The ALJ accordingly assessed a penalty for the employer's failure to pay "procedural" temporary disability benefits timely.

The employer contends on review that claimant failed to prove that the employer unreasonably failed to pay the disputed temporary disability benefits because it did not receive either Dr. Wenner's September 20, 1994 chart note or his May 24, 1995 report more than 14 days prior to June 7, 1995, the effective date of amended ORS 656.262(4)(f), thereby precluding such retroactive authorization of temporary disability benefits. We agree that the employer's failure to pay procedural temporary disability benefits was not unreasonable for the following reasons.

To establish entitlement to a penalty, claimant must prove that the employer's refusal to pay temporary disability benefits between September 20, 1994 and April 25, 1995 was unreasonable. ORS 656.262(11) (a). If the employer had a legitimate doubt about its payment obligations, or no compensation was "then due," no penalty may be awarded. Brown v. Argonaut Ins. Co., 93 Or App 588 (1988); SAIF v. Christensen, supra.

Here, Dr. Wenner authored a September 20, 1994 chart note in which he reported that claimant's symptoms had increased after working in a gas station. He again recommended surgery, reporting that claimant's worsened CTS condition "is really interfering with his life, [it] is keeping him from working * * *." (Ex. 105). Dr. Wenner also authored a May 24, 1995 letter in which he authorized temporary partial disability from November 29, 1992 through April 1995.

ORS 656.273(6) provides that an aggravation claim "shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, except that the first installment of compensation due under ORS 656.262 shall be paid no later than the 14th day after the subject employer received notice or knowledge of a claimant's medically verified inability to work resulting from a compensable worsening under [ORS 656.273 (1) or (8)]." SAIF v. Christensen, supra (the obligation to begin paying time loss benefits on an aggravation claim cannot be triggered in the absence of medical verification of an inability to work).

Here, we are unable to determine when the employer received the September 20, 1994 chart note.[3] In addition, the employer did not receive Dr. Wenner's May 24, 1995 authorization of time loss more than 14 days prior to June 7, 1995, the effective date of amended ORS 656.262(4)(f).[4] Moreover, claimant has failed to establish when either document was mailed (certificate of service, postal receipt) in order to take advantage of the presumption of receipt under ORS 40.135(1)(q). See Carol M. Cote-Williams, 44 Van Natta 367, 369 (1992); Shari Hallberg, 42 Van Natta 2750 (1990).

Consequently, claimant has failed to prove his entitlement to "procedural" temporary disability benefits under the aggravation claim for any period prior to the effective date of amended ORS 656.262(4)(f), which prohibits retroactive authorization of temporary disability under these circumstances. See Delores L. Holmes, 47 Van Natta 2359, 2361 (1995) (An attending physician's authorization of temporary disability is effective to retroactively authorize temporary disability only 14 days prior to its issuance). Absent that information, we do not find that the employer was required to pay "procedural" temporary disability compensation. Accordingly, no penalty can be assessed for the employer's alleged failure to timely pay such compensation. Carol M. Cote-Williams, supra; Shari Hallberg, supra. Therefore, we reverse that portion of the ALJ's order that awarded a penalty for the employer's allegedly unreasonable failure to pay "procedural" temporary disability on an open aggravation claim. Brown v. Argonaut, supra.[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 regarding the temporary disability issue 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 February 1, 1996 is reversed in part and affirmed in part. That portion of the order awarding a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by the self-insured employer.

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[3] There is no date stamp on Exhibit 105. In addition, we note that Dr. Wenner generally made note of letters sent to the employer and others in his chart notes. See Exs. 84, 90, 96, 105. There is no indication in Dr. Wenner's chart notes that he did so in this case.

[4] ORS 656.262(4)(f) was added to the Worker' Compensation Act by SB 369, § 28. Because that section is not excluded from the general retroactivity provisions of the bill, see SB 369, § 66, it applies to this case. See Volk v. America West Airlines, 135 Or App 565 (1995) (SB 369 applies to matters for which the time to appeal the Board's decision has not yet expired, or if appealed, has not been finally resolved on appeal).

[5] Because we have concluded that claimant failed to establish that the employer received notice of a medically verified inability to work prior to the effective date of amended ORS 656.262(4)(f), we do not need to address the employer's alternative argument that Dr. Wenner's September 1994 chart note was inadequate to establish claimant's inability to work.

Board Member Moller dissenting.

The majority holds that, by promulgating ORS 656.262(4)(f) and 656.268(3)(d), the 1995 legislature intended to prohibit unlimited retroactive authorization of temporary disability for purposes of establishing entitlement to "procedural" benefits but not for purposes of determining the worker's ultimate substantive entitlement to such benefits. I am unable to conclude that the legislature intended to maintain the distinction between procedural and substantive entitlement to temporary disability that the majority has divined in the amended statute. Rather, I believe that the legislature's intent when it promulgated ORS 656.262(4)(f) and 656.268(3) was, in part, to affirmatively reject this distinction. This intent is evident in the text and context of the 1995 amendments as well as the legislative history of the amendments. Moreover, even prior to the 1995 amendments, the Court of Appeals had rejected this distinction in the context of attending physician authorization. Because it is our obligation to construe the statute so as to pursue the intent of the legislature if possible -- which I respectfully conclude the majority fails to do -- I dissent.

An analysis of amended ORS 656.262(4)(f) must begin with an examination of the text and context of the statutory provision. ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The context includes other statutes relating to the same subject matter. Id. at 611. In this regard, the provisions of ORS 656.262 are directed to the processing of claims and the payment of compensation. ORS 656.262(4)(f), which was added to ORS Chapter 656 by Senate Bill 369 (Or Laws 1995, ch 332, § 28), 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." (Emphasis supplied.)

On its face, the first sentence of this provision indicates that the attending physician's cessation of -- or failure to -- authorize temporary disability is sufficient to prevent temporary disability compensation from becoming "due and payable pursuant to ORS 656.268." The second sentence of this provision limits retroactive authorization of temporary disability compensation by the attending physician under ORS 656.268 to a period of 14 days. Notably, both sentences contain express references to ORS 656.268.

ORS 656.268 addresses the process of claim closure including the procedure for determining awards of permanent disability, termination of temporary total disability, and the offset of overpaid benefits. Of particular significance, ORS 656.268(3) as amended contains an express reference back to ORS 656.262(4). ORS 656.268(3) provides in pertinent part:

> "(3) Temporary total disability benefits shall continue until whichever of the following events first occurs:
>
> "(a) The worker returns to regular or modified employment;
>
> "(b) The attending physician advises the worker and documents in writing that the worker is released to return to regular employment;
>
> "(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to being 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."** (Added section in bold type).

Therefore, amended ORS 656.268 permits the insurer or employer to cease paying temporary total disability benefits not only if the worker returns to work or if the attending physician releases the

worker to regular or modified work, but upon the occurrence of those events enumerated in ORS 656.262(4). Correspondingly, any event that results in the withholding or termination of temporary disability benefits under ORS 656.262(4), including the attending physician's cessation or failure to authorize temporary disability, means that no temporary disability compensation is "due and payable pursuant to ORS 656.268." ORS 656.262(4)(f).

In addition to the foregoing, ORS 656.268 authorizes adjustments in temporary and permanent disability payable prior to the determination or notice of closure. See ORS 656.268(1), (2), (4) (13). In this regard, ORS 656.268(13) 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*." (Emphasis supplied.)

By its terms, ORS 656.268(13) addresses necessary adjustments in compensation paid or payable prior to claim closure. It is directed toward arriving at a final substantive award of compensation. As relevant here, ORS 656.268(13) contemplates the payment of temporary disability payments which were "payable but not paid." In accordance with ORS 656.262(4)(f), temporary disability compensation is payable pursuant to ORS 656.268 for any period of time not authorized by the attending physician. Consequently, the text of the amended statutes, as construed together, not only requires authorization by the attending physician to establish entitlement to temporary disability compensation, but disallows any compensation "not payable" by reason of a lack of the attending physician's authorization.

The context of ORS 656.262(4)(f) supports this conclusion. ORS 656.262(4)(a), which was also amended by Senate Bill 369, now requires the attending physician's authorization to trigger the first installment of temporary disability compensation. Or Laws 1995, ch 332, § 28. ORS 656.262(4)(c) provides that temporary disability compensation is not due and payable for any period for which the attending physician cannot verify the worker's inability to work. Id. ORS 656.262(4)(d) provides that the insurer may suspend a claimant's temporary disability benefits if a worker fails to appear at a rescheduled appointment with the attending physician until the worker appears at a subsequent rescheduled appointment. Id. ORS 656.262(4)(e) provides that if the insurer has requested and failed to receive verification of the worker's inability to work from the attending physician, the attending physician's medical services are not compensable until such verification is received. Id. Each of these provisions is incorporated into ORS 656.268 by adoption of paragraph (3)(d).

These statutes indicate that the legislature deemed it essential that the worker be seen on a regular basis by his or her attending physician and that the attending physician be the person statutorily authorized to decide whether an injured worker in unable to work and should be taken off work. Thus, these statutes provide contextual support for the conclusion that, under ORS 656.262(4)(f), the legislature intended that the attending physician's authorization is required to establish any period of temporary disability compensation.

This conclusion is further supported by the decision of the Court of Appeals in SAIF v. Christensen, 130 Or App 346 (1994), where the court concluded that former ORS 656.245(3)(b)(B) (renumbered under Senate Bill 369 as 656.245(2)(b)(B) without a change in text) requires authorization by the attending physician to any claim for time loss, whether in an initial claim or an aggravation claim, and that the requirement of such authorization applies to both procedural and substantive entitlement to benefits. The majority distinguishes Christensen and instead relies on SAIF v. Taylor, 126 Or App 658 (1994), to support its holding. The majority believes that the two cases are in direct conflict and, therefore, that Taylor should control because the reference in Christensen to substantive entitlement was unnecessary to its holding. However, because the two opinions were authored by the same judge within a short period of time of one another, I am unwilling to so quickly reject the court's opinion on this issue as mere dicta.

A closer examination reveals that the majority overlooks a dispositive textual distinction between the statutory provision addressed in Taylor and the provision at issue here. In Taylor, the court was

called on to interpret subparagraph (4)(b) of former ORS 656.262. Although that provision also made use of the term "due and payable," it notably lacked any reference to ORS 656.268. Accordingly, the court in Taylor made no reference to ORS 656.268. Presumably, the inclusion of the reference to ORS 656.268 in ORS 656.262(4)(f) has significance. That significance is to insert the requirements of ORS 656.262(4)(f) into the claim closure procedures set forth in ORS 656.268. Had the legislature wished to impose the requirements of ORS 656.262(4)(f) only during the ongoing processing of a claim, there would be no reason for the provision to contain any reference to ORS 656.268.[1]

I am unpersuaded by the majority's argument that use of the present tense in ORS 656.262(4)(f) indicates that the provision is applicable only in a "procedural" context. Standing alone, paragraph (4)(f) of ORS 656.262 is undeniably addressed to the ongoing processing of an accepted claim. Use of the present tense is to be expected. It is only through the reference to ORS 656.268 and the cross-reference in that statute back to ORS 656.262(4) that the provision is applicable to determinations of substantive entitlement to benefits.

Although we need not consider the legislative history to amended ORS 656.262(4)(f), PGE, 317 Or at 611-12, it also supports that conclusion. Jerry Keene testified at the bill's sponsor's request regarding the changes to ORS 656.268:

> "To date the courts have interpreted these provisions as creating a substantive right to time-loss benefits. And following that court interpretation, the changes proposed here are intended to preclude a closure order from making a substantive award of time-loss benefits for any period of time during which procedurally the time-loss benefits were lawfully suspended or withheld or terminated."
>
> "What's been happening in some cases such as SAIF vs. Taylor [and] Sandoval vs. Crystal Pine is that where worker's benefits were lawfully suspended or terminated or withheld for lack of cooperation, for lack of providing sufficient information, for lack of an attending physician's release, those benefits were lawfully terminated, but then the courts have determined when it came down to closing the claim, they had to be reinstated in order to be paid anyway at the end point of the substantive matter. They drew a distinction between substantive and procedural benefits, one that hadn't existed before 1990 and that this language would now take away and make it all mean the same thing." Tape Recording, Joint Meeting Senate Committee on Labor and Government Operations and House Committee on Labor, January 30, 1995, Tape 19A.

Considering the clear language of ORS 656.262(4)(f), as well as the related statutes and the legislative history, there is little doubt that the legislature intended to limit all temporary disability compensation -- not just those benefits that are paid as a procedural matter -- solely to that authorized by the attending physician, and that, if the attending physician retroactively authorized temporary disability compensation, such compensation could be authorized only for a maximum of 14 days prior to the physician's authorization. The majority errs in concluding otherwise. For these reasons, I respectfully dissent.

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[1] It may well be that the legislature's failure to amend the other provisions of ORS 656.262(4) to expressly reference ORS 656.268 may have been inadvertent. Certainly, the analysis in this dissent is significantly altered when applied to the other provisions of ORS 656.262(4). However, only subsection (4)(f) is at issue in this case.

In the Matter of the Compensation of
PATRICK L. CLARKE, Claimant
WCB Case No. 96-01519
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's left upper extremity aggravation claim. On review, the issue is aggravation.

We adopt and affirm the ALJ's order with the exception of the first sentence of the second paragraph of the opinion on page 3, and with the following supplementation.

We begin with a brief recap of the relevant facts. Claimant has an accepted claim with SAIF for left wrist tendonitis, left elbow medial epicondyle tendon release, and left ulnar neurolysis. (Exs. 6, 23).

The employer issued a July 14, 1994 Notice of Closure that awarded 2 percent scheduled permanent disability for the left arm. Dr. German subsequently diagnosed claimant with a secondary ulnar neuritis, which, if claimant's symptoms worsened, might require neurolysis of the ulnar nerve with transposition anterior to remove it from the sensitive area of the elbow. (Exs. 12A, 16). Drs. Dordevich, Morton and Newman, who examined claimant for the insurer, also noted local ulnar nerve tenderness, which they attributed to adhesions. (Ex. 17).

Dr. Eisler, who performed an arbiter examination, concluded that claimant had a chronic neuromuscular condition which "would be best described as an epicondylitis which is best managed with protective padding and intermittent use of anti-inflammatory medications or ice packs but is not otherwise amenable to curative treatment." Dr. Eisler opined that this condition prevented claimant from repetitive use of the left arm. (Ex. 20). A January 13, 1995 Order on Reconsideration awarded 5 percent scheduled permanent disability for a chronic condition.

On March 28, 1995, Dr. German reported that claimant's primary condition was tendinitis over the medial epicondyle which was treated with a flexor slide to take the tension off the muscle-tendon junction as it attaches to the medial epicondyle. Dr. German also reported that claimant continued to have symptoms compatible with ulnar neuritis, but with a normal nerve conduction test. Dr. German expected that claimant's condition would resolve, although he again noted the possibility that claimant could experience a persistent, recurrent ulnar neuritis which would require an ulnar nerve transfer and neurolysis. (Ex. 23A). Claimant's scheduled permanent disability was increased to 7 percent by a June 12, 1995 Stipulation. (Exs. 22, 24).

In November 1995, claimant sought treatment from Dr. German for increased symptoms in his arm, shoulder, elbow and hand, worse at the elbow. Dr. German diagnosed ulnar neuritis, left elbow, and requested surgery. (Ex. 25). Claimant filed an aggravation claim. (Ex. 26). Dr. Hendricks examined claimant on referral from Dr. German. (Ex. 28). Claimant was subsequently examined by Dr. Button (Ex. 33) and Dr. Parsons (Ex. 42). Dr. Rosenbaum performed a records review. (Ex. 46).

Based on Dr. German's opinions, the ALJ concluded that claimant's condition had "actually worsened," either as a pathological worsening of his condition or as a symptomatic worsening greater than a waxing and waning of symptoms contemplated by his previous permanent disability award. SAIF contends that claimant has failed to establish that his accepted left arm condition has "actually worsened" under either standard. We disagree.

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."

In Carmen C. Neill, 47 Van Natta 2371 (1995), we held that an "actual worsening" under ORS 656.273(1) is established by either: (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.

Dr. German, claimant's treating physician, opined that claimant's ulnar nerve condition had pathologically worsened.[1] (Exs. 27, 44). Dr. German also noted diminished strength in claimant's left hand as compared to the right, which was not the case at claim closure. (Compare Exs. 20-4 with 31-1; see also Ex. 33-4). Although nerve conduction studies showed no nerve root problem, Dr. German opined that there was scar tissue present. (Exs. 31-1, 44). Dr. Hendricks thought claimant's symptoms were more in line with causalgia[2] of the nerve. (Ex. 31). Moreover, as discussed by the ALJ, Dr. German opined that claimant had an "entrapment" of the ulnar nerve that he did not exhibit at the time of surgery. Dr. German described the "entrapment" as an ulnar neuritis not manifested in typical numbness or weakness of the hand, but came on with activity with swelling, and was irritation-based, not an "entrapment" as would be manifested by nerve conduction studies. (Exs. 40, 44, 45).

In contrast, Dr. Button, who examined claimant and reviewed his records for SAIF, thought it possible that there was some soft tissue scarring in the region of claimant's surgery, but, because he found no signs of compression neuropathy affecting the ulnar nerve, he opined that claimant had no objective diagnosis and concluded that there had been no material worsening since claimant's claim had been closed. (Ex. 33).

Dr. Parsons, who also examined claimant for SAIF, found that, because neither nerve condition studies nor his physical examination revealed any evidence of ulnar neuropathy, claimant's physical examination findings had not changed since claim closure and represented only the waxing and waning that was to be expected from an award based on some loss of range of motion and a repetitive use limitation. (Exs. 42, 43).

Dr. Rosenbaum, who performed a records review for SAIF, focused primarily on whether the requested surgery was reasonable and necessary. Like Drs. Button and Parsons, he concluded that claimant had no ulnar neuropathy. (Ex. 46). Dr. Rosenbaum did not discuss Dr. German's hypothesis that claimant's nerve was affected by scar tissue. Moreover, he admitted that his opinion was limited by a lack of opportunity to examine claimant. (Ex. 46).

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. German's opinion. Dr. German's opinion is based on clinical evidence of progressive ulnar neuritis. Dr. German initially expected that claimant's neuritis would resolve. Instead, Dr. German has consistently described an irritation and swelling process that came on with activity and which was verified by clinical testing, tenderness, pain distribution, hand involvement, and demonstrated weakness. Under such circumstances, we find that claimant's compensable condition has pathologically worsened. Consequently, claimant has established a compensable aggravation.

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[1] Although Dr. German indicated that he was unable to judge whether claimant's worsening was greater than that anticipated by the 7 percent permanent disability award, he identified objective findings of a pathological worsening, namely weakness in the abduction and adduction of the fingers, tenderness over the medial epicondyle, soreness in the wrist flexors, and, as noted above, decreased grip strength. (See Ex. 44). Because claimant has established a pathological worsening, he is not required to establish in addition a symptomatic worsening greater than the waxing and waning contemplated by the permanent disability award. Carmen C. Neill, supra.

[2] "Causalgia" is a burning pain, often accompanied by trophic skin changes, due to injury to a peripheral nerve. Dorland's Illustrated Medical Dictionary, 25th ed., at 275.

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.

ORDER

The ALJ's order dated May 15, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by the SAIF Corporation.

December 19, 1996 Cite as 48 Van Natta 2511 (1996)

In the Matter of the Compensation of
RONALD M. HAGGMARK, Claimant
WCB Case No. 96-01511
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Craig A. Staples, Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that upheld the self-insured employer's denial of claimant's aggravation/new injury/occupational disease claims for low back and bilateral leg conditions. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change. In the fourth full paragraph on page 4, we delete the third sentence. We change the first part of the next sentence to read "At the hearing" rather than "Later in the hearing."

ORDER

The ALJ's order dated May 24, 1996 is affirmed.

Board Chair Hall dissenting.

After my review of the evidence, I would find claimant's current low back and bilateral leg conditions compensable. Therefore, I respectfully dissent.

The primary issue in this case concerns claimant's repair of a fence at his home. Claimant worked on the fence project over a period of four days. (Tr. 26). He testified that he put 2 x 4 cross rails on the fence and replaced 1 x 6 uprights (fence boards). (Tr. 24, 25, 60). Claimant described his activities as taking the rotten boards off, sawing with a skill saw, cutting the 2 x 4 cross rails, and then nailing the boards up. (Tr. 25). Claimant testified that he did not remove or replace fence posts or concrete. (Tr. 59-60). Claimant's testimony in that regard was without equivocation or reservations.

Claimant's acting foreman testified that claimant told him he was replacing a fence and had to take the old fence posts out. (Tr. 47). Claimant asked the foreman to take time off work to finish the fence. The foreman said claimant asked for November 7 off to work on the fence and called in that evening to say he was too tired to come to work the next day. (Tr. 44, 45). The foreman testified that, when claimant returned to work on November 9, he said that his hands were sore from using a pick iron and bar to dig out the fence posts that were cemented in. (Tr. 46, 48-49). The foreman said that claimant worked a half-day on November 9 and then told the foreman he had a lot of back pain and wanted to go home. (Tr. 47). However, the foreman had difficulty remembering which days claimant did not work and his "recall" of claimant's activities was not persuasive.

Similarly, the general manager's recollection of claimant's fence-building activities was not persuasive. The general manager testified that he spoke to claimant on November 9 and claimant said that he had been too tired to work on November 8 because he had been digging up fence posts and "heavy concrete blocks." (Tr. 52).

Claimant testified, however, that he did not tell either the foreman or the general manager that he had replaced fence posts or concrete bases. (Tr. 60-61). Claimant said that he did not remove any fence posts because they did not need to be replaced. (Tr. 59). Claimant was not aware of any concrete anchoring the fence posts. (Id.) Rather, the only things that needed repairs were the 2 x 4 cross rails and 1 x 6 upright boards that had been knocked off by the neighbor's dogs. (Tr. 60). Claimant testified that he did not injure his back or have any back problems in connection with the fence renovation. (Id.)

The ALJ, as well as the majority, deferred to the testimony of the foreman and general manager and concluded that claimant made inconsistent statements about the fence project. It was based solely upon the alleged "inconsistent" statements that the ALJ found claimant's credibility undercut, the reliability of his history diminished, and thus the medical opinions unpersuasive. Yet, neither the ALJ nor the majority offer any analysis or explanation for accepting the testimony of the foreman and the general manager over that of claimant. After all, claimant has made inconsistent statements only if the testimony of the foreman and the general manager is accepted over that of claimant. Since the ALJ did not make demeanor-based credibility findings, we review the transcript to determine whether any one witness is more credible or persuasive than another.

Based upon my review of the transcript, I find claimant's testimony more persuasive than the recall of the foreman and general manager. Finding claimant's testimony more persuasive, it follows that the history given to Drs. Merrick and Kitchel was accurate. With the history accepted as accurate and reliable, there is no basis on this record to reject as unpersuasive the opinions of Drs. Merrick and Kitchel.

Based on claimant's credible testimony and the opinions of Drs. Merrick and Kitchel, I would reverse the ALJ's order and find claimant's low back and bilateral leg conditions compensable.

In the Matter of the Compensation of
KARREN S. MALDONADO, Claimant
WCB Case No. 95-10171
ORDER ON REVIEW
Max Rae, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Myzak's order which: (1) increased the award of unscheduled permanent disability for claimant's injury to her low back, neck and right shoulder from 12 percent (38.4 degrees), as granted by an Order on Reconsideration, to 19 percent (60.8 degrees);[1] and (2) affirmed the reduction in the reconsideration order of claimant's award of scheduled permanent disability for injury to her right ankle from 9 percent (12.15 degrees) to zero. In its brief, the SAIF Corporation asserts that the award of unscheduled permanent disability in the reconsideration order should be reinstated. On review, the issues are extent of unscheduled and scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's finding of facts.

CONCLUSIONS OF LAW AND OPINION

Claimant previously sustained a compensable injury to her right shoulder and low back on June 21, 1991. The claim was closed by Notice of Closure on September 30, 1992, with an award of 3 percent unscheduled permanent disability for the low back. On May 12, 1993, an Order on Reconsideration affirmed the Notice of Closure. However, on June 20, 1994, a prior ALJ increased claimant's unscheduled award to 13 percent.

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[1] The ALJ's order stated that claimant was awarded an "additional" 19 percent disability. However, it is clear from the ALJ's order that the award was in lieu of the reconsideration order's 12 percent award.

In the meantime, claimant suffered a new compensable injury to the low back, right shoulder, neck and right arm on May 21, 1993, while performing modified work for the same employer. The claim was closed by Notice of Closure dated December 27, 1994. The closure notice awarded 27 percent unscheduled permanent disability and 9 percent scheduled permanent disability for loss of use or function of the right ankle. On September 8, 1995, an Order on Reconsideration reduced the unscheduled award to 12 percent and the scheduled award to zero. Claimant requested a hearing seeking additional unscheduled and scheduled permanent disability.

At hearing, the parties stipulated that the value for claimant's age under the disability standards is zero and that the value for formal education is 1. The parties further stipulated that claimant's residual functional capacity (RFC) is sedentary/light, that the impairment value for loss of lumbar extension and right and left extension is 7 percent, and that claimant is entitled to a 5 percent "chronic" condition award for the right shoulder condition. Finally, the parties agreed that claimant began modified work as a "house coordinator" on November 1, 1992 and that she worked full time in that position when injured in May 1993.

The ALJ found insufficient medical evidence to support permanent impairment greater than that to which the parties had stipulated. The ALJ then determined claimant's age and education values totaled 5 and that her adaptability value was 4 based on a base functional capacity (BFC) of medium/light and an RFC of sedentary/light. Multiplying claimant's age and education value (5) by the adaptability value (4) for a product of 20 percent, the ALJ then added the 12 percent impairment value to which the parties had stipulated for a total award of 32 percent. However, the ALJ offset claimant's prior 13 percent award for the June 1991 claim, holding that claimant's actual award for the May 1993 injury was 19 percent. Finally, the ALJ found no persuasive medical evidence to support an award of scheduled permanent disability. Thus, the ALJ affirmed the reconsideration order's reduction of scheduled permanent disability to zero.

On review, claimant contends that her adaptability value should be 6 based on a BFC of heavy and an RFC of sedentary/light, which results in a product of 30 when the adaptability factor (6) is multiplied by the sum of age and education (5). Claimant also asserts that she should receive additional impairment for reduced range of shoulder (16.2 percent) and cervical (10.4 percent) motion, as well as additional impairment for reduced lumbar flexion (4 percent). Claimant also argues for scheduled permanent disability for alleged loss of right arm strength. SAIF responds by asserting that the Order on Reconsideration's award of 12 percent unscheduled permanent disability should be reinstated.

Unscheduled Permanent Disability

We apply the disability standards in effect on the date of the Determination Order or Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C). OAR 436-35-003(2). Claimant's claim was closed by Notice of Closure dated December 27, 1994. Accordingly, those standards contained in WCD Admin. Orders 6-1992 and 93-056 apply to claimant's claim. Claimant has the burden of proving the extent of disability resulting from her compensable injury. ORS 656.266; Harriet Olson, 47 Van Natta 1917 (1995).

Age and Education Values

The parties stipulated that claimant should receive a value of zero for age and 1 for formal education. The ALJ assigned a value of 3 for the skills factor based on claimant's at-injury employment which the ALJ considered to have most closely resembled "home attendant," DOT 354-377-014, which carries an SVP value of 3. This SVP translates to a skills value of 3. OAR 436-35-300(4). SAIF contends that claimant's SVP should be based on a combination of the two DOT codes for "home attendant" (SVP 3, skills value 3) and mental-retardation aide (DOT 355.377-018, SVP 6, skills value of 2), using the highest SVP. See ORS 436-35-300(3)(a). We disagree with SAIF.

The DOT description for "Mental-Retardation Aide" states that a worker assists in providing self-care training and therapeutic treatments to residents of a mental retardation center. While claimant's job involved providing direct care at a facility for the developmentally disabled, the evidence in the record does not establish that the employer's facility was a "mental-retardation" center or that claimant provided self-care training for the residents of the employer's group home. (Exs. 7, 7A). We, therefore, decline SAIF's invitation to base claimant's skills value on that DOT code.

Instead, we agree with the ALJ's decision to base claimant's skills value on the DOT code for "home attendant."[2] We, therefore, find that the sum of claimant's age and education factors is 4.[3]

Adaptability

The ALJ calculated claimant's adaptability factor as 4 based on the difference between a BFC of light/medium and an RFC of sedentary/light. SAIF agrees with the adaptability factor the ALJ used, although it correctly notes that the applicable standards do not contain a "light/medium" category for BFC. See OAR 436-35-310(6). Citing her own testimony that her patient care duties were heavy, claimant asserts that her BFC should be based on the DOT code (355-674-018) for "orderly," which is classified as heavy employment. Thus, claimant contends that her adaptability factor should be 6 based on a BFC of heavy and the stipulated RFC of sedentary/light. OAR 436-35-310(6).

The ALJ declined to consider claimant's testimony concerning the nature of her employment duties, citing Joe R. Ray, 48 Van Natta 325 (1996). Claimant contends that Ray was incorrectly decided.

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 prior to both the September 8, 1995 Order on Reconsideration and the November 30, 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 regarding 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. 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 is 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 Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995. Id.[4]

Here, the hearing was held after June 7, 1995 on November 28, 1995, and the record was closed on November 30, 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, 1147 (1996).

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[2] We note that the prior ALJ based skills factor on the DOT code for "nursing assistant" (DOT 355.647-014) which has an SVP of 4. (Ex. 5-6). Claimant's skills value was based on her job at the time of her 1991 injury, which was subsequently modified as a result of that injury. Even if claimant's skills value were based on that job description for "nursing assistant," her SVP would not change, inasmuch as the skills value for an SVP of 4 is also 3. OAR 436-35-300(4).

[3] The ALJ awarded a value of 1 for the "training" factor. We agree with SAIF that this was an error because the applicable rules (WCD Admin. Order 93-056, effective 12-14-94) do not provide a value for lack of training.

[4] Claimant asserts that retroactive application of amended ORS 656.283(7) violates her procedural due process rights under Article 1, Section 10 of the Oregon Constitution and 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.

It follows that claimant's testimony cannot establish her entitlement to a "heavy" BFC. In any event, considering just the documents admitted into the record, we conclude that there is insufficient evidence that claimant qualifies for the heavy BFC based on the job description for orderly. The record indicates that claimant was working at modified work at the time of injury, which included light-duty administrative functions. (Ex. 7). Inasmuch as the job description for "orderly" in the DOT does not include administrative functions such as those contained in claimant's modified employment, we do not find that the DOT code for "orderly" is the appropriate job to be used in rating BFC.

Accordingly, we agree with the ALJ and SAIF that claimant's adaptability factor should be 4. When that value is multiplied by the value for age/education (4), the product is 16.

Permanent Impairment

The final step in calculating claimant's unscheduled permanent disability is the determination of claimant's permanent impairment due to the compensability injury and the addition of that amount to the product of adaptability times age/education. The ALJ determined that there was insufficient medical evidence to support an award of permanent impairment greater than the amount (12 percent) stipulated by the parties. We agree.

Claimant contends that the medical arbiter's report documenting loss of cervical and right shoulder range of motion justifies a greater award of permanent disability. We disagree. The medical arbiters stated that they could not determine whether the reductions in range of motion were attributable to the compensable injury because of factors such as lack of cooperation. (Ex. 10-4). We concur with the ALJ that, based on this record, claimant has not established additional permanent impairment based on reduced range of motion in the cervical spine and in the right shoulders.

Claimant also argues that she is entitled to permanent impairment for reduced lumbar flexion. The medical arbiters noted, however, that the lumbar flexion test did not satisfy validity criteria in Bulletin 242. (Ex. 10-2). Claimant contends that application of Bulletin 242 is improper because it is an improperly promulgated standard. We disagree.

We previously addressed a similar argument in Jeana Larson, 48 Van Natta 1278 (1996). In Larson, we upheld the validity of Bulletin 242, reasoning that the Director's bulletin established the same method for determining validity of lumbar flexion as provided in the AMA Guides, with the additional requirement that the examiner note in his or her report any measurements that do not meet the validity criterion. Hence, we concluded that the bulletin prescribed a specific application of the validity criteria set forth in a validly adopted rule. Accordingly, the provisions in the Bulletin need not have been promulgated as a rule under the Administrative Procedures Act. Therefore, Bulletin 242 was appropriately applied in that case.

We see no basis to depart from our reasoning in Larson. Therefore, we reject claimant's argument that application of Bulletin 242 is improper, and decline to award claimant permanent impairment based on reduced lumbar flexion. Accordingly, we agree with the ALJ that claimant's permanent impairment value is 12. When added to the product of age/education times adaptability (16), claimant's unscheduled permanent disability is 28 percent.

Offset

Because claimant previously was awarded 13 percent unscheduled permanent disability for his low back and neck, we consider such an award in arriving at the appropriate permanent disability for the current injury. See Offill v. Greenberry Tank and Iron Co., 142 Or App 351 (1996) (OAR 436-35-007(3) requiring offset of prior unscheduled permanent disability awards not inconsistent with ORS 656.222). This determination requires a comparison of the current extent of disability under the standards with the prior permanent disability award to decide if the current award reflects any preexisting disability for which the claimant received benefits. OAR 436-35-007(3)(b)[5]; Patrick D.

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[5] OAR 436-35-007(3)(b) 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..."

Whitney, 45 Van Natta 1670, 1671 (1993); Mary A. Vogelaar, 42 Van Natta 2846, 2848 (1990). If the preexisting disability is included in the current award, the award is reduced by an amount that represents the previously compensated loss of earning capacity. Id.

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 and vocational factors as are relied upon in the current evaluation of permanent disability. Kerri A. Houghton, 47 Van Natta 11, 12 (1995).

Here, we must decide whether the 28 percent unscheduled permanent disability award claimant would otherwise receive for her 1993 injury reflects any disability for which she has already been compensated in connection with her 1991 injury. If so, the 1993 injury award must be reduced by an amount that represents the previously compensated loss of earning capacity. Mary A. Vogelaar, supra.

Based on claimant's social/vocational factors and permanent impairment existing at the time of the prior injury, and based on those same factors existing after claimant's most recent injury, we conclude that 15 percent of the award for claimant's back, neck and right shoulder condition represents permanent disability that was not present prior to the May 1993 neck injury. The other 13 percent reflects a loss of earning capacity for which claimant has already been awarded benefits in connection with her June 1991 injury. Therefore, to avoid doubly compensating claimant for the same loss of earning capacity, we reduce claimant's current disability award of 28 percent to 15 percent.[6] Because we have reduced claimant's compensation on review, claimant is not entitled to an attorney fee. ORS 656.382(2); 656.386(2).

Scheduled Permanent Disability

The ALJ declined to award scheduled permanent disability, concluding that there is no persuasive medical evidence that claimant was entitled to such an award. Claimant argues that the medical arbiter's report documented loss of strength in the right arm which would justify a scheduled award. (Ex. 10-3). We disagree based on the arbiter's comments that claimant's efforts in testing were variable and that the arbiters were unable to determine if claimant's findings were due to the compensable injury. (Ex. 10-3, 10-4). The ALJ correctly determined that claimant is not entitled to an award of scheduled permanent disability.

ORDER

The ALJ's order dated January 2, 1996, as amended on March 18, 1996, is modified. In lieu of the ALJ's award of 19 percent (60.8 degrees) unscheduled permanent disability, and in addition to the Order on Reconsideration's 12 percent (38.4 degrees) award, claimant is awarded 3 percent (9.6 degrees) for a total award of 15 percent (48 degrees) unscheduled permanent disability. The ALJ's "out-of-compensation" attorney fee is modified accordingly. The remainder of the ALJ's order is affirmed.

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[6] The dissent asserts that we have not sufficiently explained our calculation of claimant's offset. However, our reasoning in Bill R. Offill, 47 Van Natta 833, 834 (1995) was similar. Moreover, such reasoning, which led to our conclusion in Offill, was affirmed by the Court of Appeals. Offill v. Greenberry Tank and Iron Co., supra.

Board Chair Hall dissenting.

I agree with the majority's calculation of unscheduled permanent disability prior to its consideration of claimant's previous 13 percent award for her June 1991 injury. Nevertheless, because the majority provides no explanation of its method of offsetting the prior award of unscheduled permanent disability, I must respectfully dissent.

The majority correctly concludes that we must consider claimant's prior award pursuant to Bill R. Offill, 47 Van Natta 833 (1995), aff'd Offill v. Greenbury Tank and Iron Co., 142 Or App 351 (1996). However, despite its acknowledgment that an offset under OAR 436-35-007(3)(b) is not a mathematically precise process, the majority arrives at an offset that reduces claimant's permanent disability award by the exact amount of the prior award. More importantly, the majority does not provide any explanation of how it arrived at the amount of the offset, other than in the most conclusory terms. I submit that the parties are entitled to know how we arrived at the amount of our "offset." The majority does both the parties and the bar in general a disservice by not providing such an explanation.

With respect to the merits of the offset issue, the majority, without specifically articulating it as such, offsets the adaptability factor (2) used to determine claimant's prior award of unscheduled permanent disability. I agree with claimant's argument that there should be no offset for adaptability and that, if there is an offset based on the original award, the base functional capacity (BFC) for her current injury should be based on the BFC for the 1991 injury. I reach this conclusion for the following reasons.

When we offset a prior award of permanent disability, we should recognize that permanent disability awards are based on both permanent impairment and social/vocational factors. Thus, we need to treat both components of the unscheduled permanent disability calculation similarly. Therefore, just as we measure impairment in an injured worker based on a comparison with the physical capabilities of the healthy claimant, so, too, should we compare residual functional capacity to the BFC of the healthy claimant. To do otherwise in this case is to penalize claimant by offsetting a BFC (heavy) that she no longer enjoyed at the time of her most recent injury.

December 19, 1996 Cite as 48 Van Natta 2517 (1996)

In the Matter of the Compensation of
NANCY L. PENDERGAST-LONG, Claimant
WCB Case No. 95-12710
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our November 22, 1996 Order on Review that reversed an Administrative Law Judge's (ALJ's) order which had upheld SAIF's denial of claimant's surgery claim for a low back condition. Specifically, SAIF argues that its denial was not precluded by the parties' prior Disputed Claim Settlement (DCS) because the compensability of claimant's L5-S1 condition was raisable at the time of the DCS.

SAIF contends that Dr. Louis' 1988 suspicion that claimant had mild right S1 radiculopathy and Dr. Hockey's 1990 impression that claimant had a herniated nucleus pulposus at either L4-5 or L5-S1 support a finding that compensability of an L5-S1 condition was raisable at the time of the 1992 DCS. We disagree.

In July 1990, Dr. Hockey suspected that claimant had "right L4-5 or L5-S1 herniated nucleus pulposus." (Ex. 10-2, emphasis added). In June 1992, Dr. Donahoo reported that Dr. Louie opined in 1988[1] that claimant had possible mild right S1 radiculopathy. (Ex. 14A-4).

We acknowledge that claimant's physicians experienced some difficulty identifying the exact location of claimant's low back condition. We further acknowledge that the L5-S1 area was suspected years before the 1992 DCS. However, as we explained in our prior order, claimant's diagnosis was degenerative disc disease at L4-5 by 1992. In other words, the medical experts had effectively ruled out the L5-S1 condition (appropriately or not) as the source of claimant's back problems by the time of the DCS. (See e.g., Exs. 11, 13). Under these circumstances, we continue to find that claimant's current claim for L5-S1 surgery was not raisable at the time of the DCS,[2] because it was not diagnosed at that

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[1] SAIF cites Exhibit 9-4 as Dr. Louie's opinion. We find no Exhibit 9 in the record and no opinion authored by Dr. Louie. We do find Dr. Louie's opinion referenced in Dr. Donahoo's June 1992 report as discussed above. (See Ex. 14A).

[2] SAIF also appears to argue that claimant's condition included L5-S1 from the onset because she has had radicular symptoms all along. However, Dr. Miller treating surgeon, explained why he did "not place much importance on the fact that [claimant] had a prior diagnosis of radiculitis and [did not] really think it contributes in any way to the clinical picture." (Ex. 35-3). We decline to substitute a lay inference for a medical opinion. Instead, as explained above, we continue to find that claimant had a 1995 condition at L5-S1 (and a related need for treatment) which had not been diagnosed at the time of the 1992 DCS. Because the DCS could not resolve a dispute over the compensability of a condition as yet undiagnosed, such an issue was neither raised nor raisable at the time of the DCS.

time. Therefore, the DCS has no preclusive effect on claimant's current claim for treatment for her L5-S1 disc.[3]

Accordingly, our November 22, 1996 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 22, 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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[3] We note SAIF's argument that we erred in finding its preclusion argument contrary to the DCS terms describing retained rights under ORS 656.245 and its contention that our finding on the merits is contrary to the "law of the case" (presumably, that established by the DCS). We do find SAIF's contention that the DCS extinguished claimant's entitlement to any further compensation for the 1986 injury contrary to the express terms of the DCS. Moreover, as we found in our prior order (and SAIF concedes), claimant's current condition is not the same as her condition at the time of the DCS. Under these circumstances, the L5-S1 claim is not foreclosed by the terms of the DCS, nor is it precluded by res judicata.

In the Matter of the Compensation of
KATHLEEN S. SCHULTZ, Claimant
WCB Case No. 95-10869
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

Claimant requests review of those portion of Administrative Law Judge (ALJ) T. Lavere Johnson's order that: (1) declined to take administrative notice of an order from the Director of Consumer and Business Services (Director); and (2) reinstated a Determination Order which granted claimant 7 percent (22.4 degrees) unscheduled permanent disability, whereas an Order on Reconsideration had reduced claimant's award to zero. The self-insured employer cross-requests review, contending that the Order on Reconsideration should be affirmed. On review, the issues are evidence and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the medical evidence supported claimant's contention that she was entitled to an award of 13 percent. However, relying on Duncan v. Liberty Northwest Ins. Corp., 133 Or App 605 (1995), the ALJ concluded that claimant was precluded from asserting entitlement to an award greater than the 7 percent awarded by the Determination Order, because claimant had not requested reconsideration of the Determination Order. Based on the following reasoning, we conclude that claimant has not established that she is entitled to any unscheduled permanent disability as a result of her compensable injury.

Dr. Neumann, medical arbiter, reported that claimant exhibited lost range of motion in the lumbar spine. (Ex. 43-4). However, Dr. Neumann reported that he questioned the validity of those findings based on claimant's lack of effort. (Ex. 43-4). In a spinal range of motion form attached to his report, Dr. Neumann indicated that claimant's lumbar range of motion findings were within plus or minus 10 percent or 5 degrees. (Ex. 43-7).

Although Dr. Neumann's notations on the spinal range of motion form are within the validity criterion set forth in the Director's Bulletin 242, we have previously held that the determination

regarding the validity of the testing must be made by the medical examiner performing the tests. Michael D. Walker, 46 Van Natta 1914 (1994); Harvey Clark, 47 Van Natta 136 (1995). Thus, regardless of whether the ranges of motion satisfy the Director's validity criteria, Dr. Neumann expressly questioned the validity of the findings and, therefore, those findings are not sufficient to established permanent impairment. See Beverly L. Cardin, 46 Van Natta 770 (1994) (medical arbiter's report that range of motion findings were unreliable provided no evidence of impairment). Accordingly, we conclude that Dr. Neumann's report is not sufficient to establish that claimant is entitled to an award of unscheduled permanent disability.

The only other medical evidence concerning extent of permanent disability comes from Dr. Marble, who performed an insurer-arranged examination. Dr. Marble reported that claimant had a mild limitation of mobility in the lumbar spine. (Ex. 31-5). However, Dr. Marble opined that he could not causally relate those limitations to claimant's compensable injury. (Ex. 31-5). Dr. Kemper, claimant's treating physician, concurred with Dr. Marble's report. (Ex. 32). Because Dr. Marble's opinion, as concurred in by Dr. Kemper, does not relate claimant's limitations to the compensable injury, it too is not sufficient to establish that claimant is entitled to any permanent disability as a result of the compensable injury.

Under these circumstances, claimant has not established that she is entitled to an award of unscheduled permanent disability. Accordingly, we reverse the ALJ's order and affirm the Order on Reconsideration.

Because we have concluded that claimant is not entitled to an award of unscheduled permanent disability, the evidentiary issue raised by claimant is moot.

ORDER

The ALJ's order dated June 27, 1996 is reversed. The ALJ's award of 7 percent (22.4 degrees) unscheduled permanent disability is reversed. The Order on Reconsideration, dated September 19, 1995, is affirmed. The ALJ's award of an "out-of-compensation" attorney fee is reversed.

December 19, 1996 Cite as 48 Van Natta 2519 (1996)

In the Matter of the Compensation of
LOUIS C. THOMAS, Claimant
WCB Case No. 96-01530
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's partial denial of claimant's occupational disease claim for bilateral hearing loss. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In 1976, claimant began working for the employer and, in 1984, retired. Prior to that time, claimant worked at various jobs, including the logging industry. A 1976 pre-employment audiogram showed bilateral hearing loss. A 1982 audiogram showed a worsening of claimant's hearing loss. A 1995 audiogram showed that claimant continues to suffer from severe bilateral hearing loss.

In February 1996, after claimant filed a claim for his hearing loss, the employer notified claimant that it was accepting claimant's "hearing loss that was worsened by your employment at [the employer]." Specifically, the employer accepted that portion of hearing loss based on the difference in audiogram findings between the 1976 and 1982 tests. The employer denied any preexisting hearing loss.

The ALJ upheld the denial, finding it consistent with OAR 436-035-0250(2), which states that "compensation may be given only for loss of normal hearing which results from an on the job injury or exposure[.]" Relying on the last injurious exposure rule, claimant asserts that he proved compensability for his entire hearing condition. We agree.

The administrative rule relied upon by the ALJ relates only to determining permanent disability. OAR 436-035-0002. Whether hearing loss is caused by work can be an issue in determining impairment. Nomeland v. City of Portland, 106 Or App 77 (1991) (addressing how to treat the claimant's documented preemployment hearing loss in calculating extent of disability). Here, however, the issue is the initial compensability of claimant's hearing loss. Thus, we find the rule has no application to this proceeding.

Dr. Myers, ear, nose and throat specialist, examined claimant on behalf of the employer. Dr. Myers found that claimant "did have a pre-existing hearing loss when he was hired" by the employer and, after working for the employer, "experience[d] progression of his hearing loss." (Ex. 11-3). Assuming that claimant was exposed to elevated noise when working for the employer, Dr. Myers found it "probable that his employer was a major contributing cause of his increased hearing loss." (Id.) Dr. Myers subsequently reported that claimant's need for hearing aids "was established prior to his hiring by [the employer] due to the degree of hearing loss which he acquired from noise exposure prior to his date of hiring in 1976." (Ex. 12).

Dr. Highkin, claimant's treating physician, concurred with Dr. Myers' report. (Ex. 13A).

Because Dr. Myers attributes claimant's hearing loss to work conditions (both before and after 1976) with more than one employer, we agree with claimant that the last injurious exposure rule is applicable. E.g., Silveira v. Larch Enterprises, 133 Or App 297, 300-01 (1995). Furthermore, because the medical evidence proves that claimant's hearing loss was in major part caused by employment conditions, claimant proved compensability of his hearing loss condition. Runft v. SAIF, 303 Or 493, 498 (1987); Beneficiaries of the Estate of Strametz v. Spectrum Motorwerks, Inc., 135 Or App 67, 69, reconsidered 138 Or App 9 (1995), rev allowed 323 Or 153 (1996).

We further conclude that the employer is liable for claimant's hearing loss claim under the last injurious exposure rule. Because the employer accepted his worsened hearing loss, it has essentially conceded that its exposure actually contributed to the underlying condition. In any event, Dr. Myers' report (as concurred in by Dr. Highkin) supports such a conclusion. Consequently, even if a prior employer was assigned initial responsibility, that responsibility would shift to this employer. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Kristin Montgomery, 47 Van Natta 961 (1995). Thus, the employer is responsible for claimant's entire hearing loss claim.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(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 June 11, 1996 is reversed. The self-insured employer's partial denial of claimant's preexisting hearing loss condition 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 an assessed fee of $3,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
RONALD L. TIPTON, Claimant
WCB Case No. 95-13344
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Livesley's order which: (1) increased claimant's award of scheduled permanent disability for loss of use or function of claimant's left arm from zero, as determined by an Order on Reconsideration, to 23 percent (34.5 degrees)[1]; and (2) declined the insurer's request for an offset of allegedly overpaid temporary disability. On review, the issues are scheduled permanent disability and offset. We modify in part, reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, including his "findings of ultimate fact."

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

The ALJ determined that claimant was entitled to an award of 23 percent scheduled permanent disability for loss of use or function of his left arm due to his compensable January 27, 1994 injury, accepted as "left forearm and hand muscle strain, contusion." In reaching this conclusion, the ALJ relied on the impairment findings of the medical arbiter, Dr. Neumann, in calculating claimant's award. Specifically, the ALJ based his award on a value of 10 for loss of range of left wrist motion[2], which the ALJ combined with a value of 9 for loss of strength in muscles enervated by the median nerve, which he in turn combined with a value of 6 for loss of strength in muscles enervated by the ulnar nerve. Combining this value (24) with a value of 5 for a "chronic condition" limiting repetitive use of claimant's left forearm, the ALJ determined that claimant's scheduled permanent disability equaled 28 percent of the left forearm. The ALJ then converted the 28 percent forearm award to 23 percent of the left arm.

On review, the insurer contends that the ALJ incorrectly relied on the findings of the medical arbiter in determining that claimant had permanent impairment due to the compensable injury. The insurer asserts that a preponderance of medical evidence established that claimant has no permanent impairment as a result of his compensable injury. In particular, the insurer cites the medical evidence from claimant's attending physician, Dr. Coe, who concluded that claimant had no permanent impairment. (Ex. 13). The insurer also cites medical evidence from Dr. Winans, a prior medical arbiter who determined that claimant's wrist range of motion was normal (Ex. 19-4), and Dr. Marble, an examining physician with whom Dr. Coe concurred and who also reported that claimant had normal range of wrist motion. (Ex. 22-6). The insurer also notes a medical report from Dr. Grant, a consulting physician, who reported that claimant's condition had a significant functional component. (Ex. 12-2).

We agree with the ALJ that claimant's impairment should be evaluated based on the medical arbiter's report, and further agree that claimant has permanent impairment due to the compensable injury. We also conclude that the ALJ's award of permanent disability should be modified. We reach these conclusions for the following reasons.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order.[3] ORS 656.283(7). OAR 436-35-007(9) specifically provides that, where a medical arbiter is used,

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[1] The actual number of degrees in a 23 percent scheduled award for loss of use or function of an arm is 44.16.

[2] The insurer agreed that, if claimant was entitled to permanent disability based on loss of range of motion, impairment would equal 9.33 percent. The ALJ rounded that value to 10.

[3] Claimant was medically stationary on July 5, 1994, and the first valid claim closure occurred on August 22, 1995. (See discussion, infra, under "offset"). The standards in effect on the date of the August 22, 1995 Notice of Closure 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.

impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs.[4] See Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994).

In this case, we find that Dr. Neumann, the medical arbiter, provided the most persuasive medical opinion addressing claimant's permanent impairment. Inasmuch as permanent disability is rated at the time of the reconsideration order, Dr. Neumann's evaluation is more probative than that of Dr. Coe, claimant's attending physician, who evaluated claimant's condition only once on April 18, 1994, after which he opined that claimant had no permanent impairment. (Ex. 13).[5] Although Dr. Coe concurred on August 8, 1995 with the June 6, 1995 medical report of an examining physician, Dr. Marble, who found that claimant had normal range of wrist motion, we do not find that Dr. Coe's ratification of Dr. Marble's impairment findings constitutes a preponderance of evidence establishing that claimant has no permanent impairment, given Dr. Coe's limited contact with claimant.[6]

We further conclude that the medical reports of Drs. Grant and Winans also do not constitute a preponderance of medical evidence. Although Dr. Coe acknowledged that Dr. Grant's electrodiagnostic findings did not reveal any abnormalities, he did not specifically concur with the other aspects of Dr. Grant's report, including the results of his physical examination. (Ex. 13). Thus, Dr.Grant's impairment findings cannot be considered in evaluating claimant's impairment. Koitzsch v. Liberty Northwest Ins. Corp., supra. With respect to Dr. Winans, he opined that claimant needed further treatment and evaluation. (Ex. 19-7). Since Dr. Winans' March 28, 1995 report implies that claimant was not medically stationary, we give little weight to his tentative impairment findings.

Therefore, we conclude that the medical evidence does not preponderate against a different level of impairment than that determined by Dr. Neumann, the current medical arbiter. The question then becomes: what is claimant's level of impairment as determined by Dr. Neumann's report?

The insurer conceded that, if claimant has permanent impairment as a result of the compensable injury, he would be entitled to 9.33 percent impairment for loss of range of motion. The insurer contends, however, that the ALJ should have rounded the impairment to the nearest whole number (9) instead of to the next highest whole number (10). We agree and modify the ALJ's award for loss of range of motion accordingly. See OAR 436-35-007(11) (impairment values rounded to nearest whole number before combining); see also Robert E. Roy, 46 Van Natta 1909, 1911 (1994).

The ALJ awarded 9 percent impairment for loss of strength in the muscles enervated by the median nerve and 6 percent impairment for those enervated by the ulnar nerve. The insurer contends that the ALJ incorrectly awarded permanent disability based on loss of strength because, although Dr. Neumann reported loss of strength, his report is insufficient to support an award for strength loss. We agree.

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[4] We disagree with the ALJ's conclusion that, to constitute a "preponderance of evidence," the attending physician's opinion would have to be combined with the findings of another physician. The disability standards define preponderance of the evidence as meaning "the more probative and reliable medical opinion based upon the most accurate history, on the most objective findings, on sound medical principles and expressed with clear and concise reasoning." OAR 436-35- 005(10). The attending physician's opinion by itself can constitute a "preponderance of evidence." E.g. Debra A. Ashdown, 47 Van Natta 1025 (1995).

[5] We acknowledge that a medical arbiter having examined a claimant closer in time to the reconsideration order is not always decisive. See Charlene L. Vinci, 47 Van Natta 1919, 1920 (1995) (attending physician more persuasive than medical arbiter); David J. Rowe, 47 Van Natta 1295, 1297 (1995) (same). However, in this case, given the length of time since Dr. Coe had examined claimant, we find that, under the circumstances of this claim, the medical arbiter's report is more probative because the arbiter's examination was performed closer in time to the reconsideration order.

[6] The ALJ concluded that Dr. Marble's impairment findings could not be considered in rating permanent impairment because he was not a "consulting physician," but rather an examining physician. This conclusion was incorrect. The findings of an examining physician may be considered if concurred with by the attending physician. E.g. Gary B. Bowers, 47 Van Natta 849, 850 (1995).

Loss of strength is rated when the cause is a peripheral nerve injury. OAR 436-35-110(8). The value of impairment is determined based upon the specific nerve affected as described in the table in OAR 436-35-110(8) and as modified pursuant to OAR 436-35-007(14). Id. Loss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired. OAR 436-35-110(8)(a).

OAR 436-35-007(14) provides that "[a] preponderance of medical opinion shall be used" to identify the nerve or plexus responsible for loss of strength. In this case, we do not find a preponderance of medical opinion identifying the nerve or plexus responsible for the reported loss of strength. As the ALJ noted, Dr. Neumann failed to comment on whether claimant's strength loss was due to loss of muscle, nerve damage or disruption of a musculotendonous unit. Although the ALJ reasoned that, because the claim was accepted for a muscle strain and contusion of the left forearm and hand, it "suggests" that there was a disruption of the musculotendonous unit, we decline to make such inferences in the absence of supporting medical evidence. Because Dr. Neumann failed to identify the cause of claimant's loss of strength, and because we are without the expertise to make an inference as to the cause of the strength loss, we agree with the insurer that the ALJ improperly awarded permanent disability for loss of strength. Cf. Corinne M. Esperanza, 47 Van Natta 1914 (1995) (Board is without the expertise to "infer" an injury to median nerve).[7]

The insurer also contests the ALJ's award of 5 percent scheduled disability for a "chronic condition." A worker may be entitled to scheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a scheduled body part due to a chronic and permanent medical condition. OAR 436-35-010(6). There must be medical evidence from which it can be concluded that claimant has at least a partial loss of ability to repetitively use the body part. See Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995); Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

Dr. Neumann opined that claimant had a limited or partial loss of ability to repetitively use his left forearm, wrist and hand due to a chronic and permanent medical condition related to the injury. (Ex. 30A-5). Dr. Neumann based this opinion on his examination findings of loss of range of motion and weakness in the left wrist.

While we have determined that claimant has reduced range of motion due to the compensable injury, we have also determined that claimant's loss of strength in the left wrist does not qualify for scheduled permanent disability under the standards. However, the fact that claimant's loss of strength does not qualify for a separate award under the "standards" does not necessarily mean that it cannot serve as a basis for a "chronic" condition award. In other words, there is no requirement that loss of strength which limits repetitive use of a scheduled body part be based on a specific, identifiable nerve. Therefore, we find that Dr. Neumann's opinion establishes claimant's entitlement to an award of 5 percent impairment for a "chronic" condition.

In conclusion, we find that the ALJ's award of scheduled permanent disability should be reduced to 14 percent (9 percent for reduced range of motion "combined" with 5 percent impairment for a "chronic" condition). The ALJ's award is modified accordingly.

Offset

The claim was initially closed by Notice of Closure on August 1, 1994, which awarded no permanent disability, but which awarded temporary disability from January 27, 1994 to July 25, 1994. Claimant requested reconsideration.

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[7] The dissent argues that our decision contradicts Tina L. Fischer, 48 Van Natta 2194 (1996). There, we held that the claimant was entitled to permanent impairment for strength loss when the medical evidence confirmed that the claimant's loss of strength was due to the compensable injury and the rating of permanent impairment was supported by a finding of muscle atrophy. In this case, however, Dr. Neumann provides no explanation for his findings of strength loss. In contrast to Fischer, where the strength loss was directly related to a specific finding (muscle atrophy) establishing loss of muscle or disruption of a musculotendonous unit, claimant's strength loss was not related to any findings which establish loss of muscle, nerve damage or disruption of a musculotendonous unit. Moreover, the accepted condition in this case includes a "contusion" that is not a muscle or nerve injury. Under these circumstances, we are unable to state that claimant's reported strength loss is necessarily due to muscle/nerve injury.

The insurer had issued a denial of an alleged carpal tunnel condition on May 10, 1994. An ALJ set aside the insurer's denial on December 1, 1994. In response to the prior ALJ's order, the Department rescinded the August 1, 1994 closure notice in its April 6, 1995 Order on Reconsideration.

By Order on Review of August 10, 1995, the Board reversed the prior ALJ's order and reinstated the insurer's May 10, 1994 denial. Ronald L. Tipton, 47 Van Natta 1493 (1995). On August 25, 1995, the insurer issued another Notice of Closure which "reinstated" the original August 1, 1994 Notice of Closure. The Notice of Closure did not award temporary or permanent disability. The closure notice stated that "any temporary disability payment you may have received for a period after the ending date of the time loss award will be treated as an advance payment of permanent partial disability, if any." (Ex. 25).

On August 29, 1995, the insurer sent a claimant a letter stating that an audit performed in connection with the recent claim closure had revealed an overpayment of temporary disability in the amount of $3,080.47. (Ex. 27). Advising claimant that he was under no legal obligation to return the overpayment, the insurer wrote that it intended to seek recovery of the overpayment from future disability benefits. (Ex. 27).

Claimant requested reconsideration of the August 22, 1995 Notice of Closure on September 8, 1995. (Ex. 28). The insurer raised no issues in response to the reconsideration request.

On December 5, 1995, an Order on Reconsideration issued awarding temporary disability from January 27, 1994 through July 5, 1994. No permanent disability was awarded. The reconsideration order noted that the August 22, 1995 Notice of Closure had "reinstated" the August 1, 1994 Notice of Closure, but stated that the first closure no longer existed and that the August 22, 1995 Notice of Closure was the first valid closure of the claim. (Ex. 30-6). On December 18, 1995, the insurer sent claimant another letter notifying him of an overpayment in the amount of $3,600.95 created by the December 5, 1995 Order on Reconsideration. (Ex. 31).

Claimant requested a hearing from the reconsideration order, raising extent of scheduled permanent disability. The insurer raised entitlement to its alleged $3,600.95 overpayment in its response to claimant's request for hearing.

The ALJ held that the insurer's request for an offset was "barred," reasoning that the issue was not raised in the reconsideration proceedings and did not arise out of the reconsideration order. See ORS 656.283(7).

On review, the insurer contends that the Board can authorize an offset and that the issue "arose out of" the December 1995 reconsideration order because that order modified claimant's award of temporary disability, resulting in an overpayment of temporary disability benefits. For the following reasons, we find that, under the circumstances presented here, the ALJ should have granted the insurer's offset request.

ORS 656.283(7) provides, in part: "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself." (Emphasis added). ORS 656.268(8) also provides that: "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." (Emphasis added).

The issue here is whether the insurer's failure to raise the overpayment issue in the reconsideration proceedings precludes it from raising it at hearing. The answer depends on whether the offset issue "arises out of the reconsideration order itself." ORS 656.283(7). We answer that question in the affirmative.

The initial Notice of Closure awarded temporary disability from January 27, 1994 to July 23, 1994. However, the August 1, 1994 Notice of Closure was rescinded by the April 6, 1995 reconsideration order. Although the August 22, 1995 Notice of Closure "reinstated" the original closure

notice, the December 5, 1995 Order on Reconsideration determined that the reinstatement was ineffective and that the August 22, 1995 closure was the first valid claim closure. Claimant does not contest that portion of the reconsideration order.

Inasmuch as the August 22, 1995 closure notice did not make an award of temporary disability, and because the August 1, 1994 Notice of Closure's award of temporary disability was rescinded, we conclude that the first award of temporary disability was not made until the December 5, 1995 reconsideration order. It was not until the December 1995 reconsideration order made its award of temporary disability that the existence and precise amount of the insurer's overpayment was revealed. Therefore, we find that, under the particular circumstances of this claim, the overpayment/offset issue "arose out of" the December 1995 reconsideration order itself. Consequently, we conclude that the insurer's failure to raise this issue in the reconsideration proceedings did not preclude it from raising the issue at hearing. We further find that the ALJ should have granted the insurer's offset request.

Claimant contends, however, that the insurer insufficiently documented its overpayment and is, therefore, not entitled to the requested offset. We disagree.

An ALJ may authorize an offset for overpaid temporary disability benefits if the carrier establishes its entitlement to a particular amount of overpayment by a preponderance of the evidence. Metro Machinery Rigging v. Tallent, 94 Or App 245, 248 (1988); Maxine Headley, 45 Van Natta 1213 (1993). In the absence of rebuttal evidence, a carrier can satisfy that burden by submitting evidence that: (1) shows how the payments of compensation were made; and (2) sets forth the method of calculating the claimed overpayment. Allen L. Frink, 42 Van Natta 2666 (1990).

In Francis I. Bowman, 45 Van Natta 500 (1993), we applied these principles and concluded that the carrier was entitled to an offset. The claimant had been notified by an audit letter that she had been overpaid temporary disability benefits for a particular time period; the letter also specified the precise amount of the claimed overpayment. At hearing, the claimant did not testify that she had never received the payments, or that the carrier's requested offset had been miscalculated. Id. at 502. Under the circumstances, we concluded that the carrier had presented sufficient evidence for an offset.

This case is similar to Bowman in that the record contains two letters to claimant specifying the amount of the claimed overpayment, as well as an audit sheet explaining the overpayment calculation. (Exs. 27, 30-7, 31). Although claimant argues that the audit sheet is "incomprehensible," he did not present any evidence or any testimony that the insurer's calculation of the overpayment was incorrect or that he never received the temporary disability payments.[8] As was the case in Bowman, we conclude that the carrier provided sufficient documentation of the claimed overpayment. Cf. Thomas A. Hutcheson, 46 Van Natta 354 (1994) (no entitlement to offset where, with the exception of the insurer's counsel's oral representations regarding the purported overpayments, the record was silent regarding both how the overpayments were made and what method was used to calculate the amount of the overpayments).

Because we have reduced claimant's permanent disability compensation as a result of the insurer's appeal, we do not award claimant an assessed fee pursuant to ORS 656.382(2).

ORDER

The ALJ's order dated April 5, 1996 is modified in part, reversed in part, and affirmed in part. That portion of the order which awarded 23 percent (34.5 degrees) scheduled permanent disability for loss of use or function of claimant's left arm is modified. In lieu of the ALJ's award, claimant is awarded 14 percent (21 degrees) scheduled permanent disability for loss of use or function of the left forearm. The ALJ's "out-of-compensation" attorney fee is modified accordingly. That portion of the order which declined to authorize the insurer's requested offset of $3,600.95 is reversed. The insurer is authorized to offset this amount against current and future permanent disability benefits. The remainder of the ALJ's order is affirmed.

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[8] The parties waived formal hearing and agreed to proceed on the documentary record as supplemented by closing argument.

Board Chair Hall concurring in part and dissenting in part.

I agree with the majority's analysis of the offset issue. On the other hand, I disagree with its holding that claimant is not entitled to permanent impairment for loss of strength. Because the majority elevates form over substance, I must respectfully dissent.

The administrative rules provide for permanent impairment for strength loss when due to nerve damage, muscle loss or disruption of a musculotendinous unit. Dr. Neumann, the medical arbiter, confirmed that claimant has strength loss due to the compensable injury. (Ex. 30A-3, 4). This necessarily means that the strength loss was due to either nerve damage, muscle loss or disruption of a musculotendinous unit. The majority's contrary contention notwithstanding, we are not substituting our medical opinion for that of the arbiter's, nor are we making improper inferences as to the cause of claimant's strength loss. The arbiter's report clearly confirms that claimant's strength loss is due to the compensable injury.

The majority's holding also contradicts our recent decision in Tina L. Fischer, 48 Van Natta 2194 (1996). In Fischer, we found that the claimant was entitled to permanent impairment for loss of muscle strength where the medical arbiter confirmed that the claimant's strength loss was due to the compensable injury and his rating of permanent impairment was supported by his examination findings. The facts of this case are essentially the same as those in Fischer. Here, the medical arbiter has rated claimant's loss of strength due to the compensable injury and his rating of permanent impairment is supported by his examination findings. (Ex. 30A-3). The majority ignores its own precedent in declining to award permanent impairment for strength loss.

Because the majority's decision is improper in light of controlling Board precedent, and because the majority too narrowly construes Dr. Neumann's findings, I must part company from its decision with respect to scheduled permanent disability.

December 19, 1996 Cite as 48 Van Natta 2526 (1996)

In the Matter of the Compensation of
GARLAND VIERRA, Claimant
WCB Case No. C603355
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Martin L. Alvey, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

On December 9, 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 December 16, 1996, we wrote the parties requesting an addendum to the CDA, clarifying the date of injury and removing a reference to reimbursed costs.[1] In our December 16, 1996 letter, we noted that the agreement provided two dates of injury, August 8, 1995 and September 19, 1995, but referenced only one accepted condition in connection with each of the dates of injury. We further noted that our records indicated a date of injury of August 7, 1995. Thus, we requested that the parties clarify the correct date of injury.

We have received the parties' addendum, which indicates that the reference to an August 8, 1995 injury date is incorrect, and that the correct date of injury is August 7, 1995.[2] The addendum

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[1] By addendum, the parties have removed the reference to "costs" from the CDA. See Debbie K. Ziebert, 44 Van Natta 51 (1992).

[2] Although the summary page still provides a date of injury of August 8, 1995, by this order, we correct the date to reflect a date of injury of August 7, 1995 in accordance with the parties' addendum.

further states that claimant sustained two distinct injurious events, one on August 7, 1995 and September 19, 1995. However, the addendum further explains that the separate incidents were consolidated for claim processing purposes under the August 7, 1995 claim.

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. OAR 438-009-0022(1), (3); Antonio Resendez, 48 Van Natta 1648 (1996). In addition, a separate amount of consideration must be provided for each separate claim. Antonio Resendez, supra.

Here, the CDA refers to two different dates of injury. Thus, it appears that the CDA could involve two separate claims. However, based on the parties' addendum, we interpret the parties' CDA as settling one accepted claim, the August 7, 1995 injury claim. Under such circumstances, the CDA is in accordance with the aforementioned rule.

Finally, the parties have attached a further addendum to the CDA (not solicited by the Board) which provides that part of the consideration for the CDA is the insurer's waiver of "any and all interest it may have in any of the proceeds" of a third party suit filed by claimant.

Generally, we disapprove CDAs in which consideration for the agreement consisted of the carrier's reduction of its lien, but the CDA contains no provision indicating that a third party settlement or judgment has been achieved. See, e.g., Kenneth Hoag, 43 Van Natta 991 (1991). We reach this conclusion because the "value" of any consideration flowing to the claimant as a result of the CDA where no third party settlement has been achieved is not "presently ascertainable." Id.

We have distinguished such cases, however, from those that also provide a lump sum payment to claimant along with a waiver of a lien. Where a CDA provides for a lump sum payment in addition to the lien waiver, we have found that there is an "amount to be paid claimant" that is "presently ascertainable." Amy L. Waters, 47 Van Natta 2131 (1995); Howard S. Johnson, 47 Van Natta 1049 (1995). Where the amount of the lump sum payment is sufficient, by itself to qualify the CDA as not unreasonable as a matter of law, we approve the disposition. Amy L. Waters, supra.

Here, in addition to the waiver of a lien against any third party settlement, the CDA provides for a lump sum payment by the insurer to claimant of $15,000, less a $3,000 attorney fee. Thus, the least amount of consideration flowing to claimant is $15,000, (less the attorney fee). Under such circumstances, assuming that the insurer's waiver of its lien was of no value, we would still approve the CDA because we would not consider the proposed $15,000 CDA to be unreasonable as a matter of law. See Amy L. Waters, supra.

The agreement, as interpreted by this order, is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $3,000, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES WILLHITE, Claimant
WCB Case No. C603004
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Popick & Merkel, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Haynes and Hall.

On November 8, 1996, we approved the parties' Claim Disposition Agreement (CDA) in the above-captioned matter. On November 18, 1996, we received claimant's Motion for Reconsideration of the approved CDA. In order to consider claimant's motion, we abated our order approving the CDA on November 20, 1996. Having received responses to our abatement order from claimant, his former/current attorney, and the insurer's attorney, we proceed with our reconsideration of the CDA.

In his motion for reconsideration, claimant asserts that the CDA he signed is not the same CDA which received our approval. With his November 18, 1996 motion for reconsideration, claimant has also submitted a letter from Mr. Lorenz, who is an attorney who has represented claimant in non-workers' compensation matters.

According to Mr. Lorenz' letter, claimant signed the CDA in Lorenz' presence. After signing the CDA, claimant requested that Lorenz forward the CDA to the Board for approval. Because Lorenz did not practice workers' compensation law, he advised claimant that he did not feel comfortable forwarding the CDA to the Board.

Pursuant to claimant's instructions, Lorenz contacted claimant's prior workers' compensation attorney, Mr. Beer, and advised Mr. Beer that claimant had signed the CDA and that he was willing to have it forwarded to the Board only upon confirmation that the attorney fees claimed by Mr. Beer would be reduced to not more than $2,000. Mr. Beer picked up the CDA.

The Board received the CDA on November 1, 1996. The CDA received by the Board provided for a full release of claimant's future rights to workers' compensation benefits, except medical services, in exchange for $18,000, with a $2,000 attorney fee payable to Mr. Beer out of the CDA proceeds. We approved the CDA on November 8, 1996.

Mr. Lorenz states that, on Friday, November 15, 1996, he received a phone call from claimant who indicated that he understood that the CDA submitted to the Board was different from the one signed in Lorenz' presence. Claimant requested that Lorenz prepare a letter to the Board and provide a copy of the CDA signed in Lorenz' office. Lorenz understood that claimant now wished to contest the CDA.

Mr. Beer asserts that his office had originally negotiated the CDA. Mr. Beer also reports that claimant expressly agreed through Mr. Lorenz to a $2,000 attorney fee. After a conversation with the insurer's counsel regarding how best to expedite the process, Mr. Beer explains that the attorney fee provision was inserted into the CDA. Thereafter, a copy of the CDA reflecting the $2,000 attorney fee was sent to claimant by Beer's office.

The insurer's counsel states that the amounts on the original summary sheet of the CDA were changed to reflect an attorney fee in the amount of $2,000. The insurer's counsel indicates that it was agreed to make the change in this fashion in order to expedite payment to claimant. The insurer's counsel further states that, in order to accommodate claimant, the check for the CDA proceeds was delivered to claimant's home by messenger.

Claimant replies as follows. When he and Mr. Beer were unable to reach an agreement regarding the amount of an attorney fee, Mr. Beer resigned and filed a notice of claim for attorney fees with the Board. After he reached an agreement with the insurer to settle his claim, his former attorney still claimed the entire attorney fee he had previously asserted. Mr. Lorenz did not wish to represent him with regard to his workers' compensation claim, but did agree to convey to Mr. Beer claimant's objection to the amount of the fee claimed by Beer and claimant's proposal for settlement of the fee

dispute. Claimant wished to waive the 30 day waiting period for approval of the CDA, and understood he could not waive that period unless he was represented by an attorney. Therefore, claimant asked Mr. Lorenz to forward the original CDA to his former counsel. Notwithstanding this recitation of events and his express intentions, claimant insists that he did not "authorize modifications to that agreement, nor authorize the insertion of new pages to the original document * * *."

After reviewing the parties' responses, we conclude that there is no material disagreement concerning the facts surrounding submission of the CDA to the Board. All parties, including claimant, agree that claimant authorized Mr. Lorenz to contact Mr. Beer and agree to settle the attorney fee dispute for no more than $2,000. Mr. Lorenz also conveyed to Mr. Beer claimant's desire to waive the 30 day waiting period. To this extent, despite claimant's insistence to the contrary, it appears that claimant authorized alteration of the CDA at least to provide for waiver of the 30 day waiting period, which claimant could not do without legal representation. Finally, it is clear that after claimant signed the CDA in Mr. Lorenz' office, the CDA was changed to reflect a $2,000 attorney fee and to waive the 30 day period. The $18,000 CDA with the $2,000 attorney fee, then received our approval, and claimant received $16,000 as proceeds from the CDA.

Although claimant disputes that he authorized his former attorney to alter the CDA to reflect the agreed upon attorney fee, claimant does not dispute the fact that he asked Mr. Lorenz to convey to Mr. Beer an offer to settle the attorney fee dispute for $2,000. Based on claimant's response, we conclude that claimant does not dispute that Mr. Beer is entitled to an attorney fee of $2,000 for services regarding the CDA.

In Billy L. Lemons, 46 Van Natta 2428 (1994), the claimant's former attorney filed a notice of lien seeking a portion of the CDA proceeds as payment for services rendered during negotiations which preceded the CDA. In response, the claimant raised no objection to his former attorney's request for an attorney fee out of the CDA, as long as the fee was the same as previously agreed upon. Based on his response, we concluded that the claimant agreed that his former counsel was entitled to an attorney fee from the CDA proceeds.

We find this case to be similar to Lemons. Here, claimant does not dispute that his former counsel is entitled to an attorney fee and has agreed to a fee not exceeding $2,000. Under the circumstances, we conclude that claimant's former attorney is entitled to a $2,000 attorney fee, payable from the CDA proceeds.

After reconsidering this matter, 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). An attorney fee of $2,000, payable to claimant's former counsel is also approved. OAR 438-015-0052(1). Accordingly, as supplemented herein, we republish our order approving the CDA.

IT IS SO ORDERED.

In the Matter of the Compensation of
GLENN L. SAMPSON, Claimant
WCB Case No. 95-04814
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) Davis' order that set aside its denial of claimant's L4-5 low back condition. On review, the issue is whether the employer is precluded from denying the low back condition under Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996) (Messmer II).[1]

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

The employer argues on review that it may contest the compensability of claimant's current low back condition under ORS 656.262(6)(c). That statute provides:

> "An insurer's or self-insured employer's acceptance of a combined condition or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer 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."

We have previously held that, by its express terms, ORS 656.262(6)(c) is premised on the carrier's acceptance, whether voluntary or as a result of a judgment or order, of a combined or consequential condition. Here, the employer never voluntarily accepted claimant's L4-5 condition, nor was it directed to do so by litigation order. Further, as the court reiterated in Messmer II, its prior holding in Messmer I was not premised on the employer's acceptance of the contested condition, but rather it held that the doctrine of claim preclusion barred the employer from denying the contested condition. Therefore, assuming that the contested L4-5 condition is a combined or consequential condition under ORS 656.005(7), the employer cannot avail itself of ORS 656.262(6)(c) as a means of denying the current L4-5 condition.[2] See Judy A. Tucker, 48 Van Natta 2391 (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 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 June 3, 1996 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.

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[1] 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 1995 amended version of ORS 656.262(10).

[2] Although a signatory to this order, Board Member Moller believes that the court's holding in Messmer I, as followed in Messmer II, is based on the erroneous legal assumption that an unappealed award of permanent disability benefits for the disabling effects of a compensable injury on a preexisting condition operates to render the preexisting disease a compensable aspect of the claim. This legal assumption was addressed and rejected in a prior decision of the Court of Appeals. See U.S. Bakery v. DuVal, 86 Or App 120 (1987) (relying on the Supreme Court's decision in Barrett v. D & H Drywall, 300 Or 325, on recon 300 Or 553 (1987)). Nevertheless, Board Member Moller finds Messmer I and II to be controlling in this case.

In the Matter of the Compensation of
WILLIAM WEIGAND, Claimant
WCB Case No. CV-96005
ORDER ON RECONSIDERATION (CRIME VICTIM ACT)
Robert J. Guarrasi, Claimant Attorney
Mary Campbell, Assistant Attorney General

Applicant has objected to Special Hearings Officer Celia M. Fitzwater's November 19, 1996 Findings of Fact, Conclusions and Proposed Order which found that applicant failed to show that he was the victim of a "compensable crime." Specifically, contending that the Crime Victims Compensation Act should be liberally construed in his favor, applicant argues that his claim is compensable.

After conducting our review of the record, we agree with the Hearing Officer's conclusion that applicant has failed to establish that he was a victim of a compensable crime. We base this conclusion on the following reasoning.

Applicant's injury occurred while he was commuting on his bike on the shoulder of an unlighted stretch of I-5 sometime between 10 P.M. and midnight. Applicant had pedal and rear reflectors on his bike, as well as front and rear halogen lights and a flashing red light. Applicant also wore a vest and carried saddlebags with reflective stripping. As applicant was crossing a slough, a semi-truck about to pass applicant in the lane nearest the shoulder suddenly crossed over the white line onto the shoulder. Applicant was pinned between the truck and a concrete abutment. The truck did not stop, but continued to travel down I-5.

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).

As the Special Hearings Officer found (in affirming the Department's Order on Reconsideration denying applicant's claim), the evidence does not establish whether the truck driver saw applicant, who was on an unlighted portion of a roadway that did not have bicycle lanes. Under the circumstances, it has not been established that the truck driver's action was intentional or knowing.

In addition, we are unable to conclude from this record that the driver's actions were "reckless." In this regard, the record fails to establish that the truck driver was aware of applicant's presence on the shoulder. Although applicant's bicycle had reflectors, he was on an unlighted portion of the road late at night and was not in a bike lane where a bicycle would be expected to be. Such circumstances do not support a conclusion that the truck driver saw applicant and recklessly drove onto the shoulder.

It is regrettable that applicant has sustained financial and physical setbacks as a result of this unfortunate incident. However, to receive benefits under the Act, specific requirements must be satisfied. Here, for the reasons noted, one of those requirements has not been met. In other words, it has not been established that applicant was the victim of a "compensable crime" as statitorily defined. See Dianna Lawton, 38 Van Natta 1543 (1986)(Applicant's claim for benefits properly denied by Department because applicant's injury, which occurred when struck by a vehicle in a crosswalk, was not proven to be the result of an intentional, knowing, or reckless act which would be punishable as a crime). Consequently, the Board is without authority to grant applicant's request for benefits.

In conclusion, after our review of the record, we agree with the Hearings Officer that the evidence is insufficient to show that applicant was a victim of a compensable crime. Accordingly, as supplemented herein, we adhere to and republish the Hearings Officer's November 19, 1996 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRIAN W. ANDREWS, Claimant
WCB Case Nos. 93-08329 & 93-05174
SECOND ORDER ON REMAND
Peter O. Hansen, Claimant Attorney
Stoel, Rives, et al, Defense Attorneys
Jim Thwing (Saif), Defense Attorney

On November 15, 1996, we abated our October 16, 1996 Order on Remand that reinstated the SAIF Corporation's denial of claimant's low back and left leg injury claim. We took this action to consider claimant's motion for reconsideration. Having received the SAIF Corporation's response, we proceed with our reconsideration.

Claimant first requests that reconsideration be undertaken en banc. Specifically, citing to the Oregon Rules of Appellate Procedure applying to Supreme Court review, claimant contends that this case involves "a previously unconstrued statute with broad reach and importance"; a "question that affects many people and is likely to arise often again [sic]"; and a "departure from either Court of Appeals or Supreme Court [or previous Board] case law." Claimant also asks for oral argument and for additional briefing.

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. E.g., Ralph L. Witt, 45 Van Natta 449 (1993).

We first note that, 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. Thus, before issuing our Order on Remand, we considered whether this case warranted en banc review and decided it was more appropriate for review by a panel.

Our conclusion is not changed by claimant's arguments. Because the Supreme Court took review and issued an opinion in this case, the Court has spoken to the legal issues in contention, and, in particular, discussed the application of "ultimate work" in deciding whether an injury occurred in the course and arose out of employment. The Court remanded the case to the Board in order to decide whether claimant was engaged in an activity that was within the boundaries of his "ultimate work" as that concept is defined and discussed in the Court's opinion. Consequently, we consider the legal issues to have been addressed by the Supreme Court, limiting our review to applying the Court's opinion to the facts presented in this case. Thus, at this stage of the litigation, we do not consider this case to be sufficiently significant to warrant en banc reconsideration.

For the same reasons, we deny claimant's request for oral argument and additional briefing. Furthermore, we note that claimant did not make such requests before we issued our Order on Remand, when it would have been more appropriate to consider oral argument and briefing. We also have had the opportunity to review the briefs when we initially reviewed the case, as well as the parties' briefs to the Court of Appeals and Supreme Court.

Next, claimant asserts that "the record of the case overwhelmingly preponderates toward a conclusion that the ALJ was correct in finding claimant's injury was in the course and scope of employer [sic]." Claimant points with approval to Chair Hall's analysis in his dissent and recites facts which, according to claimant, show that to "get his ultimate work done, he had to get help from other coworkers, and because of custom and practice in the industry and trade, and the reciprocal relationship between claimant and the other non-coworkers, he had to in-turn [sic] help other coworkers when he was asked to help them out."

We understand claimant as contending that we did not properly follow the Court's instructions and made incorrect factual findings. For the reasons stated in our Order on Remand, we continue to conclude that claimant's activity in helping a noncoworker lift and carry the espresso was not within his "ultimate work," and we see no need to provide further reasoning. If claimant chooses to appeal, he will have the opportunity to assert his disagreements with the order before the court.

Finally, claimant argues that the case should be remanded to the ALJ for admission of additional facts, asserting that "[a]dditional facts could not have been developed in advance of the Supreme Court's determination in this case and enunciation of law." In support, claimant submits an affidavit describing his activity on the day of injury as well as a delivery he made in March 1993.

Under ORS 656.295(5), the Board 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 the case; and (3) is reasonably likely to affect the outcome. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Although providing more details concerning some events, we find claimant's affidavit to be consistent with his testimony at hearing. In the affidavit, claimant states that his employer expected him to load supplies for delivery and assist in unloading supplies when necessary. Our Order on Remand referred to claimant's testimony at hearing showing "at times he assisted noncoworkers in loading supplies when he picked up materials to be delivered. ([Tr.] 33-34)." We find no information in the affidavit changing our findings that claimant and his employer both understood that claimant's job did not include assisting noncoworkers in unloading supplies at a construction site and claimant did not participate in any industry practice of assisting noncoworkers in unloading supplies. We relied particularly on these findings in deciding that claimant's activity in lifting and carrying the espresso machine was outside the boundaries of his job. Thus, we conclude that the information upon which claimant bases his motion for remand would not change the outcome reached in our Order on Remand.

Furthermore, as we have previously discussed, although the Court's opinion in Andrews clarified the law with regard to "ultimate work," there was no substantial change in the analysis previously employed pursuant to ORS 656.005(7)(a). Camilla R. Blanco, 48 Van Natta 1133, on recon 48 Van Natta 1703, 1704 (1996). Consequently, we find no reason to further clarify the record. Id. Finally, there is no explanation how such information was not obtainable at the time of hearing. In other words, although the evidence at hearing was developed prior to the Court's opinion, we find the record sufficiently developed for purposes of deciding the "course and scope of employment" question as held by the Court. Therefore, we find no compelling reason for remanding and we deny claimant's motion.

On reconsideration, as supplemented herein, we adhere to and republish our October 16, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Chair Hall dissenting.

For the reasons expressed in my initial dissenting opinion, I continue to conclude that claimant's injury claim should be found compensable.

December 23, 1996 Cite as 48 Van Natta 2533 (1996)

In the Matter of the Compensation of
SANDRA L. BOOKER, Claimant
WCB Case No. 95-07928
ORDER ON REVIEW (REMANDING)
Glen J. Lasken, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) admitted a "post-hearing" report submitted by the self-insured employer; (2) denied claimant's request to depose the author of that report; and (3) upheld the employer's denial of claimant's low back strain injury claim. On review, the issue are the ALJ's evidentiary rulings and compensability. We remand.

FINDINGS OF FACT

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

At the beginning of the April 24, 1996 hearing, the ALJ admitted all the offered exhibits, including Exhibit 11, a November 21, 1995 report by Dr. Takacs, claimant's current treating osteopath, "subject to deposition," pursuant to the employer's request.[1] (Tr. 14).

At the end of the hearing, the parties agreed that the record would remain open to allow the employer to decide whether to depose Dr. Takacs. (Tr. 36-37).

Six days later, the employer offered Exhibit 12, an April 29, 1996 two-line report signed by Dr. Takacs. Claimant objected to admission of Exhibit 12 and requested an opportunity to depose Dr. Takacs if Exhibit 12 was admitted.

CONCLUSIONS OF LAW AND OPINION

The ALJ stated that the record remained open after the hearing "to allow the employer to cross examine the author of exhibit 11, Dr. Tackas [sic]" (O&O p.1). Although no deposition was taken, the employer submitted Exhibit 12, a two-line report signed by Dr. Takacs. Thereafter, the ALJ issued an Interim Order admitting Exhibit 12, over claimant's objection, denied her rebuttal, and closed the record.

Claimant argues that the ALJ abused her discretion by admitting Exhibit 12 and once admitted, by denying claimant the opportunity to cross-examine Dr. Takacs, its author. We agree.

An ALJ "may continue a hearing . . . [u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence. . . ." OAR 438-006-0091(3). OAR 438-006-0091(3) is couched in permissive language and contemplates the exercise of authority to continue a hearing rests with the ALJ's discretion. See Ronald D. Hughes, 43 Van Natta 1911, 1912 (1991). Further, an ALJ is not bound by technical or formal rules of procedure and may conduct the hearing in any manner that will achieve "substantial justice." ORS 656.283(7).

We first note that the parties agreed that the record should remain open only for the purpose of deposing Dr. Takacs, if the employer chose to do so. (Tr. 36-37). Exhibit 12 is not Dr. Takacs' deposition and its admission was therefore outside the purpose for which the record remained open.

Second, by admitting Exhibit 12 after the hearing[2] and denying claimant's request to cross-examine its author, the ALJ deprived claimant of her right to last presentation of evidence and her right to cross-examine on documentary medical evidence. See OAR 438-006-0091(2), (3).

Under these circumstances, we conclude that the ALJ abused her discretion and remand is appropriate. See Edward D. Swor, 45 Van Natta 1690 (1993) (Where claimant was disadvantaged because a report was received close to the time of hearing and claimant was not afforded an opportunity to cross-examine its author, remand was appropriate); James D. Brusseau II, 43 Van Natta 541 (1991); see also Larry E. Fournier, 47 Van Natta 786 (1995) (Where the claimant did not seek to rebut "pre-hearing" evidence, due diligence was not established); Robert D. Sloan, 46 Van Natta 87 (1994).

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[1] The employer expressed concern that claimant's unexpected submission of Exhibit 11 might cause it material prejudice with regard to the accuracy and completeness of Dr. Takacs' history. (Tr. 2-14).

[2] Since the employer submitted Dr. Takacs' report after the hearing and considering that the record was held open for the possible introduction of Dr. Takacs' deposition, we are persuaded that claimant's "post-hearing" request for cross-examination of Dr. Takacs satisfies the "due diligence" requirement of OAR 438-006-0091 (2) and (3).

Accordingly, the ALJ's order dated July 30, 1996 is vacated. The case is remanded to ALJ Herman for further proceedings. Specifically, claimant shall have the opportunity to cross-examine Dr. Takacs in a manner that the ALJ deems achieves substantial justice (i.e., by deposition or additional medical report). Following presentation of that evidence and the parties' arguments, the ALJ shall reconsider her decision in light of the additional evidence and issue a final, appealable order.

IT IS SO ORDERED.

December 23, 1996 Cite as 48 Van Natta 2535 (1996)

In the Matter of the Compensation of
JESUS J. GONZALEZ, Claimant
WCB Case No. 96-03209
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl, Christian and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its denial of claimant's injury claim for an L4-5 herniated disc condition. On review, the issue is compensability.

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

We agree with the ALJ that the opinions of Drs. Hubbard and Nelson, claimant's former and current treating physicians, together, carry claimant's burden.[1] See Weiland v. SAIF, 64 Or App 810 (1983). In reaching this conclusion, we note that these opinions are based in part on an accurate history which recognizes claimant's 2 1/2 year history of heavy landscape work without back problems, prior to the grate-lifting injury with SAIF's insured. Under these circumstances, we find the opinions of Drs. Hubbard and Nelson persuasive. See 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 $1,000 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 August 22, 1996 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the SAIF Corporation.

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[1] Even assuming that claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B), we would reach the same result. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991) (No incantation of "magic words" or statutory language is required).

Board Member Haynes dissenting.

The only persuasive medical evidence in this case indicates that claimant's preexisting degeneration at least contributed to his L4-5 herniation.

The majority acknowledges claimant's concession that his preexisting degeneration is not compensable. It also relies on Dr. Nelson's opinion that both the preexisting degeneration and the work injury contributed to the herniated disc. Thus, because the noncompensable preexisting degeneration acted in concert with the work injury, ORS 656.005(7)(a)(B) applies and claimant must prove that the work injury contributed more to the herniation than all other causes combined.

Dr. Nelson expressly found it "impossible to say which of these factors predominated in producing the herniated disc." Dr. Hubbard provides the only other opinion which might support the claim, but his opinion is unpersuasive because he did not even consider claimant's documented preexisting degeneration.

I fail to see how claimant could be subject to a material contributing cause standard (as the majority says he is) when he so clearly suffers from a combined condition under ORS 656.005(7)(a)(B). I also fail to see how the majority can say that claimant has carried his burden, when his treating physician could not answer the critical question. Under these circumstances, I must respectfully dissent.

December 23, 1996 Cite as 48 Van Natta 2536 (1996)

In the Matter of the Compensation of
VIRGINIA McCLEAREN, Claimant
WCB Case No. 95-04438
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that reversed an Order on Reconsideration that awarded claimant permanent total disability. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings on pages 1 and 2 and his first finding on page 3.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Matter

This case raises a preliminary matter concerning an evidentiary matter. Hearing rights and procedures are addressed in ORS 656.283. Paragraph (7) of ORS 656.283 was amended by the 1995 legislature. As amended, the statute provides, in part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

The statute retroactively applies to this case. Joe R. Ray, 48 Van Natta 325, recon 48 Van Natta 458 (1996). Here, the ALJ received "post-reconsideration" medical, vocational and lay evidence. Although neither party raises an objection to the admissibility of this evidence, amended ORS 656.283(7) mandates that evidence on an issue regarding a Determination Order that was not submitted at the reconsideration proceeding "is not admissible at hearing." Thus, we proceed to consider the effect of the statutory exclusion in this case. See Gary C. Fischer, 46 Van Natta 60, recon 46 Van Natta 221 (1994).

In Ray, the claimant requested a hearing concerning an Order on Reconsideration, asserting entitlement to additional permanent partial disability (PPD) benefits. At hearing, the claimant testified regarding the extent of his permanent disability. Based on that testimony, the ALJ increased his PPD award. On Board review, we found the text and context of amended ORS 656.283(7), as well as its legislative history, supported the conclusion that evidence that is not submitted at reconsideration is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. 48 Van Natta at 329. Thus, we concluded that the claimant's testimony at hearing was inadmissible and we reduced the ALJ's PPD award.

Because amended ORS 656.283(7) pertains to "[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration," our holding in Ray applies to proceedings involving the reconsideration procedure required by ORS 656.268. That is, when

a party objects to a Notice of Closure or Determination Order, that party must first request reconsideration from the Department. ORS 656.268(4)(e), (5)(b). An evidentiary record is then developed by the Department on reconsideration. Based on the reconsideration record, the Department issues its Order on Reconsideration.

The parties may then request a hearing to challenge the reconsideration order. ORS 656.319(1), (4). As in other contested cases, the ALJ will develop an evidentiary record for purposes of making findings and conclusions. However, the record at any subsequent hearing concerning a challenge to the reconsideration order is limited as stated in amended ORS 656.283(7). See Precision Castparts Corp. v. Plummer, 140 Or App 227, 231 (1996) ("unmistakable import of text of ORS 656.283(7) is that any evidence * * * is inadmissible at a subsequent hearing concerning the extent of the injured worker's permanent disability if not submitted at reconsideration") (emphasis in original).

Although the substantive issue in this case is whether claimant established her entitlement to permanent total disability (PTD) benefits, as opposed to the PPD benefits that the claimant sought in Ray, this case underwent the same mandatory reconsideration procedure set forth in ORS 656.268. Given the posture of this case, we find that the PTD issue is "an issue regarding a * * * determination order" within the meaning of amended ORS 656.283(7). Therefore, by its express terms, the statutory exclusion in amended ORS 656.283(7) applies to the hearing in this case.

Among the "post-reconsideration" evidence admitted by the ALJ, however, are the reports and testimonies of Jane Hagle, claimant's vocational consultant, and Bruce McLean, the employer's vocational consultant. We note that ORS 656.287(1) addresses the use of vocational reports at hearing. Therefore, we consider its effect, if any, on the admissibility of the expert vocational evidence contained in the record of this hearing.

ORS 656.287(1) provides:

> "Where there is an issue regarding loss of earning capacity, reports from vocational consultants employed by governmental agencies, insurers or self-insured employers, or from private vocational consultants, regarding job opportunities, the fitness of claimant to perform certain jobs, wage levels, or other information relating to claimant's employability shall be admitted into evidence at compensation hearings, provided such information is submitted to claimant 10 days prior to hearing and that upon demand from the adverse party the person preparing such report shall be made available for testimony and cross-examination."

We must determine whether ORS 656.287(1) provides an exception to the evidentiary limitation set forth in ORS 656.283(7). That determination turns in part on our interpretation of ORS 656.287(1). To interpret ORS 656.287(1), we must discern legislative intent by first examining the text and context of ORS 656.287. ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The context includes other statutes relating to the same subject matter. Id. at 611. If those sources do not reveal legislative intent, we resort to legislative history and other extrinsic aids. Id. at 611-12.

Based on the express provisions of ORS 656.287(1), a condition precedent to application of the statute is that there must be an "issue regarding loss of earning capacity." In determining the meaning of the term "loss of earning capacity," we look to the statutory context. The term "loss of earning capacity" is found in ORS 656.214(5), which provides that the criteria for rating unscheduled PPD "shall be the permanent loss of earning capacity due to the compensable injury."

However, the issue in this case is claimant's entitlement to PTD benefits. The statute that addresses PTD benefits is ORS 656.206. Unlike ORS 656.214, the text of ORS 656.206 does not reference loss of earning capacity. Rather, entitlement to PTD benefits requires a showing that loss of use or function of any scheduled or unscheduled portion of the body incapacitates the worker from regularly performing work at a gainful and suitable occupation. Nevertheless, the question of lost earning capacity is also relevant in the PTD context. The Supreme Court has stated that "[a]n award of PTD or [unscheduled] PPD benefits aims to compensate an injured worker for permanently lost earning capacity, thereby promoting the goal of returning the worker to economic self-sufficiency. An injured worker who is incapable of regularly working at a gainful and suitable occupation is entitled to PTD

benefits." Tee v. Albertsons, Inc., 314 Or 633, 640 (1992) (emphasis supplied); but see Harris v. SAIF Corp., 292 Or 683 (1982) (determination of permanent total disability status does not turn upon whether the claimant has money-earning capacity, but rather upon whether the claimant is currently employable or able to sell his services on a regular basis in a hypothetically normal labor market). Although not free from doubt, we conclude that the statutory text and context indicates an intent by the legislature to apply ORS 656.287(1) in hearings where there is an issue of entitlement to either PTD or unscheduled PPD benefits.

This intent is further evident from the legislative history of ORS 656.287(1), which was enacted by the 1973 Legislature. In testimony before the Senate Labor and Industries Committee, Representative Keith Skelton, chief sponsor of House Bill 2645 (which became ORS 656.287), explained the intent of the bill:

> "This [House] Bill [2645] arises out of the problems that have been accumulated by the 'loss of earning capacity' doctrine which is developed in the Ryf [v. Hoffman Const. Co., 254 Or 624 (1969)] and Serratt cases and further aggravated by the 'odd-lot' doctrine...um...and by the Swanson [v. Westport Lumber Co., 4 Or App 417 (1971)] case.... Many times the claimant can prove his prima facie case on his own testimony that he cannot work or he cannot do the kind of work that he was able to do previously. The employer then has the burden of coming forward with information which will establish that there are jobs or job opportunities in the community which this person can perform. That's one way in which you can look at this.
>
> "The other way you look at it is that the claimant sometimes desires to establish that there are no jobs in the community which he can do. In both of these instances, the testimony of a vocational expert...becomes important." Hearing, 1973 Reg. Session, Senate Labor and Industries Committee, June 26, 1973, Tape 22, Side 2.

In Swanson, cited by Representative Skelton, the court applied the "odd-lot" doctrine for the first time in an Oregon workers' compensation case. Under that doctrine, PTD may be found in the case of workers who, while not totally incapacitated, are disabled to the extent that they are not regularly employable at a suitable occupation. Swanson, supra, 4 Or App at 420. Representative Skelton's statement that House Bill 2645 was introduced partly in response to the "odd-lot" doctrine and the Swanson case underscores the intent of the legislature that the bill apply both to PTD cases and to unscheduled PPD cases. Therefore, because the issue in this case is claimant's entitlement to PTD benefits, ORS 656.287(1) may be relevant to a determination of the admissibility of the vocational evidence offered by the parties.

Pursuant to ORS 656.287(1), reports from vocational consultants are admissible evidence at hearing, provided they comply with the other requirements of that statute, i.e., the substance of the reports relates to "job opportunities, the fitness of claimant to perform certain jobs, wage levels, or other information relating to claimant's employability"; the reports are submitted to claimant 10 days prior to the hearing; and "upon demand from the adverse party the person preparing such report shall be made available for testimony and cross-examination." In sum, considering only the text of ORS 656.287(1), the statute grants unqualified authority for the admission of a vocational consultant's reports at hearing, provided the consultant is made available for cross-examination upon request by the adverse party.

However, both the text and context of ORS 656.287(1) demonstrate that the statute is not a blanket authorization for the admissibility of any and all vocational evidence at a hearing. First, the statute expressly addresses only the admission of vocational reports. The extent to which in-person vocational testimony is encompassed within the statute arises only from the requirement that a party seeking admission of a vocational report must, upon demand from the adverse party, make available the author of the report for testimony and cross-examination. In addition, paragraph (2) of the statute directs the Board to "establish rules to govern the admissibility of reports from vocational experts, including guidelines to establish the competency of vocational experts." It logically follows that even vocational reports are subject to exclusion at hearing despite the facially unqualified terms of ORS 656.287(1).

Moreover, ORS 656.287(1) must be viewed in its statutory context. That is, it must be viewed in the context of amended ORS 656.283(7) which prohibits the admission at hearing of any evidence that was not previously submitted at the reconsideration proceeding. See Precision Castparts Corp., supra,

140 Or App at 231. Further, our analysis of the text and context includes consideration of rules of construction that "bear directly on the interpretation of the statutory provision in context." PGE, supra, 317 Or at 611. One such rule is expressed in ORS 174.010. (General rule for construction of statutes). That statute provides:

> "In the construction of a statute, the office of the judge is simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted; and where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all." (Emphasis supplied).

In the face of the 1995 Legislature's clear and unqualified intent to limit evidence at hearing to evidence submitted at reconsideration, we decline to broadly interpret ORS 656.287(1) as a grant of authority to admit "post-reconsideration" vocational evidence at such a hearing. Such an interpretation would undermine the evidentiary limitation the legislature sought to impose under the 1995 Act. Rather, in order to best harmonize the provisions of ORS 656.287(1) and amended ORS 656.283(7), we interpret ORS 656.287(1) as a grant of authority to admit at hearing vocational reports so long as: (1) the reports were previously submitted at the reconsideration proceeding; and (2) the other requirements of ORS 656.287(1) are fulfilled. These requirements include the condition that the vocational consultant whose report is being offered into evidence at hearing must be made available for testimony and cross-examination at hearing, upon request by the adverse party.

We further conclude that if the adverse party elects to cross-examine the vocational consultant, the consultant's testimony is admissible at hearing and is not subject to the evidentiary limitation in amended ORS 656.283(7). The dissent concludes otherwise, reasoning that the vocational consultant's testimony should be subject to the same evidentiary limitation which applies to the consultant's reports. We disagree. The text of ORS 656.287(1) unambiguously makes the admissibility of a vocational consultant's report "at compensation hearings" contingent on the adverse party's right to cross-examine the consultant. It is reasonably clear from the statutory text that the legislature contemplated the adverse party's right to cross-examination would be exercised at the same "compensation hearing" at which the vocational consultant's report is offered into evidence. In other words, if the vocational consultant is not made available for cross-examination at the "compensation hearing," the consultant's report is inadmissible at that hearing.

The "compensation hearing" in this case, and in other cases involving a review of a claim closure and rating of disability, is the hearing before the administrative law judge at the Board's Hearings Division. See ORS 656.268(6)(f) ("If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283...."); see generally ORS 656.283. While we can understand the dissent's reasoning for viewing the Department's reconsideration proceeding as the "hearing" for purposes of raising issues and developing the evidentiary record, we look to the statutes themselves to assist us in determining what the legislature intended by the use of the term "compensation hearing" in ORS 656.287(1). Based on our review of ORS 656.268 and 656.283, among many other statutes, it is clear that the legislature intended "compensation hearing" to mean the hearing at the Board's Hearings Division. Our textual and contextual analysis is further supported by the legislative history of ORS 656.287, which focused entirely on the admissibility of expert vocational evidence in hearings at the Hearings Division. See generally Hearing, 1973 Reg. Session, Senate Labor and Industries Committee, June 26, 1973, Tape 22, Side 2.

Having established that the legislature intended the right of cross-examination of the vocational consultant to be exercised at the "compensation hearing" at the Hearings Division, it follows that if the consultant is not made available for cross-examination at the hearing, the consultant's report is inadmissible at the same hearing. If, on the other hand, the consultant is made available for cross-examination, and the adverse party exercises that right, it follows that the consultant's testimony at hearing is admissible. To conclude otherwise would render meaningless the adverse party's right to cross-examination. We decline to do so. Thus, our interpretation of ORS 656.287(1) best harmonizes ORS 656.287(1) and amended ORS 656.283(7) while effectuating the legislative intent behind both statutes.

Turning to the facts of this case, Ms. Hagle was the only vocational consultant whose report regarding claimant's employability, (Ex. 52), was submitted at the Department's reconsideration proceeding. In addition, she was cross-examined by the employer at hearing. Therefore, Exhibit 52 and

Ms. Hagle's testimony at hearing are admissible evidence pursuant to ORS 656.287(1) and were properly admitted by the ALJ. Exhibits 56, 57 and 58 and the testimonies of claimant, Billie Christianson and Bruce McLean are excluded as inadmissible "post-reconsideration" evidence pursuant to amended ORS 656.283(7).[1] We now proceed to the merits of the PTD issue.

Permanent Total Disability

We briefly summarize the relevant facts. Claimant, age 67, worked about 18 years as a medical transcriptionist for the employer. In 1991 she compensably injured her low back and knees and came under the care of Dr. Corson. In addition to the compensable injury, claimant has a severe congenital kyphosis with angulation at the thoracolumbar junction of the back, which causes a severe pulmonary defect. The congenital back condition and pulmonary defect causes sleeping difficulties, resulting in daytime fatigue and sleepiness.

In late 1992 and early 1993, claimant began having persistent pain in her left hip and buttock, which she had not experienced prior to her compensable injury despite her severe congenital spinal kyphosis condition. In January 1993, due to increasing pain in the left low back and hip area, claimant reduced her work schedule. However, in March 1993, she resigned from her job because of pain. (Exs. 32, 33-2, 43-6, 40). Her compensable condition became medically stationary in June 1994. Dr. Corson's diagnosis was chronic muscle pain syndrome involving the left lower lumbar musculature and the left upper gluteal musculature superimposed on marked preexisting kyphosis. Dr. Corson opined that claimant's chronic pain and inability to work are related to the compensable injury. (Ex. 44-3). When asked to apportion causation of the chronic pain, Dr. Corson opined that the larger portion (60-80 percent) of the pain was due to the compensable injury. (Exs. 42-2, 45).

Claimant's claim was closed by a September 23, 1994 Determination Order which awarded 18 percent unscheduled permanent disability. Claimant requested reconsideration. An April 6, 1995 Order on Reconsideration awarded her PTD benefits. The self-insured employer requested a hearing. Relying, in part, on "post-reconsideration" evidence, the ALJ found that claimant was not permanently and totally disabled. Accordingly, the ALJ modified the Order on Reconsideration to reinstate the Determination Order award of 18 percent (57.6 degrees) unscheduled permanent disability.

In order to establish entitlement to PTD benefits, claimant must prove either that: (1) she is completely physically disabled and therefore precluded from regularly performing any work at a gainful and suitable occupation; or (2) her physical impairment, combined with a number of social and vocational factors, effectively precludes her from regularly performing any work at a gainful and suitable occupation under the "odd lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

Here, Dr. Corson has indicated that claimant could work as a transcribing machine operator out of her home if work was brought to her and picked up. Based on Dr. Corson's opinion, we conclude that claimant is not medically permanently and totally disabled. Thus, her claim falls under the "odd-lot" doctrine. In addition, because there is no dispute about whether the jobs identified for claimant are "gainful," the question is simply whether claimant is "employable," i.e., whether she is currently able to sell her services on a regular basis in a hypothetically normal labor market. See Harris v. SAIF, 292 Or 683 (1982).

The nonmedical (social and vocational) factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity, emotional condition and conditions of the labor market. Welch, supra, 70 Or App at 701. Since application of the "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although she need not engage in job seeking activities that, in all probability, would be futile. SAIF v. Simpson, 88 Or App 638, 641 (1987). Even if a work search would be futile, claimant must nevertheless prove that, but for the compensable injury, she is willing to work. SAIF v. Stephen, 308 or 41 (1989).

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[1] In this regard, we note that, inasmuch as amended ORS 656.283(7) was in effect on the date of the hearing in this case (November 10, 1995), the "post-reconsideration" evidence (other than Ms. Hagle's testimony) was inadmissible on the date of the hearing. Therefore, the ALJ's admission of such evidence was erroneous. See Precision Castparts Corp., supra; Dean J. Evans, 48 Van Natta 1092, recon 48 Van Natta 1196 (1996).

As previously stated, Dr. Corson has indicated that claimant could work as a transcribing machine operator out of her home if work was brought to her and picked up. More specifically, Dr. Corson has opined that claimant can perform the transcription work at home for up to four hours per day, in blocks of time up to 90 minutes, with appropriate rest periods and could do this five days per week. (Ex. 50). Dr. Corson further opined, however, that it would be unreasonable to expect claimant to perform this work if she had to take Percocet for her pain while working, as it would unreasonably interfere with her mental functioning. (Id.) Dr. Corson indicated that he would believe claimant if she told him she was unable to perform transcriptionist work at the described level. (Id.)

In a March 9, 1995 report, claimant's vocational consultant, Jane Hagle, concluded that claimant was unable to regularly perform work at any "sustained" gainful employment. (Ex. 52). Ms. Hagle opined:

> "[Claimant] reports that, due to chronic pain and her inability to function mentally while taking Percocet to alleviate the pain, she is unable to sustain work even at a part-time (4 hours/day) level * * * Since it is Dr. Corson's opinion that [claimant] is credible in this regard, it is my conclusion that [claimant] might occasionally be able to work a maximum of 4 hours per day in her home with 'work being brought to her and picked up.' This occasional schedule would not sustain employment as either a reader or typist, due to both having deadline requirement on an ongoing, continuous basis. Even if [claimant] could sustain continuous part-time work while taking Percocet, it is likely that not only her mental functioning but also her speed and accuracy would be inhibited." (Id.)

Ms. Hagle concluded that claimant's inability to regularly perform work at any "sustained" gainful employment was due to both exceptionally limiting physical factors and a labor market which does not offer part-time home-work positions with the degree of flexibility required to accommodate claimant's residual functioning capacity resulting from her chronic pain and the pain medication she takes for it. (Id.) Ms. Hagle opined that claimant was permanently and totally disabled. (Id.) In her testimony at hearing, Ms. Hagle did not waver from that opinion.

Based on Dr. Corson's and Ms. Hagle's opinions, we find that claimant's physical impairment due to the compensable injury, combined with social and vocational factors, precludes her from regularly performing any work at a suitable occupation. In addition, we find that it would be futile for claimant to seek work and that, but for her compensable injury, she would be willing to work. In this regard, the record shows that claimant attempted to remain employed, even on a part-time basis, but left her employment because of the increased low back and hip pain due to the compensable injury. (Ex. 35-38). In addition, the record reflects that claimant had to quit working at home as a medical transcriptionist because of increased pain since the compensable injury. (Ex. 53-15).

Based on the opinions of Dr. Corson and Ms. Hagle, we conclude that claimant is permanently and totally disabled based on a combination of medical and nonmedical factors. Accordingly, we affirm the April 6, 1995 Order on Reconsideration awarding PTD, effective June 2, 1994.

Because the self-insured employer requested a hearing contesting the Order on Reconsideration award of permanent total disability, and we have concluded that the compensation should not be disallowed or reduced, claimant is entitled to a reasonable attorney fee for services at hearing. 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 at hearing is $3,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's services might go uncompensated. In addition, claimant's attorney is entitled to an approved fee of 25 percent of the additional compensation created by this order, not to exceed $6,000, payable directly to claimant's attorney.

ORDER

The ALJ's order dated December 11, 1995 is reversed. The Order on Reconsideration is reinstated and affirmed. Claimant's attorney is awarded an attorney fee of $3,000 for services at the hearing level. Claimant's attorney is also awarded an approved fee of 25 percent of the additional compensation created by this order, not to exceed $6,000, payable directly to claimant's attorney.

Board Chair Hall specially concurring.

Although I agree that claimant is entitled to PTD benefits, I write separately because of my disagreement with the majority's decision to admit "post-reconsideration" testimony by vocational consultant, Ms. Hagle. Because her testimony was not submitted at reconsideration, I conclude it must be excluded pursuant to amended ORS 656.283(7).

As we held in Joe R. Ray, 48 Van Natta 325, recon 48 Van Natta 458 (1996), by amending ORS 656.283(7), it was the legislature's intent to limit "claim closure/rating" issues and evidence at hearing to only those issues raised and evidence submitted at the Department's reconsideration proceeding.[1] In effect, the legislature has converted the hearing (at the Hearings Division) regarding claim closure/rating to an appellate review. Though the ALJ's have de novo review authority, they may only consider those issues and evidence that were considered by the Department on reconsideration. Thus, the Department's reconsideration proceeding, for all practical purposes, is the "hearing" regarding claim closure/rating issues, where the parties must first raise issues and submit all relevant evidence.

Under this statutory scheme, any evidence regarding claim closure/rating must have been submitted at reconsideration before it is admissible at hearing. In effect, the evidentiary record is "frozen" at the time of reconsideration. This statutory scheme is the basis for the majority's holding that, notwithstanding the text of ORS 656.287(1), any vocational reports that were not previously submitted at reconsideration are inadmissible at hearing. Yet, the majority admits Ms. Hagle's "post-reconsideration" testimony.

The majority's holding is not consistent; either all of the vocational evidence is admissible without limitation, pursuant to ORS 656.287(1), or none of the "post-reconsideration" vocational evidence is admissible, pursuant to amended ORS 656.283(7). In other words, the proviso in ORS 656.287(1) (vocational consultant preparing the report must be made available for cross-examination and testimony) is subject to the same restriction under amended ORS 656.283(7) as is the written report itself. After all, both the vocational reports and the proviso are addressed in the same paragraph in ORS 656.287(1). The majority provides no persuasive explanation for treating the admissibility of vocational testimony any different than it treats the admissibility of vocational reports. If both are exceptions to amended ORS 656.283(7), they should be admitted; otherwise, both should be excluded. The majority's approach is inconsistent and its rationale for doing so unpersuasive.

Given the clear and unambiguous intent of the legislature in enacting amended ORS 656.283(7), Plummer, supra, I conclude that no "post-reconsideration" evidence is admissible at hearing. I would therefore exclude the testimony of Ms. Hagle. Because I would nevertheless conclude that claimant has carried her burden of proving she is PTD, I specially concur.

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[1] See Precision Castparts Corp. v. Plummer, 140 Or App 227, 231 (1996) ("The unmistakable import of the text of ORS 656.283(7) is that any evidence, including a claimant's testimony concerning the notice of closure or reconsideration order, is inadmissible at a subsequent hearing concerning the extent of the injured worker's permanent disability if not submitted at reconsideration and not made a part of the reconsideration record.")

December 23,1996 Cite as 48 Van Natta 2542 (1996)

In the Matter of the Compensation of
JAMES S. MODESITT, Claimant
WCB Case No. 96-02769
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) T. Lavere Johnson's order that upheld the SAIF Corporation's denial of his cervical injury claim. On review, the issue is compensability.

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

Claimant, a bus driver, alleged that he injured his cervical spine and right shoulder when he pulled on a partially opened bus door. Claimant ultimately underwent a C5-6 anterior cervical discectomy and fusion performed by Dr. Kim. SAIF denied claimant's cervical condition and claimant requested a hearing.

The ALJ upheld SAIF's denial of claimant's cervical injury claim, finding that claimant had failed to establish legal causation, i.e., that an incident of injury had occurred on January 13, 1996 as claimant had alleged. In reaching this conclusion, the ALJ determined that the testimony of the employer's maintenance supervisor, Mr. Belden, successfully "impeached" claimant's testimony that he injured himself pulling on a bus door. According to Belden, the incident of injury could not have occurred as claimant testified. Finding that claimant had failed to establish legal causation, the ALJ further concluded that claimant had not succeeded in proving medical causation because the medical opinions of the physicians who supported compensability relied on an erroneous history.

On review, claimant contends that a preponderance of evidence establishes that he was a credible witness and that he was injured as he alleged. Claimant further asserts that the medical evidence, particularly from Dr. Kim, proves that the on-the-job injury on January 13, 1996 is the major contributing cause of his cervical condition under ORS 656.005(7)(a)(B).

We need not address claimant's contentions regarding the credibility issue, for even if the incident of injury occurred as claimant alleged on January 13, 1996, we conclude that he failed to establish medical causation.

Claimant concedes, and the medical evidence establishes, that the claim is governed by ORS 656.005(7)(a)(B), because there is medical evidence that claimant's preexisting degenerative cervical condition combined with the alleged January 13, 1996 incident to cause claimant's need for treatment. (Ex. 14-2). Therefore, to establish medical causation, claimant must prove that the January 13, 1996 incident (assuming without deciding that it occurred as alleged) was the major contributing cause of his disability and need for treatment of his cervical condition. Ramona Andrews, 48 Van Natta 1652 (1996).

Considering the presence of claimant's preexisting degenerative cervical condition, the determination of the major cause of claimant's cervical 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. Michels, claimant's initial attending physician, opined that claimant's "symptoms" resulted from the January 1996 incident. (Ex. 3-4). Dr. Yarusso, who later became claimant's attending physician, opined in a "check-the-box" report that claimant's injury was due to "industrial exposure or injury." (Ex. 5). However, neither physician had the opportunity to review claimant's MRI scan and weigh the relative contribution of claimant's preexisting cervical degenerative cervical condition. Because these medical opinions are conclusory and based on incomplete information, they are not persuasive. Somers v. SAIF, 77 Or App 249 (1986); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

As previously noted, Dr. Kim performed claimant's surgery. He acknowledged that claimant had preexisting cervical spondylolysis with degenerative disc disease at multiple cervical levels. (Ex. 19-2). Dr. Kim opined that, based on a history of no prior radicular symptoms, the January 1996 incident was "a major contributing factor was the major cause of [claimants] developing right C6 radiculopathy," despite claimant's preexisting disease. Id.

Although Dr. Kim performed claimant's surgery, see Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988) (deference to treating physician who was able to observe the affected body part during surgery), we do not find his opinion establishes medical causation. Dr. Kim's opinion relies on a temporal relationship between claimant's symptoms and the alleged injury and does not sufficiently weigh the relative contributions from the preexisting degenerative condition and the alleged injury to claimant's cervical condition. 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). Finally, Dr. Kim's opinion is ambiguous in that his report is unclear whether the alleged injury is "a" major contributing factor or "the" major cause of claimant's C6 radiculopathy. See Arnold D. Schaffer, 47 Van Natta 1667 (1995).

Accordingly, we conclude that claimant failed to sustain his burden of proof under ORS 656.005(7)(a)(B), even assuming that claimant proved legal causation. It follows that the ALJ properly upheld SAIF's denial.

ORDER

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

In the Matter of the Compensation of
RICHARD M. THOMAS, Claimant
WCB Case No. 96-00614
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Hall, Christian and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its denial of claimant's injury claim for right knee cellulitis. On review, the issue is compensability.

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

In the fifth paragraph on page 2, we change the date from "January 22, 1996" to "January 17, 1996." In the last paragraph on page 2, we change the quotation to read: "Yes, the major cause of Mr. Thomas' right leg cellulitis was the cleaning work at [the employer] where he works on his knees and experiences ground contact with his knee."

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 July 17, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

Board Member Haynes dissenting.

The majority adopts and affirms the ALJ's order, which found claimant's injury claim for right knee cellulitis compensable. The ALJ found that, while at work, claimant's right knee contacted some foreign material and he sustained a small cut or puncture. Because there is no evidence whatsoever to support that finding, I dissent.

Claimant is employed as a clean-up person for the employer. After work on December 1, 1995, claimant noticed pain and swelling in his right knee. The knee inflammation and pain continued the next day. Claimant's wife testified that she had examined claimant's knee on December 2, 1995 and he had a small puncture, like broken skin. (Tr. 35, 36). Later that day, claimant sought medical treatment and was diagnosed with right leg cellulitis.

The insurer denied the claim on the basis that there was no evidence to establish whether claimant's right knee cellulitis condition was related to work activity on or about December 1, 1995. After reviewing the record, I agree with the insurer that claimant did not establish medical causation because the source of the infection is unknown and there is no way to relate the infection to his employment, aside from speculation.

Claimant acknowledges that no specific work incident can be attributed as the cause of his infection. Moreover, there is no evidence in the record that claimant sustained a small cut or puncture in his right knee while at work. Claimant could not recall any accidents or injuries to his right knee at work on December 1, 1995, or during the two weeks beforehand. (Tr. 21, 22). The swelling and pain came as a big surprise to him. (Tr. 22). Claimant testified that "it had to have happened at work 'cause there's no other place that I could have done it." (Tr. 29).

Although claimant's wife testified that claimant had a small puncture on his right knee on December 2, 1995, neither Dr. Rehwaldt nor Dr. Duncan reported any skin breaks when claimant was examined. Dr. Rehwaldt agreed that the record from claimant's admission to the hospital did "not indicate that there were any splinters or other foreign material in the knee, or any acute injury or breaks in the skin." (Ex. 13). Similarly, Dr. Duncan reported that claimant did not recall any injury and there were no clinical signs of scratches, cuts or any foreign materials in the leg. (Ex. 12).

In any event, even if claimant had a small puncture on his right knee before he sought medical treatment, there is no evidence claimant's right knee was injured at work. ORS 656.266 requires claimant to establish affirmatively that his right knee cellulitis is work related. See Mina G. Cook, 47 Van Natta 186 (1995); Lynne C. Gibbons, 46 Van Natta 1698 (1994). Here, the medical opinions from Drs. Rehwaldt and Duncan attribute claimant's infection to work activities for lack of a better explanation. However, such reasoning is speculative, and establishes nothing more than a possibility of a causal connection. See Gormley v. SAIF, 52 Or App 1055 (1981). Claimant's burden of proof is not met unless he presents medical evidence affirmatively attributing his right knee cellulitis to work activities on the basis of medical probability, rather than possibility. See Miller v. SAIF, 60 Or App 557 (1982). The medical opinions in this case do not meet that standard.

Although Dr. Duncan initially indicated that the major cause of claimant's right leg cellulitis was the cleaning work at the employer (Ex. 10), he later agreed that there was no way to objectively identify the time and source of claimant's infection. (Ex. 12). Dr. Duncan explained that the infection was most likely a common staphylococcus or streptococcus bacterial infection. He said those pathogens were always present on the skin and could infect through any small break in the skin. (Id.) Such an infection can become symptomatic over a course of hours or can take many days, depending on an individual's immune system. (Id.) Dr. Duncan agreed with the following:

> "The localization to the knee implicates an earlier scratch on the knee, and because the claimant does occasionally kneel or crawl at work, the infection appears temporally and mechanically consistent with a cut or scratch happening at work. Absent any other history, and for the lack of any better explanation, the infection is consistent with his work exposure, and provides a reasonable explanation." (Id.)

Dr. Rehwaldt also initially agreed that the major cause of claimant's right leg cellulitis was the cleaning work at the employer "where he apparently impacted a nail or pebble on his knee." (Ex. 11). In a later opinion, however, Dr. Rehwaldt agreed that the actual time and place of claimant's infection could not be objectively determined. (Ex. 13). Dr. Rehwaldt explained that "approximately 90% of these infections on an extremity are due to staphylococcus or streptococcus, which are virtually always present on the skin and can enter through even a 'micro' scratch or abrasion." (Id.) Dr. Rehwaldt agreed that claimant's work "provides the best available explanation" for the episode because this type of infection was consistent with crawling and kneeling, and the onset of symptoms was also temporally consistent with his work exposure. (Id.)

Both Drs. Duncan and Rehwaldt acknowledged that claimant's infection could have become symptomatic over a course of hours or days and neither physician could determine the actual time and place of claimant's infection. The likely pathogens are always present on the skin and the infection could have occurred through any small break in the skin or even a "micro" scratch. Both physicians attributed claimant's right knee infection to work for lack of a better explanation. The opinions of Drs. Duncan and Rehwaldt are not persuasive because they establish nothing more than a possibility of a causal connection with claimant's work activities. See Miller v. SAIF, supra; Gormley v. SAIF, supra. Claimant has not satisfied his burden of proving that his right knee cellulitis is work related. Because I would reverse the ALJ's order, I dissent.

In the Matter of the Compensation of
DAVID L. WOOD, Claimant
WCB Case No. 95-09371
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Christian and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of his injury claim for a low back condition. On review, the issue is course and scope of employment. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that, by disobeying his supervisor's prohibition against riding in a company vehicle operated by a co-worker who had been drinking alcohol, claimant overstepped the boundaries of his ultimate work. On this basis, the ALJ concluded that claimant's injuries did not arise out of and in the course of his employment.

The relevant facts are as follows: In July 1995, claimant was working for the employer controlling gophers in areas of newly replanted trees. Claimant and the rest of his crew camped at a camp site near John Day, Oregon. The crew was transported to a work site each workday and worked an eight hour shift. The workers were not allowed to drink beer while working, but when they returned to the camp site, they were allowed to drink beer and frequently did so. Claimant and his co-workers were regularly permitted to go to town in a company vehicle in order to do their laundry, shower and get food.

On July 6, 1995, claimant told his supervisor, Chris Bateman, that he needed to go to town to do laundry, shower and eat. When it appeared that Ray Brown, a co-worker, would drive claimant to town in the company vehicle, claimant told Mr. Bateman that Brown should probably not drive since he had been drinking beer. Batemen told Brown and claimant that Martell Parkinson, a co-worker who had not had any beer, would drive them into town. While Martell Parkinson was getting ready to go to town, claimant and Brown drove off in the company vehicle with Brown driving.

After getting to town, claimant showered, washed his clothes and ate dinner. Then he and Brown played pool and drank beer. On the way back to the camp site with Brown again driving, claimant and Brown began arguing and the company vehicle went off the road. Claimant suffered a broken nose in the accident when his face hit the dashboard. Police were eventually called to the scene and claimant and Brown were arrested. Brown was charged with fourth degree assault and driving under the influence of intoxicants and claimant was charged with fourth degree assault. Both men spent the weekend in jail and were released the following Monday. Claimant and Brown were both fired by the employer as a result of the accident.

When claimant returned to his home in Medford, he sought treatment for a lumbar strain and filed a worker's compensation claim. On August 11, 1995, the insurer denied the claim on the ground that claimant's injuries did not arise out of the course and scope of his employment.

Citing Andrews v. Tektronix, Inc., 323 Or 154 (1996), which issued subsequent to the date of the ALJ's order, claimant argues that violation of an employment rule does not necessarily defeat compensability. Claimant further asserts that he was a "traveling employee," that he was not engaged in a distinct departure on a personal errand, and that his trip to and from town was reasonably related to his travel status. On the basis of this reasoning, claimant asserts that his injuries arose out of and within the course and scope of his employment.

The insurer contends, among other things, that claimant was not a traveling employee and that his injuries occurred while engaging in personal errands. The insurer also contends that, under Andrews, an employee's disregard of an employer's prohibition is a factor which can be considered in determining work-relatedness.

For an injury to be compensable under Oregon's workers' compensation law, it must "arise out of" and be "in the course of" employment. ORS 656.005(7)(a). As explained in Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), we use a unitary work-connection test in which the "arising out of" and "in the course of" elements are both parts of a single inquiry, which is whether the relationship between the injury and the work is sufficient to make the injury compensable. The "course of employment" element concerns the time, place and circumstances of an injury, while the "arising out of employment" element concerns whether a causal connection existed between the injury and the employment. Id.

In Andrews, the Court rejected the idea that an employee's violation of an employment rule rendered a worker's claim per se noncompensable. Instead, the Court stated that the facts that an employer has instructed a worker to avoid certain work, and that the worker's injury occurred when he or she disregarded that instruction, are only two of many factors that must be considered in the overall calculation of work-connectedness.[1]

Here, claimant asserts that he was a "traveling employee." Generally, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987). However, one exception is where travel is a necessary incident of the employment. A person who has the status of a traveling employee is continuously within the course and scope of employment while traveling, except when it is shown that the person has engaged in a distinct departure on a personal errand. Savin Corp. v. McBride, 134 Or App 321 (1995); Proctor v. SAIF, 123 Or App 326, 330 (1993).

Our first inquiry is whether claimant was a "traveling employee." To be a "traveling employee," travel must be a necessary incident of claimant's employment. See Rolland R. Duby, 45 Van Natta 2335 (1993).

After our review, we conclude that claimant was a "traveling employee." Claimant and his co-workers were required to live in a remote camp site away from home while working for the employer. Each day, the crew traveled in a company vehicle to their worksite. Because there were no facilities for washing clothes or showering at the camp, and because it was necessary to bring in supplies such as food, it was also necessary for employees to travel into town occasionally to shower, do laundry and eat. The employer regularly permitted employees to travel to town in the company vehicle in order to perform these activities. Because this travel was a necessary incident of claimant's employment, we agree that he was a traveling employee.

Our next inquiry is whether claimant was on a "distinct departure on a personal errand" when he was injured, such that his injury did not arise in the course and scope of employment. In determining whether a traveling employee's injury is compensable, we consider whether the activity that resulted in the injury was reasonably related to the employee's travel status. Savin Corp. v. McBride, supra, 134 Or App at 325.

Here, we find that the activity that resulted in the injury was not reasonably related to claimant's travel status. In this regard, we find that claimant's injuries arose after he and Brown had been drinking alcohol in town and after they became involved in a personal argument on the way back to the camp site. These activities bear no reasonable relationship to claimant's employment and amount to a distinct departure on a personal errand. Moreover, we also find that claimant was injured while engaged in an activity which was specifically prohibited by the employer, i.e., he was riding in the company vehicle with Brown, who had been drinking alcohol.[2] An employee's violation of an employer's directives is relevant in determining whether a personal errand is "distinct." Cf. Savin

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[1] Among the additional factors cited by the Court 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. Id at 165.

[2] In reaching this conclusion, we are persuaded, as was the ALJ, that the testimonies of Mr. Bateman and Mr. Parkinson were credible and reliable, and that a preponderance of the evidence supports the conclusion that claimant understood that he was specifically prohibited from riding to town in a company vehicle driven by Mr. Brown.

Corp. v. McBride, supra, 134 Or App at 326 (fact that a claimant's trip to the bank was not in violation of the employer's directive was relevant in determining whether errand was a "distinct departure" on a personal errand).

Under these circumstances, after considering all the relevant factors, we find that claimant was engaged in a distinct departure on a personal injury when he was injured. Accordingly, claimant was not in the course and scope of his employment when his injuries occurred.

ORDER

The ALJ's order dated May 15, 1996 is affirmed.

December 24, 1996 Cite as 48 Van Natta 2548 (1996)

In the Matter of the Compensation of
CHRIS G. CLAUSEN, Claimant
WCB Case No. 95-11626
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) McKean's order that: (1) prior to claimant's withdrawal of two reports from his attending physician (Dr. Bell), granted the insurer's request to leave the record open for Dr. Bell's cross-examination; (2) found that the insurer's prior acceptance of claimant's neck injury did not include a C5-6 herniated disc; and (3) upheld the insurer's partial denial of claimant's C5-6 herniated disc condition. In the event that the Board does not find his C5-6 herniated disc condition compensable, claimant seeks remand to the ALJ with instructions to permit claimant to offer the two withdrawn reports from Dr. Bell without granting the insurer the right to cross-examine Dr. Bell. On review, the issues are remand, propriety of the ALJ's evidentiary ruling, scope of acceptance, and compensability. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception. We do not adopt the references to Exhibit 7A-1.

Evidentiary Ruling/Remand

On review, claimant contends that the ALJ abused his discretion in granting the insurer the right to cross-examine Dr. Bell. Based on the following, we find that this issue is not ripe.

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).

By letter dated April 2, 1996, claimant submitted four reports from Dr. Bell, treating physician, including an August 17, 1982 report and a March 6, 1984 report. These exhibits were ultimately numbered Exhibit 7A and 19A, respectively. At hearing, claimant withdrew several exhibits, including Exhibits 7A[1] and 19A. The circumstances behind the withdrawal of Exhibits 7A and 19A are as follows.

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[1] We note that Exhibit 7A consists of three pages. Although claimant ultimately withdrew Exhibit 7A, the insurer subsequently submitted page one of Exhibit 7A solely for the purpose of impeachment. (Tr. 41-42). The ALJ admitted page one of Exhibit 7A for that purpose. Id. That evidentiary ruling is not at issue on review.

At hearing, the insurer requested an opportunity to cross-examine Dr. Bell regarding Exhibits 7A and 19A, contending that those exhibits showed an unexplained change in Dr. Bell's opinion regarding causation because Dr. Bell previously indicated the condition was not compensable. (Tr. 2, 6, 7). The insurer also contended that, although it was aware of Exhibits 7A and 19A, they were not proffered as exhibits by claimant until April 2, 1996. Claimant countered that, if Dr. Bell changed his opinion, such a change would have been apparent to the insurer by the end of January 1996, when it received Exhibit 65, a January 4, 1996 report from Dr. Bell. Thus, citing OAR 438-006-0091(2), claimant contended that the insurer had not shown the required "due diligence" in seeking to cross-examine Dr. Bell the week of the hearing, which was held April 19, 1996. (Tr. 8-9). Noting that Exhibits 7A and 19A were 14 and 12 years old, the ALJ reasoned that the need to cross-examine Dr. Bell did not arise until claimant submitted those exhibits into evidence. Therefore, the ALJ ruled that the record would be held open for the insurer to cross-examine Dr. Bell. (Tr. 10-11). Following this ruling, claimant withdrew Exhibits 7A and 19A. (Tr. 12). Because the disputed exhibits were withdrawn, the insurer agreed there was no need to cross-examine Dr. Bell. Id. Therefore, the record was not held open for a cross-examination of Dr. Bell. Id.

Claimant argues that the ALJ abused his discretion by granting the insurer the right to cross-examine Dr. Bell, which resulted in withdrawal of the exhibits at issue. However, the ALJ did not exclude Exhibits 7A or 19A. Instead, claimant voluntarily withdrew those exhibits. Claimant was not compelled to withdraw Exhibits 7A and 19A. In addition, when claimant withdrew Exhibits 7A and 19A, the insurer agreed there was no reason to cross-examine Dr. Bell. Therefore, after the withdrawal of Exhibits 7A and 19A, the ALJ's ruling on the cross-examination of Dr. Bell became moot -- the record was not held open for the cross-examination of Dr. Bell. In other words, claimant's voluntary actions rendered the cross-examination issue not ripe; therefore, claimant cannot argue on review that the ALJ abused his discretion in making the "cross-examination" ruling.

Claimant also requests that, if we find his C5-6 disc herniation is not compensable, we remand the case to the ALJ with instructions to permit claimant to offer Exhibits 7A and 19A without granting the insurer the right to cross-examine Dr. Bell. We deny claimant's request.

We may remand to the ALJ for additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand, however, it must be shown that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Here, Exhibits 7A and 19A were obviously obtainable with due diligence at the time of hearing--claimant initially submitted those exhibits at hearing. Subsequently, claimant made a tactical decision to withdraw Exhibits 7A and 19A. This tactical decision does not support a finding that the evidence claimant seeks to have admitted was not unobtainable with the exercise of due diligence at the time of hearing. Accordingly, we deny the motion for remand.

Alternatively, if Exhibits 7A and 19A were admitted and considered, they would not change the result. The ALJ noted that two reports[2] Dr. Bell referred to in his January 4, 1996 report are not in the record. Claimant argues that the ALJ's notation supports his request for remand because it indicates that the ALJ rejected Dr. Bell's causation opinion because of these missing reports. However, the ALJ specifically found that Dr. Bell's causation opinion was not persuasive because: (1) Dr. Bell relies heavily on claimant's subjective complaints and symptoms and claimant has well-documented, severe functional overlay, which makes reliance on subjective symptoms questionable; and (2) Dr. Bell infers causation from a temporal relationship. For the reasons explained by the ALJ, even if we considered Exhibits 7A and 19A, we are not persuaded that the 1982 injuries were a material contributing cause of claimant's current C5-6 herniated disc condition. Therefore, the additional evidence does not merit remand because it is not reasonably likely to affect the outcome of the case. Id. at 646.

Scope of Acceptance

At hearing and on review, claimant argues that the insurer accepted claimant's C5-6 disc condition via a March 26, 1987 Stipulation which stated, in part, that "[o]n March 21 [sic], 1982,

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[2] These reports are Exhibits 19A and 20A, both of which were voluntarily withdrawn by claimant. On review, claimant does not seek remand for the admission of Exhibit 20A.

[c]laimant sustained a compensable injury to his neck . . . which was duly accepted and for which he received Workers' Compensation benefits." (Ex. 35-1). Therefore, claimant argues, the insurer's October 27, 1995 partial denial of claimant's C5-6 herniated disc claim is an impermissible back-up denial. The ALJ rejected claimant's arguments, finding that the insurer's denial was not an impermissible back-up denial because, based on the contemporaneous medical records, the insurer did not accept any cervical disc condition. We agree with the ALJ's reasoning and conclusions regarding the contemporaneous medical records. However, we also find that: (1) the March 26, 1987 Stipulation did not accept any condition that had not already previously been accepted; and (2) the March 1982 801 form supports a finding that the insurer specifically accepted an upper spine strain, and not any cervical disc condition. (Ex. 1).

First, we address claimant's argument that the March 26, 1987 Stipulation constitutes an acceptance of his C5-6 disc condition. The terms of a written agreement to settle a workers' compensation claim are interpreted using the standard rules of contract construction. See Good Samaritan Hospital v. Stoddard, 126 Or App 69, rev den 319 Or 572 (1994) (applying law of contracts to workers' compensation settlement agreement). The intent of the parties is to be pursued, if possible. ORS 42.240. Whether a contract is ambiguous is a matter of law. Timberline Equip. v. St. Paul Fire and Mar. Ins., 281 Or 639, 643 (1978). A contract is not ambiguous if it has only one sensible and reasonable interpretation. P & C Construction Co. v. American Diversified, 101 Or App 51, 56 (1990); D & D Co. v. Kaufman, 139 Or App 459 (1996).

The parties do not contend that the March 26, 1987 Stipulation is ambiguous. We find that this Stipulation unambiguously refers to a previously accepted neck injury. In this regard, the Stipulation states that "[c]laimant sustained a compensable injury to his neck . . . which was duly accepted and for which he received Workers' Compensation benefits." (Ex. 35-1, emphasis added). This language is in the past tense and clearly indicates a previously accepted injury. This is supported by the statement that claimant "received Workers' Compensation benefits" for this injury. Nothing in this language supports claimant's contention that the March 26, 1987 Stipulation represents the insurer's initial acceptance and includes claimant's C5-6 disc condition.

In addition, for the following reasons, we find that the March 1982 801 form represents the insurer's acceptance of claimant's injury claim. We note that the ALJ apparently did not consider the March 1982 801 form as an acceptance because it was neither signed nor dated by claimant. However, such matters go to the question of whether notice has been properly furnished, which relates to claims processing, not whether or not a claim has been accepted. Gene C. Dalton, 43 Van Natta 1191 (1991); Nancy V. Storey, 41 Van Natta 1951 (1989). Whether an acceptance occurs is an issue of fact, with formal notice occurring after acceptance has been accomplished. SAIF v. Tull, 113 Or App 449, 454 (1992). Acceptance is an act through which the insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law. Gene C. Dalton, supra; see Jannette I. Shue, 42 Van Natta 1750 (1990); Nancy V. Storey, supra. Finally, acceptance of a claim may be accomplished by checking the appropriate options on an 801 claim form. U.S. Bakery v. DuVal, 86 Or App 120 (1987). See also Georgia-Pacific v. Piwowar, 305 Or 494 (1988); Johnson v. Spectra Physics, 303 Or 49 (1987); Nancy V. Storey, supra; Alfredo G. Bustamate, 42 Van Natta 2358 (1990).

The March 25, 1982 801 form indicates the nature of injury as "[s]train . . . upper spine." (Ex. 1). The 801 form indicates it is signed by an insurer representative, with boxes checked indicating the injury was accepted as a disabling injury on March 30, 1982. Id. The initial diagnosis by Dr. Nagel, M.D., is further evidence that the insurer was presented with a claim for "upper thoracic strain" rather than any cervical disc condition. (Ex. 2). Since there is no evidence that an upper back strain is a symptom of any cervical disc condition, we find that the insurer's acceptance did not include any cervical disc condition. Compare Georgia-Pacific v. Piwowar, 305 Or at 500 (where an insurer accepts a symptom of a disease, it also accepts the disease causing that symptom); see Patty A. Durr, 45 Van Natta 940 (1993) (carrier did not accept symptoms of fibromyalgia when it accepted arm and hand strain when medical evidence did not demonstrate that arm and hand strain was a symptom of fibromyalgia). Although a March 26, 1987 Stipulation provided that claimant "sustained a compensable injury to his neck . . . which was duly accepted," the 801 acceptance specifies an upper spine strain as the injury that was "duly accepted." Based on this evidence, in addition to the ALJ's reasoning, we find that the

insurer did not accept any cervical disc condition.[3] See Tull v. SAIF, supra. Inasmuch as claimant's current condition is a C5-6 disc herniation, we conclude that the insurer is not precluded from denying compensability of that condition.

Compensability

We adopt the ALJ's reasoning and conclusions regarding the compensability issue.

ORDER

The ALJ's order dated May 24, 1996 is affirmed.

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[3] The condition at issue is a C5-6 disc herniation, a condition for which claimant underwent surgery in July 1995. The first mention of any C5-6 disc condition occurs in a September 13, 1985 myelogram report which notes "small lateral defects at the C5-6 and C3-4 levels." (Ex. 26). This occurred well after the insurer's March 30, 1982 acceptance of the "upper spine strain" on the 801 form.

Board Chair Hall specially concurring.

Under the Board's usual analysis applying Good Samaritan Hospital v. Stoddard, supra, the focus is on whether the issue in dispute "could have been negotiated before approval of the settlement." 126 Or App at 73. Applying that analysis, the Board has held that where, as here, a stipulation contained the language that "all issues raised or raisable" were resolved by the stipulation, if a party was aware of a potential issue prior to the stipulation and did not address that issue in the stipulation, the stipulation precluded the party from subsequently litigating that issue. Josef E. Tunison, 48 Van Natta 1059 (1996); Vicki D. Pollock, 48 Van Natta 463 (1996). I submit that, if the Board's "usual" Stoddard analysis was applied to the March 1987 Stipulation in this case, the insurer would be precluded from now litigating the compensability of the C5-6 herniated disc condition, since that condition and its relationship to the compensable injury was a potential issue subject to negotiation prior to the March 1987 Stipulation. However, instead of applying this analysis, the lead opinion focuses on interpreting the March 1987 Stipulation as a matter of contract law. For the following reasons, I agree that contract law is the correct focus in interpreting a settlement agreement. Therefore, I concur with the lead opinion.

In a special concurrence to Vicki D. Pollock, supra, I stated that, had I been deciding the case on an empty slate, I would have found that the aggravation issue was outside of the parties' negotiations because the subject matter of the stipulation was compensability of the claimant's injuries, and aggravation of those injuries was not contemplated by the parties' agreement. Nevertheless, I found myself bound by Good Samaritan Hospital v. Stoddard, supra, to find that the claimant's aggravation claim was barred because the issue could have been raised before the parties' stipulation was approved.

However, the court has reversed and remanded our decision in Vicki D. Pollock, supra. Pollock v. Tri-Met, Inc., 144 Or App 431 (1996). The court disagreed with our interpretation of Stoddard and concluded that:

> "[s]ettlement agreements are contracts and, as such, they implicate general principles of contract law. When such an agreement is unambiguous in its terms, the interpretation of the agreement becomes a question of law to be decided by a court based on examination of the terms of the agreement as a whole. . . . The construction to be given such an agreement is to render, if possible, all of its provisions harmonious and to carry into effect the actual purpose and intent of the parties as derived from the terms of the agreement." Id. at 43 (footnotes and citations omitted).

The court remanded the case and directed the Board to "construe the parties' settlement in such a way as to carry into effect their express purpose and intent at the time of the agreement." Id. at 435-36. Thus, the court is pulling the law back in the direction of strict application of the principles of contract law in interpreting settlement agreements. I agree with this "contractual interpretation" approach and find that, in the present case, the lead opinion applied this approach. Therefore, I specially concur.

In the Matter of the Compensation of
MARILYN A. CRISP, Claimant
WCB Case No. 96-01221
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
John Pitcher, Defense Attorney

Reviewed by Board Members Biehl, Christian and Haynes.

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

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

A prior (unappealed) ALJ's order affirmed a Determination Order's 25 percent permanent disability award for claimant's condition ("chronic lumbosacral strain superimposed on preexisting degenerative problems"). Based on this final litigation order, and a finding that claimant's permanent disability award was thereby based in part on his preexisting degeneration, we agree with ALJ Black that the employer's denial of claimant's degenerative condition is precluded. See Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996); Patricia A. Landers, 48 Van Natta 1720 (1996).[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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 July 22, 1996 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

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[1] The dissent asserts that the prior ALJ's affirmation of the Determination Order award presents a "mathematic impossibility" because the prior ALJ theoretically granted an "additional" award based on claimant's lumbosacral strain superimposed on a preexisting degenerative back condition. We see no incongruity. On review of the prior Determination Order, the prior ALJ agreed that claimant was entitled to a 25 percent unscheduled permanent disability award. However, in doing so, unlike the Determination Order, the prior ALJ based claimant's award on a strain and preexisting degenerative problems. In other words, the prior ALJ concurred with the Determination Order's ultimate conclusion, but did so for findings and reasons other than those made by the Determination Order. Consistent with Messmer and its progeny, the employer's failure to contest the partial basis for the ALJ's award (claimant's preexisting degeneration), precludes it from subsequently contesting the degeneration.

Board Member Haynes dissenting.

The majority finds that the employer accepted claimant's entire low back condition (including her underlying progressive degeneration), based on a mistaken belief that a 1983 Determination Order (and a subsequent litigation order) awarded permanent disability compensation for degeneration. I believe this is a clear misapplication of Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996).

The accepted condition in this case is a low back "sprain/strain." Claimant's low back degenerative disease was identified before the 1983 Determination Order closed her injury claim and awarded permanent disability for her low back. However, that does not necessarily mean that the employer's denial of claimant's current low back degenerative condition is precluded. The determinative question is whether the final "award included any compensation for the degenerative condition." Olson v. Safeway Stores, Inc., 132 Or App 424, 428 n.1 (1995). The prior award in this case did not include compensation for degeneration.

The evaluator's worksheet accompanying the 1983 Determination Order identified claimant's condition as a "back strain." (Ex. 2-2). There is no mention of degeneration in the Determination Order or the worksheet. Thus, the Determination Order awarded permanent disability for a chronic strain only.

The majority apparently believes that the subsequent Opinion and Order somehow awarded permanent disability for claimant's preexisting degeneration, in addition to the chronic strain, even though the ALJ's order affirmed the exact amount of permanent disability awarded by the Determination Order. This theoretical "additional" award would appear to be a mathematic impossibility.[1] Moreover, although the 1984 ALJ stated in his "Findings" that claimant's "injury is now considered to be a chronic lumbosacral strain superimposed on pre-existing degenerative back problems," that description alone does not magically transform claimant's degeneration into a compensable condition.

The ALJ's use of the term "superimposed" does not mean that claimant suffered from one inseparable condition for purposes of rating permanent disability at the time of the 1984 hearing. See Sanford v. Balteau Standard/SAIF Corp., 140 Or App 177, 183 (1996) (Superimposed "may mean to become interrelated with something else or to overlap something without interrelation.").

The record is devoid of evidence that claimant's permanent disability award was based on degeneration. Consequently, the majority errs in applying Deluxe Cabinet Works v. Messmer, supra, and in finding the denial of claimant's current degenerative condition to be precluded. See Olson v. Safeway Stores, Inc., supra; David L. Reed, 48 Van Natta 1723 (1996) (Where the record was insufficient to establish that the prior award included compensation for preexisting degeneration, the employer's denial of claimant's current condition was not precluded); Glow I. Meissner, 47 Van Natta 1486 (1995). Accordingly, I respectfully dissent.

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[1] Unlike the Landers case cited by the majority, claimant's compensation in this case was not increased on appeal to accommodate an additional basis for the final permanent disability award.

December 24, 1996 Cite as 48 Van Natta 2553 (1996)

In the Matter of the Compensation of
JOHN S. DAHL, Claimant
WCB Case No. 95-04371
ORDER ON REVIEW
Jolles, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) McKean's order that upheld the insurer's denial of claimant's bilateral knee injury claim. On review, the issues are subjectivity and compensability. We reverse.

FINDINGS OF FACT

The employer in this case is David Douglas School District No. 40 (District). Claimant is the father of a sixth grader who participated on an employer-sponsored elementary school basketball team during the 1994-1995 school year.

The employer elected to provide workers' compensation coverage for its volunteer athletic coaches. (Tr. 95). Approximately 84 volunteers coached athletic teams for the district during the 1994-1995 school year. (Tr. 61). The employer's workers' compensation carrier was not provided with a specific list of individual volunteers. (Tr. 101). Instead, the premium was based on an estimate of the number of volunteers. (Tr. 102). No paperwork was required to be completed in order to be a volunteer coach.

On Monday, November 21, claimant checked in at the school office and identified himself to the school principal as a coach for the girls' basketball team. (Tr. 28). Claimant received a Visitor's Pass (which all visitors to the school were required to obtain), obtained basketballs from the employer's building coordinator, and then coached the team during its regular Monday night practice. Claimant was the only coach in attendance that day. (Tr. 10, 25).

Claimant subsequently assisted with practices on November 28, December 5, and December 12, 1994. When claimant appeared at the administrative office for his third practice, he was given a pass to keep permanently in his wallet. The employer's building coordinator was in and out of the gymnasium performing her own duties during the team practices. (Tr. 49). On December 12, 1994, during practice, claimant fell while demonstrating a jump shot and severed tendons in both knees.

FINDINGS OF ULTIMATE FACT

Pursuant to the employer's election of coverage under ORS 656.034, claimant was a subject volunteer on December 12, 1994, when he was injured on the employer's premises. Claimant's activities at the time of injury were among those of covered volunteer athletic coaches and similar to those of full-time paid athletic coaches.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant was not a subject volunteer athletic coach at the time of his injury, based on a finding that claimant had not been selected as a designated coach by the municipal employer. Claimant argues that he was a subject volunteer at the time of his injury, because he was a volunteer athletic coach and the municipal employer had elected to cover such volunteers. We agree with claimant that he was a subject volunteer when injured, for the reasons that follow.

ORS 656.031 sets out the relevant requirements for workers' compensation coverage of municipal volunteers:

> "(1) [V]olunteer personnel * * * shall not be considered as workers unless the municipality has filed the election provided by this section.
>
> "(2) The county, city or other municipality utilizing volunteer personnel as specified in subsection (1) of this section may elect to have such personnel considered as subject workers for purposes of this chapter. Such election shall be made by filing a written application to the insurer * * * that includes a resolution of the governing body declaring its intent to cover volunteer personnel as provided in subsection (1) of this section and a description of the work to be performed by such personnel. * * *
>
> "* * * * *
>
> "(4) * * * Persons covered under this section are entitled to the benefits of this chapter if injured as provided in ORS 656.202 while performing any duties arising out of and in the course of their employment as volunteer personnel, if the duties being performed are among those:
>
> "(a) Described on the application of the county, city or municipality; and
>
> "(b) Required of similar full-time paid employees. * * * . "

Under the statute, volunteer personnel are only covered subject workers if the employer elects to provide coverage for them. See Westfall v. Multnomah County, 57 Or App 459, 463 (1982); see also Miner v. City of Vernonia, 46 Or App 393, rev den 292 Or 450 (1980). In this case, the employer acknowledges that it elected to cover some volunteer athletic coaches. (See Tr. 95). Based on this admission, we find that the employer applied for and obtained coverage under the statute.

The employer argues that it limited its election to certain "designated" volunteer athletic coaches. We reject the employer's argument to the extent it could be interpreted to assert that claimant was not a covered volunteer because he was not officially "designated" as such on a list of selected coaches. We reject that argument because that result would be contrary to the plain language of the statute.

On its face, the statute provides for elected coverage of volunteers according to descriptions of the work performed by them. The statute does not contemplate coverage of volunteers as individuals, but as classes or groups, according to their work descriptions. Individuals are not named or otherwise "designated" (except according to their volunteer duties) in the application for elected coverage.

Consequently, based on the explicit terms of the statute, we are not persuaded that the employer limited its election of coverage for volunteer athletic coaches to designated individuals.[1]

Under these circumstances, we conclude that the employer elected coverage for volunteer athletic coaches pursuant to ORS 656.031. The next inquiry is whether claimant was a covered volunteer coach at the time of his injury. The insurer contends that he was not, reasoning that he was not selected by the employer to be a volunteer coach. Based on our review of ORS 656.031, however, we find no requirement that the employer formally select an individual to serve as a volunteer. Rather, the statute provides that "[p]ersons covered under this section [i.e., volunteer personnel] are entitled to the benefits of this chapter if injured...while performing any duties arising out of and in the course of their employment as volunteer personnel...." Hence, the dispositive issue in this case is whether claimant was injured while performing duties arising out of and in the course of employment as a volunteer coach.

The insurer argues there was no employment relationship between claimant and the employer. Assuming, without deciding, that such a relationship must be established in order to be a covered volunteer, we find that the evidence in this case is sufficient to prove such a relationship actually existed between claimant and the employer.

There are two fundamental elements which must be present to establish an employer-employee relationship: (1) a contract of hire between the parties, either express or implied; and (2) a right of control. Oremus v. Ore. Pub. Co., 11 Or App 444, 446 (1973). Here, claimant identified himself as one of the athletic coaches to school officials. Claimant was the only coach in attendance at one of the practices and claimant coached alongside the other regular volunteer coach during two other practices. Claimant acted as a volunteer coach on school premises; he was given a Visitor's Pass to gain access to school premises, and he personally obtained basketballs from the school's building coordinator to use during practices.

Based on those circumstances, we find that the employer had actual knowledge that claimant was serving as a volunteer coach during team practices, and it acquiesced in that activity by permitting him access to school premises and issuing him the necessary equipment to use. Therefore, we conclude there was an implied contract between the employer and claimant for claimant to serve as a volunteer coach. Furthermore, by issuing claimant a Visitor's Pass and the necessary equipment to coach, the employer demonstrated the right to control claimant's activity as a volunteer coach. That is, if the employer disapproved of claimant's volunteer activity, it could have revoked his Visitor's Pass and/or refused to issue coaching equipment.

Having found that there was, in fact, an employment relationship between claimant and the employer, the next inquiry is to determine whether claimant was injured while performing duties arising out of and in the course of his employment as volunteer coach. The record shows that volunteer coaches' duties included obtaining balls for practice; dividing the girls into two groups (corresponding with the usual two coaches present), and instructing them on opposite ends of the court. Because claimant was instructing (i.e., coaching) by demonstrating a jump shot when injured, we reach the following conclusions: Claimant was injured while performing duties arising out of and in the course of his employment as a volunteer athletic coach;[2] his duties were those of a volunteer athletic coach (and therefore among those necessarily described in the employer's application for elected coverage); and the

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[1] Former ORS 656.031 provided that municipal volunteers were covered by election only insofar as their names appeared on "official membership rosters." The roster requirement was deleted in 1979. See SAIF v. Herman, 53 Or App 672 (1981); Miner v. City of Vernonia, supra.

[2] Claimant's coaching activity occurred on the employer's premises. Claimant's work as a volunteer coach benefited the employer generally and specifically, on the date of his injury, because it allowed two coaches to be present at the December 12, 1994 team practice. (On that date, one of the regular coaches was absent. See Tr. 11-13; Ex. 8-17.) The employer provided the equipment claimant used and claimant personally obtained basketballs from the employer's building coordinator on this occasion. There is no evidence that claimant was on a personal mission at the time of his injury. Thus, the "totality of circumstances" indicate that claimant's activity at the time of injury arose out of and in the course of his employment as a volunteer athletic coach. See e.g., Freightliner Corp. v. Arnold, 142 Or App 98, 103 (1996).

duties were similar to those of similar full-time paid athletic coaches. (See Tr. 12-14, 35, 74, 84). Therefore, claimant has established that his claim is compensable under ORS 656.031 and we conclude that he is entitled to compensation under ORS Chapter 656.

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 issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 6, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $4,000 attorney fee, payable by the insurer.

December 24, 1996 Cite as 48 Van Natta 2556 (1996)

In the Matter of the Compensation of
TWYLA J. EHMKE, Claimant
WCB Case No. 95-10787
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that upheld the insurer's denial of her injury claim for a thoracic strain. On review, the issue is compensability.

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

Citing Westmoreland v. Iowa Beef Processors, 70 Or App 642, 645 (1984), claimant contends that she has established a compensable injury claim despite the ALJ's finding that she was not a credible witness. However, given the ALJ's credibility finding, which we adopt based on our independent review of the record, we are unable to find that claimant suffered a thoracic strain as a result of her work activities on July 6, 1995. See John E. Farnes, 48 Van Natta 571 (1996). In this regard, we rely on the testimony of claimant's supervisor, Ms. Estes, that she saw claimant walk into work on the morning of July 7, 1995 without exhibiting any physical difficulties.

ORDER

The ALJ's order dated June 5, 1996 is affirmed.

Board Chair Hall dissenting.

The majority adopts the ALJ's finding that claimant is not credible and that she has not proven her back injury claim. I disagree with both findings and, therefore, dissent.

Several undisputed facts support the compensability of this claim. It is an undisputed fact, for example, that claimant was performing physically strenuous work duties on July 6, 1995. Working a long "markdown" day, she lifted and carried several racks of clothing. She felt very tired after her shift and went home feeling exhausted. The next morning, she reported back pain to her supervisor and completed an injury claim form. She sought treatment later that day. Her doctor has consistently opined that claimant suffered a back strain due in major part to her work activities on July 6, 1995.

Despite these undisputed facts, the majority concludes that claimant has not proven she injured her back at work. It does so based on a videotape showing claimant washing her truck on August 22, 1995, six weeks after suffering the alleged injury on July 6. However, given the six-week lapse of time, I find the videotape of little or no probative value in determining whether or not claimant sustained an injury on July 6, 1995.

The majority also relies on the testimony of claimant's supervisor, Penny Estes, who testified that claimant did not appear to be hurting when she walked into work on July 7, 1995. However, Estes' opportunity to observe claimant was very limited; she glanced up at claimant as claimant walked by the three-foot doorway of Estes' office. Given those limited circumstances, I am not persuaded by Estes' testimony, nor do I find claimant's credibility impeached by Ms. Estes' lay assessment of whether claimant was injured or hurting.

Finally, the majority was persuaded by Estes' contradiction of claimant's testimony that she was not upset about negative work performance evaluations and about being passed over for promotions. While claimant may have been reluctant to admit to harboring some resentment about her performance evaluations and lack of promotions, her reluctance does not, in any way, prove or disprove claimant's claim for an injury occurring on July 6, 1995.

In short, I am not persuaded that claimant's credibility has been impeached. I am persuaded that claimant has proven she suffered an injury at work on July 6, 1995. The only doctor to render a causation opinion in this case stated that work activities on July 6 were the major cause of her back strain. The lay assessment of Ms. Estes and a video of claimant washing her car six weeks after the date of injury do not defeat the claim. Based on the record as a whole, I would set aside the insurer's denial.

December 24, 1996 Cite as 48 Van Natta 2557 (1996)

In the Matter of the Compensation of
KENNETH L. DEVI, Claimant
WCB Case No. 93-10959
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Craig A. Staples, Defense Attorney

Claimant requests reconsideration of our November 26, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's current low back condition. Asserting that we erroneously declined to consider his contention that the employer was precluded from denying his low back condition, claimant seeks reconsideration of our decision.

In order to further consider this matter, we withdraw our November 26, 1996 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MINH Q. HAN, Claimant
WCB Case No. 94-06863
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the findings of ultimate fact, with the following change. We change the second sentence in the sixth paragraph on page 3 to read: "Dr. Weller reported hypoactive reflexes in both upper extremities with normal cervical motion, normal upper extremity strength and no numbness or fasciculations."

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his neck and upper back on February 15, 1993. On March 8, 1993, SAIF issued an acceptance of a scalp contusion, cervical strain and thoracic strain. (Ex. 7). SAIF issued a Notice of Closure on July 14, 1993, awarding no permanent partial disability and finding claimant's condition medically stationary on July 5, 1993. (Ex. 10).

Claimant sought treatment from Dr. Szeto on July 30, 1993, reporting an increase in cervical pain after lifting thirty pounds at work. (Ex. 1-5). Dr. Szeto provided treatment until December 17, 1993. (Ex. 1-8).

Claimant was treated by Dr. Gonzalez on January 4 and January 13, 1994. Dr. Gonzalez reported that claimant had neck pain that radiated across both shoulders posteriorly and the pain interfered with his ability to perform his work. (Ex. 12). Dr. Gonzalez diagnosed chronic neck and muscle strain.

Claimant sought chiropractic treatment from Dr. Tse from January 19, 1994 through May 1994. (Ex. 15). During that period, Dr. Tse reported intermittent flare-ups of cervical pain and upper extremity pain and numbness associated with objective findings of cervical spasm, reduced cervical range of motion, reduced upper extremity muscle strength and mildly diminished reflexes. (Exs. 15, 18, 19B).

Claimant contends that his current cervical symptoms are a compensable aggravation of his accepted condition.[1] The ALJ found that claimant's current symptoms were attributable to a chronic cervical strain superimposed on preexisting degenerative disc/joint disease and concluded that claimant's current condition was a continuation of the condition accepted by SAIF. The ALJ determined that claimant sustained an actual worsening of the compensable condition since his claim was closed in July 1993.

SAIF argues that the medical evidence does not establish that claimant's condition is compensable, nor does it establish that claimant's condition represents an actual worsening of his compensable condition supported by objective findings.[2]

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[1] At hearing, claimant also argued that his current cervical and upper extremity symptoms were attributable to multi-level cervical disc herniations caused by the February 1993 injury. The ALJ disagreed, concluding that claimant's multi-level disc herniations were currently asymptomatic. Neither party has requested review of that portion of the ALJ's order.

[2] SAIF states that it does not concede that a valid claim for aggravation was filed. There is no evidence that SAIF raised that issue at hearing. Consequently, the issue is not before us and we do not address it.

Under 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. Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." 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. An "actual worsening" is established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the compensable condition that is greater than anticipated by the prior award of permanent disability. Carmen C. Neill, 47 Van Natta 2371 (1995).

Here, SAIF accepted a "cervical strain." (Ex. 7). Claimant's current condition following the July 14, 1993 Notice of Closure has been diagnosed as a chronic cervical strain superimposed on degenerative disc/joint disease. (Exs. 19A, 19B, 31, 32, 35). Since claimant's chronic cervical strain superimposed on degenerative disc/joint disease is not an accepted condition, in order to establish a worsened condition resulting from the original injury, he must first establish that this condition is compensable. See Gloria T. Olson, supra.

Claimant acknowledges that he has a chronic cervical strain as well as preexisting degenerative joint disease and he asserts that all of the doctors have agreed with that diagnosis. Since claimant's degenerative disc/joint disease preexisted the compensable injury, it constitutes a "preexisting condition" pursuant to ORS 656.005(24). (Exs. 19A, 26, 31, 36). Furthermore, the medical evidence establishes that claimant's compensable injury combined with the preexisting degenerative disc/joint disease to cause or prolong his disability or need for treatment. (Exs. 19A, 26, 31, 36). Therefore, claimant must establish that his compensable injury was the major contributing cause of his current disability or need for treatment of his current combined condition. ORS 656.005(7)(a)(B).

Claimant relies on the opinions of his treating physicians, Drs. Szeto and Tse. Although "magic words" are not required to establish the major contributing cause, McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986), we find no medical opinion that establishes that the compensable 1993 injury was the major contributing cause of claimant's current combined condition.

Dr. Szeto treated claimant for his 1993 injury until December 17, 1993. (Ex. 1). In late July 1993, Dr. Szeto reported that claimant had increased cervical pain after lifting 30 pounds at work. (Ex. 1-5). In later reports, Dr. Szeto stated that, since he had not seen claimant since December 1993, claimant's current condition was unknown and he could not assess claimant's current treatment. (Exs. 23, 25). Dr. Szeto opined that claimant had an "obvious objective worsening" as a result of "another accident which exacerbated his condition" in July 1993, after claimant lifted 30 pounds at work. (Ex. 23). On August 19, 1994, Dr. Szeto reported:

> "I reopened [claimant's] case on July 30, 1993 and in my notes of July 30, 1993 it was well documented that the patient was lifting something at work and injured his neck or exacerbated his previous condition. I do feel the major cause of the worsening of his condition is from [claimant's] injury of February 15, 1993." (Ex. 25).

We are not persuaded by Dr. Szeto's opinion for several reasons. Dr. Szeto does not address claimant's current condition. Rather, he focuses on claimant's condition following an alleged injury in late July 1993. Furthermore, although Dr. Szeto said that the major cause of claimant's worsening following the July 1993 injury was due to the February 15, 1993 injury, the July 1993 injury has not been determined to be compensable. Dr. Szeto did not address whether claimant's February 15, 1993 compensable injury was the major contributing cause of his current disability or need for treatment. Dr. Szeto's opinion is not sufficient to establish compensability.

Claimant sought chiropractic treatment from Dr. Tse from January 19, 1994 through May 1994. (Ex. 15). Dr. Tse reported that claimant said he never totally recovered from the original injury and Dr. Tse said that claimant's case was prematurely closed. (Ex. 18). Dr. Tse believed that claimant suffered a disc herniation as a result of the February 15, 1993 injury. (Id.) In a later report, Dr. Tse reported that claimant suffered a disc herniation and a cervical sprain from the February 15, 1993 injury. (Ex. 19B). Dr. Tse believed that there was objective evidence that claimant's cervical spine condition had worsened since July 5, 1993. (Id.)

In a later report, Dr. Tse was asked to review Dr. Szeto's August 19, 1994 report, which had referred to claimant's July 30, 1993 "exacerbation." (See Ex. 25). Although Dr. Tse concurred with Dr. Szeto's report, Dr. Tse commented that he had no knowledge of claimant's July 30, 1993 injury and,

since he was not informed of claimant's condition at that period, it was difficult for him to state if claimant's condition had worsened since July 5, 1993. (Ex. 27). Dr. Tse's own report casts doubt on his earlier conclusion that claimant's condition had worsened.

The proper application of ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause of an injury, 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). On June 8, 1994, Dr. Tse reported that claimant had suffered a disc herniation from the February 15, 1993 injury and his current condition was the "continuation of the disc problem." (Ex. 21). Claimant does not contest the ALJ's conclusion that claimant's disc herniations were not compensable. Dr. Tse's reports are insufficient to establish that claimant's February 15, 1993 compensable injury was the major contributing cause of his current disability or need for treatment.

None of the other medical reports establish compensability of claimant's chronic cervical strain superimposed on degenerative disc/joint disease. Under such circumstances, we conclude that claimant has failed to establish that his February 15, 1993 injury was the major contributing cause of his current disability or need for treatment. Therefore, his aggravation claim fails.

ORDER

The ALJ's order dated May 8, 1996 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

Board Chair Hall dissenting.

The majority erroneously finds that the medical evidence establishes that claimant's compensable injury combined with the preexisting degenerative disc/joint disease to cause or prolong his disability or need for treatment. Thus, the majority incorrectly applies ORS 656.005(7)(a)(B), concludes that claimant's February 15, 1993 injury was not the major contributing cause of his current disability or need for treatment, and upholds a "current condition" denial.

Although I agree that claimant has preexisting degenerative disc/joint disease, I do not agree that his degenerative disc/joint disease combined with his work injury, particularly since the physicians discussed how insignificant and non-contributory claimant's degenerative disc/joint disease and disc herniations were to his current condition. Since there is no persuasive evidence that claimant had a "combined condition," ORS 656.005(7)(a)(B) does not apply. See Leon M. Haley, 47 Van Natta 2056, on recon 47 Van Natta 2206 (1995). Thus, contrary to the majority's conclusion, claimant's original claim for contusion, cervical and thoracic strain is his "current condition" and remains compensable, even if (as the majority concludes) that compensable condition has not "actually worsened" at this time.

In the Matter of the Compensation of
LYNDA F. HANSEN, Claimant
WCB Case No. 95-13914
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Christian and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's partial denial of claimant's mid-cervical spondylosis condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant did not establish the compensability of her preexisting mid-cervical spondylosis condition pursuant to ORS 656.225.[1] On review, claimant asserts that she has established a compensable claim regarding her mid-cervical spondylosis condition under ORS 656.225.[2] For the following reasons, we disagree with claimant.

Claimant is employed as a registered nurse. On October 24, 1995, claimant slipped and fell on a wet, freshly mopped floor at work. That same day, she filed a claim for injuries to her left knee, left shoulder, and right hip. (Ex. 1). On December 5, 1995, she first sought medical treatment for neck pain, numbness in her ring and small fingers, and other problems. (Ex. 2-6). At that time, Dr. Irvine, claimant's treating physician, found "rather significant mid-cervical spondylosis at C5-6 with disk space narrowing, osteophyte formation, and hypertrophied uncinate processes" on x-ray examination. Id.

By letter dated December 11, 1995, the employer denied compensation for all claimed injuries. (Ex. 4). By letter dated December 19, 1995, the employer amended its denial, denying compensation for claimant's current condition requiring medical services for mid-cervical spondylosis and degenerative arthritis of the left knee, as well as left knee, left shoulder, and right hip injuries. (Ex. 5). On March 13, 1996, the employer accepted the claim for nondisabling cervical and left knee strains. (Ex. 9). Claimant requested a hearing regarding the employer's denial, among other issues. At hearing, the compensability issue was limited to the preexisting mid-cervical spondylosis condition.

Here, the only medical opinion is provided by Dr. Irvine, who first treated claimant for the October 1995 work injury on December 5, 1995. (Ex. 2-6). At that time, regarding claimant's cervical condition, Dr. Irvine noted significant preexisting mid-cervical spondylosis and opined that claimant had a "[w]ork-related injury aggravating and causing symptoms associated with mid-cervical spondylosis." Id. He also stated that claimant remained capable of performing "her normal duty work as a nurse." Id. He recommended a conservative management program, prescribing medications and physical therapy.

Dr. Irvine next saw claimant on January 19, 1996, at which time he opined that claimant had a "documented cervical strain superimposed upon cervical spondylosis." (Ex. 2-7). He found that claimant was still having significant symptoms in her neck and recommended continued over-the-counter anti-inflammatory medications and home exercises.

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[1] ORS 656.225 provides, in relevant part:

"In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:

"(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.

"* * * * *

"(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) or (2) of this section, and not merely as an incident to the treatment of a compensable injury or occupational disease."

[2] We note that, although claimant asserts that "the medical services directed to her preexisting mid-cervical spondylosis condition are authorized under ORS 656.225(1), she also appears to assert that the preexisting spondylosis condition itself is compensable under ORS 656.225(1). (Appellant's Brief, pages 4-7). By its terms, ORS 656.225(1) authorizes finding "disability solely caused by or medical services solely directed to a worker's preexisting condition" compensable where "work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition." (Emphasis added). Therefore, it would appear that ORS 656.225(1) does not authorize finding the preexisting condition itself compensable. However, given the unpersuasiveness of the medical record in this case, as later explained, we need not address this issue.

On March 13, 1996, Dr. Irvine provided claimant's attorney with a narrative report. (Ex. 8). He stated that "[i]t is my opinion that [claimant] had pre-existing mid-cervical spondylosis prior to the 10/24/95 injury but that the major contributing cause as to the substantial worsening of her symptoms and the need for subsequent treatment was in fact the work-related fall of 10/24/95." (Ex. 8-2). He also stated that claimant's "cervical condition, although pre-existing, was asymptomatic prior to this [October 24, 1995] fall and her subsequent need for treatment is, in my opinion, directly related to the pathologic changes associated with this fall." Id.

Claimant relies on the Dr. Irvine's notation of "pathologic changes associated with this fall" in Dr. Irvine's March 13, 1996 report to argue that she has established compensability of her preexisting mid-cervical spondylosis condition/treatment under ORS 656.225(1). We disagree.

By its terms, ORS 656.225 is limited to "disability solely caused by or medical services solely directed to a worker's preexisting condition." (Emphasis added). Here, there is no evidence of disability in that claimant remains released to full duty, nor is there indication of other possible disability due to the preexisting condition.[3] (Ex. 2-6). Although there is evidence of medical services, there is no evidence that those medical services are solely directed to the preexisting cervical spondylosis condition. To the contrary, Dr. Irvine relates claimant's need for medical services to the work injury. Indeed, the parties stipulated at hearing that the employer would pay all outstanding medical bills. (Tr.2)

Furthermore, ORS 656.225(1) requires that the "work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition." We do not find persuasive Dr. Irvine's unexplained conclusion that the work injury caused "pathological changes" to claimant's preexisting cervical condition. In this regard, Dr. Irvine examined claimant twice regarding the October 1995 work injury. During the first examination, Dr. Irvine took x-rays that revealed preexisting spondylosis. No further radiographic tests were taken and Dr. Irvine offers no explanation for his subsequent statement that the work injury caused "pathological changes." (Ex. 8-2). 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). Here, given the fact that Dr. Irvine did not explain his statement regarding the "pathological changes", we find persuasive reasons not to defer to his opinion. See Somers v. SAIF, 77 Or App (1986) (greatest weight given to well-reasoned medical opinions); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical opinion). Therefore, we do not find that claimant has established that the work injury was the major contributing cause of a pathological worsening of the preexisting mid-cervical spondylosis condition. ORS 656.225(1).

Accordingly, on this record, claimant has failed to establish a compensable claim regarding her preexisting mid-cervical spondylosis condition pursuant to ORS 656.225.

ORDER

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

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[3] Claimant appears to argue that since, in her capacity as a nurse, she determined that it was necessary to stay home at times and reduced her work hours, she has established the "disability" factor. However, Dr. Irvine explicitly stated that claimant "remains capable of doing her normal duty work as a nurse." (Ex. 2-6). Therefore, the medical evidence does not support claimant's argument regarding the disability factor.

In the Matter of the Compensation of
PATRICIA J. HOFSTETTER, Claimant
WCB Case Nos. 96-01165 & 95-10561
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

The self-insured employer requests reconsideration of our November 19, 1996 order which set aside its denial of claimant's claim for a left shoulder condition. The employer objects to the portion of our order which finds that the employer's denial was based solely on a lack of objective findings and declines to consider medical causation.

On December 12, 1996, to further consider the employer's motion, we abated our November 19, 1996 order. In our abatement order, we granted claimant an opportunity to respond to the employer's motion. Having now received claimant's response and the employer's reply, we proceed with our reconsideration.

The employer objects to our conclusion that its denial was based on a lack of objective findings and that it would be fundamentally unfair to decide the dispute based on a theory different from that litigated at hearing. Specifically, the employer asserts that it should not be estopped from contending that medical causation has not been established by claimant.

The employer's denial stated, in pertinent part: "We are denying compensability of your left shoulder strain claim because Dr. Robert Davis reports there are no objective findings. Therefore, without waiving further questions of compensability, we issue this denial of your claim for benefits."[1] (Ex. 53). A letter from the employer's claims processor to claimant's attorney also indicates that the right shoulder claim was being denied "because there are no objective findings." (Ex. 52A). Finally, in his opening statement at hearing, the employer's counsel stated:

> " * * * I wrote Dr. Davis a letter * * * And in that I just listed or wrote out the statutory definition of objective findings. I said, this is what the objective - - how objective findings are defined by 656.005(19). And I - - the letter goes on to ask [claimant] mention (sic) that she had some left-sided complaints, are there objective findings. And so he responded that - - on January 5 and said, "you are correct in your understanding that [claimant] had some left-sided shoulder complaints, but at the time I saw her, there were no objective findings to support her problem," so [employer] issued the Denial on the basis that there wasn't any - - weren't any objective findings to support the left-sided complaints. And Dr. Davis was the treating physician for all those left - - for all those shoulder complaints, so that's why the denial was issued."

Based on this record, it appears that the issue litigated at hearing was whether or not there were "objective findings" of an injury. There was no contention raised on the record that the claim failed because medical causation was not established. A carrier is bound by the express language of its denial. Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993). Here, the specific basis given for the denial was a lack of objective findings supporting the claim. Accordingly, we find that the only compensability issue raised at hearing was the issue of whether claimant's claim was supported by "objective findings."

Parties to a workers' compensation proceeding may, by agreement, try an issue that is outside the express terms of the denial. See Weyerhaeuser Co. v. Bryant, 102 Or App 423, 435 (1990); Judith M. Morley, 46 Van Natta 882, 883, on recon 46 Van Natta 938 (1994). Based upon the transcript, the existence of objective findings was the theory that was raised by the employer at hearing in support of the denial and that was the issue litigated by the parties.

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[1] Although the denial contains a statement that further questions of compensability are not waived, the only specific basis raised at hearing was a lack of objective findings. Thus, based on the hearing record, claimant received no notice prior to the time of Board review that the employer was raising any specific defense other than a lack of objective findings.

In John E. Noyer, 46 Van Natta 395 (1994), a carrier raised a "causation" theory at hearing even though the carrier's denial had only denied the claim based on a lack of "objective findings." The Board found that, by raising the "causation" theory, the carrier had amended its denial. Accordingly, the Board remanded to allow claimant to respond to the "amended" denial. Here, in contrast to Noyer, the employer did not seek to amend its denial at hearing and, according to the record, asserted only that objective findings had not been established. Under such circumstances, we find that there was no attempt to amend the denial at hearing.

To allow the employer to raise a new defense after the close of the evidentiary hearing would prejudice claimant if the case were resolved on that basis. Based on the employer's denial, the claim was denied because there were no "objective findings." Based on the record at hearing, whether there were "objective findings" was the issue litigated. To decide the case on a different basis than was litigated at the hearing would be fundamentally unfair. See Terry Hickman, 48 Van Natta 1073 (1996); Greg S. Meier, 45 Van Natta 922, on recon 45 Van Natta 1015 (1993).[2] Thus, we continue to adhere to our prior decision not to address medical causation and to limit our review to whether there are "objective findings" supporting claimant's left shoulder claim.

Claimant's attorney is entitled to an attorney fee for his additional 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 review is $300, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response on reconsideration), the complexity of the issue, and the value of the interest involved. This fee is in addition to that awarded by our November 19, 1996 order.

Accordingly, as supplemented and modified herein, we republish our November 19, 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] The employer argues that it is not "estopped" from raising causation. We emphasize that we are not basing our decision on the basis of estoppel or waiver. Rather, we are declining to decide the case on a defense theory that was not raised or litigated at hearing. See Cynthia A. Watson, 48 Van Natta 609 (1996) (Board declined to address defense not raised at hearing); see also Joseph D. McRorie, 46 Van Natta 253 (1994).

In the Matter of the Compensation of
KARL A. McDADE, JR., Claimant
WCB Case No. TP-96005
THIRD PARTY ORDER
Victor Calzaretta, Claimant Attorney
David Jorling, Defense Attorney

The City of Portland, a self-insured employer and paying agency, has petitioned the Board for an order setting aside claimant's third party settlement with State Farm Insurance. Specifically, the employer contends the third party settlement is null and void under ORS 656.587 because it was made without the approval of the paying agency or the Board.

We conclude that the Board may properly exercise jurisdiction over this matter and that the third party settlement is void.

FINDINGS OF FACT

Claimant is a police sergeant with the City of Portland Police Bureau.[1] On April 5, 1994, claimant was compensably injured when his police car was struck by another vehicle, driven by

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[1] Claimant is not a member of the Portland Fire and Police Disability Fund ("Fund") and is therefore not exempt from workers' compensation coverage under ORS 656.027(6).

Alexandra McKenzie. He completed an 801 form, alleging an injury to his neck and back. (Ex. 1). On May 13, 1994, the employer accepted a cervical sprain/strain arising out of the April 5, 1994 accident. (Ex. 3).

On May 19, 1994, the employer notified Ms. McKenzie's insurer, State Farm Insurance, of the employer's workers' compensation lien rights. (Ex. 4). State Farm acknowledged the employer's lien by letter dated June 24, 1994. (Ex. 6).

Meanwhile, on May 23, 1994, claimant, though his attorney, initiated a personal injury/negligence action against Ms. McKenzie in Multnomah County Circuit Court.[2] (Ex. 5). The employer was not advised of claimant's election to pursue an action for damages against Ms. McKenzie.

In late June 1994, claimant was referred by his attending physician to Portland Rehabilitation for physical rehabilitation of injuries sustained in the work-related automobile accident. On July 7, 1994, Portland Rehabilitation issued a report summarizing claimant's physical evaluation and rehabilitation treatment plan. This report was copied to claimant's attorney. (Ex. 9).

In November 1994, the employer wrote to State Farm, advising Ms. McKenzie's insurer that it had paid $3,251.53 in medical services for claimant's work-related injuries. (Ex. 12).

Unbeknownst to the employer, claimant agreed to settle his third party action against Ms. McKenzie for the sum of $7,500. In a December 20, 1994 letter to claimant's counsel, Ms. McKenzie's counsel confirmed the parties' "express understanding" that claimant's attorney "will satisfy any and all existing liens and subrogated interests from the proceeds of the settlement and hold [Ms. McKenzie] and State Farm Insurance harmless from all such liens and subrogated interests." (Ex. 13). As a result of the settlement, the trial court dismissed claimant's negligence action against Alexandra McKenzie on January 13, 1995. (Ex. 15).

On January 23, 1995, the employer sent State Farm an update on the amount of its workers' compensation lien. (Ex. 16). On April 10, 1995, the employer was contacted by claimant's attorney's office requesting copies of the medical billings arising out of claimant's workers' compensation claim. Claimant's attorney advised the employer that he was not representing claimant with regard to his workers' compensation matter but was claimant's counsel in another action involving a previous motor vehicle accident which was set for trial in a few days. (Ex. 17).

On June 5, 1995, the employer wrote to State Farm asking for an update on the status of claimant's third party claim. (Ex. 19). State Farm responded that it had settled the third party claim with claimant in January 1995, and sent the employer a copy of the January 9, 1995 Release Agreement. (Ex. 14) This was the employer's first knowledge of the third party settlement.

On July 10, 1995, the employer advised State Farm that the settlement was void under ORS 656.587, and requested reimbursement of $3,251.53, the amount of its lien. (Ex. 20). By letter dated August 3, 1995, Ms. McKenzie's attorney provided the employer with a copy of his December 20, 1994 letter to claimant's attorney indicating that claimant's attorney would be responsible for satisfying all existing liens out of the settlement proceeds. (Ex. 21). On August 7 and September 19, 1995, and February 8, 1996, the employer wrote to claimant's attorney advising him that the third party settlement was void and demanding payment of its lien. (Exs. 22, 23, 24). Claimant's attorney did not respond to the employer's demand.

On May 30, 1996, the employer filed a motion in Multnomah County Circuit Court seeking to set aside the stipulated judgment of dismissal in Karl V. McDade v. Alexandra McKenzie, Case No. 9405-03541. (Ex. 29). On August 5, 1996, the trial court issued an order denying the employer's motion based on lack of standing. (Exs. 30, 31). That order is currently on appeal before the Court of Appeals. (Ex. B).

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[2] This complaint (Civil Action No. 9405-03541) also stated a negligence/ personal injury claim against Sonia Louise Strege and her employer, the State of Oregon, arising out of a June 17, 1993 automobile accident, which occurred when claimant was off duty.

CONCLUSIONS OF LAW AND OPINION

If a worker sustains 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. If the worker elects to recover damages directly from the third party, the paying agency shall be notified of the action and 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. ORS 656.576.

In this case, claimant sustained a compensable injury as a result of the negligence of a third person, Ms. McKenzie. The employer accepted claimant's claim and paid compensation. Because the employer paid benefits to claimant as a result of his compensable cervical strain, it is a paying agency under ORS 656.576. Pursuant to ORS 656.580(2), the employer has a lien against the third party cause of action which is superior to all claims except the costs of recovering such damages.

Although he did not provide notice to the employer, claimant elected to sue Ms. McKenzie and her insurer for damages arising out of the April 5, 1994 automobile accident. Since claimant elected to proceed directly against the third parties, the provisions of ORS 656.580(2) and 656.593 became applicable.[3] See Dennis Youngstrom, 47 Van Natta 1622 (1995). In other words, by virtue of the aforementioned statutory provisions, the employer's lien for its claim costs would attach to claimant's recovery and that lien would be preferred to all other claims. Santos King, 47 Van Natta 2026 (1995).

The employer contends that the third party settlement between claimant and Ms. McKenzie/State Farm is null and void because it was made without the approval of the paying agency or the Board.[4] We agree.

ORS 656.587 provides, in pertinent part:

> "Any compromise by the worker * * * of any right of action against an employer or third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the board."

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[3] Claimant asserts that the insurer lacks standing to challenge the third party settlement because it did not serve an election demand on claimant pursuant to ORS 656.583(1). Claimant is mistaken. ORS 656.583(1) provides that the paying agency may require the worker to exercise the right of election by serving a written demand. The permissive language of the statute gives the paying agency the right to compel the claimant's election when he or she fails to take prompt action but does not create any duty on the paying agency to do so. Further, in this case, ORS 656.583(1) is irrelevant because claimant promptly made the election and instituted an action against the third party on his own behalf. See ORS 656.593 (worker who elects to recover damages must notify the paying agency of the action).

[4] Claimant moved to dismiss the employer's petition based on the employer's pending appeal of the circuit court's order denying its motion to set aside the stipulated dismissal. Claimant also seeks sanctions for the employer's alleged "dual forum shopping." We deny the motion and claimant's request for sanctions, because, as discussed infra, we are the appropriate forum to approve or invalidate a third party settlement. We also find that the Court of Appeals' matter raises different issues, i.e., whether the employer was a party to the civil proceeding and whether it has standing to move to set aside the stipulated judgment of dismissal.

In addition, claimant contends that the exhibits submitted in support of the employer's petition were not properly certified or authenticated. Although claimant challenges the form of the employer's petition (specifically, the absence of an affidavit), he does not contest the ultimate facts set forth therein, i.e., that (1) he filed an injury claim with his employer arising out of an April 1994 motor vehicle accident; (2) the claim was accepted and processed; (3) he settled a third party action involving the same accepted injury; and (4) he did not seek the employer's approval of the settlement. Because claimant does not dispute these essential elements, we do not consider the lack of an authenticating affidavit fatal to the employer's petition. Moreover, even assuming such formal authentication was required, the employer submitted an affidavit of counsel along with its reply brief which attests to a phone conversation and correspondence with claimant's counsel and authenticates certain documents attached thereto. This affidavit and the attached authenticated exhibits further confirm the existence of the third party action arising out of the April 1994 incident which was settled by claimant and the third party's insurer without the employer's approval. These events are also confirmed by documents attached to claimant's response and authenticated by his counsel. (Such as the filing of a civil action for an April 1994 injury and its settlement between claimant and the third party insurer, with no indication of the City of Portland's approval). Thus, we also reject claimant's procedural challenge to the employer's petition.

In Catherine M. Knapp, 36 Van Natta 1630 (1984) we held that, by virtue of ORS 656.587, "settlement of a civil action entered into without obtaining the prior approval of the industrial insurer is void." We concluded, however, that when a paying agency is aggrieved as a result of the failure to obtain approval, the paying agency's remedy would not lie with this agency. Rather, we noted that it would be necessary for the paying agency to seek enforcement of its lien through civil proceedings.

Subsequent to our Catherine M. Knapp decision, the Oregon Supreme Court has indicated that the Board is the proper forum to invalidate a settlement made without the prior approval of the paying agency. In Toole v. EBI Companies, 314 Or 102 (1992), the Court specifically held that we acted properly in voiding third party settlements where the settlements were executed without the approval of the paying agency or order of the Board.[5] There, the issue was whether the paying agency's lien extended to the proceeds of a malpractice action against a claimant's attorney based on the attorney's mishandling of the claimant's third party action. The Court held that such malpractice actions were third party actions under ORS 656.593 to which a paying agency's lien extended. In upholding the Board orders insofar as they declared the respective malpractice settlements void, the Supreme Court stated:

> [T]he Board had jurisdiction to resolve whether the claims against the attorneys are third party claims, *whether the malpractice settlements were void for lack of approval by the paying agencies or the Board, ORS 656.587*, and whether the paying agencies were entitled to a "just and proper" share of the settlement proceeds. ORS 656.593(3). 314 Or at 109 (emphasis added).

Along the same lines, in Weems v. American International Adjustment Company, 319 Or 140 (1994), the court affirmed our decision to disapprove a third party settlement under ORS 656.587 that was, in our opinion, grossly unreasonable. In Everett L. Weems, 44 Van Natta 1182 (1992), the claimant sought Board approval of third party settlement. We declined to approve the settlement because it was disproportionate to and significantly less than the settlement of the claimant's wife's loss of consortium claim. On appeal, the claimant and the third party argued that the Board should defer to the opinion of a circuit court settlement judge that the proposed settlement was reasonable. In affirming our order, the Court held "[t]he settlement judge has no authority to approve or disapprove a claimant's compromise of a third party action. Under ORS 656.587, any such compromise is 'void' unless approved by the paying agency or the Board." Weems, supra, 319 Or at 144.[6]

Although we did not find the third party settlement in Weems "void" per se, the net effect of our order was to undo a settlement agreement between the claimant and the third party made without the approval of the paying agency. In light of Toole and Weems, we conclude that we have jurisdiction to declare a third party settlement void under ORS 656.587 where the compromise was made without approval of the paying agency or the Board.[7]

Here, the record establishes that the employer was unaware of claimant's settlement with Ms. McKenzie and State Farm. Because the employer was not allowed the opportunity to object to the settlement agreement, the settlement is void under ORS 656.587.[8]

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[5] See Charlene Toole, 41 Van Natta 1392 (1989) (third party settlement void because paying agency was not allowed an opportunity to object to settlement); see also Victor S. Lloyd, 41 Van Natta 1444 (1989) (same); Roger L. Shepard, 41 Van Natta 1749 (1989) (same).

[6] The Weems court also held as follows:

> "As the body generally charged with matters relating to the adjudication of claims under the Workers' Compensation Law, the Board plays a key role in the workers' compensation system. * * * In that role, the Board is responsible for resolving many of the disputes that arise between claimants and paying agencies, whether insurers or self-insuring employers. The legislature's choice to grant to the Board approval authority over the settlement of third-party actions reflects the important role that the Board plays in the workers' compensation system as an arbiter of disputes between participants in the system." 319 Or at 145.

[7] We also have the authority to approve proposed settlements under this section. See, e.g., John C. Lappen, 43 Van Natta 63 (1991). In this case, however, neither party has requested that the $7,500 settlement be approved. In addition, the parties have not presented any evidence regarding the reasonableness of the purported settlement.

[8] Neither claimant nor Ms. McKenzie sought Board approval of the compromise prior to executing the settlement and release.

In response to the employer's petition, claimant asserts that he was never notified of the employer's lien. We find this contention untenable as well as irrelevant. Claimant was injured in the course and scope of his employment and filed a claim arising out of the April 1994 accident. The employer sent claimant an acceptance. Claimant had treatment for his injuries, including a rehabilitation evaluation and treatment plan. Claimant's counsel was copied on the rehabilitation evaluation report. In addition, claimant's counsel later requested from the employer copies of claimant's medical billings arising out of his compensable injury. On this evidence, we find that claimant had at least constructive knowledge of the employer's lien. More importantly, regardless of whether claimant was aware of the lien, the employer is a paying agency under ORS 656.576 and has a statutory right to recovery from the proceeds of claimant's third party action.[9] ORS 656.580(2) and 656.593.

In conclusion, we find that we have the authority under ORS 656.587 to declare void a third party settlement made without the paying agency's knowledge or consent. Because claimant's $7,500 settlement with Ms. McKenzie and State Farm was made without the employer's approval or an order of the Board, the settlement is void.[10]

IT IS SO ORDERED.

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[9] There is no requirement that the paying agency "notify" the claimant of its lien. Rather, under the third party statutes, a paying agency has an automatic lien when a claimant receives a compensable injury in the course and scope of employment due to the negligence or wrong of a third person. See ORS 656.578, 656.580(2).

[10] Claimant also disputes the amount of the employer's lien, arguing that the employer may have paid medical bills arising out of the noncompensable June 1993 automobile accident. Our determination that the third party settlement is void renders moot any question about the extent of the employer's lien as applied to that settlement. See Toole v. EBI Companies, supra, 314 Or at 112.

In the Matter of the Compensation of
JAY L. STILES, Claimant
WCB Case No. 96-01331
ORDER ON REVIEW
Gatti, Gatti, 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) Spangler's order that: (1) concluded that claimant's injury claim for broken rib and herniated disc conditions was procedurally barred under the terms of a Stipulation; and (2) upheld the SAIF Corporation's partial denials of claimant's injury claim for the same conditions. Claimant contends that the Board should consider extrinsic evidence of the parties' intent in entering into the Stipulation. On review, the issue is the preclusive effect of the parties' stipulation.

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

We briefly summarize the relevant facts. On July 6, 1995, claimant filed a claim for "back strain, broken rib, kidney" on the right side, allegedly resulting from an industrial accident on June 21, 1995. (Ex. 4). On August 15, 1995, Dr. Litcher filed an 827 claim form in which he diagnosed claimant's condition as "contusion right flank" and "right leg radiculopathy." On July 27, 1995, an MRI scan revealed a right herniation of the L5-S1 disc with displacement of the S1 nerve root. (Exs. 6, 11). On September 21, 1995, SAIF denied claimant's injury claim, stating that work activities were not the major contributing cause of the "Contusion Right Flank." (Ex. 10). On October 18, 1995, claimant sought neurological evaluation of his right leg symptoms from Dr. Buza, who requested authorization for surgical decompression. (Ex. 11). That same day, Dr. Buza completed an 827 claim form diagnosing S1 radiculopathy on the right and relating the condition to work. (Ex. 12).

On October 31, 1995, claimant requested a hearing on the September 21, 1995 denial. (Ex. 13). Claimant and SAIF subsequently entered into a Stipulation and Order that stated:

> "Claimant filed a claim for an injury to his right side sustained on or about June 21, 1995. SAIF Corporation denied the claim on September 21, 1995. Claimant filed a Request for Hearing to appeal the denial and raise other issues.
>
> "The parties agree to settle all issue(s) raised or raisable at this time as follows:
>
> "SAIF Corporation agrees to accept the following condition: Contusion, right flank.
>
> "Claimant's attorney is allowed a fee of $1,700.00 for prevailing on a denied claim, payable in addition to compensation.
>
> "The Request for Hearing is dismissed with prejudice." (Ex. 16).

The Stipulation and Order was signed by a prior ALJ on December 20, 1995. SAIF accepted the right flank contusion as a disabling injury. (Ex. 17). Subsequently, claimant requested that the claim acceptance be amended to include the broken rib and herniated disc conditions. (Ex. 21). By letters dated January 30 and February 7, 1996, SAIF denied the broken rib and herniated disc conditions, contending that the claim for those conditions was barred by the December 20, 1995 stipulation. (Exs. 22, 23). Claimant requested a hearing on those denials. Concluding that the rib and disc conditions were barred by the terms of the stipulation, the ALJ upheld the denials.

On review, claimant argues that the stipulation is ambiguous on a material matter, and that, therefore, the parties' intentions and the circumstances under which the agreement was reached are relevant in ascertaining the meaning of the agreement. Specifically, claimant contends that the term "all issues" was limited to the issues raised or raisable out of his October 31, 1995 request for hearing and was not intended to settle all claims for all conditions arising out of the injury, and, had the parties intended to include other issues, i.e., compensability of the herniated disk and broken rib issues, they would have so indicated. Accordingly, claimant asks the Board to consider extrinsic evidence of the parties' intent in interpreting the stipulation.

The stipulation states that it covers the June 21, 1995 injury claim; it also states that it is an agreement by the parties to settle "all issue(s) raised or raisable at this time." At the time the parties entered into the stipulation, claimant had filed a claim for a broken rib and his doctors had filed claims for the right radiculopathy on his behalf. In addition, both claimant and SAIF knew that Dr. Buza's request for surgical decompression of his herniated disc at L5-S1 was pending. (Exs. 4, 6, 11, 12). Although the stipulation did not specifically mention the broken rib and herniated disc conditions, it unambiguously provided that claimant's hearing request on the denial of his June 21, 1995 injury claim would be dismissed with prejudice as to all issues which were raised or could have been raised as of the date of the ALJ's signature.

In light of such circumstances, we conclude the stipulation was intended to be a complete and unambiguous statement of the parties' rights and obligations regarding issues "raised or raisable" at that time, including the issue of compensability of the rib and disc conditions. Because we find no ambiguity in the document, we decline to consider extrinsic evidence of the parties' intent in interpreting the stipulation. See Sisters of St. Joseph v. Russell, 318 Or 370 (1994) (unambiguous contracts must be enforced according to their terms).

Rather, the proper inquiry is to determine whether the compensability of claimant's rib and disc conditions could have been negotiated before approval of the settlement. The ALJ found, based on Good Samaritan Hospital v. Stoddard, 126 Or App 69, rev den 319 Or 572 (1994), that claimant was barred from asserting the compensability of his disc and rib conditions because those issues could have been raised and negotiated before approval of the parties' December 20, 1995 stipulation.

Claimant argues that the ALJ's reliance on Stoddard is misplaced. Citing Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993), claimant reasons that, because SAIF had not denied the disc and rib conditions prior to the December 20, 1995 stipulation, there was no controversy to negotiate at the time of the stipulation. Claimant's argument is inapposite.

Although in Seney, a denial had issued, the court held that, by the terms of their settlement, the parties settled all issues that were raised or could have been raised before the settlement was approved. The Seney holding was clarified in Stoddard, in which the court rejected the idea that the compensability of the claimant's condition was not ripe until the insurer had issued a denial. Instead, the court held that the correct inquiry was "whether claimant's condition and its compensability could have been negotiated before approval of the settlement." 126 Or App at 73. This analysis is based on contract law, not principles of claim or issue preclusion. See id. at 72.

Subsequent to the ALJ's order, the Court of Appeals issued Pollock v. Tri-Met, Inc., 144 Or App 431 (1996), stating that the correct interpretation of an unambiguous agreement is a question of law to be decided based on the terms of the agreement as a whole, and that the construction to be given such an agreement is to render all of its provisions harmonious and to carry into effect the actual purpose and intent of the parties as derived from the terms of the agreement. Id. at 435.

Here, the evidence shows that claims for the broken rib and herniated disc were filed with SAIF, either by claimant or by his doctors on his behalf, prior to the settlement negotiations that took place between the parties beginning approximately November 1, 1995 (the date SAIF received claimant's request for hearing on its September 21, 1995 denial), and which culminated in the proposed stipulation on December 12, 1995. (Exs. 13, 14). This executed stipulation was approved by a prior ALJ on December 20, 1995.

Moreover, the settlement agreement states that claimant filed a claim for a June 21, 1995 injury to his right side, which had been denied. The language of the document then states that "[t]he parties agree to settle all issue(s) raised or raisable at this time" by SAIF's agreement to accept a "contusion, right flank." The parties also agreed that claimant's attorney was allowed a fee for "prevailing on a denied claim." (Emphasis added). Finally, the parties agreed that claimant's request for hearing on the denial (of the June 21, 1995 claim) was dismissed with prejudice.

Consequently, we conclude that the express purpose and intent of the parties at the time of the agreement, as derived from all of the provisions of the agreement, was to settle the dispute over claimant's denied June 21, 1995 injury claim by SAIF's agreement to accept claimant's right flank contusion.

ORDER

The ALJ's order dated May 17, 1996 is affirmed.

Board Chair Hall dissenting.

The majority concludes that claimant's claim for broken rib and herniated disc conditions was filed prior to approval of the parties' stipulation, and is therefore barred under the terms of the stipulation. Because the majority misanalyzes case law concerning the interpretation and preclusive effect of settlement agreements, I respectfully dissent from its decision.

As clarified by the court in Pollock v. Tri-Met, Inc., 144 Or App 431 (1996), settlement agreements are contracts and must be construed based on general principles of contract law. Those principles require that the agreement be construed so as to give effect to the actual purpose and intent of the parties, as derived from the terms of the agreement itself. Id. at 435.

Thus, the critical inquiry in this case is whether the parties intended to resolve the issues of compensability of the rib and disc conditions. Contrary to the majority's assertion, the fact that a claim was filed for a condition prior to the settlement agreement is, in and of itself, not dispositive; the terms of the agreement itself must still be examined to determine what the parties actually intended to resolve, i.e., over what terms was there a "meeting of minds."

Based on my examination of the terms of the parties' stipulation, I must disagree with the majority's conclusion that the parties' intended to resolve any and all "issues raised or raisable" regarding the June 21, 1995 injury claim (i.e., the entire universe of potential issues). The stipulation expressly refers to SAIF's September 21, 1995 denial and claimant's "Request for Hearing to appeal the

denial and raise other issues." The stipulation then states that "[t]he parties agree to settle all issue(s) raised or raisable at this time." (Ex. 16-1). Based on the language of the settlement itself, "issue(s) raised or raisable" was intended to refer to issues relating to SAIF's September 21, 1995 denial and claimant's hearing request from the denial. Had the parties intended all "issue(s) raised or raisable" to cover all issues relating to the injury claim as a whole, the stipulation would not have so narrowly referenced the September 21, 1995 denial and claimant's request for hearing of that denial; more importantly, the parties would have used broader language to include the entire scope of the injury claim. Instead, the terms of the stipulation limit its scope to issues arising from SAIF's denial.[1]

To the extent the stipulation is ambiguous, the underlying documents support the dissent's interpretation. Turning to the denial itself, though it is also somewhat ambiguous in referring to claimant's claim "for an alleged injury to [the] chest," the denial goes on to specifically deny the condition diagnosed as "Contusion Right Flank." (Ex. 10). Based on the specific and unambiguous portion of the denial, I interpret it as denying the right flank contusion only. My interpretation of the denial is supported by the fact that the parties resolved their dispute concerning the denial by stipulating to acceptance of the right flank contusion. No other condition is mentioned in either the denial or the parties' stipulation. The scope of the stipulation reflects the scope of the denial and the request for hearing of that denial.

Under these circumstances, I would interpret the parties' stipulation as being limited to the condition diagnosed as right flank contusion. In other words, I conclude that the parties' "meeting of minds," as reflected by the terms of the stipulation, was to settle the denied claim for the flank condition only. Moreover, only issues "raised or raisable" in relation to the denied flank condition were intended to be resolved by the parties, not issues relating to the June 21, 1995 injury claim as a whole. Therefore, I would conclude that claimant's claim for the rib and disc conditions is not barred by the stipulation. Further, based on SAIF's concession at hearing that those conditions are related to the June 21, 1995 denial, I would set aside SAIF's denials. For these reasons, I respectfully dissent.

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[1] As support for its conclusion that the parties intended to resolve all issues relating to the June 21, 1995 injury claim, the majority cites to the portion of the stipulation which allowed claimant's attorney a fee for "prevailing on a denied claim." (Emphasis added.) However, a "claim" is not necessarily a reference to the entire injury claim; it can also be any written request for compensation. See ORS 656.005(6). Therefore, a request for acceptance of a component of an injury claim is itself a "claim." With that in mind, I find that the parties' use of the term "denied claim" is entirely consistent with my conclusion that they intended to resolve the denied right flank contusion claim only, not the entire June 21, 1995 injury claim.

In the Matter of the Compensation of
JOWELL WHITE, Claimant
WCB Case No. 96-02739
ORDER ON REVIEW
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that awarded claimant 5 percent scheduled permanent disability for loss of use or function of the right hand, whereas an Order on Reconsideration did not award any scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the ALJ's order. We do not adopt the "Findings of Ultimate Fact" as set forth in the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Based on lost range of motion findings for claimant's right index, middle, and ring fingers, the ALJ concluded that claimant was entitled to a 5 percent award of scheduled permanent disability. We disagree.

To be entitled to permanent disability compensation for his right hand injury, claimant must establish that the impairment is due to the compensable injury. ORS 656.214(2). If a treating physician or medial arbiter makes findings consistent with claimant's compensable injury, and does not attribute the impairment to causes other than the compensable injury, we will construe those findings as showing that claimant's impairment is due to the compensable injury. Kim E. Danboise, 47 Van Natta 2163 (1995).

Here, the compensable injury was to the right hand, specifically, a fracture of the fourth metacarpal shaft. (Exs. 3, 9, 21). There is no evidence that the fingers of claimant's right hand were also injured in the compensable incident. Consequently, although the medical arbiter did report reduced range of motion in claimant's index middle and ring fingers, those findings are not necessarily consistent with an injury to a different body part, i.e., the right hand (fracture of the fourth metacarpal shaft). Therefore, we cannot infer that those findings, absent further explanation, are attributable to claimant's compensable injury. See Silverio Frias-Molinero, 48 Van Natta 1285, 1286 (1996).

Under these circumstances, claimant has not established that he has any permanent impairment attributable to the compensable right hand injury. Accordingly, the ALJ's award of 5 percent scheduled permanent disability is reversed and the Order on Reconsideration is affirmed.

ORDER

The ALJ's order dated June 27, 1996 is reversed. The February 16, 1996 Order on Reconsideration, which did not award any scheduled permanent disability, is affirmed. The ALJ's "out-of-compensation" attorney fee award is reversed.

Board Chair Hall dissenting.

The majority concludes that claimant is not entitled to an award of scheduled permanent disability for lost range of motion in his fingers because "There is no evidence that the fingers of claimant's right hand were also injured in the compensable incident. Consequently, although the medical arbiter did report reduced range of motion in claimant's fingers, those findings are not necessarily consistent with an injury to a different body part, i.e., the right hand (fracture of the fourth metacarpal shaft)". I disagree based on the following reasoning.

To begin, the majority appears to accept the employer's argument that the fourth metacarpal joint is considered a part of the "hand" and thus claimant did not injure his "fingers" and is not, therefore, entitled to permanent disability for his fingers. Although the fingers may not be part of the legal definition of the hand under the "standards," involvement of the fingers is consistent with the medical reality of claimant's "hand" injury. Claimant was injured when he punched a shoplifter with a closed hand with enough force to break the fourth metacarpal bone. The mechanism of injury, hitting the shoplifter with a fist, clearly establishes involvement of claimant's fingers in this injury. Contrary to the majority's conclusion, there is evidence that claimant's fingers were injured. Consequently, the majority errs in concluding that the arbiter's report of reduced range of motion in claimant's fingers are not consistent with the nature of claimant's injury.

Moreover, the medical arbiter specifically indicated that the lost range of motion in claimant's right little finger was due to an old injury and not the compensable injury. Given the medical arbiter's specific exclusion of the little finger, it follows that he believed that the remaining decreased range of motion findings in the fingers were due to the compensable injury. See Kim E. Danboise, supra. On this record, I would conclude that the lost range of motion findings in claimant's fingers are consistent with the compensable injury. Therefore, claimant is entitled to the award of scheduled permanent disability granted by the ALJ. For these reasons, I respectfully dissent.

December 26, 1996 Cite as 48 Van Natta 2573 (1996)

In the Matter of the Compensation of
ATHER FRAZIER, Claimant
Own Motion No. 95-0612M
OWN MOTION ORDER OF ABATEMENT
Martin L. Alvey, Claimant Attorney
Roberts, et al, Defense Attorneys

Claimant requests reconsideration of our November 7, 1996 Own Motion Order Reviewing Carrier Closure, as reconsidered on November 29, 1996, in which we affirmed the insurer's April 8, 1996 Notice of Closure of his claim.

Claimant has obtained new counsel, and requests that the Board extend the time within which counsel may review claimant's claim file. We grant claimant's request, and abate our prior orders. The insurer is requested to file a response to the motion within 14 days of the date of this order. Claimant shall be allowed 30 days from the date of mailing of the insurer's response to submit further evidence and argument. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDDY L. MINER, Claimant
WCB Case No. C603215
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael Strooband, Claimant Attorney
Stan F. Kapustka (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

On November 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 December 2, 1996, we received a "Notice of Claim of Lien" from claimant's former attorney. By letter dated December 4, 1996, we granted the SAIF Corporation and claimant an opportunity to give their respective positions regarding the lien notice. We also granted claimant's former attorney an opportunity to reply. In giving their responses, we invited the parties to address the effect on this matter, if any, of the following cases: Cheri A. Wilson, 48 Van Natta 14 (1996); Ewell McCrae, 47 Van Natta 207, recon den 47 Van Natta 260, recon den 47 Van Natta 422 (1995); Billy Lemons, 46 Van Natta 2428 (1994). Having received claimant's response and his former attorney's reply, we now proceed with our review of the CDA.[1]

In his response, claimant indicates that he hired his former attorney in connection with a proceeding involving temporary disability. Claimant disputes that he fired his attorney in order to avoid paying him a fee. Claimant asserts that he did not need his attorney's services to reach a settlement and indicated that SAIF's claims examiner would not negotiate directly with him regarding a settlement as long as he was represented by an attorney.

Claimant's former attorney disputes claimant's assertions. The former attorney contends that claimant was aware that his attorney had requested reconsideration of SAIF's Notice of Closure with regard to extent of disability. Claimant's former counsel further states:

> "Here, this firm expended considerable efforts representing [claimant] at a hearing regarding an issue concerning his time loss rate. This matter was still pending in November 1996 when he terminated our services and negotiated a CDA with SAIF Corporation. * * * At no time prior to [claimant] terminating our firm in November 1996 did he indicate he wished to abandon the time loss rate claim and enter into settlement negotiations with SAIF concerning his entire claim." (Emphasis added).

Based on his response, we find that claimant's former attorney was not involved in any negotiations regarding the CDA and provided no legal services in connection specifically with the CDA.

In Ewell McCrae, 47 Van Natta 207, recon den 47 Van Natta 260, recon den 47 Van Natta 422 (1995), we declined to approve an attorney fee payable out of the claimant's CDA proceeds where the CDA before the Board was not the same settlement previously negotiated by the former attorney. We reasoned that since the former attorney did not provide services related to the proposed CDA, the attorney had not established an entitlement to a fee from the CDA proceeds.

Here, it is clear from his reply that claimant's former counsel was not involved in any negotiations regarding any settlement, let alone the CDA presently before the Board. Under the circumstances presented here, we are unable to find that claimant's former counsel rendered services on behalf of claimant regarding this CDA.

Accordingly, for the reasons given above, we decline to approve an attorney fee payable from the CDA or to enforce claimant's former attorney's lien. See Ewell McCrae, supra; see also Cheri A. Wilson, 48 Van Natta 14 (1996) (Board declined to approve lien where former attorney and the claimant disputed former attorney's entitlement to an attorney fee from the CDA, and other avenues were available to former attorney to pursue his lien).

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[1] SAIF has not filed a response.

The parties' CDA is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1). There is no statutory basis for disapproving the agreement. Id. Accordingly, the parties' claim disposition agreement is approved.

IT IS SO ORDERED.

December 30, 1996 Cite as 48 Van Natta 2575 (1996)

In the Matter of the Compensation of
JANENNE R. ASTI, Claimant
WCB Case No. 96-02544
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl, Christian and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's mental disorder claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change. In the second paragraph on page 3, we change the date in the first sentence to "mid-February 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 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 July 8, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

Board Member Haynes dissenting.

The majority adopts and affirms the ALJ's order that found claimant's stress-related claim for an adjustment disorder compensable. Because I believe the majority has misconstrued the medical evidence, I respectfully dissent.

The ALJ concluded that claimant had a mental disorder generally recognized in the medical or psychological community. The ALJ and the majority erroneously deferred to Dr. Rasor's opinion. Since Dr. Rasor's opinion is conclusory, confusing and inconsistent, it is not persuasive and is certainly not entitled to any deference.

On December 28, 1995, Dr. Rasor, claimant's family physician, reported that claimant was "stressed out" and had been verbally abused by a fellow employee on December 21, 1995. (Ex. 1). Dr. Rasor indicated that the coworker had previously struck claimant on the back and she was afraid that the coworker would physically assault her. (Id.) The coworker had physically assaulted another employee. (Id.) Dr. Rasor took claimant off work.

On January 2, 1996, Dr. Rasor again authorized time loss "due to stress, neck & back aches, and sleeplessness arising from an on the job situation." (Ex. 3).

The employer wrote to Dr. Rasor on February 6, 1996, asking for a specific diagnosis and whether psychiatric treatment was necessary. Dr. Rasor responded that he did not plan to refer claimant for psychiatric treatment and his diagnosis was "anxiety * * * to verbal and potential physical abuse by a fellow employee." (Ex. 10).

In a later "check-the-box" letter from claimant's attorney, Dr. Rasor agreed that claimant "had an Adjustment Disorder with mixed emotional features which has now resolved." (Ex. 16). Under the "comments" section, Dr. Rasor said:

> "I agree with Dr. Davies' report, specifically, his answer to question #10 (last paragraph in report). Whatever we label her problem as, she obviously was very stressed by the situation at work and now is asymptomatic." (Id.)

The last paragraph of Dr. Davies' report stated:

> "As mentioned above, [claimant] has no psychological or psychiatric diagnosis at this time. There is a possibility that she experienced an Adjustment Disorder with mixed emotional features as a result of her interactions with [a co-worker], but this is less than clear. The situation was certainly stressful and she had an acute emotional response. Nevertheless, I am not convinced that she had a psychiatric disorder. If, indeed, she satisfied the criteria, in the past, for an Adjustment Disorder, it is totally resolved without any evidence of residuals. There is no permanent psychological impairment." (Ex. 12-8).

Dr. Rasor's opinion is not persuasive. Although Dr. Rasor's "check-the-box" letter indicated claimant "had an Adjustment Disorder with mixed emotional features which has now resolved" (Ex. 16), Dr. Rasor had previously diagnosed claimant with "anxiety." (Ex. 10). Dr. Rasor's opinion is entitled to little probative weight because he did not explain why he changed the diagnosis. See Kelso v. City of Salem, 87 Or App 630 (1987).

Moreover, Dr. Rasor's agreement with the "check-the-box" letter was, at best, equivocal. In the "comment" section of the "check-the-box" letter, Dr. Rasor referred to "[w]hatever we label her problem as." (Ex. 16). Dr. Rasor also specifically concurred with the portion of Dr. Davies' report in which Dr. Davies was not convinced that claimant had a psychiatric disorder and there was only a "possibility" that she had experienced an adjustment disorder with mixed emotional features. (Exs. 12-8, 16). Such reasoning is speculative and does not establish claimant's mental disorder diagnosis on the basis of medical probability. See Miller v. SAIF, 60 Or App 557 (1982); Gormley v. SAIF, 52 Or App 1055 (1981).

Dr. Rasor is not a psychiatrist or a psychologist. He did not perform any tests in order to diagnose claimant and he did not refer her for further treatment. Although Dr. Rasor indicated that claimant was "stressed at work," "stress," in and of itself, is not a condition which is generally recognized as a "mental disorder." See, e.g., Keith D. Gregersen, 46 Van Natta 2249 (1994); Nancy L. Lucas, 43 Van Natta 911 (1991).

There are no other medical opinions that support compensability. Claimant has not established that she experienced a mental disorder generally recognized in the medical or psychological community. See ORS 656.802(3)(c). For that reason, I find it unnecessary to address the remaining factors under ORS 656.802(3). The ALJ's order should be reversed.

In the Matter of the Compensation of
JOHN B. SHAW, Claimant
Own Motion No. 96-0277M
OWN MOTION ORDER OF ABATEMENT
Craine & Love, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Claimant requests reconsideration of our December 6, 1996 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The self-insured employer 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.

December 30, 1996 Cite as 48 Van Natta 2577 (1996)

In the Matter of the Compensation of
MANUEL G. DIMAS, Claimant
WCB Case No. 96-00268
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Otto's order that increased claimant's 3 percent (9.6 degrees) unscheduled permanent disability award for a low back condition, as awarded by an Order on Reconsideration, to 13 percent (41.6 degrees). Claimant cross-requests review of that portion of the ALJ's order that authorized SAIF to offset allegedly overpaid temporary disability benefits against claimant's future permanent disability benefits. On review, the issues are extent of unscheduled permanent disability, temporary disability benefits and offset. We modify in part and affirm in part.

STIPULATIONS OF FACT

We change the first stipulation to: "Exhibits 1 through 16, 20 and 21 were submitted at reconsideration and made a part of the reconsideration record. (Tr. 1)."

FINDINGS OF FACT

In the first paragraph, we change "Exhibits 1 through 22" to "Exhibits 1 through 16, 20 and 21."

We adopt the ALJ's "Permanent Disability Findings of Fact" with the following change. We change the last sentence of the "Permanent Disability Findings of Ultimate Fact" to read: "Claimant's residual functional capacity is medium."

We adopt the ALJ's "Overpayment Findings of Fact" with the following changes. In the first paragraph, we change "March 3, 1995" to "March 3, 1994" and we change "March 16, 1995" to "March 16, 1994." We change the last sentence of the first paragraph to read: "In late August, September and October, claimant worked for the employer, but was paid on a piece work basis, rather than an hourly wage, according to how much fruit he picked." We delete the second paragraph of the "Overpayment Findings of Fact." We delete the first paragraph of the "Overpayment Findings of Ultimate Fact" and we change the date in the second paragraph to "1994."

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

The ALJ increased claimant's 3 percent (9.6 degrees) unscheduled permanent disability award for a low back condition, as awarded by an Order on Reconsideration, to 13 percent (41.6 degrees).

Citing ORS 656.726(3)(f)(D)(ii), SAIF argues that claimant is not entitled to a value of 10 for the age, education and adaptability factors because claimant was released by his attending physician to regular work.

ORS 656.726(3)(f)(D) provides:

"Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if:

"(i) The worker returns to regular work at the job held at the time of injury;

"(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

"(iii) The attending physician releases the worker to regular work at the job held at the time of the injury but the worker's employment is terminated for cause unrelated to the injury."

The amendments to ORS 656.726(3)(f) apply only to claims that were medically stationary on or after the effective date of the Act. Or Laws 1995, ch 332, § 66(4). Since claimant became medically stationary on August 4, 1995 (Exs. 13, 21), after the June 7, 1995 effective date of Senate Bill 369, the amendments to ORS 656.726(3)(f) apply to this case. The applicable standards that apply to rating claimant's permanent disability are set forth in Workers' Compensation Department Administrative Orders Nos. 6-1992, 93-056 and 96-068.

SAIF relies on the ALJ's finding that claimant's treating physician released him to regular work without restrictions. SAIF contends that impairment is the only factor to be considered in the evaluation of claimant's disability. ORS 656.726(3)(f)(D)(ii). Claimant argues that he was not released to his job at injury at any time.

On July 18, 1995, Dr. Aversano reported that claimant was "not able to return to his employment as an apple picker but could do light duty work of some sort." (Ex. 9-2). Dr. Aversano reported on August 4, 1995 that claimant was medically stationary. (Ex. 11). In a "check-the-box" letter, Dr. Aversano indicated that claimant was released to regular work on August 21, 1995 and claimant's lumbar strain was medically stationary as of August 4, 1995. (Ex. 12). Dr. Aversano also indicated that claimant had no permanent impairment. (Id.) On September 5, 1995, Dr. Aversano reported that claimant had "tried doing some landscaping work" and was having difficulty tolerating it because of increased pain. (Ex. 14). Dr. Aversano said that, although claimant was medically stationary as of August 4, 1995, he continued to have chronic low back pain and spondylolisthesis. (Id.) Dr. Aversano commented: "He should not be doing heavy labor and I would recommend that while he could work and is medically stationary that he do so in an employment that is less taxing." (Ex. 14).

Claimant relies on Dr. Aversano's September 5, 1995 comment that he "should not be doing heavy labor" to argue that Dr. Aversano never felt claimant could return to his job at injury. Claimant's fruit picker job at injury, however, was not "heavy." Rather, the strength rating of DOT 403.687-018 (Harvest Worker, Fruit) was "medium." We agree with the ALJ that claimant was released to regular work without restrictions on August 21, 1995. (Exs. 11, 12).

Alternatively, claimant argues that ORS 656.726(3)(f)(D)(ii) does not apply because there is no evidence that claimant's job at injury was available.[1]

ORS 656.726(3)(f)(D)(ii) provides that impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if the "attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job[.]" (Emphasis added).

SAIF asserts that there is no direct evidence in the reconsideration record to establish whether or not claimant's regular job was available when he was released to work on August 21, 1995. SAIF contends that, absent evidence to the contrary, it should be presumed that claimant's regular job was available to him when he was released to work.

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[1] Claimant also argues that the ALJ erred by declining to admit Exhibits 19A and 20A and not allowing claimant to testify. Claimant acknowledges that Exhibits 19A and 20A were not part of the reconsideration record, but he contends that excluding this type of evidence unduly deprives him of a fair hearing. We addressed procedural due process arguments in Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), and Dean J. Evans, 48 Van Natta 1092 (1996), and determined that retroactive application of amended ORS 656.283(7) does not violate workers' due process rights.

SAIF has not cited any authority for its argument that we should "presume" that claimant's job was available when he was released to regular work. ORS 656.726(3)(f)(D)(ii) applies only if its terms are met. Here, although claimant's attending physician released him to regular work, the record is insufficient to establish that claimant's job was available. Under these circumstances, we conclude that ORS 656.726(3)(f)(D)(ii) does not apply to this case.

Alternatively, SAIF argues that, if claimant is entitled to a value for the adaptability factor, that value should be 1, rather than 2. SAIF contends that the ALJ erred by concluding that claimant's residual functional capacity was "medium with other restrictions" or "medium/light."

The ALJ relied on the medical arbiter's conclusion that claimant was capable of returning to work in a medium job capacity, but was precluded from frequently "stooping and bending." The ALJ found that claimant's residual functional capacity was "medium with other restrictions" or "medium/light."

Adaptability is measured by comparing claimant's base functional capacity (BFC) to his residual functional capacity (RFC) at the time of becoming medically stationary. Former OAR 436-35-310(2). RFC means 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).

Claimant has an RFC of "medium." He is entitled to use a different classification if he has "restrictions." Former OAR 436-35-310(7) provides, in part:

> "For those workers determined by these rules to have a RFC established between the two categories and also have restrictions, the next lower classification shall be used."

"Restrictions" means that the worker is permanently limited:

> "From frequently performing at least two of the following activities: stooping/bending, crouching, crawling, kneeling, twisting, climbing, balancing, reaching, or pushing/pulling." Former OAR 436-35-310(3)(l)(C) (emphasis added).

Dr. Bald, medical arbiter, reported that claimant "is permanently precluded from frequently performing the following tasks as a result of the work related injury: stooping and bending." (Ex. 20-5). Under former OAR 436-35-310(3)(l)(C), "stooping/bending" constitutes one "restriction." Katherine A. Wood, 48 Van Natta 2196, 2199 n.3 (1996) ("bending" and "stooping" are treated as a single activity). However, claimant has the burden of showing that he is permanently precluded from "at least two" of the aforementioned activities. Former OAR 436-35-310(3)(l)(C). Since claimant has only proven one restriction (stooping/bending), his RFC is correctly determined to be "medium." See Hamlin v. Salem Area Transit, 137 Or App 497 (1995).

Claimant argues that, if we find that bending and stooping constitute one restriction, former OAR 436-35-310(3)(l)(C) is inconsistent with ORS 656.726(3)(f) because the rule "unduly limits the entitlement to impairment as outlined in the statutes."

Under ORS 656.726(3)(f), the Director is charged with the duty to "[p]rovide standards for the evaluation of disabilities." The Board and ALJ's, on the other hand, are charged with the duty to apply the standards adopted by the Director pursuant to ORS 656.726. ORS 656.283(7). We have no statutory authority to invalidate a Director's rule regarding the evaluation of permanent disability and are bound by statute to apply the standards adopted by the Director. Gregory D. Schultz, 47 Van Natta 2265, 2266 (1995).

Claimant's BFC of "medium" is the same as his RFC, which results in an adaptability factor of 1. OAR 436-035-0270(4)(a); 436-035-0310(6). Claimant was 35 years old and was entitled to a value of zero for age. Former OAR 436-35-290(2). Claimant had a fourth grade education. Therefore, he was entitled to a value of 1 for formal education. Former OAR 436-35-300(2)(b). The value for a worker's Specific Vocational Preparation (SVP) time is the highest SVP of any job that the worker has met in the five years prior to determination. Former OAR 436-35-300(3)(b). Harvest Worker, Fruit (DOT 403.687-018), the at-injury job, is claimant's job with the highest SVP in the five years prior to determination. That

job has a SVP of 2, which is rated as an SVP value of 4. Former OAR 436-35-300(4). Adding the age (0) and education (5) factors results in a value of 5. Former OAR 436-35-280(4). That value is multiplied by the adaptability factor of 1, for a total of 5. Former OAR 436-35-280(6). That value is added to the impairment factor of 3, for a total award of 8 percent unscheduled permanent disability. We reduce the ALJ's award accordingly.

Offsett/Overpayment

At hearing, SAIF requested authorization to offset an alleged $8,070.69 overpayment from future disability awards on the basis that it miscalculated temporary disability benefits. Citing Ernest C. Vroman, 48 Van Natta 795 (1996), the ALJ concluded that an extended gap must include a break in the work and the "break" must cause a change in the work relationship between the employer and employee. The ALJ found that, since the breaks in claimant's work activities did not cause a change in the work relationship, there were no extended gaps in claimant's work activities. the ALJ concluded that claimant was overpaid $8,070.69 in temporary disability benefits. Although we agree with the ALJ's conclusion, we base our decision on the following reasoning.

In Ernest C. Vroman, supra, we relied on Earin J. Hadley, 48 Van Natta 216 (1996). After the issued the order in the present case, the Court of Appeals reversed Hadley. Hadley v. Cody Hindman Logging, 144 Or App 157 (1996). In Hadley, the court interpreted an earlier version of former OAR 436-60-025(5)(a) (WCD Admin. Order 12-1992), which provided, in part:

> "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 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."

In this case, the Hadley and Vroman cases are inapposite because a later version of former OAR 436-60-025(5)(a) applies.

Former OAR 436-60-025(1) provides that the rate of compensation shall be based on the wage of the worker at the time of injury, except in the case of an occupational disease. Here, claimant was injured on October 12, 1994. Thus, the rules contained in Workers' Compensation Department Order No. 94-055 apply to this claim. Former OAR 436-60-025(5) (WCD Admin. Order 94-055) provides, in part:

> "The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * *
>
> "(a) 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."

Claimant was employed less than 52 weeks prior to the date of injury. The question is whether there has been a "change in the amount or method of the wage earning agreement during the previous 52-week period." See former OAR 436-60-025(5)(a).

The employer owns and operates a fruit orchard which requires seasonal work to prune and thin trees and pick fruit. At the time claimant was hired on March 3, 1994, the agreement was that claimant would be paid hourly for some duties and by piece work for other duties. (Tr. 20-22). The hourly rate

remained the same while claimant worked for the employer. (Tr. 22). The piece work rate depended on the type of work performed. (Id.) The employer testified that, during claimant's employment, he was paid in the same manner as when he was hired. (Tr. 26).

Claimant worked from March 3, 1994 through March 16, 1994 pruning trees, for which he was paid $5.25 per hour. (Tr. 23). Claimant did not work for the employer during April, May and most of August. (Ex. 17, Tr. 27-28). During those months, claimant worked elsewhere as an orchard laborer. From late August to October, claimant was paid on a piece work basis, according to how much fruit he picked. (Tr. 27). Claimant injured his low back on October 12, 1994, when he fell from a ladder. Claimant did not work for the employer after the injury.

Although claimant had duties that were paid in a different manner, there was no "change in the amount or method of the wage earning agreement" during his employment. Compare Patsy G. Harper, 48 Van Natta 1454 (1996) (the amount and method of the wage earning agreement changed since the claimant was hired). Former OAR 436-60-025(5)(a) provides that, for workers employed less than 52 weeks, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. Thus, since claimant was employed less than 52 weeks, SAIF was required to calculate claimant's temporary total disability by using claimant's actual weeks of employment.

Claimant's temporary disability benefits were initially based on a wage of $420 per week based on the information on the "801" form. However, after performing an audit, SAIF recalculated the temporary disability benefits based on claimant's gross earnings with the employer divided by the 32 weeks he worked there. We conclude that SAIF correctly recalculated claimant's temporary disability benefits and claimant was overpaid $8,070.69. We agree with the ALJ that SAIF is entitled to offset that amount against claimant's future permanent disability benefits.

ORDER

The ALJ's order dated June 3, 1996 is modified in part and affirmed in part. In lieu of the ALJ's award and in addition to the Order on Reconsideration award of 3 percent (9.6 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, for a total award of 8 percent (25.6 degrees) unscheduled permanent disability for the low back. Claimant's counsel's out-of-compensation attorney fee from this award shall be adjusted accordingly. The remainder of the ALJ's order is affirmed.

December 30, 1996 Cite as 48 Van Natta 2581 (1996)

In the Matter of the Compensation of
LARRY C. JACOBS, Claimant
WCB Case No. 96-01722
ORDER ON REVIEW
Coons, Cole, 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) Stephen Brown's order that: (1) found that claimant's aggravation claim for a right shoulder condition was filed prior to the expiration of his five-year aggravation rights; and (2) set aside its denial of claimant's aggravation claim. On review, the issues are jurisdiction and aggravation. We vacate the ALJ's order and dismiss claimant's hearing request.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction and supplementation. On October 20, 1995, Dr. Young, attending physician, filed an aggravation claim with SAIF on a form prescribed by the Director. (Ex. 16).

On June 9, 1989, claimant underwent a right shoulder arthrogram that revealed a rotator cuff tear. (Ex. 5).

On October 30, 1990, claimant's right shoulder claim was closed by a Determination Order that awarded 5 percent unscheduled permanent disability for the surgery and temporary total disability from July 11, 1989 through March 11, 1990. (Ex. 11).

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

On June 15, 1988, claimant sustained a right shoulder injury. On May 19, 1989, the parties entered into a Stipulation wherein SAIF rescinded its "de facto" denial and agreed to accept the right shoulder claim as a nondisabling injury. (Exs. 3, 4). On June 9, 1989, claimant underwent a right shoulder arthrogram that revealed a rotator cuff tear. (Ex. 5). On July 11, 1989, Dr. Young, treating physician, surgically repaired the right rotator cuff tear. (Exs. 6, 7). On August 4, 1989, SAIF reclassified claimant's claim as disabling. (Ex. 8).

On October 30, 1990, the right shoulder claim was closed by a Determination Order that awarded 5 percent unscheduled permanent disability for the surgery and temporary total disability from July 11, 1989 through March 11, 1990. (Ex. 11). The Determination Order also stated that claimant had five years from October 30, 1990, the date of the Determination Order, in which to file an aggravation claim. Id.

Relying on Liberty Northwest Ins. Corp. v. Koitzsch, 140 Or App 194 (1996), the ALJ determined that claimant's aggravation rights had not expired at the time he saw Dr. Young, attending physician, in October 1995. Specifically, the ALJ found that claimant's claim was in "nondisabling status" for only 77 days (from May 19, 1989, the date of the Stipulation, to August 4, 1989, the date SAIF reclassified the claim as disabling). Therefore, the ALJ concluded that ORS 656.273(4)(b)[1] did not apply to limit the filing of an aggravation claim to five years from the date of injury. Instead, the ALJ concluded that, pursuant to ORS 656.273(4)(a), claimant had five years from the date of the October 30, 1990 Determination Order, the first claim closure, within which to file an aggravation claim. Because the ALJ found that claimant perfected a valid aggravation claim within that five year period, the ALJ concluded that the Hearings Division had jurisdiction over the aggravation claim. We disagree with the ALJ's interpretation of Koitzsch. Based on the following reasoning, we find that claimant's aggravation rights expired on June 15, 1993, five years from the date of the June 15, 1988 nondisabling injury.

The filing requirements of ORS 656.273 are jurisdictional. SM Motor Co. v. Mather, 117 Or App 176 (1992);[2] Timothy D. Beard, 43 Van Natta 432 (1991). A claim for additional compensation made outside the time limits of ORS 656.273 falls within the Board's own motion jurisdiction. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Edward R. Reuter, 42 Van Natta 19 (1990).

Unlike the ALJ, we find Liberty Northwest Ins. Corp. v. Koitzsch, supra, distinguishable on its facts. In Koitzsch, the insurer accepted the claimant's left carpal tunnel syndrome condition as disabling. However, the determination order that closed the claim stated that the claimant had five years from the date of injury within which to file an aggravation claim. The claimant requested a hearing regarding this aggravation date. On review, the Board determined that, pursuant to ORS 656.273(4)(a), the aggravation date should be modified to the date of the determination order, i.e., the date of the first claim closure.

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[1] ORS 656.273(4) provides:

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

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

[2] The dissent argues that the Mather decision supports its interpretation of ORS 656.273(4)(b). We disagree. In Mather, the court stated: "[a]s we read ORS 656.2734)(b), it applies only to injuries that were nondisabling at the beginning and remain so for at least 1 year after the original injury." 117 Or App at 181 (emphasis in original). Only by interpreting the phrase "at the beginning" to mean at the time of acceptance, does the dissent find that Mather supports its interpretation. However, we find that the court was referring to the date of injury when using the phrase "at the beginning." Therefore, no elaborate interpretation of the phrase is needed.

On appeal, the court affirmed our decision, agreeing with our prior holdings that "a claim is not deemed to be in nondisabling status unless and until it is accepted and classified as nondisabling." 140 Or App at 197. The court also found the insurer's reliance on Stacy v. Corrections Div., 131 Or App 610 (1994), rev den 320 Or 567 (1995), and Papen v. Willamina Lumber Co., 123 Or App 249 (1993), rev den 319 Or 81 (1994), was misplaced because the claims in those cases had been accepted as nondisabling. Finally, the court concluded that "because the claim here was not in nondisabling status at the time of acceptance, ORS 656.273(4)(a) applies." 140 Or App at 197.

Thus, in Koitzsch, the court focused on whether the claim was accepted as nondisabling in determining whether it was in nondisabling status, a prerequisite making ORS 656.273(4)(b) applicable. In Koitzsch, because the claim had been accepted as disabling rather than nondisabling, ORS 656.273(4)(a) applied. In the present case, unlike Koitzsch, the carrier accepted the claim as nondisabling. (Exs. 3, 4). Therefore, here, unlike Koitzsch, the claim was in nondisabling status at the time of acceptance. Thus, barring reclassification of the claim as disabling within one year from the date of injury, a circumstance that did not occur, ORS 656.273(4)(b) applies.

Under the ALJ's and claimant's interpretation of Koitzsch and ORS 656.273(4)(b), claimant's claim was in "nondisabling status" for 77 days from the date of acceptance as nondisabling until the claim was reclassified as disabling more than a year after the date of injury. Based on this interpretation, the ALJ and claimant conclude that ORS 656.273(4)(b) does not apply. We disagree with this interpretation.

In the first place, this interpretation overlooks the impact of the parties' agreement that the claim was in nondisabling status as of May 19, 1989. Presumably, if the claim had been disabling at any point prior to that time, claimant would not have agreed to have the claim accepted as "nondisabling."

Second, under this interpretation, aggravation rights for claims accepted as nondisabling would essentially run from the date of acceptance rather than the date of injury, as ORS 656.273(4)(b) requires.[3] Neither Koitzsch nor ORS 656.273(4)(b) support this interpretation. In this regard, ORS 656.273(4)(b) explicitly states that for injuries that have "been in nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury." (Emphasis added). Thus, the statute clearly states that aggravation rights on nondisabling claims run from the "date of injury." To hold otherwise would violate the clear language of the statute and essentially omit a major portion of the statute. Neither we nor the court is permitted to do that. ORS 174.010 (in interpreting a statute, we are "not to insert what has been omitted, or to omit what has been inserted"). Furthermore, Koitzsch does not mandate such a holding. In this regard, although the

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[3] The dissent's interpretation of ORS 656.273(4)(b) has the same problem. Although characterizing the matter as one involving the "nondisabling status" of the claim and arguing that aggravation rights run from the date of "nondisabling status" determination, the fact remains that the dissent's interpretation results in a worker's aggravation rights running from the date of acceptance, rather than the date of injury, as required by ORS 656.273(4)(b). The dissent apparently wants to return to an interpretation that the Board has disavowed. Specifically, in Donald G. Stacy, 45 Van Natta 2360 (1993), aff'd Stacy v. Corrections Division, 131 Or App 610 (1994), we disavowed our holding in Robert E. Wolford, 45 Van Natta 435 (1993), which had held that in the case of an occupational disease claim, the "date of injury" for purposes of determining a claimant's aggravation rights is the date that the insurer accepts the occupational disease claim. Relying on Papen v. Willamina Lumber Company, 123 Or App 249 (1993), we held that, for the purposes of determining aggravation rights for nondisabling claims, the "date of injury" in occupational disease claims is either the date of disability or the date when medical treatment is first sought. Thus, the date of acceptance is not the starting point for determination of aggravation rights even in occupational disease claims, where the "date of injury" is more difficult to determine than in an injury claim.

We note that, subsequent to our decision in Stacy, which disavowed Wolford, we issued Mark A. Rosenbloom, 46 Van Natta 1040 (1994), which, without citing Wolford, essentially relied on the reasoning in Wolford in determining that ORS 656.273(4)(a) applied to the claimant's claim because that claim was not in nondisabling status for more than one year after the date the claim was accepted as nondisabling. Because the Rosenbloom reasoning was based on the reasoning expressed in Wolford and since that reasoning has previously been rejected in Stacy, the Rosenbloom holding has no precedential value.

court agreed that "a claim is not deemed to be in nondisabling status unless and until it is accepted and classified as nondisabling," it does not follow that aggravation rights run from the date of acceptance, especially where the statute specifically states that aggravation rights run from the "date of injury." ORS 656.273(4)(b); 140 Or App at 197.

Third, this interpretation overlooks the statutory scheme and a long line of case law regarding classification of claims. Pursuant to ORS 656.277, a claimant has one year, from the date of injury, in which to seek reclassification of his or her claim. See Donald R. Dodgin, 45 Van Natta 1642 (1993). If a request for reclassification is not made within the one year time period, the claim cannot be reclassified and a claimant must make a claim for aggravation pursuant to ORS 656.273. ORS 656.277(1) and (2); Charles B. Tyler, 45 Van Natta 972 (1993). However, the claimant must be notified of the classification of the claim, as well as the right to challenge that classification, within a sufficient time period that would allow the status of the claim to be challenged. ORS 656.262(6)(b) & (c); Degrauw v. Columbia Knit, Inc., 118 Or App 277, rev den 316 Or 527 (1993);[4] Carmen C. Neill, 47 Van Natta 2371 (1995); Charles L. Simons, 47 Van Natta 908 (1995); Dennis Hutchison, 46 Van Natta 539 (1994). If the carrier fails to notify the claimant of the nondisabling classification in sufficient time to allow the claimant to challenge the classification to the Department within one year from the date of injury, claimant is precluded, through no fault of his own, from seeking reclassification from the Department. Under those circumstances, the claimant may request a hearing pursuant to ORS 656.283(1) to challenge the nondisabling classification. Donald R. Dodgin, supra; Degrauw v. Columbia Knit, Inc., supra.[5]

Thus, a claimant is provided a forum before which to challenge a carrier's nondisabling classification where the carrier's actions prevent the claimant from timely challenging the classification before the Department. However, the claimant must still establish, on the merits, that the claim was disabling within a year from the date of injury in order to establish a disabling claim for which the aggravation rights run from the date of first claim closure. ORS 656.273(4)(a) and (b), 656.277(1); Carmen C. Neill, supra (relying on Degrauw v. Columbia Knit, Inc., supra, the Board held that the Hearings Division had jurisdiction to entertain the claimant's objection to her initial claim classification; however, on the merits, the Board determined that claimant had failed to establish the injury was disabling).

Under the ALJ's and claimant's interpretation of Koitzsch and ORS 656.273(4)(b), in all circumstances, the time to seek reclassification would necessarily run from the date the claim was

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[4] In Degrauw v. Columbia Knit, Inc., the court reviewed the statutory scheme in former ORS 656.262(6), ORS 656.268 and ORS 656.277. Although these statutes were amended in 1995, those amendments do not affect the analysis in Degrauw. Specifically, part of the analysis in Degrauw relied on the requirement in former ORS 656.262(6) that an acceptance must include notification of the right to object to classification of a claim as nondisabling within one year of the date of injury. That requirement was not changed in the 1995 amendments. See ORS 656.262(6)(b)(C). In addition, the requirement under former ORS 656.277(1) that the carrier report a claim to the Director for determination pursuant to ORS 656.268 when, within one year after the injury, the worker claims a nondisabling injury "is disabling" essentially remains the same. See ORS 656.277(1) (language changed from "is disabling" to "originally was or has become disabling"); Gary L. Swanson, 48 Van Natta 792 (1996) (legislature did not intend to make any major substantive changes by amending ORS 656.277).

[5] The dissent overlooks the underpinning reasoning in Degrauw and its progeny, which establish that, where the carrier accepts or reclassifies a claim as nondisabling such that the worker, through no fault of his or her own, does not have time to challenge that classification before the Department within one year from the date of injury, the worker may request a hearing to challenge the classification. If the one year period to challenge a nondisabling claim ran from the date of acceptance, or the "status" determination date as the dissent phrases it, there would be no need for the reasoning relied on in Degrauw or its progeny regarding a classification challenge to the Department within one year from the date of injury.

accepted as nondisabling, not from the date of injury. Such an interpretation is contrary to the statutory scheme and case law.[6]

Here, by Stipulation dated May 19, 1989, the parties agreed that claimant's claim was nondisabling and the claim was accepted as nondisabling. (Exs. 3, 4). Therefore, claimant had about three weeks from the date of the Stipulation to request reclassification of the claim from the Department within a year from the date of injury. ORS 656.277. Under the facts of this case, we find that that was sufficient time to request reclassification. This is especially true because the initial "nondisabling" classification was made by Stipulation. In this regard, the terms of the parties' stipulation are binding. See Evans v. Rookard, Inc., 85 Or App 213, 214 (1987); Richard A. Colclasure, 46 Van Natta 1246, 1251 (1994); Timothy W. Fletcher, 43 Van Natta 1359, 1361 (1991), aff'd mem Asplundh Tree Service v. Fletcher, 110 Or App 634 (1992). The stipulation is a negotiated, signed, meeting of the minds, based on a weighing of choices and the exercise of judgment as to the most beneficial outcome for each party; when approved by an ALJ, it has the finality and effect of a judgment. Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993); International Paper Co. v. Pearson, 106 Or App 121 (1991). There is no evidence that claimant requested reclassification of his claim within a year after the date of injury. Thus, on this record, we find that the claim was in nondisabling status for one year or more after the date of injury; therefore, the claim for aggravation must be filed within five years after the date of injury. ORS 656.273(4)(b).

Finally, citing Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) [Messmer II], claimant argues that the "aggravation date" on the October 30, 1990 Determination Order controls because that order was not appealed. We find Messmer II distinguishable on its facts. In Messmer II, interpreting amended ORS 656.262(10), the court held that the carrier was precluded from subsequently denying compensability of a condition for which a prior determination order awarded permanent disability because the carrier had not appealed that prior order.[7] However, here, the issue is not compensability of a condition or the interpretation of amended ORS 656.262(10). Therefore, neither Messmer decision is applicable to the facts of this case. In addition, an incorrect date on an administrative form cannot modify the specific language of controlling statutes, and therefore, does not change the correct date from which the aggravation rights run. See Miltenberger v. Howard's Plumbing, supra; Timothy D. Beard, supra. Thus, the "aggravation date" on the October 30, 1990 Determination Order does not control.

Accordingly, claimant must make an aggravation claim within five years after the date of the June 15, 1988 injury, or by June 15, 1993. Inasmuch as claimant's 1995 claim was filed more than five years after the date of injury, the ALJ did not have jurisdiction to decide the 1995 claim. Rather, claimant's request for benefits is within the sole jurisdiction of the Board under its own motion authority. See ORS 656.278; Miltenberger v. Howard's Plumbing, supra. Accordingly, we vacate the ALJ's order and dismiss claimant's request for hearing related to the January 19, 1996 denial.

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[6] Perhaps this is best demonstrated by an example. Assume that worker 1 and worker 2 are both injured while working for the same employer on January 1, 1995. The carrier accepts worker 1's claim as a nondisabling injury on January 2, 1995; and it accepts worker 2's claim as a nondisabling injury on December 30, 1995. Both workers' injuries become disabling on July 1, 1996, a year and a half after the date of injury. Both workers' claims are reclassified as disabling by the carrier on July 1, 1996. Pursuant to ORS 656.277, worker 1 has one year from the date of injury to request reclassification of his claim. However, under the facts of this hypothetical, if worker 1 timely requests reclassification of his claim from the Department, the claim will remain classified as "nondisabling" because it did not become disabling within a year from the date of injury, the time within which worker 1 could timely request reclassification from the Department. Thus, worker 1's aggravation rights would run five years from the date of injury. ORS 656.273(4)(b). Pursuant to Degrauw and its progeny, worker 2 may request reclassification through the Hearings Division because he was prevented from timely requesting reclassification from the Department due to actions of the carrier. However, although different forums hear the separate claims, on the merits, the result should remain the same. Worker 2's claim should be determined to be in nondisabling status for aggravation purposes because, under the facts of this hypothetical, it did not become disabling within a year from the date of injury. ORS 656.273(4)(b). But the result would change for worker 2 under the ALJ's, claimant's, and the dissent's reasoning. Under their reasoning, worker 2's claim would have remained in "nondisabling status" only six months (from the date of acceptance on December 30, 1995, to the date it became disabling and was reclassified as such on July 1, 1996). Therefore, under their reasoning, worker 2's aggravation rights would run five years from the date of first claim closure, whereas worker 1's aggravation rights would run five years from the date of injury.

[7] We note that in Deluxe Cabinet Works v. Messmer, 130 Or App 254 (1994) [Messmer I], the court made the same holding interpreting former ORS 656.262(9), which was amended and renumbered as amended ORS 656.262(10) by the 1995 legislative amendments.

ORDER

The ALJ's order dated May 29, 1996 is vacated. Claimant's request for hearing related to the January 19, 1996 denial is dismissed.

Board Chair Hall dissenting.

I find that the majority misinterprets Liberty Northwest Ins. Corp. v. Koitzsch, supra. Furthermore, under a correct interpretation of Koitzsch, the record establishes both that ORS 656.273(4)(a)[1] applies to claimant's claim and that claimant filed a timely aggravation claim pursuant to ORS 656.273(4)(a). Therefore, I respectfully dissent from the majority's holding that claimant's request for benefits is within the Board's own motion jurisdiction.

The majority's interpretation of Koitzsch hangs on a single sentence in that opinion: the court's conclusion that "because the claim here was not in nondisabling status at the time of acceptance, ORS 656.273(4)(a) applies." 140 Or App at 197. However, that sentence is not the focus of the court's decision. Instead, the court focused on the fact that the status of a claim is not determined until the claim is accepted. In Koitzsch, the claim was accepted as disabling. Therefore, in making the above-quoted statement, the court was simply stating the obvious -- since that case did not involve a nondisabling claim, ORS 656.273(4)(b) did not apply.

ORS 656.273(4)(b) provides that "[i]f the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury." In interpreting that statute, the court in Koitzsch agreed with the Board's holding that "the claim must be accepted as nondisabling before it is in 'nondisabling status' under ORS 656.273(4)(b)." 140 Or App at 197. Thus, the period of "nondisabling status for one year or more after the date of injury" under ORS 656.273(4)(b) does not begin to run until the claim is accepted as nondisabling.

The majority argues that such an interpretation would mean that "aggravation rights" for claims accepted as nondisabling would run from the date of acceptance rather than the date of injury, as ORS 656.273(4)(b) requires. That is not what this dissent says, nor would that be the result of applying this dissent's interpretation to the statute. The majority overlooks the fact that the predicate to requiring an aggravation claim to be filed within five years after the date of injury is the fact that the injury must be "in a nondisabling status for one year or more after the date of injury." ORS 656.273(4)(b) (emphasis added). In other words, it is the length of time the claim is in nondisabling status after the date of injury that counts. That status is not determined until the claim is accepted as nondisabling. Koitzsch, supra. Thereafter, if the claim is in nondisabling status for a year or more after the date of injury, then any aggravation claim must be filed within five years of the date of injury. Thus, aggravation rights do not run from the date of acceptance; rather, acceptance identifies the status of the claim. Depending on the status of the claim, aggravation rights run five years after the date of injury or five years after the date of the first determination or notice of closure. ORS 656.273(4)(a) and (b).

This interpretation of ORS 656.273(4)(b) is consistent with the clear language of the statute and the court's holding in Koitzsch. In addition, it is in line with Degrauw v. Columbia Knit, Inc., supra,

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[1] ORS 656.273(4) provides:

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

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

and its progeny.[2] In that regard, this interpretation removes gamesmanship from the length of time available to challenge classification of a claim.

Moreover, the majority's interpretation is not in accordance with the actual language of the statute. In this regard, under ORS 656.273(4)(b), both the prerequisite "nondisabling status" of "one year or more" and the five year period in which to file a claim for aggravation run "after the date of injury." (Emphasis added). However, the majority contends that the time periods in ORS 656.273(4)(b) run from the date of injury.[3] Thus, the majority's interpretation of ORS 656.273(4)(b), in effect, changes the preposition "after" to "from," which is inconsistent with the actual language of the statute.

In interpreting a statute, we assume that the legislature's choice of words is purposeful; therefore, we should not disregard that choice. See Martin v. City of Albany, 320 Or 175, 181 (1994) (Court stated that it does "not lightly disregard the legislature's choice of verb tense, because [it assumes] that the legislature's choice is purposeful"). Thus, I assume the legislature's use of the term "after" in ORS 656.273(4)(b) is purposeful, and interpret that statute to require the running of the statutorily defined periods "after the date of injury."

Finally, the majority cites SM Motor Co. v. Mather, supra, in support of their interpretation. However, I find that Mather supports my interpretation. In Mather, the court rejected the carrier's assumption that the one year period without disability under ORS 656.273(4)(b) may begin any time within five years after the injury. Instead, the court found that ORS 656.273(4)(b) "applies only to injuries that were nondisabling at the beginning and remain so for at least 1 year after the original injury." Id. at 181 (emphasis in original). Because the claimant's injury was initially disabling, the court concluded that ORS 656.273(4)(a) applied. In other words, as the court explained in Mather, once the status of the claim is initially determined it does not go back and forth between disabling and nondisabling to where a period of nondisability for a year of more somehow converts the status of the claim to nondisabling, thereby triggering application of ORS 656.273(4)(b) versus ORS 656.273(4)(a).

However, while determining that the one year period of nondisabling status under ORS 656.273(4)(b) may not arise at any time during the claim, but must arise "at the beginning," the Mather court did not define the phrase "at the beginning." Based on the language of ORS 656.273(4)(b) and Koitzsch, as addressed above, I submit that "at the beginning" refers to the time the claim was accepted as nondisabling. That interpretation is the only one that brings the decision in Mather in alignment with ORS 656.273(4)(b) (nondisabling status for one year or more) and Koitzsch ("status" of claim is determined at time of acceptance).[4]

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[2] The focus of Degrauw and its progeny is the determination of a process that would enforce the statutory scheme so that a worker is not foreclosed through no fault of his or her own from contesting classification of the claim within one year from the date of the injury. ORS 656.262(6), 656.268, 656.277; Degrauw, supra; Donald R. Dodgin, supra; Carmen C. Neill, supra. To the extent that Degrauw and its progeny focused on the period of a year from the date of injury, it is not clear that they entertained my interpretation of ORS 656.273(4)(b) as providing that it is the length of time the claim is in nondisabling status that counts, with the acceptance determining the status of the claim. Nor is it clear that they would disagree with my interpretation if they had considered it. I also note that Degrauw did not interpret ORS 656.273(4), so it necessarily did not address the "trigger" date from which aggravation rights are calculated. As discussed in the body of my dissent, I find that the "trigger" date under ORS 656.273(4)(b) is the date the claim is accepted as nondisabling. This interpretation makes the holding in Degrauw consistent with ORS 656.273(4)(d) and less likely to be considered a judicially created remedy. Thus, the majority is mistaken in their statement in footnote 5 that I overlook the "underpinning reasoning" in Degrauw. My interpretation both considers the reasoning in Degrauw and renders it consistent with the statutory scheme.

[3] Had the legislature chosen the term "from," it would indicate that the triggering event was the date of injury. By using the term "after," the legislature has indicated its focus was on the period of nondisabling status occurring at some point subsequent to (after) the injury.

[4] Thus, I disagree with the majority's statement in footnote 2 that my interpretation of the Mather court's phrase "at the beginning" requires an "elaborate interpretation." My interpretation is no more elaborate than the majority's. Furthermore, unlike the majority's interpretation, my interpretation renders Mather consistent with ORS 656.273(4)(b) and Koitzsch.

In summary, I submit that the determination of whether aggravation rights run five years after the date of injury or five years after the first claim closure involves the following three step process. (1) Was the claim accepted as nondisabling? Status is determined at acceptance; a claim is not in nondisabling status until it is accepted as such. (2) Did the claim accepted as nondisabling remain in nondisabling status for one year or more? (3) Only if the questions in steps (1) and (2) are answered in the affirmative does ORS 656.273(4)(b) apply, requiring that the claim for aggravation be filed within five years after the date of injury.[5]

Here, the claim was accepted as a nondisabling injury on May 19, 1989. The claim remained in nondisabling status for 77 days there after, i.e., until SAIF reclassified the claim as disabling on August 4, 1989. Therefore, because the claim was in nondisabling status less than a year after the date of injury, ORS 656.273(4)(b) does not apply. Instead, ORS 656.273(4)(a) applies and claimant's aggravation rights run five years from October 30, 1990, the date of the first determination.

Finally, I would adopt the ALJ's reasoning and conclusions regarding his findings that: (1) claimant filed a timely aggravation claim prior to the expiration of his aggravation rights on October 30, 1995; thus, the Hearings Division had jurisdiction over the aggravation claim; and (2) on the merits, claimant established a compensable aggravation claim.

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[5] The hypothetical the majority presents in footnote 6 does not diminish the logic of my interpretation of the statutory scheme. In fact, the majority's hypothetical is of little value since the carrier is required by statute to accept or deny a claim within 90 days of notice or knowledge of the claim. ORS 656.262(6)(a). Furthermore, any incongruous result in the majority's hypothetical is the result of the failure of the hypothetical carrier to timely accept the claim. Such failure is not the fault of the worker. That is why Degrauw and my interpretation would give both worker 1 and worker 2 in the majority's hypothetical equal footing vis-a-vis the time within which to challenge the claim classification.

In addition, even recognizing that the majority's hypothetical results in different aggravation rights for the two workers, that result represents a choice made by the legislature in selecting the phrase "disabling status" rather than "disabling" in ORS 656.273(4)(b). Moreover, the legislature's choice of words makes sense in light of the statutory scheme, which requires acceptance or denial within 90 days. ORS 656.262(6)(a). In other words, had worker 1 and 2 in the majority's hypothetical not only been injured on the same date but had their claims timely accepted, there would be no incongruous result regarding their aggravation rights. It is the hypothetical carrier's inaction in failing to timely accept worker 2's claim that caused the different results regarding the aggravation rights. Such failure should not be rewarded by interpreting ORS 656.273(4)(b) differently than the clear language of that statute requires.

In the Matter of the Compensation of
KATHARINA (OLSON) KING, Claimant
WCB Case No. 96-04294
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that declined to award a penalty for the SAIF Corporation's untimely denial. On review, the issues are penalties and attorney fees.

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

The ALJ declined to award a penalty pursuant to ORS 656.262(11) for SAIF's untimely denial, finding no evidence of "amounts then due." On review, claimant asserts that she is entitled to an attorney fee pursuant to ORS 656.382(1) even in the absence of "amounts then due." We disagree. See Melody L. Rivers, 48 Van Natta 2089 (October 10, 1996) (no entitlement to assessed fee under ORS 656.382(1) for untimely denial where no amounts due at time of unreasonable delay in denying claim) (citing SAIF v. Condon, 119 Or App 194, rev den 317 Or 162 (1993)); Errol L. Schrock, 48 Van Natta 1613 (1996).

ORDER

The ALJ's order dated August 8, 1996 is affirmed.

December 30, 1996 Cite as 48 Van Natta 2589 (1996)

In the Matter of the Compensation of
JIMMIE L. McCARTNEY, Claimant
WCB Case No. 95-07515
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the insurer's denial of claimant's occupational disease claim for pneumonia and empyema (pleural effusion). On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We agree with the ALJ's ultimate conclusion that claimant has not established a compensable occupational disease claim based on the following rationale.

To establish compensability of his pneumonia and empyema as an occupational disease, claimant must prove that his work activities were the major contributing cause of the onset or pathological worsening of those conditions. ORS 656.802(1) and (2). Claimant has the burden of establishing compensability under this standard by a preponderance of the evidence. ORS 656.266. Claimant may not solely rely on the deductive reasoning that, because his conditions did not occur until after work exposure and cannot be proven to have been caused by another causative agent, it must have been caused by the work exposure. ORS 656.266; Bronco Cleaners v. Velazquez, 141 Or App 295, 299 (1996); Tamara D. Hergert, 45 Van Natta 1707 (1993), aff'd mem 130 Or App 678 (1994).

The application of the "major contributing cause" standard in this case presents a complex medical question that must be resolved by expert medical opinion that is well-reasoned and based on an accurate and complete history. See Somers v. SAIF, 77 Or App 259 (1986). As this case involves expert analysis rather than expert external observation, we do not give special credit to the opinion of the treating physician as opposed to other doctors. Hammons v. Perini, 43 Or App 299 (1979).

The record contains causation opinions from two pulmonary specialists, Dr. Fennell, the treating physician, and Dr. Vitums, who performed a file review for the insurer. Both experts agree that claimant's pneumonia was due, at least in part, to exposure to bacteria "some number of days" prior to claimant's hospitalization on April 8, 1995. These experts also agree that claimant developed empyema as a result of his failure to seek medical care promptly after contracting pneumonia. However, Dr. Fennell opined that claimant's bacteriological exposure probably occurred at work, whereas Dr. Vitums could not determine whether claimant's exposure occurred at work or away from work.

Although Dr. Fennell opined that the exposure to bacteria probably occurred at work, he provided no rationale for his conclusion other than the fact that claimant's illness occurred while he was at work. (Ex. 29). Without further explanation from Dr. Fennell, this temporal relationship between claimant's work and his exposure to bacteria does not persuasively establish a causal relationship by a preponderance of the evidence. Allie v. SAIF, 79 Or App 284 (1986). In addition, claimant urges us to accept Dr. Fennell's opinion because it is consistent with the fact that, during the two-week period prior to his hospitalization for pneumonia, claimant devoted most of his time to his work as a long-haul truck

driver. However, the record does not disclose what period of time Dr. Fennnell intended when he referred to an exposure "some number of days" prior to claimant's hospitalization. Therefore, we are unable to determine the significance of claimant's activities during the two-week period.

Moreover, the record establishes additional potential contributors to claimant's condition. One such contributor identified by Dr. Fennel was a "recent upper respiratory infection." (Ex. 29). Although Dr. Fennell referred to this condition as one that claimant had "gotten while at work," he did not attribute the cause of this infection to claimant's work. Dr. Vitums, for his part, identified preexisting chronic obstructive pulmonary disease as a contributor to claimant's development of pneumonia. (Ex. 30). Although Dr. Fennell ultimately indicated his concurrence with the statement that claimant's probable exposure to bacteria while working combined with his continued work, were the major cause of his pneumona and related respiratory illness, the physician does not weigh the other potential contributing causes. For this reason, as well as those discussed above, Dr. Fennell's opinion lacks persuasiveness.

Moreover, although both Dr. Fennell and Dr. Vitums believed it to be likely that claimant's continued work in wet weather conditions worsened his pneumonia, neither physician explains whether the worsening was of symptoms or was of a pathological nature. Consequently, their opinions are insufficient to meet claimant's burden of proof under ORS 656.802(2).

Accordingly, we conclude that claimant has not established compensability of his pneumonia and empyema as an occupational disease.

ORDER

The ALJ's order dated March 19, 1996 is affirmed.

In the Matter of the Compensation of
DANIEL S. MOORE, Claimant
WCB Case No. 96-03982
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

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

FINDINGS OF FACT

On March 19, 1996, after working for the employer for six days, claimant informed his supervisor that he had experienced a sudden onset of stabbing pain in his right lumbar area while pushing a heavy cart loaded with glass at work. His supervisor sent him home.

Two days later, Dr. Bradley, emergency room physician, examined claimant and released him to regular work.

On April 4, 1996, claimant sought treatment for mid-back pain from Dr. Holmes.

Claimant filed a claim for a back injury, which the employer denied.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant carried his burden of proving that work activities were a material contributing cause of claimant's disability and need for treatment for a thoracic strain. See ORS 656.005(7)(a).

The employer argues that claimant has not proven that he suffered a compensable injury established by medical evidence supported by objective findings. We agree.

To prove a compensable injury, claimant must establish, by medical evidence supported by objective findings, that the claimed work incident was a material contributing cause of his disability or need for medical treatment. ORS 656.005(7)(a).[1] See Albany General Hospital v. Gasperino, 113 Or App 670 (1992). See also ORS 656.005(19).[2]

Considering claimant's prior history of back problems, we find that the causation issue is essentially a medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally rely on the opinion of a worker's treating physician, because he or she is in the best position to evaluate the worker's condition. Givens v. SAIF, 61 Or App 490, 494 (1983).

In this case, the medical evidence is provided by Dr. Bradley, who examined claimant two days after the alleged work incident, and Dr. Holmes, who first saw claimant two weeks later.

Dr. Bradley recorded claimant's prior low back problems (associated with overexertion while doing construction work) and noted that claimant suffered a "slip and fall" injury (with a week of time loss at another employment), about two months previously. Dr. Bradley measured claimant's range of motion, found no spine tenderness, no paraspinal muscle spasm, and no trapezius spasm. Although claimant complained of right trapezius pain, Dr. Bradley noted, "when he stood up for range of motion back measurements, his gown slipped off his right shoulder, and with a rapid movement he placed his hand on the neckband and flipped it up over his shoulder." (Ex. 4-1). She also noted that claimant appeared comfortable and "laughed frequently during his history and physical examination." (Ex. 4-2). Although Dr. Bradley's "impression" was "back strain," she released him to full work duty and opined he had "no objective physical findings." (Id.).

Considering Dr. Bradley's full work release, her opinion that claimant had no physical findings, and the recorded inconsistency between claimant's complaints and his behavior (two days after the claimed event), we find that Dr. Bradley's opinion supports a conclusion that claimant either had no work injury on March 19, 1996, or had no objective findings of injury when he sought treatment.[3]

Dr. Holmes, in contrast, opined that claimant's March 19, 1996 work injury, "when combined with the preexisting low back problems and slip and fall at McDonalds, remains the major contributing cause (greater than 50%) of [claimant's] thoracic condition, need for medical service, and disability." (Ex. 10-1, emphasis in original).

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[1] The employer argues that claimant should be subject to the major contributing cause standard of proof under ORS 656.005(7)(a)(B).

Considering claimant's long history of low back problems, the fact that he initially complained of low back problems (to the emergency room doctor) in this case, and Dr. Holmes' opinion that claimant had a preexisting condition, (see Ex. 10-1), we think that claimant probably did have a preexisting back condition within the meaning of ORS 656.005(7)(a)(B) (despite claimant's insistence that this is a claim for the thoracic area only). (See Exs. 1, 4, 10). However, we find herein that the claim fails even if claimant is only subject to the material cause standard, because the injury is not persuasively established by medical evidence supported by objective findings.

[2] "'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."

[3] We acknowledge that Dr. Bradley recorded claimant's (slightly) reduced thoracic range of motion on March 21, 1996. However, we also note that Dr. Bradley explicitly described the "rapid movement" with which claimant "flipped" the hospital gown back onto his right shoulder when it slipped off, just before she measured his range of motion. (Ex. 4-1). Based on Dr. Bradley's ultimate conclusion that claimant had no objective findings, we are persuaded that Dr. Bradley did not consider claimant's range of motion measurements to be valid.

Dr. Holmes may never have personally examined claimant. (See Tr. 15-17). In any event, neither Nurse Emery (who did examine and treat claimant) nor Dr. Holmes was in as good a position as Dr. Bradley to evaluate claimant's back condition close to the time of the claimed work injury. Under these circumstances, particularly considering Dr. Bradley's advantageous position and her detailed, well-reasoned report, we find Dr. Bradley's opinion more persuasive than Dr. Holmes'. See Givens v. SAIF, supra. Accordingly, based on Dr. Bradley's opinion, we find that claimant has not carried his burden of establishing compensability of his claim. Consequently, the claim must fail.

ORDER

The ALJ's order dated July 25, 1996 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

Board Chair Hall dissenting

Based on Dr. Bradley's opinion, the majority finds that claimant either had no work injury on March 19, 1996, or had no objective findings of injury when he sought treatment two days later. I disagree.

The presence or absence of physical findings is a medical question. However, the Board's answer to the question of "objective findings" is a legal conclusion, because "objective findings" are defined by ORS 656.005(19) for purposes of ORS Chapter 656. In other words, a physician's opinion about objective findings does not necessarily satisfy or fail to satisfy the statutory requirements.

Here, claimant credibly testified that he had an onset of mid-back pain while pushing a 6,000 pound cart of glass while working for the employer on March 19, 1996. (Opinion and Order, p.2). Moreover, when he sought emergency treatment, Dr. Bradley noted reduced thoracic ranges of motion and diagnosed a back strain. Although she also opined that claimant had "no objective findings," her conclusion in this regard is unpersuasive because it is inconsistent with her findings and diagnosis. See George A. McGee, 48 Van Natta 585 (1996).

In this case, Dr. Bradley's range of motion findings and Dr. Holmes' reliance on examination findings, including thoracic muscle spasms and reduced range of motion, clearly satisfy the statutory requirement. In fact, ORS 656.005(19) specifically lists range of motion and muscle spasm as objective findings. The majority errs, as a matter of law, because it fails to call findings "objective" which are expressly described as such in the statute. Under these circumstances, I must respectfully dissent.

In the Matter of the Compensation of
CHARLES SCOTT, Claimant
WCB Case No. 96-02159
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by Board Members Biehl and Christian.

The self-insured employer (Minnesota Twins) requests review of those portions of Administrative Law Judge (ALJ) Menashe's order which: (1) determined that claimant's occupational disease claim for right shoulder subluxation/instability was timely; (2) held that the occupational disease claim was not barred by claim preclusion; and (3) set aside the employer's denial of the claim. On review, the issues are timely claim filing, claim preclusion and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a baseball pitcher, first developed a right shoulder problem in 1988. At the time, claimant was playing for another employer (Cleveland). Claimant underwent arthroscopic surgery in November 1988, which revealed a partial rotator cuff tear with a torn posterior glenoid labrum. Cleveland accepted claimant's right shoulder condition as a compensable workers' compensation claim.

Claimant later pitched for the Minnesota Twins' farm team (Portland Beavers). In May 1991, claimant sought treatment for right shoulder pain, for which he filed a workers' compensation claim. Minnesota accepted the claim as right shoulder tendonitis. (Ex. 10). Dr. Butler began treating claimant in June 1991. The claim was later closed on September 9, 1992 by Notice of Closure that did not award permanent disability. (Ex. 15).

Claimant left baseball for several years, but, in 1995, attempted a comeback with the Atlanta Braves. During spring training, however, claimant's right shoulder condition flared-up once more. A Georgia physician, Dr. Chandler, opined that claimant had "multi-directional" instability of the right glenohumeral joint with secondary impingement symptoms. (Ex. 16). Although Dr. Chandler believed that no new damage occurred in the right shoulder because of claimant's pitching that spring, he nevertheless concluded that claimant's condition prevented his return to baseball.

In May 1995, Minnesota's processing agent issued a Notice of Intent to Disclaim Responsibility. (Ex. 17). Claimant thereafter underwent evaluations by Drs. DeMayo, Farris and Norris. Dr. Butler, who had treated claimant in 1991, also reviewed medical records and provided analysis of the causation issue.

On January 11, 1996, Minnesota issued an aggravation denial. (Ex. 26). Claimant requested a hearing.

At the hearing, claimant asserted that the right shoulder subluxation/instability condition was compensable as an occupational disease (Trs. 10, 11) and that Minnesota, the only employer joined in the proceedings, was responsible. Minnesota agreed that the subluxation condition was compensable on the merits, but argued that it was not responsible for the right shoulder condition under the last injurious exposure rule (LIER). Minnesota also contended that the occupational disease claim was untimely and was also precluded under Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 307 (1995) (Messmer I); Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (Messmer II).

The ALJ found that claimant's occupational disease claim was timely filed and that the claim was not precluded under Messmer. On the merits, the ALJ found Minnesota responsible, rejecting its assertion that Cleveland should be responsible for the subluxation/instability condition because claimant first received treatment for the condition in 1988. The ALJ cited Kevin P. Silveira, 47 Van Natta 2359 (1995), in which we held that an out-of-state employer could not be assigned initial responsibility for an occupational disease claim. Finally, the ALJ upheld Minnesota's aggravation denial, concluding that the accepted tendonitis claim had not worsened.

On review, Minnesota again asserts that claimant's right shoulder occupational disease claim is time-barred and that claimant is precluded from litigating the responsibility issue. Moreover, citing United Parcel Service v. Likos, 143 Or App 486 (1996) (responsibility can be initially assigned to an employer not subject to Oregon workers' compensation law), Minnesota contends that it is not responsible for the occupational disease claim on the merits.

For the following reasons, we agree with the ALJ that the right shoulder occupational disease claim is not time-barred or barred by claim preclusion. While we also agree with the ALJ that Minnesota is responsible for the right shoulder condition, our reasoning differs from the ALJ's.

Timeliness

We first address Minnesota's timeliness argument. ORS 656.807(1) provides that an occupational disease claim shall be void unless it is filed with the insurer or self-insured employer by whichever is the later of the following dates:

"(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or

"(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease."

In Bohemia Inc. v. McKillop, 112 Or App 261, 265 (1992), the court held that the phrase "the later of the following dates" modifies each clause within subparagraphs (a) and (b) and, therefore, the relevant date for filing a claim was the later of the dates in each subparagraph. The court further held that the legislature intended that the dates in subparagraph (a) are alternative dates to be compared with the dates in subparagraph (b) to determine the later date.

Here, Minnesota argues that the occupational disease claim is time-barred because claimant was disabled by the subluxation condition or had constructive notice of the condition in 1988, or 1991 at the latest. Although there were references to a subluxating shoulder in 1988, based on our de novo review of the record, we conclude that claimant was not clearly informed that he was suffering from a right shoulder subluxation/instability condition until Dr. Chandler diagnosed the condition on March 29, 1995. We, therefore, find that March 29, 1995 was the date claimant first discovered, or should have discovered, the occupational disease. Thus, even assuming that claimant was disabled by the subluxation condition in 1988 and 1991, claimant filed his claim within a year of Dr. Chandler's report, the latest date for the purposes of the statute. We, accordingly, find that his occupational disease claim was timely.

Alternatively, occupational disease claims are to be processed in the same manner as provided for accidental injuries, ORS 656.807(3). Prior to passage of Senate Bill 369, a carrier had to prove that it was prejudiced by untimely claim filing. Former ORS 656.265(4)(a). Senate Bill 369 did not amend ORS 656.807, but it did, however, amend ORS 656.265. As amended, ORS 656.265(4)(a) now provides that "[f]ailure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the injury and: (a) The employer had knowledge of the injury or death[.]" As amended, the statute eliminates the prejudice requirement.

The amended statute, however, applies only to injuries occurring on or after June 7, 1995, the effective date of the Act. Or Laws 1995, ch 332, secs. 66(2), 69. As to injuries (or diseases) occurring before June 7, 1995, pre-Senate Bill 369 law remains viable in this context. Melvin L. Gordon, 48 Van Natta 1275 (1996). Accordingly, because claimant's occupational disease arose before that date, under ORS 656.807(3) and former ORS 656.265(4)(a), Minnesota can avoid claimant's claim only by establishing that it was prejudiced by the failure to receive timely notice of the claim. Joanne C. Rockwell, 44 Van Natta 2290, 2292 (1992).

Minnesota has not contended, and we do not find, that it was prejudiced by the timing of claimant's filing of his occupational disease claim. Therefore, even if the claim filing was untimely, the claim would not be time-barred for lack of prejudice to Minnesota.

Claim Preclusion

We now turn to Minnesota's claim preclusion argument. Citing Messmer, supra, Minnesota argues that the right shoulder subluxation/instability condition predated the September 1992 Notice of Closure. Thus, it contends that claimant could have litigated the scope of the compensable claim at the time of claim closure. Minnesota further asserts that, because claimant failed to challenge the closure notice, he is now precluded from establishing that it is responsible for his subluxation/instability condition. We disagree.

In Messmer I, the court held that, by virtue of the carrier's failure to appeal a Determination Order that awarded permanent disability compensation based in part on the underlying fact that the claimant experienced impairment from the effects of a surgery for the claimant's apparently noncompensable degenerative condition, the carrier was barred by claim preclusion from denying that the degenerative condition was part of the claimant's compensable claim.

Here, unlike the circumstances in Messmer, the Notice of Closure awarded no permanent disability. Consequently, there are no underlying facts presented by the Notice of Closure relating to the compensability of claimant's unaccepted right shoulder condition. Thus, we conclude that the right shoulder subluxation/instability condition was not a basis of the Notice of Closure. Consequently, claim preclusion does not bar claimant from proving that the denied condition is compensable. See Mark R. English, 47 Van Natta 681, 682 (1995).

Responsibility

Having determined that claimant's occupational disease claim is timely and not barred by claim preclusion, we next turn to the merits of the responsibility issue. Under LIER, when a worker proves that an occupational disease was caused by work conditions that existed when one or more carriers 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, Dr. Butler opined that claimant had low grade instability in the right shoulder from the "outset." (Ex. 34-1). Although he acknowledged that claimant had major pain episodes throughout the years, described as "tendonitis" or "bursitis," Dr. Butler emphasized that the underlying process was instability that allowed abnormal "gliding" motion in claimant's shoulder. Id. Based on Dr. Butler's analysis, as well as references to shoulder subluxation in the medical records pertaining to claimant's treatment in 1988 (Exs. 3, 4), we conclude that claimant's first treatment for the compensable right shoulder subluxation/instability condition was in 1988 while pitching for Cleveland.

The ALJ determined, however, that in an occupational disease claim, initial responsibility could not be assigned to an out-of-state employer. See Kevin P. Silveira, supra. Subsequent to the ALJ's decision, the court in United Parcel Service v. Likos, supra, held that initial responsibility can be assigned under LIER to an employer not subject to Oregon workers' compensation law. 143 Or App at 490. Therefore, in accordance with the court's decision in Likos, we conclude that Cleveland should be assigned initial responsibility for claimant's right shoulder condition.[1] Minnesota is not responsible unless its employment actually contributed to a worsening of the right shoulder condition. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992).

Although no physician directly addressed the issue of whether claimant's pitching for the Portland Beavers worsened the right shoulder condition, Dr. Butler opined that each pain episode, which would include the 1991 flare-up while claimant pitched for Portland, "represent[ed] an aggravation of his pathologic anatomy." (Ex. 34-2). Dr. DeMayo opined that as a "result of pitching, and the combination of the stress of the pitching have caused this instability to increase over the years." (Ex. 32).

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[1] We acknowledge that the nonsubject employment in Likos was a period of self-employment; whereas in this case, the nonsubject employment is out-of-state. However, we do not find that distinction material and conclude that Likos is controlling. Moreover, we find, as did the court in Likos, Progress Quarries v. Vaandering, 80 Or App 160 (1986) (rejecting the employer's attempt to shift responsibility to an out-of-state carrier where the claimant did not rely on the out-of-state employment to establish compensability) to be distinguishable. As did the claimant in Likos, claimant in this case also relied on his entire employment history (which would include the non-subject, out-of-state employment) when asserting that the right shoulder occupational disease claim was compensable. (Tr. 10, 11).

Based on these medical reports, we conclude that claimant's employment for Minnesota worsened the underlying right shoulder pathology. Therefore, we agree with the ALJ that Minnesota is responsible for claimant's occupational disease claim for right shoulder subluxation/instability.[2] We, accordingly, affirm.

Because Minnesota's continued "empty chair" responsibility defense, as well as its timeliness and claim preclusion arguments, placed claimant's compensation at risk on review, claimant's attorney is entitled to an attorney fee pursuant to ORS 656.382(2) for services on review. See Harley J. Gordineer, 47 Van Natta 2138, 2145(1995), on recon 48 Van Natta 80 (1995). 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 Minnesota. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 24, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by Minnesota.

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[2] Based on Dr. Chandler's March 29, 1995 medical report, which concluded that claimant's pitching that spring did not cause new harm or damage to claimant's right shoulder, we find that claimant's one inning of pitching for Atlanta did not contribute to a worsening of claimant's right shoulder condition. (Ex. 16, Tr. 31). Thus, responsibility would not shift from Minnesota to Atlanta.

In the Matter of the Compensation of
CONSTANCE I. GASSNER, Claimant
WCB Case No. 95-10907
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Daughtry's order that: (1) affirmed the Order on Reconsideration award of 19 percent (60.8 degrees) unscheduled permanent disability for a neck and upper back injury; and (2) awarded claimant's attorney an assessed fee of $1,700. In her brief, claimant contends that Exhibit 28, a report by the medical arbiter, should not be considered. On review, the issues are evidence, extent of unscheduled permanent disability, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

The ALJ received into evidence Exhibit 28, a narrative report by the medical arbiter, Dr. Farris, issued in response to an inquiry from the employer's attorney. The report is dated August 26, 1995, the same date as the medical arbiter examination.[1] In the report, Dr. Farris stated that the ranges of motion in claimant's cervical and thoracic spine, as recorded in the medical arbiter report, are invalid. She

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[1] By letter dated July 18, 1995, Dr. Farris was notified that claimant had been scheduled for an examination on August 26, 1995. Both claimant and the employer's attorney were provided copies of that letter. (Ex. 23).

added that claimant was capable of performing the tasks listed in a job description which had been enclosed with the employer's attorney's letter.

On review, claimant contends that Exhibit 28 should not be considered.[2] Citing our decision in Daniel L. Bourgo, 46 Van Natta 2505 (1994), claimant argues that a supplemental medical arbiter's report which was requested by a party is not admissible at hearing. Our decision in Bourgo was subsequently affirmed by the Court of Appeals. Tinh Xuan Pham Auto v. Bourgo, 143 Or App 73 (1996). However, as the court noted in its opinion, our decision in Bourgo applied former ORS 656.268(7), which provided, in pertinent part:

> "The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure." (Emphasis supplied.)

This former version of ORS 656.268(7) prohibited admission of medical evidence of impairment that was developed after the medical arbiter's report. Bourgo, supra, 143 Or App at 76 n 3; Pacheco-Gonzalez v. SAIF, 123 Or App 312, 316 (1993). This case, by contrast, is governed by the current version of ORS 656.268(7), which was amended by Senate Bill 369 in 1995. As amended, it provides, in pertinent part:

> "(f) The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure.
>
> "(g) 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." (Emphasis supplied.)

Based on the emphasized text, we find that ORS 656.268(7) no longer prohibits the admission of medical evidence of impairment subsequent to the medical arbiter's report; rather, its express terms prohibit admission of subsequent medical evidence of impairment after issuance of the reconsideration order.[3] See Bourgo, supra, 143 Or App at 76 n 3; see also ORS 656.283(7); Precision Castparts Corp. v. Plummer, 140 Or App 227, 231 (1996); Dean J. Evans, 48 Van Natta 1092, recon 48 Van Natta 1196 (1996); Joe R. Ray, 48 Van Natta 325, recon 48 Van Natta 458 (1996) ("Post-reconsideration" evidence on an issue regarding a notice of closure or determination order is inadmissible at hearings held after June 7, 1995). In Bourgo, the "supplemental" medical arbiter's report in dispute was issued after the reconsideration order and was offered into evidence for the first time at hearing. Id. Here, by contrast, the "supplemental" arbiter's report was submitted to the Department prior to issuance of the reconsideration order and was made a part of the reconsideration record. Thus, the prohibition in amended ORS 656.268(7)(g) against "post-reconsideration" evidence of impairment does not apply in this case.

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[2] Claimant notes that Pages 3 and 4 of Exhibit 28 are "Spinal Range of Motion" forms generated by the Department of Consumer and Business Services (the Department) and completed by Dr. Farris as part of the medical arbiter's examination report. For that reason, claimant contends those pages should be considered part of Exhibit 29, the medical arbiter's report, rather than Exhibit 28. The employer does not dispute claimant's contention. Therefore, we have re-marked Pages 3 and 4 of Exhibit 28 as Pages 7 and 8 of Exhibit 29.

[3] There remains one exception to the general rule prohibiting "post-reconsideration" evidence regarding impairment: ORS 656.268(6)(e) (former ORS 656.268(6)(a)) allows for the admission at hearing of "[a]ny medical arbiter report" which was not prepared in time for use in the reconsideration proceeding. It was under this statutory exception that the carrier in Bourgo sought to admit into evidence a "supplemental" report from a medical arbiter, which was requested by the carrier. We declined to admit the report, reasoning that former ORS 656.268(6)(a) only authorized admission of either an initial medical arbiter report, or a "supplemental" medical arbiter report in those instances when either the Department or the arbiter acknowledged that the initial report was incomplete. Daniel L. Bourgo, supra; see also Ryan F. Johnson, 46 Van Natta 844 (1994); Anne M. Younger, 45 Van Natta 68 (1993). The court agreed with our holding that the carrier-requested report from the medical arbiter was not admissible pursuant to former ORS 656.268(6)(a), but it expressly declined to address the validity of our conclusion that a "supplemental" medical arbiter's report would be admissible if the initial report indicated that it was not complete or if the Department requested the supplemental report. Bourgo, supra, 143 Or App at 78 n 5.

Because the prohibition of "post-reconsideration" medical evidence of impairment does not apply in this case -- and we find no other statutory bar to the admission of impairment evidence which was made a part of the reconsideration record -- we conclude that Exhibit 28 is admissible. Therefore, we uphold the ALJ's evidentiary ruling.

Nevertheless, we conclude that Exhibit 28 may not be considered in rating claimant's disability. For the purpose of rating disability, only the opinions of claimant's attending physician at the time of claim closure and the medical arbiter(s), if any, may be considered. See ORS 656.245(2)(b)(B), 656.268(7); Roseburg Forest Products v. Owen, 129 Or App 442, 445 (1994); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). The term "medical arbiter" is not defined by statute; however, the function of the medical arbiter is reasonably clear from the text of ORS 656.268(7) and the legislative history surrounding implementation of the medical arbiter process in 1990.

ORS 656.268(7)(a) requires the Director to appoint a physician as a medical arbiter in either of two instances: (1) if the basis for objection to the closure notice or determination order is disagreement with the impairment finding(s) used in rating claimant's disability; or (2) if the Director determines there is insufficient medical information available to rate disability. Once the medical arbiter is appointed, he is authorized to examine claimant and perform "reasonable and necessary" tests to establish impairment. ORS 656.268(7)(d). The arbiter's impairment findings must then be submitted to the Department for reconsideration of the closure notice or determination order. ORS 656.268(7)(f).

The text of ORS 656.268(7) makes clear that the function of the medical arbiter is to make impairment findings and report those findings to the Department in cases where a party disagrees with the impairment findings or there is insufficient information available to determine impairment. Furthermore, the 1990 legislative history shows that the medical arbiter procedure was implemented as part of the reconsideration process to further the legislative purpose of providing a nonlitigious, less costly administrative forum for resolving disputes over extent of disability. We reviewed the 1990 legislative history concerning the medical arbiter procedure in Daniel L. Bourgo, supra:

> "Testimony at the Hearings of the [1990] Joint Interim Committee indicated that amended ORS 656.268(7) was proposed to insure that medical professionals decided medical questions and to eliminate "dueling doctors." (Hearings of the Joint Interim Committee on Workers' Compensation, May 3, 1990, Tape 9, Side B). Testimony also indicated that the medical arbiter procedure was expected to save the workers' compensation system expense by reducing hearings. (Id. at Tape 2, Side B). This was further confirmed by the comments of Representative Shiprack during the House floor debates. He stated:
>
> "'If there is a disagreement related to the impairment of your disability, then what we're going to have from now on, and should this bill pass, is what's known as a medical arbiter. One of the biggest single complaints that injured workers have today about the Workers' Comp [sic] system is when there is a dispute about extent of disability both sides go out and hire their own hired guns. We've talked about it on the floor. I recently talked to a carpenter in my district just this weekend who had had eight separate independent medical examinations on this one claim related to his knee. This would be cut off. There would be no more IME's on extent cases. And the medical arbiter's opinion would be binding.' (House Floor Debates on SB 1197, May 7, 1990)." 46 Van Natta at 2506.

Given the legislature's intent to reduce litigation costs by implementing an administrative forum for resolving "extent of disability" disputes, in Bourgo we refused to admit into evidence a "supplemental" report by a medical arbiter, which was solicited by the carrier. We explained:

> "[P]ermitting [parties] 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." 46 Van Natta at 2507.

The court expressly endorsed our reasoning in Bourgo. Bourgo, supra, 143 Or App at 78. While we recognize that the "supplemental" arbiter's report in Bourgo was not submitted at reconsideration, whereas the "supplemental" arbiter's report in this case was included in the reconsideration record, we nevertheless conclude that our reasons for excluding the report in Bourgo are valid in this case. If we allow a party to solicit a supplemental report from the medical arbiter, the arbiter's objectivity would be undermined and the arbiter arguably would become a witness for that party.[4] As we discussed above, it is not the medical arbiter's function to serve as a party's witness; rather, the arbiter's statutory function is to make impairment findings and to report those findings to the Department.[5] Because a party's solicitation of additional reports from the medical arbiter would interfere with the arbiter's proper function, we decline to consider those reports.

In declining to consider party-solicited reports from the medical arbiter, we distinguish ORS 656.268(6)(a) which provides that at the reconsideration proceeding, a party "may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure." This provision permits a party to correct "erroneous" information in the record or submit medical evidence that should have been submitted by the attending physician; it does not, however, permit a party to solicit opinions from the medical arbiter. Moreover, a medical arbiter is appointed by the Director if the Director determines that the medical information in the record is insufficient to rate disability, or there is a disagreement with impairment findings. ORS 656.268(7)(a). Thus, the medical arbiter procedure is initiated by the Director pursuant to ORS 656.268(7)(a) and is conducted independently of the parties' efforts to correct any erroneous information and/or supplement medical information in the reconsideration record pursuant to ORS 656.268(6)(a).

Consistent with our holding in Bourgo, we conclude that the only report which qualifies as a "medical arbiter report" is an initial report prepared by the medical arbiter at the Department's request, or a supplemental or clarifying report from the arbiter in those instances when the initial arbiter's report itself indicates it is incomplete or when the Department requests supplementation or clarification of the initial report. 46 Van Natta at 2508; see also Larry A. Thorpe, 48 Van Natta 2608 (1996) (Department-requested, "post-reconsideration" clarifying report from medical arbiter is admissible pursuant to ORS 656.268(6)(e)); Robert K. Warren, 47 Van Natta 1471 (1995); Ryan F. Johnson, 46 Van Natta 844 (1994); Anne M. Younger, 45 Van Natta 68 (1993). Where, as in this case, the initial report did not indicate that it was incomplete, and the supplemental report was solicited by a party rather than the Department, we conclude the supplemental report is not a "medical arbiter report" and may not be considered in rating claimant's disability. Therefore, Exhibit 28 shall not be considered.

Extent of Disability

We turn to the merits of the extent of disability issue in this case. The ALJ concluded claimant is entitled to an impairment value of 9 based on the cervical and thoracic spine range-of-motion findings reported by the medical arbiter, Dr. Farris, in Exhibit 29. On review, the employer argues that Dr. Farris' impairment findings are not reliable because she opined in Exhibit 28 that they were invalid. Because we do not consider Exhibit 28 in rating claimant's disability, and the medical arbiter report itself did not indicate that the range-of-motion findings were invalid, (Ex. 29), we reject the employer's contention. See Kim E. Danboise, 47 Van Natta 2163, 2164 (1995) (Member Haynes dissenting) (Where the medical arbiter makes impairment findings that are consistent with the compensable injury, and does not attribute the findings to other causes, the findings are deemed to be due to the compensable injury.)

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[4] In Bourgo, we noted that allowing a party to solicit further reports from the medical arbiter would create a situation wherein the other party would likely wish to cross-examine the arbiter regarding the supplemental report, pursuant to ORS 656.310(2). 46 Van Natta 2507 n 1. Inasmuch as the arbiter is appointed by the Director to prepare a report for the Department, and is not intended to be a witness for either party, we question whether there is any authority for compelling an arbiter to submit to cross-examination. Id.

[5] Our view of the medical arbiter as an objective evaluator is consistent with the definition of the term "arbiter": "A person chosen to decide a controversy." Black's Law Dictionary 55 (Abr. 5th Ed., 1983). Under that definition, the arbiter does not stand on either side of a controversy but remains a neutral decision-maker.

Based on Dr. Farris' cervical and thoracic spine range-of-motion findings, we agree with the ALJ that the Department properly calculated claimant's impairment value as 9 percent. (Ex. 30, pp. 3-4).[6]

Next, citing ORS 656.726(3)(f)(D), the employer argues that claimant is not entitled to values for the non-impairment (age, education and adaptability) factors because she returned to her job at injury. We disagree. Like the ALJ, we find no evidence that claimant has actually returned to her regular job, nor do we find that the attending physician, Dr. Maloney, has released claimant for her regular job. Hence, we conclude ORS 656.726(3)(f)(D) has no application in this case.

There is no contention that the Department miscalculated the value of the non-impairment factors as 10. Therefore, based on the sum of the non-impairment value (10) and the impairment value (9), we conclude the ALJ properly affirmed the reconsideration order award of 19 percent unscheduled permanent disability.

Attorney Fees

The employer contends that the ALJ's assessed fee award of $1,700 is excessive. We disagree. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that $1,700 is a reasonable fee for claimant's attorney's services at hearing concerning the evidentiary and extent of disability issues. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the hearing record and claimant's written closing argument), the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney may go uncompensated.

Because we have not reduced claimant's award, claimant's attorney is also entitled to an assessed attorney fee for services on Board 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 concerning the evidentiary and extent of disability issues is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant respondent's brief), the complexity of the issues, and the value of the interest involved. We have not considered claimant's attorney's services in defending the ALJ's assessed fee award.

ORDER

The ALJ's order dated April 15, 1996 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, payable by the self-insured employer.

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[6] It is undisputed that the applicable standards for rating claimant's disability are set forth in WCD Admin. Order 6-1992, as amended by WCD Admin. Order Nos. 93-056 and 96-068.

In the Matter of the Compensation of
ADA M. JOHNSON, Claimant
WCB Case No. 95-13115
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) upheld the insurer's partial denial of her claim for upper back, trapezius and left shoulder strains; (2) declined to assess a penalty-related attorney fee for an allegedly unreasonable denial; (3) affirmed an Order on Reconsideration that awarded her no permanent disability benefits for cervical and lumbar strains; and (4) authorized the insurer to offset an overpayment against future compensation. On review, the issues are compensability, attorney fees, extent of unscheduled permanent disability, and offset.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated May 9, 1996 is affirmed.

Board Chair Hall dissenting in part and concurring in part.

Because I disagree with the ALJ's conclusion that claimant has not proven she suffered permanent disability due to the compensable injury, I respectfully dissent from the majority's decision to affirm on that issue. I also write separately to concur with the majority's decision to affirm the ALJ's conclusion that the insurer did not waive its right to assert an offset for overpaid compensation.

On the permanent disability issue, the majority concludes that the medical arbiter, Dr. Martens, invalidated his examination findings of reduced ranges of motion (ROM) in the cervical and lumbar spine. The majority relies on the arbiter's comment that claimant "had some pain behavior during the range of motion of the cervical and lumbar spine which makes the validity of the measurements questionable." (Ex. 32-3). It is undisputed, however, that the arbiter found that claimant's ROM measurements met the reproducibility and straight leg raising (SLR) criteria for valid results.

We have held that if a medical arbiter makes impairment findings consistent with the compensable injury and does not attribute the impairment to causes other than the compensable injury, we construe those findings as showing that the impairment is due to the compensable injury. Kim E. Danboise, 47 Van Natta 2163, 2164 (1995). Here, the arbiter measured lost ranges of motion that were consistent with the accepted cervical and lumbar strain, and did not attribute those findings to causes other than the accepted injury. Moreover, the findings met the validity criteria for ROM findings. Under these circumstances, I conclude that the arbiter's passing comment about "questionable" measurements is insufficient to invalidate his ROM findings. Based on those findings, I conclude claimant has proven she suffered permanent partial disability due to the compensable injury. Therefore, I dissent on this issue.

On the offset issue, the majority concludes the insurer did not waive its offset request at hearing. I agree. Waiver is "the intentional relinquishment of a known right." Drews v. EBI Companies, 310 Or 134, 150 (1990). Waiver must be plainly and unequivocally manifested, either "in terms or by such conduct as clearly indicates an intention to renounce a known privilege or power." Great American Ins. v. General Ins., 257 Or 62 (1970). In other words, a waiver need not be explicit to be enforceable; it can also be implied from a party's conduct. Wright Schuchart Harbor v. Johnson, 133 Or App 680, 686 (1995). The question of whether a waiver has occurred is resolved by examining the particular circumstances of each case. State v. Meyrick, 313 Or 125, 132 (1992).

Here, the insurer expressly raised the offset issue in responsive pleading prior to hearing. At hearing, the attorneys and the ALJ engaged in an extensive colloquy prior to testimony. During the colloquy, the attorneys thoroughly discussed the issues of compensability, penalty and extent of permanent disability, the stipulations and the exhibits; yet, at no time during the colloquy did anyone mention the offset issue which had been formally raised in pleading. (Tr. 3-22). At one point prior to opening statements, the ALJ asked: "Anything else, counsel, before we go into opening remarks?" Both attorneys answered "No." (Tr. 9).

As the courts have held, a waiver can be either explicit or implicit. Nevertheless, in order to establish an implicit waiver, the conduct must unequivocally evidence an intention to knowingly renounce a right or privilege. Without revisiting the Board's Johnson decision (on remand), I believe it is better to err on the side of requiring unequivocal evidence of an intentional and knowing waiver. That is, where conduct could reasonably be interpreted as either a waiver or not, I would conclude that a waiver has not been established.

Turning to the facts of this case, in order to determine whether there was an enforceable waiver of the offset issue, we must examine whether, as a factual matter, the insurer's attorney's remarks and/or conduct at hearing unequivocally evinced/expressed an intent to knowingly relinquish the right to assert an offset. See Wright Schuchart Harbor v. Johnson, supra. I conclude they did not. During the entire discussion of issues and exhibits at hearing, the insurer's attorney said nothing to indicate she

did not intend to pursue the offset request. Further, although the insurer's attorney responded in the negative when asked if there was "anything else," I conclude that response was equivocal. Had there been some indication that the discussion of issues was exhaustive, or had the ALJ asked if there were any other issues or any cross-issues and the insurer's attorney had responded in the negative, I would have concluded otherwise. Based on this record, however, I must concur with the majority's decision on the offset issue.

In the Matter of the Compensation of
JAMES W. JORDAN, Claimant
WCB Case No. 95-02636
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas, Defense Attorney
Jenny Ogawa, Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) declined to set aside a Notice of Closure as premature; and (2) enforced a prior ALJ's order which had remanded the claim to the Department for reconsideration pursuant to ORS 656.268. In its respondent's brief, the SAIF Corporation contends that the ALJ did not have jurisdiction over this matter. On review, the issues are jurisdiction, remand, and premature closure. We reverse.[1]

FINDINGS OF FACT

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

Claimant was compensably injured on March 14, 1986. Following SAIF's acceptance, and a subsequent reopening of the claim, SAIF generated a Notice of Closure (NOC) on approximately November 23, 1992. On June 28, 1994, claimant filed a request for reconsideration of the NOC, contending that: (1) SAIF had neglected to mail a copy of the NOC to either him or his attorney; and (2) his first notice of the NOC occurred on June 24, 1994. On July 20, 1994, the Department issued an "Order Denying Request for Reconsideration," on the ground that claimant's request was untimely. The notice provision of the order stated that a dissatisfied party had 30 days within which to request a hearing before the Director under ORS 656.704(2), the Administrative Procedures Act (ORS 183), and OAR 436-30-008(6).

Claimant filed a hearing request with the Board, contesting the Department's order denying reconsideration. In a November 29, 1994 Opinion and Order, ALJ Davis found that claimant's request for reconsideration of the NOC was timely, and remanded the matter to the Department for processing of claimant's reconsideration request. The ALJ's order was not appealed.

On February 24, 1995, the Department issued a letter declining to accept remand from ALJ Davis. The Department reasoned that, by requesting a hearing pursuant to ORS 656.283, claimant had

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[1] The Board has received the Director's request for participation pursuant to ORS 656.726(3)(h). We acknowledge the Director's statutory authority to participate in any proceeding before the Board which the Director determines involves a matter that affects or could affect the discharge of the Director's duties. See Larry A. Thorpe, 48 Van Natta 2608 (1996). At the same time, we recognize our obligation to conduct our review of the appealed ALJ's order in an expeditious manner. ORS 656.295(4). Likewise, we appreciate the parties' desire for a prompt decision concerning the matters in dispute.

After considering each of these factors, we have issued our order without establishing a supplemental briefing schedule as requested by the Director. We have reached this conclusion for the following reasons.

Claimant's appeal of the ALJ's order has been pending since March 1996 and the parties' briefing schedule was completed in June 1996. In addition, our decision was ready for issuance at the time of our receipt of the Director's request. To now institute an additional briefing schedule at this late date would further delay the parties' receipt of a Board decision. Such an action would not be in the interests of substantial justice, particularly when our decision is consistent with, and gives statutory effect to, the Director's Order Denying Reconsideration.

not followed the notice of appeal rights to the Department and, accordingly, "the Order Denying Request for Reconsideration became final on August 19, 1994, when the 30 day appeal period expired." Consequently, the Department concluded that the Hearings Division did not have jurisdiction to review or remand the matter.

On March 2, 1995, claimant requested another hearing with the Board's Hearings Division. In her order, ALJ Poland "enforced" ALJ Davis' order and again remanded the matter to the Department. Claimant requested Board review, requesting that, in light of the Department's refusal to accept remand, we proceed to review the merits of his objections to the NOC.

CONCLUSIONS OF LAW AND OPINION

ALJ Poland concluded that ALJ Davis' order, which found that claimant's request for reconsideration of the NOC was timely and remanded the claim to the Department for processing, had become final by operation of law. In other words, ALJ Poland ordered the enforcement of ALJ Davis' order. On review, claimant essentially contends that the Board, rather than the Department, has jurisdiction over this matter, and the NOC should be set aside as premature. Because claimant's assertion is premised on the validity of ALJ Davis' order, we must first address whether jurisdiction over the Department's Order Denying Reconsideration rested initially with ALJ Davis. See SAIF v. Roles, 111 Or App 597 (1992).

After receiving claimant's request for reconsideration, the Department issued an "Order Denying Request for Reconsideration." (Ex. 26). The Department's order provided a notice stating that, if a party disagreed with the order, within 30 days from the mailing date of the order, the party may request a "hearing before the Director as provided by ORS 656.704(2), the Administrative Procedures Act (ORS Chapter 183) and [former] OAR 436-30-008(6)." (Emphasis added). Notwithstanding the notice provision on the Department's order, however, claimant filed a hearing request with the Board's Hearings Division.

We conclude that, in light of the fact that claimant failed to request a hearing before the Director, ALJ Davis did not have jurisdiction to issue the first opinion and order in this case. Specifically, ORS 656.268(6)(f) provides that, if any party objects to a "reconsideration order," the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order. See also OAR 436-030-0008(2)(a)(3) (Order denying reconsideration does not involve payment of compensation). Here, however, the Department did not issue an order "reconsidering" its prior decision. Rather, the Department denied reconsideration.

Accordingly, we conclude that it is not dispositive whether claimant timely filed his request for reconsideration, as claimant's recourse from the order denying reconsideration was to request a hearing before the Director, rather than the Board's Hearings Division.[2] See Guardado v. Simplot, 137 Or App 95 (1995) (The Appellate Review Unit issued an order denying the claimant's request for reconsideration, which was subsequently affirmed by the Director's hearings officer and appealed directly to the court).[3]

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[2] We contrast this case to a case involving an Order on Reconsideration, over which we have jurisdiction to consider a claimant's hearing request. Eugenia S. Torres, 48 Van Natta 125 (1996). We note that, in Torres, we distinguished our prior decision in Gerald H. Coulsey, 46 Van Natta 873 (1994). In Coulsey, the carrier issued a NOC, followed by a corrected NOC. The claimant requested reconsideration and the Department issued an Order Denying Reconsideration. The claimant requested a hearing, and we affirmed the ALJ's order, which dismissed the claimant's hearing request as untimely. Insofar as Coulsey could be interpreted as holding that the Board is the proper review forum for "Orders Denying Reconsideration," and to the extent that it is inconsistent with our holding in this case, we disavow our decision in Coulsey.

[3] We recognize that the Guardado court did not address the precise "jurisdictional" issue which we face today. Nonetheless, without qualification, the Guardado court reviewed a direct appeal from a Director's order which affirmed the Department's Order Denying Reconsideration. It is well-settled that jurisdiction cannot be waived and that a decision-making body can address a "jurisdiction" issue if not raised by the parties. Southwest Forest Industries v. Anders, 299 Or 205 (1985); Spencer House Moving, NCE, 44 Van Natta 2522 (1992), aff'd Miller v. Spencer, 123 Or App 635 (1993). Likewise, pursuant to rules of appellate procedure, litigants are required to designate the authority under which the court will be conducting its review. ORAP 5.40(5). Thus, the court's review of the Director's order in Guardado (an order which had followed the same type of Department hearing that was offered to this claimant), provides further support for the conclusion that review of a Department Order Denying Reconsideration does not rest with the Board's Hearings Division under ORS 656.283, but rather that the appeal process for such orders is subject to the procedures prescribed in ORS 183.310 to 183.550.

Because claimant did not do so, the first ALJ did not have jurisdiction over this matter. In light of such circumstances, although ALJ Poland had authority to consider claimant's hearing request regarding "enforcement" of ALJ Davis' invalid order, there was no valid order for ALJ Poland to "enforce."

In reaching this conclusion, we distinguish this case from SAIF v. Roles, supra. In Roles, the ALJ had jurisdiction to review the appeal of Determination Orders (DO's). Consequently, even though the ALJ in Roles erroneously found that the DO appeals were timely, the statutory scheme allowed for ALJ review of DO's. On the other hand, we do not find any statutory authority in the present case to review an order denying reconsideration. Consequently, without such statutory authority, we find that ALJ Davis' order was invalid.

Therefore, we reverse the ALJ's order.[4] Finally, in light of this conclusion, we do not reach the issues of remand or premature closure.

ORDER

The ALJ's order dated February 23, 1996 is reversed. Claimant's request for enforcement or relief resulting from ALJ Davis' order is denied.

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[4] Although the ALJ concluded that claimant's request for hearing involved a "matter concerning a claim," over which the Board had jurisdiction, the Department's rule provides that contested cases before the Department include orders denying reconsideration. OAR 436-030-0008(3). Accordingly, because the initial dispute fell within the Director's authority, we do not find that the original case involves a matter concerning a claim within the definition of ORS 656.283(1) and 656.704(3). See, e.g., Lankford v. Copeland, 141 Or App 138 (1996) (Review of a Director's subjectivity order was not a matter concerning a claim, because the worker's right to receive compensation, or the amount thereof, was notdirectly in issue pursuant to ORS 656.704(3). The court found that the Director only decided whether the claimant could seek compensation under the Act, and it was only if and when the claim was assigned to a carrier for processing that the claimant's right to receive compensation and the amount thereof became directly in issue.)

Here, an order denying reconsideration does not directly affect the amount of, or entitlement to, compensation; rather, it denies the request for reconsideration which, if set aside, would only result in reconsideration of the NOC. Thus, only after that reconsideration is conducted would the amount of, or entitlement to, compensation be directly affected.

In this regard, we disagree with the dissent's assertion that the Department's Order Denying Reconsideration placed claimant's right to receive compensation directly in issue. Were that the case, there would have been no reason for the initial ALJ's order to have "remanded" the claim to the Department. Instead, the initial ALJ would have merely proceeded to evaluate the extent of claimant's temporary and / or permanent disability pursuant to claimant's appeal of the Notice of Closure. Of course, such an action would have been inconsistent with the statutory scheme, which envisions a reconsideration proceeding (including the possibility of a medical arbiter appointment) eventually culminating in an Order on Reconsideration. Thus, the dissent's concurrence with this ALJ's "enforcement" of the initial ALJ's "remand" order essentially acknowledges that claimant's right to receive compensation, or the amount thereof, was not directly in issue at the hearing regarding the Department's Order Denying Reconsideration. In other words, just as in Lankford, where the "subjectivity" hearing regarding a Director's determination that a claimant was not a subject worker could have significant ramifications on the claimant's right to receive compensation once the claim was assigned to a claims agent under ORS 656.054, a hearing involving the Department's Order Denying Reconsideration could also have similar profound implications on this claimant's entitlement to additional compensation. Nevertheless, as with Lankford, the appealed determination or order from the Director / Department was not a "matter concerning a claim" because the disputed determination / order itself did not directly affect claimant's right to receive compensation, or the amount thereof.

Board Chair Hall concurring in part and dissenting in part.

I agree with that portion of the majority's opinion which concludes that, under these circumstances, it does not achieve substantial justice to delay the issuance of a decision to await the receipt of the Director's written position. However, I dissent from the remaining portions of the majority's opinion.

Citing to Guardado v. J.R. Simplot, 137 Or App 95 (1995),[1] the majority concludes that the Board lacks review authority over the Department's Order Denying Request for Reconsideration, and that claimant's recourse from that order was to request a hearing before the Director. I dissent, because I believe the Board has jurisdiction to review such orders and to remand this matter to the Department for further reconsideration pursuant to ORS 656.268. My reasoning is as follows:

As an administrative agency, the Department's powers are limited to those delegated to it by statute. See University of Oregon Co-Operative Store v. Dept. of Revenue, 273 Or 539, 550 (1975); Gouge v. David, 185 Or 437, 459 (1949). Although the Department may "supplement" incomplete legislation or fill legislative "gaps," see, e.g., Springfield Education Assn. v. School Dist., 290 Or 217, 221-30 (1980), it may not assume jurisdiction over matters not authorized by statute or adopt rules that are inconsistent with the applicable statutes.

ORS 656.268 sets forth the procedure for determining awards, claim closure and reconsideration. Under ORS 656.268(4)(e), a party objecting to a notice of closure "must first request reconsideration" by the Department. The Department must then complete the reconsideration within a specific time and issue an "order on reconsideration." ORS 656.268(6)(d). ORS 656.268(6)(f) allows any party who objects to the Department's "reconsideration order" to file a request for hearing with the Board's Hearings Division under ORS 656.283. Thus, the statutory procedure is clear and simple: a party requests reconsideration, the Department issues a reconsideration order and, if a party objects to that order, review of the reconsideration order rests with the Hearings Division and Board. The statutory scheme neither provides for nor contemplates what the Director issued in this case, i.e., an "order denying reconsideration" which is purportedly subject to review under the contested case provisions of the Administrative Procedures Act.

To further support my construction of the statutory authority and procedure, I need only look to the language of the statute itself. ORS 656.262(6)(d) provides, in pertinent part, that if an order on reconsideration has not been timely mailed, "reconsideration shall be deemed *denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or determination order was mailed* on the date the order was due to issue." (emphasis added). Thus, pursuant to this provision, a denial of reconsideration is the equivalent of an order on reconsideration affirming the closure in all respects. Yet, contrary to this provision and without statutory authority, the Director has issued an "order denying reconsideration" and promulgated a rule providing that such orders are subject to a separate review process. See OAR 436-030-0008(3).

I respectfully disagree with the majority's determination that an order denying reconsideration is not a "reconsideration order" for purposes of ORS 656.268 and 656.283. First, as noted above, nothing in ORS 656.268 (or any other provision of ORS Chapter 656) authorizes the Department to issue an "order denying request for reconsideration." Assuming, arguendo, that orders denying reconsideration are authorized under ORS 656.268, the statute does not provide any authority for distinguishing between orders on reconsideration and orders denying reconsideration for purposes of further appellate review. Because the applicable statute makes no distinction, I believe that all Department orders issued in response to a request for reconsideration, i.e. all "reconsideration orders," should be subject to the review process set forth in subsection (6)(f).

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[1] With all due respect, I believe that the majority's reliance on Guardado v. J.R. Simplot, 137 Or App 95 (1995) is misplaced. In Guardado, the court held the claimant was not precluded from requesting reconsideration by virtue of the fact the employer had previously requested reconsideration, when the claimant's request was filed within the (then) requisite 180-day period. The court did not address the Director's authority to review orders denying reconsideration, or hold that the Board lacked jurisdiction over such orders.

Furthermore, while footnote 2 in the majority's opinion reflects an accurate statement of the law, I disagree with my fellow members' conclusion that Guardado is supportive authority for the proposition that the Board's Hearings Division lacks jurisdiction to consider an appeal from an Order Denying Reconsideration. As the majority acknowledges, the Guardado court did not address the issues which are specifically raised by the parties in the present case; i.e., the precise jurisdictional issue concerning a hearing request from an Order Denying Reconsideration or the issue of whether the Director exceeded his statutory grant of authority in issuing an Order Denying Reconsideration.

As the court explained in Langford v. Copeland, 141 Or App 138 (1996), the demarcation line between the Director's and the Board's authority to conduct hearings and review orders is set out in ORS 656.704. The essential factor in determining whether the Board has review authority is whether the matter concerns a claim. If the matter is one in which "a worker's right to receive compensation, or the amount thereof, are directly in issue" then the Board has review jurisdiction. ORS 656.704(1), (3). If the order is not a matter concerning a claim, the Board does not have jurisdiction. ORS 656.704(2), Langford, supra, 141 Or App at 143.

As noted above, ORS 656.268 specifically vests the Board and Hearings Division with the authority to review reconsideration orders. By assigning such review authority to the Board, the legislature has fully expressed its intention that reconsideration orders are matters concerning a claim. Moreover, reconsideration orders, like determination orders and notices of closure, are the very instrument by which a claimant's entitlement to compensation and the amount thereof is determined. Thus, whether the order is designated as an order on reconsideration or an order denying reconsideration, a worker's right to receive compensation is still directly in issue. Because of this fact, I cannot accept the majority's position that an "order denying reconsideration" does not involve a worker's right to receive compensation and does not constitute a "matter concerning a claim" within the definition of ORS 656.283(1) and 656.704.

In addition, I find nothing in the text of ORS 656.704 to indicate that a Department order denying reconsideration is anything other than a matter concerning a claim. ORS 656.704(3) specifically excludes disputes arising under ORS 656.245, 656.248, 656.260 and 656.327 as well as other medical services and vocational assistance disputes from the purview of "matters concerning a claim." Had the legislature intended that Department orders denying reconsideration be also excluded from Board review, it could have said so. In light of the provisions of ORS 656.268(6) and the absence of any specific mention of orders denying reconsideration in ORS 656.704, I would conclude that all Department "reconsideration orders" are subject to the Board's review authority.[2]

Accordingly, insofar as OAR 436-030-0008(3) provides that "orders denying reconsideration" qualify for review before the Director as a contested case, I would find this rule inconsistent with ORS 656.268, 656.263 and 656.704, and therefore invalid. See, e.g. Carroll v. Boise Cascade Corp., 138 Or App 610 (1996) (court invalidated administrative rule which conflicted with provisions of ORS Chapter 656).

In conclusion, contrary to the majority, I would affirm ALJ Poland's order "enforcing" ALJ Davis' order, which set aside the Order Denying Request for Reconsideration and remanded the matter to the Department for further processing of claimant's reconsideration request.[3]

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[2] My agreement with the ALJ's decision to "enforce" the prior ALJ's "remand" order is not, as asserted by the majority in footnote 3, inconsistent with my conclusion that claimant's right to compensation was directly at issue in the initial proceeding. The majority misses the point for two major reasons.

First, as the majority acknowledges, the statutory scheme requires a reconsideration process culminating in an Order on Reconsideration. In the present case, that reconsideration was not undertaken by the Director, thereby necessitating remand for the Director to fulfill his statutory obligation. Thus, by agreeing with the "enforcement" of the prior "remand" decision, I am merely attempting to require the Director to comply with the specific statutory process. Until that statutory process is completed there is no "reconsideration record" for the ALJ to review. See ORS 656.283(7). Consequently, the majority is mistaken in footnote 3 to say that remand would not be necessary if compensation was directly at issue. It is in this same regard that the majority's reliance on Lankford is misplaced. In Lankford (where the issue involved the appropriate forum for appellate jurisdiction over an initial subjectivity determination), there was no statutorily created process for determining "subjectivity." Here, in contrast, the statute is not silent, but rather expressly prescribes the "reconsideration" process, including a dissatisfied party's appeal rights and procedures in a situation where reconsideration is deemed "denied."

Second, assuming arguendo that compensation is not directly in issue by virtue of the Director's Order Denying Reconsideration, the majority begs the question of whether the Director is statutorily authorized to place compensation not directly in issue by simply creating a creature entitled "Order Denying Reconsideration."

[3] Moreover, like the ALJ, I would conclude that the statement of appeal rights on the Department's Order Denying Reconsideration (which advised the parties to request a hearing before the Director pursuant to ORS 656.704(2), ORS Chapter 183 and OAR 436-30-008(6)) is not controlling because the notice was, in fact, erroneous. See, e.g., Langford v. Copeland, supra.

In the Matter of the Compensation of
GORDON W. NAYLOR, Claimant
WCB Case No. 96-03368
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order which set aside its "back-up" denial of claimant's bilateral wrist and right knee injury claim. On review, the issue is the propriety of SAIF's "back-up" denial.

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

The ALJ set aside SAIF's "back-up" denial of claimant's injury claim issued pursuant to ORS 656.262(6)(a)[1], finding that the denial was not based on "later obtained evidence" that the claim was not compensable. In reaching this conclusion, the ALJ rejected SAIF's argument that it did not obtain evidence that claimant's injury was due to consumption of alcoholic beverages until after it had accepted the claim.[2]

The ALJ noted that, at the time of its acceptance, SAIF had available to it an emergency room report that indicated that claimant's blood-alcohol level was .21 and a pre-operative report which stated that claimant had drunk a substantial quantity of alcoholic beverages prior to the accident. In addition, the ALJ observed that the employer was aware, prior to SAIF's acceptance of the claim, that alcohol was involved in claimant's accident. The ALJ reasoned that, because the medical reports were in existence prior to SAIF's acceptance, and because the employer's knowledge of claimant's alcohol consumption was attributable to the carrier, SAIF's denial was not based on "later obtained evidence."

On review, SAIF asserts that its denial was properly based on evidence obtained after its acceptance. Specifically, SAIF asserts that it did not have the above medical records in its possession prior to its acceptance, and that the employer's knowledge of claimant's alcohol consumption should not be imputed to SAIF. We do not need to address SAIF's first contention that medical records in existence but not discovered prior to acceptance can constitute "later obtained evidence," because we agree with the ALJ that the employer's "pre-acceptance" knowledge of claimant's consumption of alcohol was properly imputed to SAIF.[3]

To constitute "later obtain[ed] evidence," the statute requires that there be something other than evidence the insurer or employer had at the time of initial acceptance. A re-evaluation of known evidence does not constitute later obtained evidence. See CNA Ins. Co. v. Magnuson, 119 Or App 282 (1993) (the legislature intended that evidence warranting the retroactive denial "come about" after the insurer's original acceptance). In Ralph E. Murphy, 45 Van Natta 725 (1993), we set aside a "back-up" denial based on lack of coverage, where the employer knew at the time of the carrier's acceptance that the claimant was not an Oregon subject worker. In so doing, we attributed the employer's knowledge to the carrier and held that the carrier's "back-up" denial was not based on "later obtained evidence."

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[1] Under ORS 656.262(6)(a), if a carrier accepts a claim in good faith and "later obtains evidence" that the claim is not compensable or the carrier is not responsible, it may revoke its acceptance of a claim and issue a denial as long as the denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on the "back-up" denial, the carrier has the burden of proving by a preponderance of the evidence that the claim is not compensable or that it is not responsible for the claim.

[2] Under ORS 656.005(7)(b)(C), a "compensable injury" does not include:

"Injury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of such consumption."

[3] If we were to address the first contention, we would likely find that the medical records documenting claimant's alcohol consumption are evidence that could have been discovered prior to the time the claim was accepted had SAIF been reasonably diligent in its investigation of the claim. See Darwin G. Widmar, 46 Van Natta 1018 (1994), aff'd mem 134 Or App 414 (1995); see also Charles A. Tureaud, 47 Van Natta 306 (1995).

SAIF urges us to reconsider Murphy, asserting that the case was wrongly decided because its holding would preclude a carrier from ever issuing a "back-up" denial in instances where the employer was the claimant or where the claimant was a friend or relative of the employer and the employer intentionally withheld information from the carrier. SAIF cites evidence that claimant was a friend of the employer in this case and that claimant had lived with the employer's sister for several years. (Trs. 7-9, 29). However, despite its suggestion of impropriety, SAIF cites no evidence that the employer intentionally withheld information from SAIF prior to acceptance. In any event, we decline to depart from our holding in Murphy under these circumstances.

Accordingly, based on our decision in Murphy, we agree with the ALJ that SAIF had knowledge of claimant's alcohol consumption prior to its acceptance. It follows that SAIF's "back-up" denial on that ground was not based on "later obtained evidence." We, therefore, affirm the ALJ's decision to set aside the "back-up" denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(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 July 29, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
LARRY A. THORPE, Claimant
WCB Case No. 96-01360
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to admit a medical arbiter's clarification report that was not considered by the Director; and (2) awarded 22 percent (33 degrees) scheduled permanent disability for loss of use or function of the left wrist (forearm), whereas an Order on Reconsideration awarded no permanent disability. On review, the issues are evidence and extent of permanent disability. We reverse the ALJ's evidentiary ruling, and modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and briefly summarize the pertinent facts as follows:

Claimant compensably injured his left wrist on March 25, 1994. The claim was ultimately closed by a September 21, 1995 Determination Order which awarded no permanent disability. Claimant timely requested reconsideration, and a medical arbiter was appointed.

The medical arbiter examined claimant on January 9, 1996. The arbiter reported that claimant sustained between 31 to 60 percent loss of strength in the left wrist due to the injury and lost range of motion of the DIP joint of the left ring finger.

On January 18, 1996, the Department wrote to the medical arbiter requesting clarification of his findings. The next day, January 19, 1996, the Department issued an Order on Reconsideration affirming the Determination Order in all respects. In "Explanatory Notes" accompanying the reconsideration

order, the appellate reviewer noted that: (1) the medical arbiter's initial report was not used because the findings were not in the required form and format; (2) the Department requested clarifying information from the medical arbiter; (3) the requested information could not be obtained in time to complete the reconsideration pursuant to the statutory requirements; and (4) the clarification report (when received) "will be included in the record." (Ex. 38-4).

Exhibit 39, the medical arbiter's clarification report, was created and received by the Department subsequent to the issuance of the Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Evidence

The evidence issue in this case arises as a result of ORS 656.283(7), which provides in pertinent part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

Citing to ORS 656.283(7), Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996) and Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), the ALJ concluded that the medical arbiter's clarification report (Exhibit 39) could not be considered because it was not included in the record developed on reconsideration.

On review, the insurer argues that the medical arbiter's clarification report can be considered.[1] We agree. Notwithstanding ORS 656.283(7), the arbiter's clarification report is admissible at hearing pursuant to ORS 656.268(6)(e).

ORS 656.268(6)(e) provides: "Any medical arbiter report may be received as evidence at a hearing *even if the report is not prepared in time for use in the reconsideration proceeding.*" (Emphasis added). Consistent with this section, we held in Terry L. Maltbia, 48 Van Natta 1836 (1996) (issued subsequent to the ALJ's order), that a supplemental medical arbiter report received by the Department after it had issued the Order on Reconsideration was admissible at hearing even though it was not considered during the reconsideration process. See also Patricia A. Brown, 48 Van Natta 1164 (1996) ("post-reconsideration" medical arbiter report may be considered at hearing); Joyce A. Crump, 47 Van Natta 1516 (1995) (construing former ORS 656.268(6)(a), the predecessor to ORS 656.268(6)(e)).

ORS 656.268(6)(e) (formerly part of ORS 656.268(6)(a)), was enacted in 1991 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." Tinh Xuan Pham Auto v. Bourgo, 143 Or App 73 (1996) (affirming Daniel L. Bourgo, 46 Van Natta 2505 (1994)); Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). As we explained in Daniel L. Bourgo, supra, this provision was added in response to the court's decision in Benzinger v. Oregon Dept. of Ins. & Finance, 107 Or App 449 (1991). There, the court upheld the mandatory 15 day time limit for completing reconsideration set forth in former ORS 656.268(6)(a) (as amended by Oregon Laws 1990, chapter 2, section 16), which created a problem regarding whether an ALJ (then Referee) could consider a "post-reconsideration order" medical arbiter report. Although the question was subsequently answered in the affirmative in Pacheco-Gonzalez, supra, it was unresolved during the 1991 legislative session.

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[1] The Department has also submitted a brief stating its position that the medical arbiter's clarification report is admissible at hearing under ORS 656.268(6)(e). Pursuant to ORS 656.726(3)(h), the Department is authorized to participate in any proceeding before the Hearings Division, Board or Court of Appeals which the Director determines involves a matter that affects or could affect the discharge of the Director's duties. Since this case involves such a matter, we accept the Department's brief and consider it on review.

On the other hand, by amending ORS 656.283(7) in 1995, the legislature intended to limit evidence concerning issues arising from a Notice of Closure or Determination Order to the evidence submitted at reconsideration and made a part of the reconsideration record. As we explained in Joe R. Ray, supra, the amendments were designed to overrule cases such as Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993), which held that, under the former version of ORS 656.283(7), the ALJ was allowed to consider evidence that the parties could not have submitted to the Department on reconsideration under ORS 656.268. See also Precision Castparts v. Plummer, supra.[2]

As a rule, statutes should be construed in a manner that gives validity to all provisions whenever possible. ORS 174.010; see also Circuit Court v. AFSCME, 295 Or 542, 545 (1983) (whenever possible, court construes statutes so as to achieve consistency); Davis v. Wasco IED, 286 Or 261, 272 (1979) (if possible, court construes statutes on same subject in harmony with each other). Here, if we construe the evidentiary prohibition of ORS 656.283(7) as applying to "post-reconsideration" evidence submitted by the parties, but not reports prepared on behalf of the Department,[3] then ORS 656.283(7) is not inconsistent with ORS 656.268(6)(e). However, to the extent that ORS 656.283(7) may be interpreted to apply to all evidence, regardless of its source, and thereby operates to preclude admission of a medical arbiter's report simply because that report was not submitted in time to be used on reconsideration, then the statute is directly contrary to ORS 656.268(6)(e).

When two statutes cannot be harmonized, the specific provision shall govern over the general. ORS 174.020;[4] State v. Guzek, 322 Or 245, 268 (1995). This is true even if the general statute was enacted later.[5] Davis v. Wasco IED, supra. Applying these rules of statutory construction, we conclude that, to the extent these two provisions are inconsistent, the specific exception for admitting "post-reconsideration" medical arbiter reports set forth in ORS 656.268(6)(e)[6] controls over the general evidentiary prohibition set forth in ORS 656.283(7). Indeed, to hold otherwise would render ORS 656.268(6)(e) essentially meaningless.[7]

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[2] In Plummer, the court explained: "The unmistakable import of the test of ORS 656.283(7) is that any evidence, including a claimant's testimony concerning the notice of closure or reconsideration order, is inadmissible at a subsequent hearing concerning the extent of the injured worker's permanent disability if not submitted at reconsideration and not made part of the reconsideration record."

[3] As we explained in Daniel L. Bourgo, supra, a medical arbiter or panel of arbiters is appointed by the Department to prepare a report on behalf of the Appellate Review Unit, and is not intended to be a witness for a claimant or a carrier. See Constance I. Gassner, 48 Van Natta 2596 (1996).

[4] This section provides, in pertinent part: "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."

[5] See also Thompson v. IDS Life Ins. Co., 274 Or. 649, 656 (1976) ("a specific or special act controls over a general act. This is the rule even if, as here, the general act was enacted later. * * * Absent a plain indication of intent to repeal the special act the special act will continue to have effect and the general act will be modified by construction so the two can stand together; one as the general law of the state and the other as the law of the particular case or as an exception to the general rule.")

[6] As explained in Tinh Xuan Pham Auto v. Bourgo, supra, this exception is limited to initial medical arbiter reports that were requested, but not completed, before the statutory time for reconsideration and "supplemental" or "clarifying" reports when that arbiter report was requested by the Department or when the initial report itself indicated it was not complete. 143 Or App at 78, n.5; see also Constance I. Gassner, supra; Jason O. Olson, 47 Van Natta 2192 (1995).

[7] For the same reason, we do not consider ORS 656.268(6)(e) to be inconsistent with the evidentiary limitation of 656.268(7)(g). Subsection (7)(g) provides "[a]fter reconsideration, no subsequent medical evidence of the workers' impairment is admissible before the department, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure." To the extent these two statutes cannot be harmonized in this manner, we conclude that the specific exception set forth in ORS 656.268(6)(e) also governs over the general prohibition of "post-reconsideration" medical evidence in ORS 656.268(7)(g).

Accordingly, in this case, we conclude that Exhibit 39, the clarification report requested by the Department during the reconsideration proceeding, should have been considered at hearing pursuant to ORS 656.268(6)(e). Because we find Exhibit 39 admissible, we consider it on review. See Terry L. Maltbia, supra.

Extent of Scheduled Permanent Disability

Construing the medical arbiter's original report, which set forth a loss of grip strength consistently within the 31 to 60 percent range on the Jamar dynamometer, the ALJ determined that claimant has approximately 50 percent loss of strength in his left forearm due to the injury, entitling him to an award of 22 percent scheduled permanent disability for loss of use or function of the left wrist.

On review, the insurer contends that the ALJ erred in rating claimant's loss of grip strength based the arbiter's initial findings. The insurer further asserts that claimant's scheduled permanent disability award should be determined based upon the medical arbiter's clarification report, which sets forth claimant's impairment findings in the specific method required by the disability rating standards. We agree.

We rely on the medical arbiter's findings, as clarified in Exhibit 39, because the arbiter's reports are a complete, well-reasoned evaluation of claimant's impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994) (Board does not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough, complete and well-reasoned evaluation of the claimant's injury related impairment).

The medical arbiter found that claimant sustained a loss of grip strength as a result of his March 25, 1994 left wrist injury. Using the method required by the standards, the arbiter rated claimant's grip strength as 4/5, and explained that the loss of strength was due to injury to the muscles and musculotendinous unit arising out the March 25, 1994 accident, and not due to loss of motion.

OAR 436-35-007(16)(a) (WCD Admin. Order 95-060) provides for a 20 percent impairment at a 4/5 rating. OAR 436-35-007(16)(b) provides that this percentage value (20 percent) shall be multiplied by the appropriate percent value allowed for the affected body part which, in this case, is 44 percent. See OAR 436-35-110(8) (providing for forearm impairment of 44 percent for injury to the median nerve below mid-forearm). 44 percent multiplied by 20 percent equals 8.8 percent. Therefore, claimant is entitled to 9 percent for loss of grip strength of the left wrist, for a total scheduled permanent disability award of 9 percent for loss of use or function of the left wrist (forearm).

ORDER

The ALJ's order dated May 24, 1996 is modified in part and affirmed in part. In lieu of the ALJ's award of 22 percent (33 degrees) scheduled permanent disability, claimant is awarded 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the left wrist (forearm). Claimant's "out-of-compensation" attorney fee is modified accordingly. The remainder of the order is affirmed.

In the Matter of the Compensation of
KATHY A. ZUERCHER, Claimant
WCB Case No. 96-01040
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
James Northrop (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: (1) set aside its partial denial of claimant's congenital and degenerative low back condition; and (2) assessed a penalty for an unreasonable denial. On review, the issues are scope of denial, compensability and penalties. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In April 1995, claimant injured her back. X-rays revealed partial sacralization of the left L5 transverse process with L5-S1 lateral mass pseudarthrosis and associated degenerative subcorical sclerosis, a congenital and degenerative condition. SAIF accepted a claim for "lumbar strain." Claimant became medically stationary on November 22, 1995. On January 16, 1996, SAIF issued a denial of claimant's congenital and degenerative low back condition as unrelated to her April 1995 injury.

Applying ORS 656.005(7)(a)(B), the ALJ set aside SAIF's denial, reasoning that the compensable April 1995 injury combined with the preexisting condition to cause claimant's need for treatment and disability. On review, SAIF contends that the ALJ misinterpreted the scope of its partial denial. Specifically, SAIF contends that its denial is a partial denial solely of disability and medical treatment for claimant's preexisting, degenerative low back condition and is not a "back up" denial of its accepted lumbar strain claim. Alternatively, SAIF argues that, if its denial is construed as a "current condition" denial, it must be upheld, as the accepted lumbar strain has resolved.

We adopt and affirm those portions of the ALJ's opinion regarding the scope of SAIF's partial denial and compensability, with the following supplementation.

An insurer is bound by the express language of its denial. Tattoo v. Barrett Business Services, 118 Or App 348 (1993). Here the ALJ appropriately found that the basis for SAIF's partial denial was "[t]he April 4, 1995 injury is not the major contributing cause of your partial sacralization of the left L5 transverse process with L5-S1 lateral mass psuedoarthorsis (sic) and associated degenerative subcortial sclerosis." (Emphasis added). Although SAIF's denial letter stated that it had accepted claimant's lumbar strain, it also stated that it was denying payment for treatment or disability related to the preexisting congenital and degenerative condition because the April 4, 1995 injury was not the major contributing cause of that condition. (Ex. 44).

Because the employer's denial is couched in terms of ORS 656.005(7)(a)(B), we conclude that the first inquiry before the ALJ was whether claimant's April 4, 1995 industrial injury resulted in a combined condition under ORS 656.005(7)(a)(B). The medical record establishes that it did. (Exs. 33, 35, 46). Consequently, the ALJ properly addressed the scope of the denial and correctly concluded that claimant's April 4, 1995 industrial injury resulted in a compensable combined condition under ORS 656.005(7)(a)(B).[1] However, our inquiry does not end here.

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[1] We note that the evidence does not establish the independent compensability of claimant's partial sacralization and related degenerative condition under ORS 656.005(7)(a)(B). See Richard P. Beckel, 46 Van Natta 2364, on recon 46 Van Natta 2461 (1994).

The record shows that by January 3, 1996, claimant's lumbar strain had resolved, and that any continuing symptoms were due to her preexisting condition. (Exs. 35, 36, 43, 46, 47, 49). Under ORS 656.005(7)(a)(B), the "combined condition" is compensable so long as the compensable injury is the major contributing cause of the "combined condition." See, e.g., Danny B. Conner, 48 Van Natta 1227 (1996). Based on the evidence that claimant's compensable injury had resolved, we conclude that there was no "combined condition" after January 3, 1996. Moreover, even assuming the continued existence of a "combined condition," there is insufficient proof that the compensable injury was the major contributing cause after that date. Consequently, we conclude that claimant proved compensability of her combined condition from April 4, 1995 through January 3, 1996. ORS 656.005(7)(a)(B); Danny B. Conner, supra.

Penalty

The ALJ found that, at the time that SAIF issued its January 16, 1996 denial, it had the October 3, 1995 opinion of its own medical examiner, who had opined that the major contributing cause of claimant's need for treatment and disability immediately following the April 1995 injury was the lumbar strain rather than her preexisting condition, and no contrary medical opinions. Concluding that the denial was unreasonable, the ALJ assessed a penalty. SAIF contends that its denial was not unreasonable. We agree.

At the time of SAIF's denial, it not only had the above-mentioned medical evidence regarding claimant's condition at the time of injury, but it also had medical evidence that claimant's compensable injury had resolved and was no longer the major contributing cause of claimant's condition, and that claimant's condition was medically stationary. (Exs. 41, 43). There was no contrary evidence.[2] Under such circumstances, we conclude that the denial was not unreasonable. We accordingly reverse the ALJ's penalty award.

Attorney Fees

Inasmuch as we have, in part, reversed the ALJ, we also modify the assessed attorney fee award for services 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 $2,000. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

Moreover, inasmuch as claimant's compensation was reduced on review, claimant's attorney is not entitled to an assessed attorney fee for services on review. See ORS 656.382(2).

ORDER

The ALJ's order dated May 1, 1996 is affirmed in part, reversed in part and modified in part. The SAIF Corporation's denial of claimant's need for treatment and disability after January 3, 1996, is reinstated and upheld. The remainder of SAIF's denial remains set aside. The ALJ's assessed penalty is reversed. In lieu of the ALJ's $2,500 attorney fee award, claimant's counsel is awarded an assessed fee of $2,000 for services at hearing, to be paid by the SAIF Corporation. The remainder of the ALJ's order is affirmed.

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[2] Dr. Eisendorf's April 5, 1996 report addresses initial compensability and does not address whether the industrial injury was the major cause of claimant's condition as of January 1996. (Ex. 46).

Board Chair Hall dissenting.

The majority sets aside SAIF's denial in part and reverses the ALJ's penalty assessment, concluding that SAIF correctly denied the compensability of claimant's condition after January 3, 1996. I respectfully dissent from the majority's analysis and conclusions.

The majority correctly points out that an insurer is bound by the express language of its denial. See Tattoo v. Barrett Business Services, 118 Or App 348 (1993). Here, SAIF's January 16, 1996 denial was of claimant's then-current low back condition in its entirety, i.e., after the accepted April 1995 injury The denial was contrary to unrebutted medical evidence establishing that claimant's accepted injury was the major contributing cause of her low back condition at least up to January 1996. For that reason alone, the denial should be set aside and a penalty assessed.

Yet, despite the court's holding in Tattoo, the majority effectively rewrites SAIF's denial in order to fashion a compromise remedy. In particular, the majority finds that SAIF denied claimant's condition in portions, i.e., before and after the date of the denial. The majority then sets aside the "denial" of claimant's before-denial condition and upholds the "denial" of claimant's after-denial condition. This analysis, however, relies on the fiction that SAIF's denial can be interpreted in this manner. In fact, the denial cannot be read as anything but a denial of claimant's current back condition in its entirety. Because the denial, as written, is contrary to the medical evidence, it should be set aside and a penalty assessed. Further, the ALJ's assessed fee award should not be disturbed, and an assessed fee should be awarded on Board review. For these reasons, I dissent from the majority's decision.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court: Page

[None in this reporting period.]

Decided in the Oregon Court of Appeals:

Boise Cascade v. Borgerding (9/11/96) 2616
Bowman v. Esam, Inc. (12/4/96) 2636
Clausing v. K-Mart Corporation (11/20/96) 2632
Deaton v. Hunt-Elder (12/4/96) 2638
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United Parcel Service v. Likos (9/18/96) 2618
Vega v. Express Services (11/27/96) 2633

Cite as 143 Or App 371 (1996) September 11, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Darcy Borgerding, Claimant.

BOISE CASCADE, *Petitioner,*
v.
Darcy BORGERDING, *Respondent.*
(WCB No. 94-05241; CA A89178)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 17, 1996.
Richard D. Barber, Jr., argued the cause for petitioner. With him on the brief was Bostwick, Sheridan & Bronstein.
Hollis Ransom argued the cause and filed the brief for respondent.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DEITS, P. J.
Affirmed.

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143 Or App 373> Employer seeks review of an order of the Workers' Compensation Board (Board) setting aside its denial of claimant's "current condition." We affirm.

Claimant began working for employer in October 1990. In June 1991, while sweeping wood dust at the job site, she experienced a skin rash, breathing difficulties and swelling of her tongue and face. Claimant sought medical treatment from Dr. Thornfeldt, who diagnosed her condition as an allergy to red spruce and fir. She also underwent an independent medical examination by Dr. Bilstrom, at employer's request. He diagnosed eczema and angioedema due to wood dust at work. Thornfeldt concurred with Bilstrom's report. After receiving the medical reports, employer accepted the claim.

Thornfeldt continued to treat claimant for her condition. In February 1994, claimant was examined by Dr. Bardana. He concluded that Thornfeldt had misdiagnosed claimant's condition. He diagnosed the condition as chronic urticaria/angioedema, which, in his opinion, was idiopathic, preexisted claimant's work and was not related to her work exposure. Following receipt of Bardana's opinion, employer issued the following denial:

> "[The employer has] received Dr. Bardana's report regarding your allergy condition and [has] completed [its] review of it. [The employer has] determined that your current condition is not related to your accepted workers' compensation claim. Therefore, we cannot accept further responsibility for treatment of this condition. We must respectfully issue this partial-denial of your current condition."

Employer then closed the claim with no award of permanent disability.

Claimant requested a hearing on employer's denial arguing that it was an impermissible backup denial, because the denial was issued more than two years after acceptance. Employer argued that the denial was proper as a partial denial of an unrelated condition. Both the referee and the Board concluded that the condition employer sought to deny was the same condition employer had previously accepted **<143 Or App 373/374>** and, therefore, that the new denial was an impermissible backup denial, because it occurred more than two years after the initial acceptance of the claim. ORS 656.262(6). The Board also concluded, alternatively, that the denial was an impermissible preclosure denial of an accepted condition.

On review, employer first argues that the Board was wrong in concluding that its 1994 denial was for the same condition that it accepted in 1991 and that, accordingly, the Board erred in holding that employer's 1994 denial was an improper backup denial. Claimant asserts that the Board's finding that this was the same condition is supported by substantial evidence and, therefore, the Board was right in concluding that employer's denial must be set aside.

We agree with claimant that there is substantial evidence supporting the Board's conclusion that employer is attempting to deny the same condition that it had earlier accepted. As the ALJ explained:

> "My complete review of the documents since the hearing convinces me that the denial letter is a backup denial of the accepted condition and it is not a partial denial of an unrelated condition. *The symptoms which were accepted are the same symptoms which are now denied.* The conditions that Dr. Thornfeldt and Dr. Bilstrom described by one set of terminology are the same conditions now denied by use of Dr. Bardana's terminology. Dr. Bardana is providing his own interpretation of the same evidence that formed the basis of the opinions of Dr. Thornfeldt and Dr. Bilstrom regarding claimant's onset and appearance of symptoms while she was working for the employer. This is a classic backup denial because there is nothing different about claimant but only a different interpretation of what claimant has and had."

Accordingly, the Board did not err in setting aside employer's 1994 denial.[1]

Employer also argues that a procedural error that occurred here requires a remand of the Board's order. At hearing, employer orally sought to amend its written denial **<143 Or App 374/375>** of claimant's "current condition" to a denial of "chronic idiopathic urticaria and angioedema." The ALJ allowed employer's oral amendment. At the time that employer sought to amend the denial, claimant requested a continuance, but, from the record, it does not appear that claimant specifically objected to the amendment.[2] The request for a continuance was denied. After the hearing record was closed, however, the ALJ determined, based on *Dolph M. Wiedenmann*, 46 Van Natta 1584 (1994), that the oral amendment to employer's denial should not have been allowed and ruled that the amendment to the denial would not be allowed and that he would proceed as if there were no amendment of the denial. Employer moved for reconsideration of the ALJ's decision, which the ALJ denied, explaining that there was no need to reconsider his decision, because the arguments raised would not make a difference in his decision. The Board agreed. It stated:

> "At hearing, the employer noted that it had accepted the original claim for an allergy to red spruce and Douglas fir. The employer requested to amend its denial to specify the denied current conditions as chronic idiopathic urticaria and angioedema. The Referee disallowed the amendment request. On review, the employer contends that the Referee should have ruled on the denial as amended and that he erred in concluding that the denial was a 'backup' denial of the accepted condition. Like the Referee, we find that the 'urticaria' and 'angioedema' diagnoses merely describe the same condition/symptoms which the employer accepted under the original claim. Because the employer sought to deny responsibility for the accepted condition, it was properly set aside as an invalid 'backup' denial."

In view of our conclusion that the Board's finding that the condition that employer sought to deny was the same as the condition that it had earlier accepted is supported by substantial evidence, it is unnecessary to address the question of the permissibility of the oral amendment. As both the referee and the Board explained, the amendment **<143 Or App 375/376>** would not make a difference here. The Board did not err in setting aside employer's denial.

Affirmed.

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[1] In view of our conclusion that the Board was correct regarding the backup denial, it is unnecessary to consider the Board's alternative basis for setting aside the denial as an impermissible preclosure denial.

[2] The ALJ found that claimant had objected.

Cite as 143 Or App 486 (1996) September 18, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kathleen L. Likos, Claimant.

UNITED PARCEL SERVICE, Liberty Northwest Insurance Corporation,
Petitioners,
v.
Kathleen L. **LIKOS**, McLellan/SAIF Corporation, Old Peak Construction/SAIF Corporation, *Respondents.*
(WCB 94-08968, 94-06781, 94-03441; CA A89647)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 22, 1996.

Richard D. Barber, Jr. argued the cause for petitioners. With him on the brief was Bostwick, Sheridan & Bronstein.

James L. Edmunson argued the cause for respondent Kathleen L. Likos. On the brief were Thomas Cary and Coons, Cole, Cary & Wing, P.C.

Deborah Sather argued the cause for respondents McLellan Temporaries/SAIF Corporation. With her on the brief was Stoel Rives LLP.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondents Old Peak Construction/ SAIF Corporation. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

WARREN, P. J.

Reversed.

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143 Or App 488> United Parcel Service (UPS) and its insurer Liberty Northwest Insurance Corporation (Liberty) seek review of an order of the Workers' Compensation Board (Board) holding that UPS is responsible for claimant's work-related carpal tunnel syndrome. We agree with UPS that the Board erred in assigning it responsibility for the claim and reverse the Board.

From 1985 to 1987, claimant worked for UPS, where her work involved lifting heavy boxes. She suffered a compensable but nondisabling left shoulder injury that Liberty accepted on behalf of UPS. That injury is not at issue here. From 1987 to 1993, claimant was self-employed at Genesis Services; as a sole proprietor, she chose not to be subject to the Workers' Compensation Act or to obtain coverage for her own possible injuries. In July 1991, claimant saw Dr. Honeyman, a chiropractor, for right shoulder, arm and hand symptoms that Honeyman diagnosed as thoracic outlet syndrome and "probable carpal tunnel syndrome." In 1993, claimant worked for McLellan Temporaries and then Old Peak Construction, both insured by SAIF Corporation. In 1993, claimant sought treatment from Honeyman for right wrist pain. Honeyman referred claimant to a specialist who diagnosed carpal tunnel syndrome.

Because claimant has had multiple periods of employment, more than one of which provided conditions that could have caused her carpal tunnel syndrome, she sought to establish the compensability of her claim through the last injurious exposure rule. *Bracke v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982). Under that rule, the last employer whose employment could have materially contributed to a worsening of the claimant's condition is responsible for the condition. *Id.* at 244.

As pointed out in *Bracke,* reference to the rule as if it were a single concept is somewhat misleading. There are at **<143 Or App 488/489>** least two aspects of the last injurious exposure rule: proof of the claim and assignment of liability. *Id.* at 245 and n 1. As a rule of proof, the rule operates to relieve the claimant of the burden of proving actual medical causation as against any particular employer or insurer, *id.* at 246, and instead assigns liability for the claim to the carrier on the risk during the last period of potentially causal employment before the date of disability. *Id.* at 248. Potentially causal employment is employment involving conditions that could cause the claimed condition over some indefinite period of time. *Fossum v. SAIF,* 293 Or 252, 256, 646 P2d 1337 (1982). The date of disability is the date on which the claimant becomes disabled by the condition or, if not disabled, first receives

medical services for the condition. *Timm v. Maley*, 125 Or App 396, 865 P2d 1315 (1993), *rev den* 319 Or 81 (1994); *United Pacific Insurance Co. v. Harris*, 63 Or App 256, 260, 663 P2d 1307, *rev den* 295 Or 730 (1983). The date of disability is significant additionally because it is considered to be the date on which the right to benefits accrues. As the Supreme Court said in *Bracke*, it is "the decisive event for fixing liability." 293 Or at 247.

Purporting to apply the last injurious exposure rule, the Board considered all of claimant's work history, including her period of self-employment, for the purpose of determining whether her condition is work related. The Board found that claimant's carpal tunnel syndrome is related to her employment. The Board then said:

> "Within the context of this case, that satisfies claimant's burden of proof regarding *compensability*. The question then becomes one of responsibility." (Emphasis supplied.)

Assuming that the condition is compensable because it is work related, the Board then discussed the question of assignment of initial responsibility for the claim.

The Board found that claimant first sought medical treatment for her condition in 1991, while she was self-employed at Genesis Services. The last injurious exposure **<143 Or App 489/490>** rule would ordinarily require assignment of initial responsibility for the claim to that employer. *Timm*, 125 Or App at 401. However, relying on *Fossum*, *Bracke*, and *Progress Quarries v. Vaandering*, 80 Or App 160, 722 P2d 19 (1986), the Board held that, because Genesis Services was not a subject employer, the claim could not be attributed to it and responsibility should be assigned to UPS, the next most recent employment with potentially causal conditions before the onset of disability.

We agree with the Board that all of claimant's potentially causal employments, including her period of self-employment with Genesis Services, should be considered for the purpose of determining whether her condition is work related. *Beneficiaries of Strametz v. Spectrum Motorwerks*, 135 Or App 67, 897 P2d 335, *on recon* 138 Or App 9, 906 P2d 825 (1995), *rev allowed* 323 Or 153 (1996); *Silveira v. Larch Enterprises*, 133 Or App 297, 891 P2d 697 (1995). Substantial evidence supports the Board's findings that claimant's disability arose during her period of self-employment and that the condition is work-related. However, we disagree with the Board's conclusion that UPS is responsible for it. Genesis Services, the employment at which claimant's disability arose and the last potentially causal employment, is the employment at which claimant's right to benefits, if any, accrued. *Bracke*, 293 Or at 248. The evidence supports the Board's findings that claimant's subsequent employments at McLellan Temporaries and at Old Peak Construction did not contribute to claimant's condition. Under the last injurious exposure rule of proof, claimant would have met her burden to establish that her claim is compensable and the responsibility of Genesis Services if Genesis Services had been a subject employer. Claimant is not entitled to receive compensation, however, because Genesis Services, the last potentially causal employment before claimant sought medical treatment and at which claimant's claim accrued, was not subject to the Workers' Compensation Law. *Compare Beneficiaries of Strametz; Bennett v. Liberty Northwest Ins. Corp.*, **<143 Or App 490/491>** 128 Or App 71, 78, 875 P2d 1176 (1994).[1] Accordingly, the Board erred in assigning responsibility to UPS.

Reversed and remanded for reconsideration.

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[1] Claimant relies on *Progress Quarries* to support her view that if initial responsibility under the last injurious exposure rule of proof would fall on a nonsubject employer, then the next previous potentially causal employer is deemed responsible. In *Progress Quarries*, the insurer that had been held responsible for the claim asserted that a subsequent employer, not in Oregon, was the last potentially causal employment before treatment had been sought, and that before the Oregon employer could be held responsible for the claim, the claimant must establish that benefits had been sought from the out-of-state employer. *Progress Quarries* is distinguishable. There, the claimant did not rely on the subsequent out-of-state employment to establish that the condition was work related; the out-of-state employment was offered defensively by the last, potentially causal Oregon employer. We rejected the defense, stating that "[t]he basic overall fairness [of the last injurious exposure rule] can be achieved only if application of the rule remains under control of the Oregon workers' compensation system. * * * [O]nly if the Oregon employment environment is injurious and a potential cause of the disease can the claimant be entitled to compensation under the rule of proof aspect of the doctrine." *Id.* at 166.

Cite as 144 Or App 96 (1996) October 16, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wonder Windom-Hall, Claimant.
NORDSTROM, INC., *Petitioner - Cross-Respondent,*
v.
Wonder **WINDOM-HALL**, *Respondent - Cross-Petitioner.*
(WCB 90-06799; CA A89067)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 22, 1996.
Karen O'Kasey argued the cause for petitioner - crossrespondent. With her on the briefs were Mildred J. Carmack and Schwabe, Williamson & Wyatt.
Karen Stolzberg argued the cause for respondent - crosspetitioner. With her on the brief was Goldberg, Mechanic & Stuart.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
On petition, remanded for reconsideration; affirmed on cross-petition.
Armstrong, J., concurring in part and dissenting in part.

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144 Or App 98> Claimant suffers from a number of conditions, including several vestibular disorders, encephalopathy and dysthymia, all of which she asserts are compensable because they resulted from her exposure to toxic or noxious fumes at her place of employment. Employer seeks review of an order of the Workers' Compensation Board upholding the compensability of one of the vestibular disorders, perilymph fistulas. Claimant cross-petitions, contending that the Board erred in determining that her other conditions are not compensable and in denying claimant attorney fees and penalties.

Claimant's claim form described her injury as headache, nausea and dizziness. On employer's portion of the form, it accepted a claim for "prolonged exposure to fumes from roofing--caused dizziness and headaches." There was evidence that claimant's symptoms are the symptoms of the three vestibular disorders from which she suffers, each of which employer subsequently denied. Claimant sought a determination that employer's acceptance encompassed the three vestibular disorders. The Board concluded that claimant was correct, relying on *Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988). Accordingly, the Board concluded that employer's subsequent denial of the vestibular disorders was a back-up denial.

Contrary to the Board's view, we think that employer's acceptance of the claim was qualified, as a matter of law, 305 Or at 501, and was limited to those symptoms caused by prolonged exposure to fumes from roofing. Conditions not caused by that exposure were not encompassed by the acceptance. Because the Board believed that employer had accepted the vestibular disorders it treated employer's denial of the disorders as a back-up denial, and it determined, pursuant to ORS 656.262, that employer had the burden to show, by clear and convincing evidence, that the vestibular disorders were not compensable.[1] It found, with respect to **<144 Or App 98/99>** each vestibular disorder, that claimant's exposure to *toxins* at work did not cause them and with reference to two of the vestibular disorders that claimant's exposure to noxious odors did not cause them. The Board's findings are supported by substantial evidence. Although, in determining that two of claimant's vestibular disorders are not compensable, the Board incorrectly assigned the burden of proof to employer, because substantial evidence supports the Board's findings it would serve no purpose to remand the case to the Board for reconsideration under the correct burden of proof, which is more onerous to claimant. Accordingly, we affirm the Board with respect to the compensability of claimant's vestibular disorders other than perilymph fistulas.

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[1] We note that in 1995 the legislature amended ORS 656.262, which governs back-up denials, to change the employer's burden of proof to a preponderance of the evidence.

The Board found additionally that employer had not carried its burden to show that claimant's perilymph fistulas[2] were not caused by her nausea and vomiting, which in turn had been caused by her exposure to *noxious* odors at work. Thus, it held that the perilymph fistulas remained an accepted condition. Because we have held that claimant's perilymph fistulas were never accepted, it remains claimant's burden to show that the condition was work related. There is no evidence that the perilymph fistulas were directly caused by the exposure to noxious fumes. There is some evidence they may have been caused by claimant's coughing or vomiting. If that is the case, then the condition may be compensable as a consequential condition. ORS 656.005(7)(a)(A). With respect to the perilymph fistulas, we therefore remand the case to the Board for it to consider in the first instance on this record whether claimant has met her burden to show that the perilymph fistulas are a consequential condition.

144 Or App 100> In her cross-petition, claimant contends that the Board erred in holding that her encephalopathy and dysthymia are not compensable.[3] The Board found that claimant had failed to show that she was exposed to a sufficient level of toxins at work to have caused those conditions. Those findings are supported by substantial evidence. Accordingly, we affirm the Board with respect to its affirmance of the denial of the compensability of encephalopathy and dysthymia. In view of our determinations, we do not address claimant's remaining contentions with regard to attorney fees and penalties.

On petition, remanded for reconsideration; affirmed on cross-petition.

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[2] A "fistula" is

"[a]n abnormal duct or passage resulting from injury, disease, or a congenital disorder that connects an abscess, a cavity, or a hollow organ to the body surface or to another hollow organ."

The American Heritage Dictionary of the English Language (3rd ed 1992).

The inner ear is divided into three different compartments that are separted by membranes and filled with fluid. A perilymph fistula is a leakage of fluid from one of the outer two membranes' fluid compartments, typically caused by trauma to the membrane, that allows fluid to pass between the inner ear and the middle ear.

[3] Those two conditions were not subject to the alleged back-up denial.

ARMSTRONG, J., concurring in part and dissenting in part.

The majority holds that, as a matter of law, employer's acceptance of claimant's symptoms is limited to those symptoms caused by "[p]rolonged exposure to fumes at work." Consequently, it concludes that employer's subsequent denial of claimant's vestibular disorders was not a backup denial controlled by ORS 656.262(6)(a), but a denial of a new claim. The majority reaches that result by failing to apply *Georgia-Pacific v. Piwowar,* 305 Or 494, 753 P2d 948 (1988). I dissent from that holding.

Under *Piwowar,* if an employer accepts a claim that only describes symptoms, it accepts all conditions that caused those symptoms, even if those conditions are not work related. *Piwowar*'s holding resulted from an analysis of two earlier workers' compensation cases: *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), and *Johnson v. Spectra Physics,* 303 Or 49, 733 P2d 1367 (1987).

In *Bauman,* the court held that, once an employer accepts a claim, it cannot subsequently deny it without "a showing of fraud, misrepresentation or other illegal activity." *Id.* at 794. The court reasoned that allowing the employer to deny a previously accepted claim "would encourage degrees of instability in the workers' compensation system that we do **<144 Or App 100/101>** not believe the statute contemplates." *Id.* at 793. Further, the potential for delayed litigation would frustrate the statutory scheme's provision for a "speedy resolution of workers' compensation claims." *Id.* at 794.

In *Johnson,* the employer accepted a claim for a "back injury" located in the "middle back and arm." 302 Or at 52. The employer subsequently denied the claimant's carpel tunnel syndrome, a wrist affliction. The court upheld the denial, concluding that the *Bauman* standard "applies only to a claim 'specifically' or 'officially' accepted by the insurer." *Id.* at 55. Allowing the insurer to accept one condition and deny another, the court concluded, was "consistent with the rule of *Bauman* because [it promoted] timely closure of the accepted aspects of the claim." *Id.* at 58.

In *Piwowar* the court stated:

> "[r]ead together, *Johnson* and *Bauman* require the employer to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition."

305 Or at 501. It followed that allowing the employer to accept symptoms and then subsequently deny conditions would subvert the principles of *Bauman* and *Johnson*. The employer would be free to "litigate compensability in any case in which the accepted condition may be attributed to a more specific cause." *Id.* Therefore, the court concluded that, when the employer in *Piwowar* accepted a claim for a sore back, it had accepted all conditions that caused that symptom, whether or not the conditions were caused by work. *Id.* at 501-02.

Following *Bauman, Johnson* and *Piwowar*, this court has distinguished a partial denial from a backup denial by determining whether the employer's acceptance encompassed "symptoms" or "conditions." In conducting that analysis, we have recognized the difficult line an employer must walk: if it accepts symptoms, it has to cover all conditions that caused the symptoms, even those not related to work; but if it refuses to take action until it gets a clear diagnosis of the conditions causing the symptoms, it will very likely be subject to penalties. *Reynolds Metals v. Mendenhall*, 133 Or **<144 Or App 101/102>** App 428, 434, 891 P2d 706 (1995) (citing *Weyerhaeuser Co. v. Warrilow*, 96 Or App 34, 36-38, 771 P2d 295, *rev den* 308 Or 184 (1989)). As a result, subsequent cases have suggested that if an employer identifies a condition, any condition, it will escape the rigors of *Piwowar*. *See, e.g., Reynolds Metals*, 133 Or App at 430 (claimant claimed a lower back injury, stating he had a "possible ruptured disc"; employer accepted claim for "low back strain," although claimant had not been diagnosed with that condition; court held only claim for "low back strain" accepted); *SAIF v. Abbott*, 107 Or App 53, 55, 810 P2d 878 (1991) (if employer accepted a claim for "numbness in hands, arm aches," then it had to cover a claim for carpel tunnel syndrome; if it accepted a claim for "right wrist strain," and "right shoulder strain," then it did not have to cover carpel tunnel syndrome); *Boise Cascade Corp. v. Katzenbach*, 104 Or App 732, 802 P2d 709 (1990) (acceptance of "right wrist strain" does not cover avascular necrosis), *rev den* 311 Or 261 (1991).

Until today, however, the court has not allowed the employer to avoid the consequences of *Piwowar* by identifying a work-related "cause" of the accepted symptoms, as opposed to identifying an underlying physical "condition." The distinction between those two terms is significant. If the employer accepts a condition, the claimant knows with certainty what the employer will cover. The employer does not have unlimited discretion to deny future claims relating to that condition, which can lead to delay and instability. On the other hand, if the employer identifies only a work-related "cause" of the symptoms, it really accepts nothing. As each condition becomes known, the employer can dispute whether the condition is related to the "cause" it accepted.

At least one case, in dictum, has recognized that reality. In *Weyerhaeuser Co. v. Warrilow*, 96 Or App 34, 771 P2d 295, *rev den* 308 Or 184 (1989), the claimant appealed a partial denial. In its acceptance, the employer stated:

> "We hereby accept that you did suffer an accident while engaged in your work activities * * *. We will be responsible for any treatment related to the effects of this incident." *Id.* at 36.

144 Or App 103> The acceptance then continued to list conditions that the employer specifically did not accept. The court noted:

> "We agree with the Board that the letter is vague as to what Weyerhaeuser has accepted, if anything. It expressly 'accepts' all conditions 'related to' the accident, but does not specify what those conditions are; it would appear to leave Weyerhaeuser the option later to deny other conditions not specifically accepted on the ground that they are not related to the accident." *Id.* at 37.

Because the claimant did not challenge that aspect of the acceptance, however, the court did not analyze the consequences of it. Nevertheless, our comments illustrate the point that, in practice, accepting a work-related "cause" of symptoms is indistinguishable from accepting symptoms.

The case before us aptly illustrates that point. On her claim form, claimant described her injury as "headache dizzy." She described the accident as "headache--vomiting--dizzyness." The employer accepted the claim, stating that "[p]rolonged exposure to fumes from roofing--caused dizziness and headaches." As a matter of law, "prolonged exposure to fumes" appended to the symptoms does not alter the fact that the employer was accepting the symptoms. "Prolonged exposure to fumes" is not a condition that manifests itself with certain symptoms; it is a cause of the symptoms and their underlying conditions. Because the fumes encountered were at the workplace, the employer essentially asserted that it had accepted the symptoms to the extent that the underlying conditions causing those symptoms were related to work. Thus, employer's "qualification" did nothing more than make explicit that which is implicit in every accepted workers' compensation claim: that claimant qualifies for workers' compensation because employer accepts that she was injured at work.

The stated "qualification," then, does not alter the fact that the employer was accepting claimant's symptoms. Otherwise, claimant would have no idea what conditions employer had accepted; with every condition, the employer could dispute whether it was caused by work. Thus, the case before us is materially identical to the case in *Piwowar*. If **<144 Or App 103/104>** *Piwowar* is to mean anything, the court must hold, as a matter of law, that employer accepted all the conditions that caused the symptoms listed by claimant.[1]

I would affirm the Board's conclusion that employer's "qualification" did not alter its acceptance of claimant's symptoms. The Board concluded, correctly, that employer's subsequent denial of claimant's vestibular disorders was only permissible if employer could satisfy the requirements of ORS 656.262(6)(a), which, at the time of the Board's decision, required the employer to establish by clear and convincing evidence that the vestibular disorders were not compensable. The Board held that employer had failed to do that. Since the Board's decision, however, the legislature has amended ORS 656.262(6)(a) to reduce the employer's burden of persuasion on a backup denial to a preponderance of the evidence. Or Laws 1995, ch 332, § 28. That change is applicable to this case. 1995 Or Laws, ch 332, § 66; *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996). Therefore, the burden imposed on employer by the Board was too stringent and the matter must be remanded for reconsideration under the new standard.

I concur with the majority's conclusion that it would serve no purpose to remand the denial of the other conditions on which employer prevailed under the clear and convincing evidence standard. Substantial evidence supports those conclusions. I also concur with the majority's decision to affirm the Board's denial of the compensability of claimant's **<144 Or App 104/105>** encephalopathy and dysthymia, because substantial evidence supports the Board's finding that claimant failed to show that toxins in the workplace caused those conditions.

Therefore, I respectfully concur in part and dissent in part.

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[1] In other words, the qualification simply described the conditions at work that employer believed led to the symptoms. That is no different from accepting a claim for symptoms to the extent that the symptoms are work related, which is what *Piwowar* said is ineffective to preserve the issue whether the acceptance covered a particular condition that caused the symptoms, on the ground that the condition is not work related. Were it otherwise, the principle established in *Piwowar* could be evaded by coupling every acceptance of a claim described by symptoms with a statement that the employer does not accept any condition causing the symptoms that is not work related. That would leave claimants in the very position where, according to *Piwowar*, the workers' compensation law did not intend them to be. In the absence of reasons to believe that the principle established in *Piwowar* has been affected by later amendments to the workers' compensation law, and I am aware of none, I believe that *Piwowar* requires us to conclude that the denial at issue in our case is a backup denial.

Cite as 144 Or App 157 (1996) October 16, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Earin J. Hadley, Claimant

Earin J. **HADLEY**, *Petitioner,*
v.
CODY HINDMAN LOGGING and SAIF Corporation, *Respondents.*
(WCB 95-01763; CA A91835)

Judicial Review from Workers' Compensation Board.
Argued and submitted August 7, 1996.
Michael A. Gilbertson argued the cause and filed the for petitioner.
Julene M. Quinn argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Reversed and remanded for reconsideration

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144 Or App 159> Claimant seeks review of an order of the Workers' Compensation Board. The Board ruled that SAIF Corporation had correctly computed the amount of temporary total disability (TTD) owed claimant following his compensable injury. Claimant disagrees and assigns error to the Board's interpretation of the phrase "extended gap" in OAR 436-60-025(5)(a). We reverse and remand for reconsideration.

The facts are not in dispute. Claimant is a logger who began working for employer in November 1993. Both claimant and employer contemplated that layoffs during the winter season were likely because of inclement weather conditions and that work would be more steady once summer arrived. Claimant sustained an injury in June 1994 that made him eligible for TTD benefits. SAIF computed the TTD amount based on claimant's average wage during the 26 weeks preceding his compensable injury. That period of time included layoffs, including a time during which claimant received unemployment compensation. The last period of layoff began in March 1994 and ended in May 1994, when employer called claimant back to work. Claimant contends that under OAR 436-60-025(5)(a), SAIF should have used only the four weeks' wages that claimant earned before his injury as the basis for the average. If that method is used, the TTD amount is considerably higher.

The text of OAR 436-60-025(5)(a) provides, in part:

> "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 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."

OAR 436-60-025(5)(a) was adopted by the Director of the Department of Consumer and Business Services (Director) pursuant to ORS 656.210(2)(c), which provides in part:

> "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 **<144 Or App 159/160>** of Consumer and Business Services, by rule, may prescribe methods for establishing the worker's weekly wage."

The statute acts to delegate certain rule-making authority to the Director. In *England v. Thunderbird,* 315 Or 633, 848 P2d 100 (1993), the Supreme Court summarized the three classes of statutory terms that delegate rule-making authority to an agency, " 'each of which conveys a different responsibility for the agency in its initial application of the statute and for the court on review of that application.' " *Id.* at 637, *quoting Springfield Education Assn v. School Dist.*, 290 Or 217, 233, 621 P2d 547 (1980). They are:

> " '1.) Terms of precise meaning, whether of common or technical parlance, requiring only factfinding by the agency and judicial review for substantial evidence;

" '2.) Inexact terms which require agency interpretation and judicial review for consistency with legislative policy; and

" '3.) Terms of delegation which require legislative policy determination by the agency and judicial review of whether that policy is within the delegation." ' *Id.*

Specifically, ORS 656.210(2)(c) delegates to the Director broad authority to prescribe by rule "methods" of approximating the wage amount at the time of injury of those workers who are not regularly employed. So long as the Director prescribed a method that is within the delegation by the legislature, neither we nor the Board may substitute our own judgment regarding the method of computation. *See Booth v. Tektronix,* 312 Or 463, 473, 823 P2d 402 (1991) (holding that delegation of responsibility for policy refinement under a policy-delegating statute is to the agency, not to a reviewing court. The review function of a court is to determine whether the agency's decision is within the range of discretion allowed by the general policy of the statute.).

ORS 656.210 also contains an inexact term. ORS 656.210(2)(b)(A), provides that:

"[For the purposes of ORS 656.210(2)(a-c)] [t]he benefits of a worker who incurs an injury shall be based upon the wage of the worker *at the time of injury.*" (Emphasis supplied.)

144 Or App 161> The phrase "wage * * * at the time of injury" is an inexact term, *i.e.,*:

"[T]he legislature has expressed its meaning completely, but that meaning remains to be spelled out in the agency's rule or order. An inexact term gives the agency interpretive but not legislative responsibility." *England,* 315 Or at 638.

Respondents argue that we should defer to the Board's interpretation in this case. We disagree, because no delegative authority has been granted in this instance to the Board. Under ORS 656.210, the remainder of the Workers' Compensation Act and OAR 436-60-025(5)(c), the Board is required to apply the methods prescribed by the Director to the cases that come before it in a manner that is consistent with the intention of the legislature. *See Harrison v. Taylor Lumber & Treating, Inc.,* 111 Or App 325, 328, 826 P2d 75, (1992) ("The agency may not alter, amend, enlarge or limit the terms of an applicable statute by rule."). The Board concluded that an "extended gap" as used in OAR 436-60-025(5)(a), requires a break in the performance of work activities that causes a change in the employment relationship between the claimant and the employer. It reasoned that because the breaks in claimant's employment were seasonal and were anticipated, there was no change in the employment relationship. Therefore, the 26-week average was applicable because no "extended gap" occurred within the meaning of OAR 436-60-025(5)(a).

The Director's rule is consistent with the legislature's intent. The best indication of legislative intent is the words of the statute themselves. *State ex rel Juv. Dept. v. Ashley,* 312 Or 169, 174, 818 P2d 1270 (1991). ORS 656.210(2)(b)(A) contains a clear expression of a legislative policy to pay injured workers benefits based on the wage of the worker at the time of injury. The Director's rule fulfills the legislature's intention because, when extended gaps exist during the 26-week period, insurers are required to focus more directly on the worker's wage at the time of injury by using the no-less-than-four-weeks rule.

In contrast, the Board's interpretation of the Director's rule as applied to the facts of this case inhibits what the rule was meant to accomplish. According to the Board, an **<144 Or App 161/162>** "extended gap" requires more than a hiatus in employment. The Board adds the requirement to the rule that a change in employment relationship must occur if the four-week rule is to be used. That additional requirement disqualifies some workers from being compensated at a rate based on their wage at the time of the injury, even though there are gaps in the 26-week period of employment. Claimant is an example of that effect. At the time of the injury, he had been working more than four weeks since the end of the last layoff period and there were gaps in the previous 26 weeks of his employment. Nonetheless, under the Board's interpretation, he is compensated on the basis of earnings during a period of time that includes the gaps.

In sum, the Board has no delegative authority to add a requirement to the rule. It is required by law to apply the methods prescribed by the Director in accordance with the intent of the legislature. The Director's rule instructed the Board to use no less than the last four weeks of earnings as a basis for the computation of TTD benefits when extended gaps occurred. We conclude that the Board's interpretation constitutes an unauthorized limitation on the Director's authority granted from the legislature to prescribe methods of establishing wages at the time of injury.

Reversed and remanded for reconsideration.

Cite as 144 Or App 259 (1996) October 30, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lois J. Schoch, Claimant.
Lois J. **SCHOCH**, *Petitioner,*
v.
LEUPOLD & STEVENS and Liberty Northwest Insurance Corporation, *Respondents.*
(93-12032; 93-08669; CA A88999)

Judicial Review from Workers' Compensation Board.
Argued, and submitted April 17, 1996.
Meagan A. Flynn argued the cause for petitioner. With her on the brief was Pozzi Wilson Atchison.
Alexander Libmann argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Award of attorney fees vacated and remanded for reconsideration.

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144 Or App 261> Claimant seeks review of an order of the Workers' Compensation Board awarding attorney fees of $4,200 pursuant to ORS 656.386(1), for claimant's successful challenge of employer's denial of two of her conditions. She contends that the Board erred in failing to approve her requested fee, which was based on an hourly rate of $175 for the attorney, $60 for the paralegal and a contingency multiplier of 1.5. We review the Board's award of attorney fees for an abuse of discretion, *Weyerhaeuser Co. v. Fillmore,* 98 Or App 567, 779 P2d 1102 (1989), and vacate the award and remand for reconsideration.

The standards that the Board must consider in setting a reasonable attorney fee are set out in OAR 438-15-010(4).

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) *The risk in a particular case that an attorney's efforts may go uncompensated;* and

"(h) The assertion of frivolous issues or defenses." (Emphasis supplied.)

The Board held that it is prohibited from applying a contingency multiplier in setting claimant's attorney fee for the reason that contingency is already among the factors to be considered under OAR 438-15-010(4), and it believed that application of a multiplier would result in consideration of contingency twice.

We agree with claimant's contention in her first assignment of error that the Board erred when it held that, because OAR 438-15-010(4)(g) describes contingency as one of the factors to be considered in awarding the fee, the Board **<144 Or App 261/262>** is precluded from applying a multiplier. If the Board finds that there is a risk in a particular case that the attorney will be uncompensated, then the Board must take that risk into account pursuant to OAR 438-15-101(4)(g) in determining the reasonable attorney fee. Without deciding whether a multiplier is the exclusive way that risk can be taken into account, we conclude that a multiplier is one way that the Board may take into account the risk, specified in subsection (g), that the attorney will go uncompensated. However, the Board's erroneous conclusion that it is precluded from applying a multiplier does not, in and of itself, require reversal. If the Board has correctly applied the factors under the rule, and we can discern from its order that it has done so, then we would affirm the Board.

Claimant contends in her second assignment that the Board's order does not demonstrate that it considered the factors set forth in OAR 438-15-010(4). The rule does not specify how the Board must consider the factors or even require the Board to make findings regarding the factors, *Diamond Fruit Growers v. Davies*, 103 Or App 280, 282, 796 P2d 1248 (1990); however, we have held that the Board must at least explain the basis for the award in sufficient detail to inform the court that it has considered the factors. The Board has not done that here. Accordingly, we vacate the award of attorney fees and remand the case to the Board for reconsideration.

Award of attorney fees vacated and remanded for reconsideration.

Cite as 144 Or App 431 (1996) November 13, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Vicki D. Pollock, Claimant.

Vicki D. **POLLOCK**, *Petitioner,*
v.
TRI-MET, INC., *Respondent.*
(Agency No. 94-10269; CA A92228)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 19, 1996.
Robert Wollheim argued the cause for petitioner. With him on the brief was Welch, Bruun, Green & Wollheim.
Travis Terrall argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Reversed and remanded for reconsideration.

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144 Or App 433> Claimant seeks review of a Workers' Compensation Board order that upheld employer's denial of claimant's aggravation claim for right shoulder bursitis. The Board reasoned that the compensability of the aggravation claim was an issue that claimant could have raised before entering into a settlement regarding other pending claims. Consequently, the Board concluded that the settlement agreement barred claimant from raising the issue. We review for errors of law, ORS 183.482(8)(a)(A), and reverse.

Claimant is a Tri-Met bus driver. Between July 1993 and February 1994, she filed three workers' compensation claims for injuries to her neck, shoulders and arms. Employer denied each claim, and claimant requested a hearing on each denial. The hearing on the claims was scheduled for June 14, 1994. Before the hearing, the parties entered into an oral agreement to settle the claims. Under the terms of the agreement, employer agreed to rescind all three denials, all the claims were processed under one claim, that claim was classified as nondisabling, claimant received $2,500 and employer agreed to pay claimant's attorney fees.

Before the written settlement agreement was prepared and executed, claimant returned to her attending physician. Her physician found that claimant's condition had worsened and that claimant was unable to work. There is no evidence as to when the physician reported those facts to the employer. Claimant returned to work in early July.

On July 26, 1994, the administrative law judge approved the parties' written settlement agreement after the parties had executed it. The agreement stated in part, "[c]laimant agrees that all her requests for hearing, and all issues that have been or could be raised at this time are hereby deemed settled by this settlement agreement." On August 19, 1994, employer issued a denial to the aggravation claim, maintaining that it had been settled by the terms of the settlement agreement. The denial resulted in a request for hearing. The Board subsequently upheld the denial, relying in part on our holding in *Good Samaritan Hospital* **<144 Or App 433/434>** *v. Stoddard,* 126 Or App 69, 867 P2d 543, *rev den* 319 Or 572 (1994). This petition for review followed.

In *Stoddard,* the physician reported to the employer that the claimant had a nerve entrapment condition involving her right hand and requested authorization for surgery. 126 Or App at 71. Thereafter, the claimant entered into a settlement agreement concerning an accepted right wrist claim. The employer argued that the claimant's nerve entrapment condition and the requested surgery were encompassed by the terms of the settlement agreement, which purported to resolve "all issues which were raised and could have been raised on or before the date of this settlement." *Id.* at 72. The Board ruled as a matter of law that, because the employer had not yet denied or accepted the claim for the nerve entrapment condition, the settlement of that claim was not included in the settlement. We disagreed, noting that the correct inquiry was "whether the claimant's condition and its compensability could have been negotiated before approval of the settlement." *Id.* at 73.

In other words, we held that the correct inquiry was whether the nerve entrapment condition was an issue contemplated by the parties to be within the purview of the settlement agreement. Thus, we disagreed with the Board's premise that the denial by the employer was a legal predicate to holding that the claimant had settled the claim for her nerve condition. Because neither party argued that the language of the settlement agreement was ambiguous, we then analyzed the issue of whether the parties had contemplated settlement of the nerve entrapment condition by examining the terms of the agreement. We concluded that, based on the language of the agreement and the circumstances of when the parties became aware of the claim, the claimant's nerve condition was an issue that was contemplated by the agreement.

In this case, the Board relied on *Stoddard* and one of its own cases for the proposition that a stipulation that settles all issues then "raised or raisable" bars a claimant from subsequently litigating entitlement to benefits, because the claimant is on notice of a potential dispute before the settlement agreement was approved. Relying on that authority, **<144 Or App 434/435>** the Board reasoned that, considering the undisputed evidence that claimant was aware of a potential dispute concerning her aggravation claim before July 25, 1994, the compensability of the aggravation claim was an issue that "could have been raised by claimant before approval of the parties' stipulation." Therefore, the Board concluded that, based on the language of the settlement agreement, claimant was barred from litigating her aggravation claim.

We disagree with the Board's analysis. Settlement agreements are contracts and, as such, they implicate general principles of contract law. When such an agreement is unambiguous in its terms, the interpretation of the agreement becomes a question of law to be decided by a court based on an examination of the terms of the agreement as a whole.[1] *Timberline Equip. v. St. Paul Fire and Mar. Ins.,* 281 Or 639, 643, 576 P2d 1244 (1978). The construction to be given such an agreement is to render, if possible, all of its provisions harmonious and to carry into effect the actual purpose and intent of the parties as derived from the terms of the agreement. *See, e.g., International Paper Co. v. Pearson,* 106 Or App 121, 124, 806 P2d 189 (1991) (holding that the settlement agreement resolved that certain medical services were compensable but did not resolve the compensability of the underlying condition).

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[1] Pertinent to the proper analysis in this case are at least the following clauses that are contained in the settlement agreement:

> "It is hereby stipulated and agreed that the parties, now wishing to resolve all issues relating to all of claimant's request for hearings (August 13, 1993; September 7, 1993; and March 15, 1994) agree to the following * * *
>
> "It is further stipulated and agreed that, in consideration for the above, claimant agrees that all her requests for hearing, and all issues that have been or could be raised at this time are hereby deemed settled by this settlement agreement."

In this case, the Board did not undertake to ascertain the intent of the parties at the time of their settlement. In fact, the existence of the aggravation claim was unknown to claimant at the time of the oral agreement, and there is no evidence that employer had notice of claimant's aggravation claim before July 26, 1994, the date of the written settlement. On remand,[2] the Board must construe the parties' settlement **<144 Or App 435/436>** in such a way as to carry into effect their express purpose and intent at the time of the agreement.

Reversed and remanded for reconsideration.

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[2] Because the Board did not conclude whether or not the agreement was ambiguous, we do not address that issue here.

Cite as 144 Or App 471 (1996) November 13, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jean M. Gordon, Claimant.

Jean M. **GORDON**, *Petitioner,*
v.
CITY OF PORTLAND, *Respondent.*
(94-06925; CA A90778)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 17, 1996.
Linda C. Love argued the cause for petitioner. On the brief was Anthony A. Allen.
David L. Jorling, Senior Deputy City Attorney, argued the cause for respondent. With him on the brief was Scott Kozuma, Associate Deputy City Attorney.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Affirmed.

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144 Or App 473> Claimant sought review from the Workers' Compensation Board's order on reconsideration that adhered to an earlier order on review, finding claimant to have 100% impairment of one eye, pursuant to ORS 656.214(2).[1] We affirm.

This case involves the proper rating, for scheduled disability purposes, of binocular diplopia. A person with binocular diploplia "sees double" when both eyes are open.[2] Plaintiff first experienced binocular diplopia when she was 10 years old, but, through eye exercises and surgery addressing the ocular motility[3] impairment that caused her condition, she was generally able to successfully "fuse" her vision. On March 31, 1991, claimant tripped and fell, striking her head, while entering an elevator at work. The next day, she temporarily lost vision in her left eye, and when her vision returned, so had her binocular diplopia. Thereafter, claimant sought permanent partial disability benefits for her binocular diplopia.

The administrative law judge determined that claimant's binocular diplopia resulted in 100% *binocular* vision loss--that is, that claimant was entitled to permanent partial disability benefits for a 100% impairment of *both* eyes. Employer sought review from the Board, and the Board modified, holding

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[1] Although the injury that is the subject of this appeal arose before the 1995 Workers' Compensation Amendments, claimant argues, and employer does not dispute, that ORS 656.214(2), as amended in 1995, applies.

[2] In contrast to binocular diplopia, monocular diplopia is the condition of "seeing double" when only one eye is open. It is, apparently, medically possible for a person to experience both binocular diplopia and monocular diplopia. The record here indicates that claimant suffers only from binocular diplopia.

[3] "Ocular motility" is the eye's power of spontaneous movement. *Stedman's Medical Dictionary* 887, 973 (4th unabridged lawyers' ed 1976).

that, under ORS 656.214(2) and OAR 436-35-260, claimant was entitled to scheduled permanent partial disability benefits for 100% vision loss for *one eye* (100% loss of monocular vision), and not 100% vision loss for both eyes (100% loss of binocular vision). Claimant moved for reconsideration, and the Board, in its order on reconsideration, adhered to its previous ruling.

144 Or App 474> On review, plaintiff argues that the Board erred in its application of ORS 656.214 and OAR 436-35-260. She asserts that, under those provisions, her ocular motility impairment resulting in binocular diplopia is properly rated as yielding a 100% loss of vision of both eyes, not of only one eye. ORS 656.214(2) 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 $347.51 for each degree stated against such disability in subsections (2) to (4) of this section as follows:
>
> "(h) For partial or complete loss of vision of one eye, that proportion of 100 degrees which the loss of monocular vision bears to normal monocular vision. For the purposes of this paragraph, the term 'normal monocular vision' shall be considered as Snellen 20/20 for distance and Snellen 14/14 for near vision with full sensory field.
>
> "(i) For partial loss of vision in both eyes, that proportion of 300 degrees which the combined binocular visual loss bears to normal combined binocular vision. In all cases of partial loss of sight, the percentage of said loss shall be measured with maximum correction. For the purpose of this paragraph, combined binocular visual loss shall be calculated by taking three times the visual loss in the less damaged eye plus the visual loss in the more damaged eye and dividing that amount by four. In the case of individuals with compensable visual loss involving both eyes, either the method of calculation for monocular visual loss or that for combined binocular visual loss shall be used, depending upon which allows the greater award of disability."

Under OAR 436-35-260,[4] a claimant's visual loss is rated based on three factors: central visual acuity, integrity of the peripheral visual fields, and ocular motility. OAR 436-35-260(1). The rule specifies that central visual acuity and integrity of peripheral visual fields are to be tested for "*each* **<144 Or App 474/475>** eye." OAR 436-035-260(2) and (3) (emphasis supplied). Conversely, ocular motility is tested somewhat differently:

> "(4) Ratings for ocular motility impairment resulting in *binocular diplopia* are determined as follows:
>
> "(a) Determine the single highest value of loss for diplopia noted on each of the standard 45 meridians as scheduled in the following table;
>
> "(b) Add the values obtained for each meridian to obtain the total impairment for loss of ocular motility. A total of 100 percent or more shall be rated as 100 percent of *the eye.* As an example: Diplopia beyond 30 degrees in a nasal direction is valued at ten percent. Diplopia in a temporal direction between 21 and 30 degrees is valued at 20 percent. For diplopia in both ranges, the rating would be 10 percent plus 20 percent resulting in a total of 30 percent." OAR 436-35-260(4) (emphasis supplied).

Thus, with respect to assessing ocular motility impairment, subsection (4) is concerned only with such impairment that results in binocular diplopia. Unlike the other two factors for which the tests are repeated twice, once for each eye, ocular motility impairment resulting in binocular diplopia--a condition that by definition occurs only when both eyes are open--is tested only once, yielding only one result.

The rule then prescribes two formulas for determining visual loss, the monocular loss method and binocular loss method. The monocular loss method is as follows:

> "The total rating for monocular loss is found by combining (not adding) the ratings for loss of central vision, loss of visual field, and *loss of ocular motility* and loss for other conditions specified in section (5) of this rule." OAR 436-35-260(6) (emphasis supplied).

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[4] The Director promulgated OAR 436-35-260 pursuant to ORS 656.726(3)(f), which grants the Director authority to "[p]rovide standards for the evaluation of disabilities."

The binocular loss method is as follows:

"(a) Find the percent of monocular loss for each eye;

"(b) Multiply the percent of loss in the better eye by three;

"(c) Add to that result the percent of loss in the other eye;

144 Or App 476> "(d) Divide this sum by four. The result is total percentage of binocular loss;

"(e) This method is expressed by the formula:

$$\frac{3(A) + B}{4}$$

" 'A' is the percent of loss in the better eye;

" 'B'is the percent of loss in the other eye." OAR 436-35-260(7).

Finally, OAR 436-35-260(8) provides that the total vision loss is determined by whichever loss results in "the greater disability rating." *See also* ORS 656.214(2)(h) ("In the case of individuals with compensable visual loss involving both eyes, either the method of calculation for monocular visual loss or that for combined binocular visual loss shall be used, depending upon which allows the greater award of disability.").

Claimant argued to the Board, and reiterates on appeal, that, based on OAR 436-35-260 (4) and (7), her ocular motility impairment must be attributed to each eye, and not just to one eye. From the premise that she has suffered a loss of vision in each eye, claimant reasons that, when her impairment is rated under the "binocular loss" formula, her impairment is correctly rated as 100% of both eyes.[5]

Claimant's position rests on a false first premise: Neither OAR 436-35-260 nor ORS 656.214 requires that ocular motility impairment resulting in binocular diplopia be attributed to each eye, rather than to only one eye. OAR 436-35-260(4) states that if the binocular diplopia is 100%, it is to be rated as "100% of *the eye*," not "100% of each eye," or "100% of both eyes." (Emphasis supplied.) When considered in the light of the rule's entire context, the use of the singular is significant. In particular, as we have already noted, unlike the **<144 Or App 476/477>** tests for central visual acuity and visual fields, the test for binocular diplopia does not involve an assessment of each eye's monocular impairment level; instead, it only assesses a type of binocular impairment. Thus, the applicable regulations provide that ocular motility impairment resulting in binocular diplopia is to be considered as yielding an impairment of one eye, not both.[6]

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[5] In claimant's view, she has no "better" eye for purposes of the subsection (6) formulation. Thus, she asserts that the proper calculation is $\frac{3(100) + 100}{4} = 100$.

If claimant's ocular motility impairment resulting in binocular diplopia is properly attributed to only one eye, instead of to both, her binocular loss is 25%: $\frac{3(0) + 100}{4}$.

[6] That construction of OAR 436-35-260 is consistent with the text of an earlier version of the rule as well as with standard methods of rating visual impairments. *Former* OAR 436-35-260(5)(c), required binocular diplopia to be "rated in the eye with the greatest loss." Furthermore, the American Medical Association's *Guides to the Evaluation of* Permanent Impairment 217 (4th ed 1993), which is included in the record, instructs that, in determining the visual system's impairment, ocular motility impairment, or binocular diplopia, is combined with "the combined value for central vision and visual field *in the eye manifesting the greater impairment[.] Disregard the loss of ocular motility in the other eye.*" (Emphasis supplied.)

Nor does ORS 656.214 dictate a different result. The loss formula in ORS 656.214(2)(i) assumes that each eye has been rated individually for its impairment level. However, as noted, testing of ocular motility impairment resulting in binocular diplopia does not conform to that assumption. That is, such impairment is not determined separately for each eye. Thus, the statute, which is phrased in much less precise terms than the implementing regulations, does *not* address the unique circumstances of binocular diplopia, *i.e.*, those circumstances where the vision in either eye individually is not impaired and the impairment is manifested only when both eyes are open. Nothing in the statute precludes the Board's determination that, under OAR 436-35-260, petitioner's impairment should be attributed to one eye, not both.

The Board correctly determined that claimant had total monocular loss of 100%.

Affirmed.

Cite as 144 Or App 552 (1996) November 20, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bret Clausing, Claimant.
Bret **CLAUSING**, *Petitioner,*
v.
K-MART CORPORATION, *Respondent,* and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, *Intervenor.*
(95-04958; CA A92152)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1996.
Robert F. Webber argued the cause for petitioner. With him on the brief was Black, Chapman, Webber & Stevens.
Karen O'Kasey argued the cause for respondent. With her on the brief was Schwabe, Williamson & Wyatt.
Stephanie L. Striffler, Assistant Attorney General, argued for intervenor. With her on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Reversed and remanded.

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144 Or App 554> Claimant seeks review of a Workers' Compensation Board order that reinstated K-Mart Corporation's denial of his claim. ORS 656.298. The question is whether K-Mart is responsible under ORS 656.029(1) for providing workers' compensation coverage for claimant. The Board concluded that it is not.

Claimant worked for a company that contracted with K-Mart to provide janitorial services. Claimant was injured while cleaning one of K-Mart's stores. ORS 656.029(1) requires that

> "If a person awards a contract involving the performance of labor where such labor is *a normal and customary part or process of the person's trade or business,* the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals * * * who perform labor under the contract * * *." (Emphasis supplied.)

Claimant and intervenor correctly point out that the Board's order does not show whether it considered OAR 436-050-0040(4)(c), which interprets the phrase "normal and customary part or process of the person's trade or business" to mean "the day-to-day activities or operations which are necessary to successfully carry out the business or trade." The Department of Consumer and Business Services promulgated that rule pursuant to ORS 656.726(3). Properly promulgated administrative rules have the force of law. *Bronson v. Moonen*, 270 Or 469, 476, 528 P2d 82 (1974). Accordingly, we remand to the Board to consider the facts of this case in the light of that rule.

Because of this disposition, we need not address respondent's cross-assignment of error.

Reversed and remanded.

Cite as 144 Or App 602 (1996) November 27, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Eliecer Vega, Claimant.
Eliecer **VEGA**, *Petitioner - Cross-Respondent,*
v.
EXPRESS SERVICES and AIAC, *Respondents - Cross-Petitioners.*
(WCB No. 93-08731; CA A86290)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 6, 1996.
Donald M. Hooton argued the cause for petitioner - crossrespondent. With him on the briefs was L. Scott Lumsden.
Jerald P. Keene argued the cause for respondents - crosspetitioners. On the brief were Craig A. Staples and Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DEITS, P. J.
Affirmed on petition; reversed on cross-petition.

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144 Or App 604> Claimant seeks review of a Workers' Compensation Board order holding that employer, American International Adjustment Company, was not required to comply with that portion of a reconsideration order that required employer to pay $6,405 in permanent partial disability (PPD) compensation. ORS 656.298. Employer cross-petitions the Board's assessment of penalties for failure to pay the entire $6,405 award. ORS 656.298. We affirm on the petition and reverse on the cross-petition.

Claimant injured his right knee and employer accepted a claim for the injury in 1991. In November 1992, a notice of closure was issued and claimant was awarded seven percent PPD of the right leg, which amounted to $3,202.50. Employer paid that amount to claimant. In May 1993, claimant requested reconsideration and appointment of a medical arbiter. On July 21, 1993, after receiving the medical arbiter's report, the department issued an order on reconsideration providing that:

> "THE TOTAL SCHEDULED AWARD TO DATE FOR THE FOLLOWING BODY PART(S) IS:
>
> "14 PERCENT EQUAL TO 21 DEGREES FOR RIGHT LEG(KNEE)
>
> " * * * * *
>
> "THE INSURER IS ORDERED TO PAY THE WORKER AN AWARD OF $6,405.00 THIS IS IN ADDITION TO ANY PREVIOUS AWARDS."

On July 26th, claimant filed a request for a hearing with the Hearings Division on the reconsideration order. On that same date, the department was contacted by employer and asked to clarify the order on reconsideration. Employer paid an additional $3,202.50 pursuant to the July 21 order, but pointed out to the department that while the order increased the award by seven percent, which would entitle claimant to an additional $3,202.50, the order provided that employer was to pay claimant an additional $6,405. That would give claimant a total award of $9,607.50. Employer **<144 Or App 604/605>** was told by department staff that the order would be corrected. On August 4, 1993, the department issued an amended order clarifying the order as requested by employer.

After the hearing, on January 14, 1994, the ALJ issued an order that set aside the department's August 4 amended order on the ground that, under the applicable administrative rule, OAR 456-30-008(1), the department lacked authority to correct the order after a request for a hearing on the reconsideration order was received by the department. The ALJ also concluded, however, that claimant was substantively entitled only to a total award of 14 percent, and therefore, held that the order on reconsideration should be corrected to award only an additional $3,202.50. In addition, the ALJ imposed

a 25 percent penalty against employer under ORS 656.262(10)[1] on the ground that employer had unreasonably failed to pay the amount ordered in the July 21 reconsideration order. Both claimant and employer requested Board review of the ALJ's order. The Board affirmed the order from which claimant and employer now seek review.

Claimant argues that the Board erred in concluding that employer was not obligated to pay claimant an additional $6,405, the amount ordered by the department in its July 21 order. He asserts that if employer disagreed with the order, it was required to file a timely request for a hearing on the order or seek abatement of the order rather than unilaterally deciding not to comply with it. Employer responds that claimant was never statutorily or substantively entitled to the overpayment and, consequently, under our decision in *Lebanon Plywood v. Seiber,* 113 Or App 651, 833 P2d 1367 (1992), the Board was correct that it had no authority to order employer to pay an additional $6,405, of which $3,202.50 would clearly be an overpayment of compensation.

144 Or App 606> We agree with the Board that our decision in *Seiber* is controlling here and that employer is not obligated to pay claimant the disputed $3,202.50. In *Seiber,* the employer did not pay temporary disability benefits to the claimant after his medically stationary date pending claim closure. The employer thereby avoided the overpayment that normally is incurred as a result of the delay in the administrative closure of the case. *Id.* at 653. The Board concluded that the employer had to pay temporary disability benefits from the medically stationary date to the date of claim closure even though that would result in an overpayment because these payments were " 'procedural' overpayments[,]" to which claimant was entitled. *Id.* at 653-54.

On review, we held that the payments that the employer withheld for the period following the claimant's medically stationary date were not an entitlement but rather were "a consequence of the administrative process of claim closure[.]" *Id.* at 654. Thus, we concluded that the Board had no authority to impose an overpayment that the claimant was not entitled to receive. *Id.* We noted then that the proper manner to ensure compliance and to prevent employers from unreasonably delaying or refusing to pay temporary disability benefits is to impose penalties. *Id.*

Claimant argues that *Seiber* is distinguishable because it involved a procedural "entitlement" as opposed to a substantive entitlement. Claimant contends that this case is controlled by the decisions in *Roseburg Forest Products v. McDonald,* 116 Or App 448, 841 P2d 697 (1992), and *Georgia Pacific Corp. v. Piwowar,* 305 Or 494, 753 P2d 948 (1988), in which the claimants were found to have a substantive entitlement to the benefits in dispute. Although claimant acknowledges that, in this case, the amount that the July 21 order required employer to pay is a mistake, he asserts that he has a substantive entitlement to the $6,405 included in the department's order on reconsideration. He argues that his entitlement is "created by the mere existence of a valid Order awarding a specific amount of compensation, whether the amount awarded was based upon an erroneous calculation or not."

144 Or App 607> We do not agree that the erroneous order creates a substantive entitlement to the extra compensation. These circumstances are different from those in the cases on which claimant relies and from those in *Anodizing, Inc. v. Heath,* 129 Or App 352, 879 P2d 218 (1994), in which we also held that the claimant had an entitlement to the disputed benefits. In that case, the employer sought review of the order on reconsideration under ORS 656.313(1). Under the version of the statute applicable at that time, during the pendency of judicial review, the employer was required to continue to pay benefits.[2] The employer did not do so. We held that, despite the fact that the employer prevailed on review of claimant's award, the payments in that case were not "overpayments" because the claimant

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[1] ORS 656.262(10)(a) was renumbered by the 1995 legislature as ORS 656.262(11)(a). However, both provisions are identical and provide, in part:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due."

[2] ORS 656.313 was amended by Oregon Laws 1995, chapter 332, section 38. Under the current version, claimant is not entitled to permanent disability benefits pending appeal.

was substantively entitled under the statute, ORS 656.313, to continue to receive payments pursuant to the determination order, regardless of the eventual outcome of the review. Had the employer paid the benefits, it would not be entitled to recoup any of those benefits, even if it eventually prevailed. We pointed out in *Heath* that this presented different circumstances from those in *Seiber,* where the employer was entitled to recoup any compensation paid after the medically stationary date out of future awards to claimant. *Id.* at 357; *see also Roseburg Forest Products,* 116 Or App at 452, (time loss payments must be made pending review of the determination order pursuant to ORS 656.313(1)).

Here, claimant does not identify any authority that gives him a substantive entitlement to the extra compensation. This case does not involve an employer's petition for review and, as claimant concedes, ORS 656.313 is thus not applicable. Claimant does have a substantive right under ORS 656.214 to be compensated for his injury, but, in the absence of statutory authority providing otherwise, that right extends only to the actual amount of the award deemed appropriate for the degree of his injury. That statute does not provide a right, either substantively or procedurally, to receive an award in excess of that provided by the statute. Nor does ORS 656.295, the statute under which claimant **<144 Or App 607/608>** requested a hearing, provide a substantive right to payment regardless of the ultimate outcome of an administrative appeal. The Board's conclusion that employer was not obligated to pay the overpayment was correct.

In its cross-petition, employer argues that the Board erred in imposing a penalty under ORS 656.262(10) for employer's unreasonable failure to pay benefits. As noted above, the Board concluded that employer's failure to pay the erroneous amount of compensation included in the July 21 reconsideration order was unreasonable.

Our review of the Board's determination of whether an employer has unreasonably withheld compensation under ORS 656.262(10) was explained in our decision in *Tattoo v. Barrett Business Service,* 118 Or App 348, 353, 847 P2d 872 (1993):

> "Whether a delay in paying compensation is unreasonable under ORS 656.382(1) and ORS 656.262(10) involves both legal and factual questions. 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." (Citations omitted.)

See also Dawes v. Summers, 118 Or App 15, 19, 845 P2d 1308 (1993) (employer's failure to pay was based on a legitimate doubt as to its liability where language of determination order was ambiguous).

The Board acknowledged the apparent ambiguity in the July 21 reconsideration order, but then went on to conclude that the ambiguity did not excuse employer, because employer did not follow the procedures that it should have. The Board did not directly consider the question of whether employer had a legitimate doubt as to its obligation to pay the $6,405 awarded in the reconsideration order. It implicitly did so, however, in rejecting employer's arguments that it did not act unreasonably. The Board concluded that despite the fact that employer immediately contacted the department about the error in the order and was assured that it would be corrected, employer's failure to either to request a hearing on **<144 Or App 608/609>** the order on reconsideration or to pay the amount designated compels the conclusion that employer acted unreasonably. The Board reasoned that employer knew that claimant had requested a hearing and, therefore, it was charged with knowledge that under *former* OAR 436-30-008(1),[3] the department no longer had the authority to correct the order. Therefore, the Board concluded that employer could not rely on the fact that it thought that it had taken care of the problem in not paying the full amount awarded on the July 21 order in arguing that it did not act unreasonably.

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[3] OAR 436-30-008(1) provided:

"Evaluation and the Appellate Unit may change or cancel any order it issues if it has made an inadvertent error or omission which affects the order. Evaluation will act within 180 days after the Determination Order being changed or canceled is mailed only if a request for reconsideration pursuant to OAR 436-30-050 has not been made. The Appellate Unit will act within the remainder of the appeal period after the reconsideration order being changed or cancelled *[sic]* is mailed *only if a hearing has not been requested.*" (Emphasis supplied.)

We disagree with the Board's conclusion. The July 21 reconsideration order was ambiguous because it states both that the total scheduled award is 14 percent, which is equal to 21 degrees, and that employer must pay claimant $6,405 in addition to any past awards, which would have brought claimant's total award to 21 percent PPD.

Further, we do not agree with the Board that, based on this record, employer did not have a legitimate doubt about its obligation to make the full payment under the July 21 order. The Board's conclusion is based principally on its view that, under OAR 436-30-008(1), as a matter of law, employer could not have had any doubt that it had an obligation to pay the full amount due in the July 21 order. We do not agree. The evidence in the record does not support the Board's apparent assumption that employer knew that claimant's request for a hearing preceded its own request, much less that employer knew that claimant had sought a hearing at all. The evidence establishes that employer did have a legitimate doubt about its obligation to pay the full amount in the July 21 order. We conclude that the Board's holding that employer unreasonably resisted the payment of **<144 Or App 609/610>** compensation for purposes of ORS 656.262(10) is not supported by the record. Accordingly, the Board erred in imposing a penalty on employer.

Affirmed on petition; reversed on cross-petition.

Cite as 145 Or App 46 (1996) December 4, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James C. Bowman, Claimant.

James C. **BOWMAN**, *Petitioner - Cross-Respondent,*
v.
ESAM, INC., and SAIF Corporation, *Respondents - Cross-Petitioner*
(WCB No. 94-05091: CA A92110)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1996.
Robert Wollheim argued the cause for petitioner - cross-respondent. With him on the brief was Welch, Bruun, Green & Wollheim.
Michael O. Whitty argued the cause and filed the brief respondents - cross-petitioners.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
On petition, reversed with regard to attorney fees; referee's award of fees reinstated; affirmed on cross-petition.

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145 Or App 48> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in reversing an award of attorney fees made by the administrative law judge (ALJ) pursuant to ORS 656.382(2). SAIF crosspetitions, contending that the Board erred in holding that it was barred from asserting its entitlement to an overpayment of temporary total disability (TTD). We reverse the Board on the petition and affirm the Board on the cross-petition.

Claimant filed a claim for a bilateral arm condition, which SAIF accepted. The 801 form erroneously listed claimant's wage rate as $8.00 per hour, when it was actually $6.50 per hour. From February 26, 1993, to August 11, 1993, SAIF paid claimant TTD at the erroneous wage rate. It then discovered the error and began paying benefits at the correct rate through April 5, 1994. SAIF notified claimant of the wage rate error on August 27, 1993. On April 18, 1994, SAIF issued a notice of closure *awarding* TTD at the erroneous rate from February 26, 1993, to August 11, 1993, and at the correct rate from August 12 through March 14, 1994. On the section of the form relating to permanent disability benefits, the notice also stated, that "deduction of overpaid benefits, if any, from unpaid permanent disability is approved." Claimant did not seek reconsideration of the notice of closure.

On the same day that it closed the claim, SAIF denied further treatment for claimant's arm condition. Claimant requested a hearing, and SAIF filed a cross-request for hearing, seeking a determination that it was entitled to a future offset of overpaid TTD benefits. The ALJ, ultimately affirmed by the Board, held that the notice of closure had become final and that SAIF is barred from litigating its entitlement to an offset against future benefits for amounts paid from February 26, 1993, through March 14, 1994.

We address SAIF's cross-petition first. SAIF contends that the finality of the notice of closure does not preclude it from asserting its right to an offset of an overpayment pursuant to ORS 656.268(13), because the notice of closure does not determine the existence or nonexistence of an overpayment. We disagree. The notice of closure sets forth **<145 Or App 48/49>** a claimant's award of benefits. In this case, SAIF *awarded* to claimant benefits for TTD that it had previously paid and that were based, in part, on an erroneous wage rate. The award established claimant's entitlement to those benefits, erroneous though they may have been, and when unappealed by claimant, the notice became final and not subject to challenge. *Hammon Stage Line v. Stinson,* 123 Or App 418, 423, 859 P2d 1180 (1993). The Board correctly held that SAIF is now precluded from litigating the correctness of the award. SAIF's attempt to obtain approval for an overpayment is, in effect, a challenge to the correctness of the award.

We reject SAIF's alternate contention that its notation on the notice of closure reserved SAIF's right to deduct from future awards any amounts that had been awarded in excess of claimant's correct wage. The notice of closure did not show that there had been an overpayment. The most that the notation reserved was the right to an offset for any future overpayment.

In her petition for review, claimant asserts that the Board erroneously relied on *Strazi v. SAIF,* 109 Or App 105, 817 P2d 1348 (1991), in support of its conclusion that "an offset for overpayment of temporary disability benefits is not a reduction in a claimant's award of compensation" and that without a finding that claimant's compensation should not have been disallowed or reduced "there is no foundation for an attorney fee award under ORS 656.382(2)." We agree with claimant that *Strazi* is distinguishable and that the Board erred. In *Strazi,* the claimant's benefits had been reduced by an order on reconsideration from an award of 70 percent to 11 percent permanent partial disability. On the claimant's request, a referee reinstated the award of 70 percent disability and denied the employer's request for an offset of any overpayment. The referee awarded the claimant an attorney fee pursuant to ORS 656.382(2) for having prevailed on the employer's request for an offset. The employer appealed the referee's order, seeking a reduction in the award and reversal of the referee's ruling on the offset. The Board upheld the 70 percent award but reversed the referee's award of attorney fees that had been based on the rejected request for an offset. The Board held that a request for an offset of an overpayment does not in and of itself place a claimant's benefits at risk of **<145 Or App 49/50>** being disallowed or reduced; therefore, it concluded, prevailing on a request for an offset is not a circumstance for which a fee may be awarded under ORS 656.382(2). *Strazi* is distinguishable on its facts.

In *Strazi,* if the claimant had not prevailed before the referee with regard to the request for an increase in the disability award, the employer's request for an offset would not have resulted in a reduction of the award. It would only have permitted an offset of amounts paid in excess of the award. Here, in contrast, the parties'very dispute concerns whether the award includes an overpayment for which SAIF may claim an offset. Had SAIF prevailed at the Board level or here on its contention that the award includes an overpayment, the effect would have been a reduction in claimant's award. As we have held, the matter of the amount of the award has been finally determined and is not subject to challenge. For having prevailed on employer's challenge to the award of benefits, we hold that claimant is entitled to attorney fees under ORS 656.382(2).

On petition, reversed with regard to attorney fees; referee's award of fees reinstated; affirmed on cross-petition.

Cite as 145 Or App 110 (1996) December 4, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Karen K. Deaton, Claimant.
Karen K. **DEATON**, *Petitioner,*
v.
Debbie **HUNT-ELDER**, SAIF Corporation, and Phil and Mary Cantonwine, *Respondents.*
(94-04671, 91-18480, 94-04050; CA A91653)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 29, 1996.
Robert Pardington argued the cause for petitioner. With him on the brief was Pozzi Wilson Atchison.
Julene M. Quinn argued the cause for respondents SAIF Corporation and Debbie Hunt-Elder.
Mark D. Clarke waived appearance for respondents Phil and Mary Cantonwine.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Reversed and remanded.
Landau, J., dissenting.

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145 Or App 112> Claimant petitions for review of an order of the Workers' Compensation Board (Board) that upheld the administrative law judge's (ALJ) ruling that claimant's attorney is not entitled to fees under ORS 656.382(2). We review for errors of law, ORS 183.482(7), (8); ORS 656.298(6), and reverse and remand.

In August 1989, claimant injured her light knee while cleaning a room at the motel where she was employed. She was declared medically stationary, on January 2, 1990. Claimant's employer was not covered by workers' compensation insurance. On November 16, 1989, the Compliance Section of the Department of Consumer and Business Services[1] issued an order declaring employer to be a noncomplying employer (NCE) and referred the claim to SAIF for processing. On January 12, 1990, SAIF accepted the claim. An August 14, 1990, determination order awarded claimant 20 percent permanent partial disability.

On February 8, 1990, employer, Hunt-Elder, wrote a letter to the Compliance Section contesting the order of noncompliance. The following month, Hunt-Elder requested a hearing to challenge SAIF's acceptance of the claim. She contended that there was no employer/employee relationship at the time of claimant's injury and that claimant did not suffer a compensable injury.

The hearing originally was scheduled for March 27, 1992, but it was postponed at Hunt-Elder's request. After several more delays, the hearing was convened on January 12, 1993. Both parties were represented by counsel. The hearing was continued to allow Hunt-Elder to submit receivership papers and to obtain the testimony of the Cantonwines, trustees of the motel. It reconvened a year later, on January 12, 1994. In separate orders, the ALJ subsequently joined the Compliance Section as a party and the Cantonwines as potentially responsible employers and rescheduled the hearing to reconvene 11 months later, on **<145 Or App 112/113>** December 14, 1994. Claimant's attorney, the Cantonwines' attorney and counsel for SAIF and the Compliance Section attended the hearing. Hunt-Elder participated without counsel by telephone from California.

Before the hearing concluded, the ALJ asked the parties about the possibility of a settlement. After considerable discussion, they agreed to settle rather than to continue with the hearing and, off the record, they negotiated a settlement. Hunt-Elder agreed to dismiss any claims against the Cantonwines, withdraw her challenge to the compensability of claimant's claim, accept responsibility as a noncomplying employer for claimant's accepted right knee strain and withdraw her request for a hearing. The ALJ drafted a proposed order reflecting the parties' agreement.

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[1] The Department of Consumer and Business Services was then known as the Department of Insurance and Finance.

On January 10, 1995, the ALJ submitted a proposed order to the parties. It included an award of $8,175 to claimant's attorney pursuant to ORS 656.382(2), payable by SAIF. SAIF objected to the award of attorney fees on the ground that an attorney is not entitled to an assessed fee under ORS 656.382(2) when a request for hearing is withdrawn without a decision on the merits. The ALJ agreed and on March 10, 1995, issued a Stipulated Settlement Order that reflected the parties' agreement and affirmed SAIF's acceptance of claimant's disabling right knee strain. In addition to resolving all issues raised by Hunt-Elder, the order denied claimant's attorney fee request.[2] Claimant appealed the attorney fee **<145 Or App 113/114>** issue to the Board. It affirmed on the ground that "the stipulation does not address the merits of this case."

On review, claimant contends that the Board erred in affirming the ALJ's decision not to award claimant her attorney fees under ORS 656.382(2). She contends that a stipulated settlement order, approved by the ALJ, is equivalent to a finding on the merits that claimant's compensation was neither disallowed nor reduced. SAIF responds that a decision on the merits is a prerequisite for an award of attorney fees under ORS 656.382(2) and that, because the case was dismissed following Hunt-Elder's withdrawal of her request for a hearing, there was no decision on the merits.

ORS 656.382(2) provides:

> "*If a request for hearing,* request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court *is initiated by an employer* or insurer, *and the Administrative Law Judge,* board or court *finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee* in an amount set by the Administrative Law Judge, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal." (Emphasis supplied.)

An award of attorney fees under that statute requires (1) that an employer initiate a request for a hearing to obtain a disallowance or reduction in a claimant's award of compensation; (2) that the

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[2] The Stipulated Settlement Order provided, in relevant part:

"In lieu of proceeding to hearing, the parties agreed to settle all issues raised or raisable as of December 14, 1994 on the following terms:

"1. [Employer] withdraws her request for hearing protesting the Department's Proposed and Final Order dated November 16, 1989 and said Order is to be affirmed.

"2. [Employer] withdraws her request for hearing appealing SAIF's January 12, 1990 acceptance of claimant's disabling right knee strain WCB #91-18480 is to be dismissed and said acceptance affirmed.

"3. [Employer] accepts responsibility as a non-complying employer for claimant's August 15, 1989 accepted disabling right knee strain.

"4. The Cantonwines were joined as potential employers responsible for claimant's workers' compensation claim in WCB #94-04671 * * * . In light of the above stipulations, WCB #94-04671 is to be dismissed.

"5. Claimant's attorney's request for an attorney fee * * * is denied based on SAIF's * * * objection thereto. *Donna J. Spencer*, 47 Van Natta 117 (1995).

"6. [Employer] is aware that *the above stipulations and my approval of* this Stipulated Settlement Order may result in the Department seeking reimbursement for the costs of claimant's accepted disabling right knee strain claim from [employer]. * * *.

"Therefore, IT IS HEREBY ORDERED that *the above stipulated terms are approved, WCB numbers 94-04050, 91-18480 and 94-04671 are dismissed, the Department's November 16, 1989 Proposed and Final Order No. 14912 is affirmed and SAfFs January 12, 1990 acceptance of claimant's August 19, 1989 disabling right knee strain is affirmed.*" (Emphasis supplied.)

claimant's attorney perform legal services in defending the compensation award; and (3) that the ALJ find on the merits that the claimant's award of compensation **<145 Or App 114/115>** should not be disallowed or reduced. *Strazi v. SAIF*, 109 Or App 105, 107-108, 817 P2d 1348 (1991).

It is undisputed in this case that the first two requirements have been satisfied. Hunt-Elder's request for a hearing challenging both compensability and responsibility unquestionably put at risk claimant's entitlement to compensation. Claimant's attorney represented her throughout the several years of hearings and delays and in the settlement negotiations recommended by the ALJ. The only question is whether the Stipulated Settlement Order, approved and signed by the ALJ, which affirms SAIF's acceptance of claimant's disabling knee strain and leaves intact claimant's compensation, is the equivalent to a finding on the merits that claimant's compensation should not be disallowed or reduced. We hold that it is.[3]

ORS 656.289(1) provides:

> "Upon the conclusion of any hearing, *or prior thereto with concurrence of the parties,* the Administrative Law Judge shall promptly and not later than 30 days after the hearing *determine the matter* and make an order in accordance with the Administrative Law Judge's determination." (Emphasis supplied.)

The phrase, "determine the matter," refers to a "matter concerning a claim." ORS 656.704(1). Matters concerning a claim "are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3). ORS 656.289(1) unambiguously provides two methods by which the ALJ may determine a claim: at the conclusion of a hearing, or before the conclusion of a hearing if the parties concur. There is no disagreement in this case that if the ALJ had followed the first method and determined that the compensation awarded to claimant should not be disallowed or reduced, claimant's attorney would have been entitled to a fee under ORS 656.382(2).

<145 Or App 115/116> OAR 438-09-005 was adopted by the Board to implement the second method provided by ORS 656.289 for resolving a matter concerning a claim. That method is a stipulated settlement agreement, which is

> "a written agreement * * * approved in writing by [an ALJI, in which *any matter contested* between the parties, other than matters resolvable in a claim disposition agreement or disputed claim settlement, *[is] resolved* by agreement of the parties." OAR 438-09-001(3). (Emphasis supplied.)

OAR 438-09-005(4) provides:

> "For purposes of ORS 656.289(1)-(3), [an *ALJ's] order approving a settlement stipulation is a determination of all matters* included within the terms of the settlement stipulation." (Emphasis supplied.)

Those rules unambiguously provide that a stipulated settlement order approved by the ALJ resolves contested matters concerning a claim. SAIF does not challenge the validity of those rules. In this case, at the recommendation of the ALJ, the parties entered into negotiations that resulted in a stipulated settlement agreement. That agreement was approved by the ALJ and incorporated into the Stipulated Settlement Order that he issued on March 10, 1994. The order states that "the parties agreed to settle all issues raised or raisable as of December 14, 1994." The order resolves the contested issues of compensability, Hunt-Elder's responsibility, and the liability, if any, of the Cantonwines. Under OAR 438-09-005(4), the order is a determination of the matter involving claimant's claim. Because it "determines the matter," it is the equivalent of an order the ALJ would have issued at the conclusion of the hearing and is a decision on the merits. Consequently, the Stipulated Settlement Order is a finding for purposes of ORS 656.382(2) that claimant's compensation award should not be disallowed or reduced.

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[3] At oral argument, SAIF conceded that if a stipulated settlement agreement resolves the merits of the dispute, then approval of that agreement in an order issued by the ALJ could constitute the type of finding that is required under ORS 656.382(2) as the prerequisite to an award of attorney fees.

Like SAIF, the dissent relies on *SAIF v. Curry*, 297 Or 504, 686 P2d 363 (1984), and *Agripac, Inc. v. Kitchel*, 73 Or App 132, 698 P2d 69 (1985), to reach a contrary conclusion. Those cases are inapposite. In *Curry*, the Supreme Court reiterated that its denial of a petition for review carries **<145 Or App 116/117>** no implication that a decision or opinion of this court is correct. *Curry*, 297 Or at 508. Denial of review may not be taken as "even a slight sign that this court approves the decision or opinion of the Court of Appeals." *Id., citing 1000 Friends of Oregon v. Bd. of Co. Commissioners* 284 Or 41, 44, 584 P2d 1371 (1978). In *Kitchell*, we held only that when an employer's petition for review is dismissed before a decision on the merits, claimant's attorney is not entitled to a fee under ORS 656.382(2). *Kitchell* did not involve a stipulated settlement agrebment, which, as explained earlier, is one of two methods provided by ORS 656.289(1) for resolving a matter concerning a claim.[4] A stipulated settlement order signed by an ALJ signifies not only that the agreement has resolved contested matters concerning a claim but also that the agreement has the approval of the ALJ.

In addition to relying on cases that are inapposite, the dissent maintains that a stipulated settlement order is not the equivalent of a "finding" for purposes of ORS 656.382, notwithstanding the requirement that the ALJ approve the settlement. In its view, the only "matter" resolved by the stipulated settlement agreement was that the employer withdrew her request for a hearing. Consequently, it reasons, there was no final determination as to the merits. 145 Or App at 122. Stipulated settlement agreements are recognized by the Workers' Compensation Board as an award of compensation, *see Cindy A. Cawrse-Schrader*, 1192 WL 1865 (1992) (stipulated settlement order is an award of compensation in a case involving the claimant's aggravation rights), and become part of the official record of a case. *See Aletha R. Samperi*, 44 Van Natta 1173-74 (1992) (determination order and stipulated settlement award are part of the record of the case). It is not surprising that one facet of a stipulated settlement order is to dismiss a request for a hearing, because one consequence of such an agreement is to remove a case from **<145 Or App 117/118>** the Hearings Division's docket. The dissent errs in concluding that employer's agreement to dismiss her request for a hearing is the only effect of the Stipulated Settlement Order.

We conclude that the Board's determination that "the stipulation does not address the merits of this case" is contrary to both ORS 656.289(1), which allows matters concerning a claim to be determined before or after hearing, and to OAR 438-09-005(4), which provides that an ALJ's order approving a settlement stipulation is a determination of all matters.[5] Consequently, the Board also erred in affirming the ALJ's denial of claimant's request for an attorney fee under ORS 656.382(2). *See Shoulders v. SAIF*, 300 Or 606, 610, 716 P2d 751 (1986) (because compensation necessarily follows from a finding of compensability, ORS 656.382(2) provides the basis for an attorney fee); *see also Curry*, 297 Or at 507 (one purpose of ORS 656.382(2) is to discourage employers or insurers from "wearing down claimants with harassing and frivolous appeals" and the employer or insurer does not win a reduction or elimination of the claimant's award).

Reversed and remanded.

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[4] In addition, the dissent points to two cases not cited by SAIF: *Terlouw v. Jesuit Seminary*, 101 Or App 493, 790 P2d 1215, *rev den* 310 Or 282 (1990); and *Liberty Northwest Ins. Corp. v. McKellips*, 100 Or App 549, 786 P2d 1321 (1990). Neither of those cases involved stipulated settlement agreements and each is likewise inapposite.

[5] Nothing in ORS 656.289(1) or the relevant rules suggests that the legislature or the Board intended to pit an attorney's interest against the client's in the process of defending a claimant's entitlement to compensation, However, that is the effect of the dissent's analysis. Under its rule, an attorney who agreed to enter into a stipulated settlement agreement that preserved the client's compensation award would lose an attorney fee. In order to be entitled to a fee under OPS 656.382(2), the attorney would have to refuse the ALJ's offer to settle and proceed with the hearing, thereby risking the possibility that the ALJ will reduce or disallow the client's award of compensation. Such a conflict would undermine settlements, which both the legislature in ORS 656.289(1) and the Board in OAR 438-09-001(3) and OAR 438-09-005(4) have sought to facilitate.

LANDAU, J., dissenting.

ORS 656.382(2) provides that attorney fees may be awarded to a claimant when an employer initiates a request for review "and the Administrative Law Judge, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced." The Supreme Court has construed the statute to apply only when review of the matter actually is exercised and there is a decision on the merits that the award of compensation should not be disallowed or reduced. We similarly have held that the statute requires a **<145 Or App 118/119>** finding on the merits as a predicate to recovery of attorney fees. That did not happen in this case, in which the employer merely withdrew her appeal and stipulated to her responsibility. The majority nevertheless holds that such a stipulation, and the acceptance of it by an ALJ, constitutes the required "finding" that compensation should not be disallowed or reversed and, on the basis of such an approved settlement, awards claimant attorney fees in this case. I disagree.

Claimant's entitlement to fees turns on the meaning of the statutory phrase, "and the Administrative Law Judge, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced." To determine the meaning of that phrase, we examine its language, in context, and, if necessary, legislative history and other aids to statutory construction. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). Also relevant to the task are prior judicial decisions concerning the meaning of the statute and related provisions. *State v. Sullens*, 314 Or 436, 443, 839 P2d 708 (1992).

We begin with the language of the statute and, in particular, its requirement that the "Administrative Law Judge, board or court find" that compensation should not be reduced. Ordinarily, the word "find" or "finding" refers to a judicial or quasi-judicial determination on the merits after hearing the relevant evidence and arguments on a matter. *See, e.g., Webster's Third New Int'l Dictionary* 852 (1976) ("to determine a case judicially or quasi-judicially by a verdict or decision"); *Black's Law Dictionary* 569 (5th ed 1979) ("A decision upon a question of fact reached as the result of a judicial examination or investigation by a court, jury, referee, coroner, etc."); *The Random House College Dictionary* 494 (1973) ("to determine after judicial inquiry to pronounce as an official act").

Examination of the relevant case law construing ORS 656.382(2) reveals that the Oregon courts uniformly have held that the legislature intended the statutory reference to the "find [ing] " of an ALJ, board or court to mean what it ordinarily means in common parlance. In *SAIF v. Curry*, 297 Or 504, 686 P2d 363 (1984), the Supreme Court held **<145 Or App 119/120>** that, when that court denies review of a workers'compensation decision awarding compensation, the denial of review does not constitute a "find[ing]" within the meaning of the statue. The court held that the legislature intended ORS 656.382(2) to apply

> " 'only when this court actually allows an employer's petition for review and decides that theretofore awarded compensation should not be disallowed or reduced.' "

Id. at 510.

Similarly, in *Agripac, Inc. v. Kitchel*, 73 Or App 132, 698 P2d 69 (1985), we held that, when an employer's petition for judicial review is dismissed on the claimant's motion, the claimant is not entitled to an award of attorney fees, because there has been no finding on the merits as to compensation. *Id.* at 135. We followed that decision in *Terlouw v. Jesuit Seminary*, 101 Or App 493, 790 P2d 1215, *rev den* 310 Or 282 (1990), in which the employer voluntarily dismissed its own petition for Board review. We held that, without "a decision on the merits," there is "no authority to award attorney fees under ORS 656.382(2)." *Id.* at 494. To the same effect is our decision in *Liberty Northwest Ins. Corp. v. McKellips*, 100 Or App 549, 550, 786 P2d 1321 (1990), in which the employer withdrew its request for Board review. We held that claimant was not entitled to an award of attorney fees under ORS 656.382(2), because "the Board did not make the finding that the statute requires to support an award of fees."

In this case, employer voluntarily withdrew its request for a hearing by an ALJ. The ALJ did not have occasion to decide whether, on the evidence in the record, employer's position was well taken. There was no "finding" on the merits, therefore, and claimant was not entitled to attorney fees any more than the claimants were in *Curry*, *Kitchel*, *Terlouw* and *McKellips*.

The majority concludes that, in this case, there actually was a "finding" on the merits as to compensability, based on the fact that the ALJ "approved" a stipulated dismissal of the proceeding. The majority does not explain how approving a stipulation to withdraw a request for a hearing constitutes **<145 Or App 120/121>** a "finding" on the merits as that term is commonly understood and has been construed in the foregoing cases.[1] Instead, the majority takes a more indirect route. It begins with OAR 438-09-005(4), which provides that approval of a settlement stipulation "is a determination of all matters included within the terms" of the stipulation. The majority then reasons that, because approval of the stipulation

> " 'determines the matter,' it is the equivalent of an order the ALJ would have issued at the conclusion of the hearing and is a decision on the merits."

145 Or App at 116. I remain unpersuaded.

To begin with, OAR 438-09-005(4) provides that, *"[f]or purposes of ORS 656.289(1)-(3),"* a referee's approval of a settlement stipulation is a final determination of the matter. ORS 656.289(1) through (3) provide:

> "(1) Upon the conclusion of any hearing, or prior thereto with concurrence of the parties, the Administrative Law Judge shall promptly and not later than 30 days after the hearing determine the matter and make an order in accordance with the Administrative Law Judge's determination.
>
> "(2) A copy of the order shall be sent forthwith by mail to the Director of the Department of Consumer and Business Services and to all parties in interest.
>
> "(3) The order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests a review by the Workers' Compensation Board under ORS 656.295. When one party requests a review by the board, the other party or parties shall have the remainder of the 30-day period and in no case less than 10 days in which to request board review in the same manner. The 10-day requirement may carry the period of time allowed for requests for board reviews beyond the 30th day. The order shall contain a statement **<145 Or App 121/122>** explaining the rights of the parties under this subsection and ORS 656.295."

Those provisions clearly describe the effect of the ALJ's decision and the process by which review of it may be sought. It is for that purpose that approval of a settlement stipulation is a "determination of all matters," *viz.*: with the approval of the settlement, the dispute is concluded. Neither the text of OAR 438-09-005(4) itself nor the statutory context to which it explicitly refers suggests that the "determination" involves "findings" on the merits as to any issue.

To the contrary, approval of a settlement or stipulation by an ALJ, the Board or the courts generally involves no more than a determination that the disposition is "reasonable." ORS 656.236(1)(a), for example, provides that the parties to a claim "may make such disposition of any or all matters regarding a claim," except for medical services, and that the proposed disposition shall be approved as long as it is not "unreasonable as a matter of law" or was not procured by "intentional misrepresentation of material fact." Similarly, ORS 656.289(4)(a) provides that, when there is a dispute over compensability, the parties may, with the approval of the ALJ, the Board or the court, "by agreement make such disposition of the claim as is considered reasonable." The majority cites no rule or statute that calls for a different level of review of the stipulation in this case. In my view, merely reviewing for reasonableness is not "the equivalent of an order the ALJ would have issued at the conclusion of the hearing," 145 Or App at 116, nor does it in any way suggest what the ALJ in this case would have found had he decided the issues before him on the evidence presented.

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[1] The majority declares that *Curry, Kitchel, Terlouw* and *McKellups* are "inapposite," because they did not involve stipulated settlement orders. The asserted distinction, however, is beside the point, which is that the courts defined in those cases the sort of "findings" that are required to trigger an award of attorney fees under ORS 656.382(2) and did so in a manner that cannot be squared with the majority's holding in this case.

The majority insists that the approval of the stipulated settlement is sufficient, because Board decisions reveal that the Board itself considers the approval of such stipulations as having the effect of ending the dispute. 145 Or App at 117. That the Board considers settled claims to be at an end comes as no surprise; that is precisely what ORS 656.289(3) says. It simply does not follow, however, that merely because a stipulation terminates a controversy and results in an award of compensation it also constitutes a "finding" on the merits as to any issue.

145 Or App 123> Aside from that, the rule itself does not support the majority's conclusion in this case. OAR 438-09-005(4) provides that the approval of a stipulated settlement is a final determination only as to "matters included within the terms of the settlement stipulation." In this case, the only "matter" that was the subject to the stipulation was that employer withdrew her request for a hearing and, as a consequence of the withdrawal, chose not to contest SAIF's acceptance of the claim. At oral argument, counsel for claimant conceded that the language in the settlement stipulation accepting responsibility did no more than state the legal effect of withdrawing the request for a hearing. There was, in other words, no final determination on the merits as to any disputed matter, even assuming the rule has the effect the majority proposes.

In my view, there has been no "finding" within the meaning of ORS 656.382(2) that the compensation awarded to claimant should not be disallowed or reduced. There is, therefore, no basis for awarding claimant attorney fees under that statute, and from the majority's contrary conclusion I respectfully dissent.

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